Summary of Dental Benefits and Coverage Disclosure Matrix(SDBC)

Part I: GENERAL INFORMATION

Insurer Name: AARP Dental Insurance Plan
Type of Product Line: DPPO
Effective Date: 1/1/2025

Plan Name: Protect Propel
Insurer Phone #:866-261-4275
Insurer Website: deltadentalins.com/aarp

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 insurer website deltadentalins.com/aarp or call 866-261-4275.

This matrix is not a guarantee of expenses or payment.

Part II: DEDUCTIBLES

Deductible	All Providers
Dental	$75 per individual
Orthodontia	Year 1: Not Applicable; Year 2: Not Applicable; After Year 2: $50 per individual

- The deductible applies to all services except Diagnostic and Preventive services.
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer 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 insurer for alternative rates of payment for 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 insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	All Providers
Annual Maximum	Year 1: $1,000 per Individual; Year 2: $1,250 per Individual; Year 3: $1,500 per Individual; Year 4+: $1,750 per Individual
Lifetime or Annual Maximum for Orthodontia	Year 1: Not Applicable; Year 2: Not Applicable; After Year 2: $1,500 lifetime maximum per Individual

- **Annual maximum** is the maximum dollar amount your policy 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 policy 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	All Providers	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	0% Deductible does not apply	• 2 per calendar year; 1 per lifetime per dentist/dental office • Refer to Certificate of Coverage document for the full limitation and exclusion
Bitewing X-ray	Preventive & Diagnostic	0% Deductible does not apply	• 2 per calendar year, to age 18; 1 per calendar, age 18+ • Refer to Certificate of Coverage document for the full limitation and exclusion
Cleaning	Preventive & Diagnostic	0% Deductible does not apply	• 2 per calendar year • Refer to Certificate of Coverage document for the full limitation and exclusion

Common Dental Procedures	Category	All Providers	Benefit Limitations and Exclusions
Filling	Basic	Year 1: 60%; Year 2: 50%; Year 3: 50%; Year 4+: 40%	• Not billable to Delta or individual within 24-months to same dentist/dental office that performed original restoration on same surface • Refer to Certificate of Coverage document for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Major	Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%	• 1 per lifetime • Refer to Certificate of Coverage document for the full limitation and exclusion
Root Canal	Major	Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%	• 1 per lifetime • Refer to Certificate of Coverage document for the full limitation and exclusion

Scaling and Root Planing	Major	Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%	• 1 per 24 months • Refer to Certificate of Coverage document for the full limitation and exclusion
Ceramic Crown	Major	Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%	• 1 per 60 months, age 12 and over • Refer to Certificate of Coverage document for the full limitation and exclusion
Removable Partial Denture	Major	Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%	• 1 per 60 months; age 16 and over • Refer to Certificate of Coverage document for the full limitation and exclusion
Extraction, Erupted Tooth with Bone Removal	Major	Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%	• 1 per lifetime • Refer to Certificate of Coverage document for the full limitation and exclusion

Orthodontia	Orthodontia	Year 1: Not Covered Year 2: Not Covered Year 3: 50%; Year 4+: 50%	• Refer to Certificate of Coverage document 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.

	Example 1	Example 2	Example 3
Activity	**Dana Has a Dental Appointment with a New Dentist**	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
Procedure	New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

	Example 1	Example 2	Example 3
Total Cost	In-network: $400 Out-of-network: $550	In-network: $150 Out-of-network: $200	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: $0 Out-of-network: $0	In-network: $75 Out-of-network: $75	In-network: $75 Out-of-network: $75
Annual Maximum (Plan Will Pay)	In-network: Year 1: $1,000; Year 2: $1,250; Year 3: $1,500; Year 4+: $1,750 Out-of-network: Year 1: $1,000; Year 2: $1,250; Year 3:	In-network: Year 1: $1,000; Year 2: $1,250; Year 3: $1,500; Year 4+: $1,750 Out-of-network: Year 1: $1,000; Year 2: $1,250; Year 3:	In-network: Year 1: $1,000; Year 2: $1,250; Year 3: $1,500; Year 4+: $1,750 Out-of-network: Year 1: $1,000; Year 2: $1,250; Year 3:

	Example 1	Example 2	Example 3
	$1,500; Year 4+: $1,750	$1,500; Year 4+: $1,750	$1,500; Year 4+: $1,750
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: $0	In-network: Year 1: 60%; Year 2: 50%; Year 3: 50%; Year 4+: 40% Out-of-network: Year 1: 60%; Year 2: 50%; Year 3: 50%; Year 4+: 40%	In-network: Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50% Out-of-network: Year 1: 90%; Year 2: 75%; Year 3: 60%; Year 4+: 50%

	Example 1	Example 2	Example 3
Patient would pay (includes copays/coinsurance and deductible, if applicable):	Dana would pay (includes copays/coinsurance and deductible, if applicable): In-network: $0 Out-of-network: $0	Sam would pay (includes copays/coinsurance and deductible, if applicable): In-network: Year 1: $120; Year 2: $112.5; Year 3: $112.5; Year 4+: $105 Out-of-network: Year 1: $150; Year 2: $137.50; Year 3: $137.50; Year 4+: $125	**Maria would pay** (includes copays/coinsurance and deductible, if applicable): In-network: Year 1: $1177.50; Year 2: $993.75; Year 3: $810; Year 4+: $687.50 Out-of-network: Year 1: $1582.50; Year 2: $1331.25; Year 3: $1080; Year 4+: $912.50

	Example 1	Example 2	Example 3
Summary of what is not covered or subject to a limitation	Oral examinations: allowed twice per calendar year. Cleanings: (regular and periodontal) are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider's office.	Replacement of a resin-based composite restoration is covered within 24 months of treatment if the service is provided by the same Provider. Replacement restorations within 24 months are included in the fee for the original restoration.	Limited to 1 per 60 months, age 12+.