Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: FRESNO UNIFIED SCHOOL DISTRICT
Type of Product Line: PPO
Effective Date: Beginning on or after 01/01/24.

Name of Product: Delta Dental PPO/Premier Incentive
Plan Phone #: 866-499-3001
Plan Website: deltadentalins.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE DELTADENTALINS.COM OR CALL 866-499-3001.
THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	PPO - None Premier - None	None
Orthodontia	PPO - None Premier - None	None

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	PPO - $2500 Premier - $2500	$1500
Lifetime Maximum for Orthodontia	PPO - $2000 Premier - $2000	$2000

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package does not contain waiting periods.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive and Diagnostic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Benefit is limited to two of any oral evaluation procedure within a calendar year. • Refer to your Evidence of Coverage for the full limitations and exclusions.
Bitewing X-ray	Preventive and Diagnostic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Benefit is limited to two of any bitewing x-ray procedure within a calendar year.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				• Refer to the Evidence of Coverage for full limitations and exclusions.
Cleaning	Preventive and Diagnostic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Benefit is limited to two of any prophylaxis procedures within a calendar year. • Refer to Evidence of Coverage for full limitations and exclusions.
Filling	Basic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Benefit is limited to once per surface, per tooth within a 24 month period. • Refer to Evidence of Coverage for full limitations and exclusions.
Extraction, Erupted Tooth or Exposed Root	Basic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Once per lifetime. • Refer to Evidence of Coverage for full limitations and exclusions.
Root Canal	Major	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Once per 12 months. • Refer to Evidence of Coverage for full limitations and exclusions.
Scaling and Root Planing	Basic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• Scaling and root planing in the same quadrant are limited to once every 24 months. • Refer to Evidence of Coverage for full limitations and exclusions.
Ceramic Crown	Major	PPO - 30%-0% Premier - 30%-0%	30%-0%	• One in 60 months. • Refer to Evidence of Coverage for full limitations and exclusions.
Removable Partial Denture	Major	PPO - 50% Premier - 50%	50%	• One in 60 months. • Refer to Evidence of Coverage for full limitations and exclusions.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Extraction, Erupted Tooth with Bone Removal	Basic	PPO - 30%-0% Premier - 30%-0%	30%-0%	• One in a lifetime. • Refer to Evidence of Coverage for full limitations and exclusions.
Orthodontia	Orthodontia	PPO - 50% Premier - 50%	50%	• Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered. • Refer to the Evidence of Coverage for full limitations and exclusions.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (Full-mouth x-ray) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: **$400** Out-of-network: **$550**	Total Cost of Care	In-network: **$150** Out-of-network: **$200**	Total Cost of Care	In-network: **$1,300** Out-of-network: **$1,750**
Deductible	In-network: PPO - **$0** Premier - **$0** Out-of-network: **$0**	Deductible	In-network: PPO - **$0** Premier - **$0** Out-of-network: **$0**	Deductible	In-network: PPO - **$0** Premier - **$0** Out-of-network: **$0**
Annual Maximum (Plan Will Pay)	In-network: PPO - **$2500** Premier - **$2500** Out-of-network: **$1500**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$2500** Premier - **$2500** Out-of-network: **$1500**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$2500** Premier - **$2500** Out-of-network: **$1500**

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: PPO – **30% - 0%** Premier - **30% - 0%** Out-of-network: **30% - 0%**	Patient Cost (copayment or coinsurance)	In-network: PPO – **30% - 0%** Premier - **30% - 0%** Out-of-network: **30% - 0%**	Patient Cost (copayment or coinsurance)	In-network: PPO – **30% - 0%** Premier - **30% - 0%** Out-of-network: **30% - 0%**
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: PPO - $120 - $0 Premier - $120 - $0 Out-of-network: $165 - $0**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $45 - $0 Premier - $45 - $0 Out-of-network: $60 - $0**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $390 - $0 Premier - $390 - $0 Out-of-network: $525 - $0**
Summary of what is not covered or subject to a limitation:	Exam: Benefit is limited to two of any oral evaluation procedure within a calendar year X-Rays (FMX): Benefit is limited to once every 36 months. Cleaning: Benefit is limited to two of any prophylaxis procedures within a calendar year.	Summary of what is not covered or subject to a limitation:	Benefit is limited to once per surface, per tooth within a 24 month period	Summary of what is not covered or subject to a limitation:	Benefit is limited to once per tooth within a 5 year period