Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: San Juaquin Valley Employee Retiree
Type of Product Line: TOA (DPPO)
Effective Date: 07/01/2025

Name of Product: Delta Dental Table of Allowance
Plan Phone #: 888-335-8227
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** 888-335-8227**.**

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	PPO $50 per individual $150 per family Premier $50 per individual $150 per family	$50 per individual $150 per family
Orthodontia	Not Covered	Not Covered

- The deductible applies to all services except Diagnostic and Preventive.
- 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 $1,000 Premier $1,000	$1,000
Lifetime Maximum or Annual Maximum for Orthodontia	Not Covered	Not Covered

- **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. There are no 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 & Diagnostic	The Dentist's Submitted Fee for the service less the Allowance of $38	The Dentist's Submitted Fee for the service less the Allowance of $38	Two per Calendar Year.
Bitewing X-ray	Preventive & Diagnostic	The Dentist's Submitted Fee for the service less the Allowance of $16	[The Dentist's Submitted Fee for the service less the Allowance of $16	Two per Calendar Year.
Cleaning	Preventive & Diagnostic	The Dentist's Submitted Fee for the service less the Allowance of $48	The Dentist's Submitted Fee for the service less the Allowance of $48	Two per Calendar Year.
Filling	Basic	The Dentist's Submitted Fee for the service less the Allowance of $84	The Dentist's Submitted Fee for the service less the Allowance of $84	Replacement of an amalgam or composite fillings are not covered within 24 months of treatment if the service is provided by the same Dentist.
Extraction, Erupted Tooth or Exposed Root	Basic	The Dentist's Submitted Fee for the	The Dentist's Submitted Fee for the	One per lifetime.

		service less the Allowance of $75	service less the Allowance of $75	
Root Canal	Basic	The Dentist's Submitted Fee for the service less the Allowance of $511	The Dentist's Submitted Fee for the service less the Allowance of $511	One per 12 month period.
Scaling and Root Planning	Basic	The Dentist's Submitted Fee for the service less the Allowance of $114	The Dentist's Submitted Fee for the service less the Allowance of $114	Scaling and root planning in the same quadrant are limited to [once] every 24 months.
Ceramic Crown	Major	The Dentist's Submitted Fee for the service less the Allowance of $523	The Dentist's Submitted Fee for the service less the Allowance of $523	One in 60 months.

Removable Partial Denture	Major	The Dentist's Submitted Fee for the service less the Allowance of $810	The Dentist's Submitted Fee for the service less the Allowance of $810	One in 60 months.
Extraction,Erupted Tooth with Bone Removal	Basic	The Dentist's Submitted Fee for the service less the Allowance of $222	The Dentist's Submitted Fee for the service less the Allowance of $222	One per lifetime.
Orthodontia	Orthodontia	Not Covered	Not Covered	

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: None Out-of-network: None	Deductible	In-network: PPO $50 Premier $50 Out-of-network: $50	Deductible	In-network: PPO $50 Premier $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: PPO $1,000 Premier $1,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: PPO $1,000 Premier $1,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: PPO $1,000 Premier $1,000 Out-of-network: $1,000

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: The Dentist's Submitted Fee for the service less the Allowance of $150 Out-of-network: The Dentist's Submitted Fee for the service less the Allowance of $150.	Patient Cost (copayment or coinsurance)	In-network: The Dentist's Submitted Fee for the service less the Allowance of $88 Out-of-network: The Dentist's Submitted Fee for the service less the Allowance of $88.	Patient Cost (copayment or coinsurance)	In-network: The Dentist's Submitted Fee for the service less the Allowance of $523 Out-of-network: The Dentist's Submitted Fee for the service less the Allowance of $523.
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** PPO $250 Premier $250 **Out-of-network:** $400	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network**: PPO $112 Premier $112 **Out-of-network:** $162	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** PPO $827 Premier $827 **Out-of-network:** $1,277
Summary of what is not covered or subject to a limitation:	Oral exams are limited to two per Calendar Year. Cleanings are limited to two per Calendar Year. Benefits are limited to either one 1 comprehensive intraoral series or one 1 panoramic image once every 60 months.	Summary of what is not covered or subject to a limitation:	Replacement of an amalgam or composite fillings are not covered within 24 months of treatment if the service is provided by the same Dentist.	Summary of what is not covered or subject to a limitation:	Crowns are limited to one in 60 months.