

## Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

### Part I: GENERAL INFORMATION

**Plan Name:** NantWorks, LLC – 23117 High Plan

**Type of Product Line:** DPPO

**Effective Date:** 01/01/25

**Name of Product:** Delta Dental PPO

**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 - Individual = \$25<br>Family = \$75<br>Premier - Individual = \$25<br>Family = \$75 | Individual = \$25<br>Family = \$75 |
| Orthodontia | PPO - None<br>Premier - None                                                             | None                               |

- **The deductible applies to all services except Diagnostic, Preventive & Orthodontic services for all 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**

| <b>Maximums</b>                            | <b>In-Network</b>                                  | <b>Out-of-Network</b> |
|--------------------------------------------|----------------------------------------------------|-----------------------|
| Annual Maximum                             | PPO - \$5000<br>Premier - \$5000                   | \$5000                |
| Lifetime or Annual Maximum for Orthodontia | PPO - \$2000 Lifetime<br>Premier - \$2000 Lifetime | \$2000 Lifetime       |

- **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.**

| <b>Common Dental Procedures</b> | <b>Category</b>           | <b>In-Network</b>        | <b>Out-of-Network</b> | <b>Benefit Limitations and Exclusions</b>                                                                          |
|---------------------------------|---------------------------|--------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------|
| <i>Oral Exam</i>                | Preventive and Diagnostic | PPO - 0%<br>Premier - 0% | 0%                    | <ul style="list-style-type: none"><li>• Two per plan year.</li></ul>                                               |
| <i>Bitewing X-ray</i>           | Preventive and Diagnostic | PPO - 0%<br>Premier - 0% | 0%                    | <ul style="list-style-type: none"><li>• Two per plan year to age 18; One per plan year, age 18 and over.</li></ul> |

| <b>Common Dental Procedures</b>                    | <b>Category</b>           | <b>In-Network</b>          | <b>Out-of-Network</b> | <b>Benefit Limitations and Exclusions</b>                                                                                                                                                                           |
|----------------------------------------------------|---------------------------|----------------------------|-----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Cleaning</i>                                    | Preventive and Diagnostic | PPO - 0%<br>Premier - 0%   | 0%                    | <ul style="list-style-type: none"> <li>Two per plan year.</li> </ul>                                                                                                                                                |
| <i>Filling</i>                                     | Basic                     | PPO - 20%<br>Premier - 20% | 20%                   | <ul style="list-style-type: none"> <li>Replacement of an amalgam or composite fillings are not covered within 24 months of treatment if the service is provided by the same dentist.</li> </ul>                     |
| <i>Extraction, Erupted Tooth or Exposed Root</i>   | Basic                     | PPO - 20%<br>Premier - 20% | 20%                   | <ul style="list-style-type: none"> <li>Once per lifetime.</li> </ul>                                                                                                                                                |
| <i>Root Canal</i>                                  | Major                     | PPO - 20%<br>Premier - 20% | 20%                   | <ul style="list-style-type: none"> <li>Once per lifetime.</li> </ul>                                                                                                                                                |
| <i>Scaling and Root Planing</i>                    | Basic                     | PPO - 20%<br>Premier - 20% | 20%                   | <ul style="list-style-type: none"> <li>Scaling and root planing in the same quadrant are limited to once every 24 months.</li> </ul>                                                                                |
| <i>Ceramic Crown</i>                               | Major                     | PPO - 50%<br>Premier - 50% | 50%                   | <ul style="list-style-type: none"> <li>One in 60 months.</li> </ul>                                                                                                                                                 |
| <i>Removable Partial Denture</i>                   | Major                     | PPO - 50%<br>Premier - 50% | 50%                   | <ul style="list-style-type: none"> <li>One in 60 months.</li> </ul>                                                                                                                                                 |
| <i>Extraction, Erupted Tooth with Bone Removal</i> | Major                     | PPO - 50%<br>Premier - 50% | 50%                   | <ul style="list-style-type: none"> <li>One in a lifetime.</li> </ul>                                                                                                                                                |
| <i>Orthodontia</i>                                 | Orthodontia               | PPO - 50%<br>Premier - 50% | 50%                   | <ul style="list-style-type: none"> <li>Orthodontic treatment must be provided by a licensed dentist.</li> <li>Benefits for Orthodontic Services are covered for adults and dependent children to age 26.</li> </ul> |

