Plan Benefit Highlights for: Fresno Unified School District
(COBRA, Self Paid Retirees & Active)
Group No: 00697 - 00004, 00010 & 05555

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).		
Deductibles	None		
Maximums	**Delta Dental PPO dentists:** $2,000 per person each calendar year **Non-Delta Dental PPO dentists:** $1,000 per person each calendar year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	50 %
Basic Services Fillings, posterior composites and sealants	100 %	50 %
Endodontics (root canals) Covered Under Basic Services	100 %	50 %
Periodontics (gum treatment) Covered Under Basic Services	100 %	50 %
Oral Surgery Covered Under Basic Services	100 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	100 %	50 %
Prosthodontics Bridges and dentures	50 %	50 %
Dental Accident Benefits	100 % (Separate $1,000 maximum per person each calendar year)	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	866-499-3001	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Fresno Unified School District
Type of Product Line: PPO
Effective Date: 01/01/2023 – 12/31/2023

Name of Product: Delta Dental of California
Plan Phone #: (866) 499-3001
Plan Website: www.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 www.deltadentalins.com **OR CALL** (866) 499-3001

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	None

- **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	$2,000	$1,000
Lifetime Maximum for Orthodontia	Not Applicable	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
Oral Exam	Preventive & Diagnostic	0%	50%	Benefit is limited to two of any oral evaluation procedure within a calendar year. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Bitewing X-ray	Preventive & Diagnostic	0%	50%	Benefit is limited to two of any bitewing x-ray procedure within a calendar year.

				Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Cleaning	Preventive & Diagnostic	0%	50%	Benefit is limited to two of any prophylaxis procedures within a calendar year. Prophylaxis procedures are a benefit following active periodontal therapy once a 30 day post-operative period has completed. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Filling	Basic	0%	50%	Benefit is limited to once per surface, per tooth within a 24 month period. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Extraction, Erupted Tooth or Exposed Root	Basic	0%	50%	Benefit is limited to once per tooth per lifetime. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Root Canal	Basic	0%	50%	Benefit is limited to once per tooth within a 12 month period. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Scaling and RootPlaning	Basic	0%	50%	Benefit is limited to once per quadrant within a 24 month period. Radiographic images and a copy of the treatment record are required if more than two quadrants of scaling and root planing are performed on the same date of service. Frequency may be affected by other periodontic services. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.

Ceramic Crown	Major	0%	50%	Benefit is limited to once per tooth within a 5 year period. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Removable Partial Denture	Prosthodontics	50%	50%	Benefit is limited to once per quadrant within a 5 year period. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
Extraction,Erupted Tooth with Bone Removal	Basic	0%	50%	Benefit is limited to once per tooth per lifetime. Refer to your Combined Evidence of Coverage and Disclosure Form for the full limitations and exclusions.
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 (FMX) 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: None	Deductible	In-network: None Out-of-network: None	Deductible	In-network: None Out-of-network: None
Annual Maximum(Plan Will Pay)	In-network: $2,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,000	Annual Maximum(Plan Will Pay)	In-network: $2,000 Out-of-network: $1,000
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network:50%	Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network:50%	Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network:50%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $275	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $0 **Out-of-network:** $100	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $0 **Out-of-network:** $875
Summary of what is not covered or subject to a limitation:	Exam: Benefit is limited to two of any oral evaluation procedure within a calendar year X-Rays (FMX): Benefit is limited to	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 once per tooth within a 5 year period

	two of any bitewing x-ray procedure within a calendar year Cleaning: Benefit is limited to two of any prophylaxis procedures within a calendar year. Prophylaxis procedures are a benefit following active periodontal therapy once a 30 day post-operative period has completed.				