Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: DeltaCare® USA – CAA54
Type of Product Line: DHMO
Effective Date: Beginning on or after 01/01/25
Name of Product: DeltaCare USA
Plan Phone #: 888-282-9501
Plan Website: deltadentalins.com/individuals

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/individuals OR CALL 888-282-9501.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable
Orthodontia	None	Not Applicable

- **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	None	**Not Applicable**
Lifetime or Annual Maximum for Orthodontia	None	Not Applicable

- **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 has 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	$0	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Cleaning	Preventive & Diagnostic	$5	Not Covered	• 1 per 6 months • Refer to the Disclosure Form for the full limitation and exclusion

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Filling	Basic	$35	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Basic	$40	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Root Canal	Basic	$340	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Scaling and Root Planing	Basic	$50	Not Covered	• Up to 4 quadrants during any 12 consecutive months • Refer to the Disclosure Form for the full limitation and exclusion
Ceramic Crown	Major	$375	Not Covered	• Replacement of crowns requires the existing restoration to be 5+ years old • Refer to the Disclosure Form for the full limitation and exclusion
Removable Partial Denture	Major	$565	Not Covered	• Replacement of a partial denture requires the existing denture to be 5+ years old. • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth with Bone Removal	Basic	$70	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion

Orthodontia	Orthodontia	$1,400 - $2,800	Not Covered	• The Copayment for orthodontic treatment covers up to 25 months of active treatment. Beyond 25 months, an additional monthly fee, not to exceed $125, may apply. • Refer to the Disclosure Form for the full limitation and exclusion

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: Not Covered	Deductible	In-network: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: **Not Covered**	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: **Not Covered**	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: **Not Covered**

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: $5 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $35 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $375 Out-of-network: Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $10 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $40 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $380 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	• X-rays: limited to 1 series every 25 months • Cleaning: 1 per 6 months	Summary of what is not covered or subject to a limitation:	No limitations	Summary of what is not covered or subject to a limitation:	• Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old