## 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.

| <b>Dana Has a Dental Appointment with a New Dentist</b>  | <b>Sam Needs a Tooth Filled</b>                | <b>Maria Needs a Crown</b>          |
|----------------------------------------------------------|------------------------------------------------|-------------------------------------|
| New patient exam, x-rays (Full-mouth x-ray) and cleaning | Resin-based composite – one surface, posterior | Crown – porcelain/ceramic substrate |

| <b>Dana's Visit</b>            | <b>Dana's Cost</b>                                                                                    | <b>Sam's Visit</b>             | <b>Sam's Cost</b>                                                                                     | <b>Maria's Visit</b>           | <b>Maria's Cost</b>                                                                                   |
|--------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------|
| Total Cost of Care             | In-network:<br><b>\$400</b><br>Out-of-network:<br><b>\$550</b>                                        | Total Cost of Care             | In-network: <b>\$150</b><br>Out-of-network:<br><b>\$200</b>                                           | Total Cost of Care             | In-network:<br><b>\$1,300</b><br>Out-of-network:<br><b>\$1,750</b>                                    |
| Deductible                     | In-network:<br>PPO - <b>\$0</b><br>Premier - <b>\$0</b><br><br>Out-of-network:<br><b>\$0</b>          | Deductible                     | In-network:<br>PPO - <b>\$25</b><br>Premier - <b>\$25</b><br><br>Out-of-network:<br><b>\$25</b>       | Deductible                     | In-network:<br>PPO - <b>\$25</b><br>Premier - <b>\$25</b><br><br>Out-of-network:<br><b>\$25</b>       |
| Annual Maximum (Plan Will Pay) | In-network:<br>PPO - <b>\$5000</b><br>Premier - <b>\$5000</b><br><br>Out-of-network:<br><b>\$5000</b> | Annual Maximum (Plan Will Pay) | In-network:<br>PPO - <b>\$5000</b><br>Premier - <b>\$5000</b><br><br>Out-of-network:<br><b>\$5000</b> | Annual Maximum (Plan Will Pay) | In-network:<br>PPO - <b>\$5000</b><br>Premier - <b>\$5000</b><br><br>Out-of-network:<br><b>\$5000</b> |

| <b>Dana's Visit</b>                                                                                 | <b>Dana's Cost</b>                                                                                                                                                                                                            | <b>Sam's Visit</b>                                                                                 | <b>Sam's Cost</b>                                                                                                                            | <b>Maria's Visit</b>                                                                                 | <b>Maria's Cost</b>                                                                          |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
|                                                                                                     |                                                                                                                                                                                                                               |                                                                                                    |                                                                                                                                              |                                                                                                      |                                                                                              |
| Patient Cost<br>(copayment or coinsurance)                                                          | In-network:<br>PPO - <b>0%</b><br>Premier - <b>0%</b><br><br>Out-of-network:<br><b>0%</b>                                                                                                                                     | Patient Cost<br>(copayment or coinsurance)                                                         | In-network:<br>PPO - <b>20%</b><br>Premier - <b>20%</b><br><br>Out-of-network:<br><b>20%</b>                                                 | Patient Cost<br>(copayment or coinsurance)                                                           | In-network:<br>PPO - <b>50%</b><br>Premier - <b>50%</b><br><br>Out-of-network:<br><b>50%</b> |
| <b>In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):</b> | <b>In-network:<br/>PPO - \$0<br/>Premier - \$0<br/><br/>Out-of-network:<br/>\$0</b>                                                                                                                                           | <b>In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):</b> | <b>In-network:<br/>PPO - \$50<br/>Premier - \$50<br/><br/>Out-of-network:<br/>\$60</b>                                                       | <b>In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):</b> | <b>In-network:<br/>PPO - \$663<br/>Premier - \$663<br/><br/>Out-of-network:<br/>\$888</b>    |
| Summary of what is not covered or subject to a limitation:                                          | Oral exams are limited to two per plan year.<br><br>Cleanings are limited to two per plan year.<br><br>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.                                                      |

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