Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: San Francisco Health Service System
Type of Product Line: DPPO
Effective Date: Beginning on or after 01/01/26

Name of Product: Delta Dental PPO Plus Premier
Plan Phone #: 888-335-8227
Plan Website: deltadentalins.com/ccsf

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/CCSF 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 - None Premier - Individual = $50 Family = $100	Individual = $50 Family = $100
Orthodontia	Not Covered	Not Covered

- **The deductible applies to all services except Diagnostic & Preventive services for Premier dentists, and for Out-of-Network dentists.**
- 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 - $1250 Premier - $1250	$1250
Lifetime 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. **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 - 0% Premier - 0%	20%	• Limited to two per calendar year.
Bitewing X-ray	Preventive and Diagnostic	PPO - 0% Premier - 0%	20%	• Refer to evidence of coverage.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Cleaning	Preventive and Diagnostic	PPO - 0% Premier - 0%	20%	• Limited to two per calendar year.
Filling	Basic	PPO - 20% Premier - 20%	20%	• Limited to one within a 24-month period.
Extraction, Erupted Tooth or Exposed Root	Basic	PPO - 20% Premier - 20%	20%	• Limited benefit once per tooth per lifetime.
Root Canal	Major	PPO - 40% Premier - 50%	50%	• Limited to once per tooth per 12 month period.
Scaling and Root Planing	Basic	PPO - 20% Premier - 20%	20%	• Scaling and root planing in the same quadrant are limited to once every 24 months.
Ceramic Crown	Major	PPO - 40% Premier - 50%	50%	• Limited to one in 60 months.
Removable Partial Denture	Major	PPO - 40% Premier - 50%	50%	• Limited to one in 60 months.
Extraction, Erupted Tooth with Bone Removal	Major	PPO - 20% Premier - 20%	20%	• Limited benefit once per tooth 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: PPO - **$0** Premier - **$0** Out-of-network: **$0**	Deductible	In-network: PPO - **$0** Premier - **$50** Out-of-network: **$50**	Deductible	In-network: PPO - **$0** Premier - **$50** Out-of-network: **$50**
Annual Maximum (Plan Will Pay)	In-network: PPO - **$1250** Premier - **$1250** Out-of-network: **$1250**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$1250** Premier - **$1250** Out-of-network: **$1250**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$1250** Premier - **$1250** Out-of-network: **$1250**

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 - **0%** Premier - **0%** Out-of-network: **20%**	Patient Cost (copayment or coinsurance)	In-network: PPO - **20%** Premier - **20%** Out-of-network: **20%**	Patient Cost (copayment or coinsurance)	In-network: PPO - **40%** Premier - **50%** Out-of-network: **50%**
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: PPO - $0 Premier - $0 Out-of-network: $110**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $30 Premier - $70 Out-of-network: $80**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $520 Premier - $675 Out-of-network: $900**
Summary of what is not covered or subject to a limitation:	**Exam:** Oral exams are limited to two per calendar year. **Full Mouth:** Limited to one full mouth series of intra-oral films within a 5 year period. **Cleanings:** Limited to two per 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 one crown procedure per tooth within a 60 month period.