

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: CAM85-City of San Jose
Type of Product Line: DHMO
Effective Date: Beginning on or after 1/1/2026

Name of Product: Delta Dental DHMO
Plan Phone #: 800-422-4234
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 800-422-4234. THIS MATRIX

IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	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 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 period.**

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
<i>Oral Exam</i>	Preventative & Diagnostic	\$0	Not covered	- No limitations or exclusions
<i>Bitewing X-ray</i>	Preventative & Diagnostic	\$0	Not covered	- No limitations or exclusions

<i>Cleaning</i>	Preventative & Diagnostic	\$0	Not covered	- 1 per 6 month period
<i>Filling</i>	Basic	\$0	Not covered	- No limitations or exclusions
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	\$0	Not covered	- No limitations or exclusions
<i>Root Canal</i>	Basic	\$0	Not covered	- No limitations or exclusions
<i>Scaling and Root Planing</i>	Basic	\$0	Not covered	- Limited to 4 quadrants during any 12 consecutive months
<i>Ceramic Crown</i>	Major	\$175	Not covered	- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old. - Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150.
<i>Removable Partial Denture</i>	Major	\$0	Not covered	- Replacement of a partial denture requires the existing denture to be 5+ years old. - Includes after delivery adjustments and tissue conditioning, if needed, for the first six (6) months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for three (3) months following installation.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	\$0	Not covered	- No limitations or exclusions

<i>Orthodontia</i>	Orthodontia	\$1,000	Not covered	<ul style="list-style-type: none">- Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19.- Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of \$75.00 applies
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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: \$15 Out-of-network: Not covered	Patient Cost (copayment or coinsurance)	In-network: \$75 Out-of-network: Not covered	Patient Cost (copayment or coinsurance)	In-network: \$300 Out-of-network: Not covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$15 Out-of-network: \$550	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$25 Out-of-network: \$200	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):	In-network: \$300 Out-of-network: \$1,750
Summary of what is not covered or subject to a limitation:	Exam: - No limitations or exclusions X-rays (FMX): Full mouth x-ray is limited to 1 series every 36 months. Cleaning: Cleanings are limited to 1 per 6 month period Must be performed by a general dentist.	Summary of what is not covered or subject to a limitation:	- An amalgam is the Benefit. - Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions of the Plan. The applicable charge is the	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. - Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$75.

			<p>difference between the Contract Dentist's "submitted fee" for the Optional procedure and the "submitted fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits.</p>		
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