Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: UnitedHealthcare Insurance Company

Name of Product: San Francisco Health Service System - Actives Plan 250 (D1065/D1015)

Policy Type: DCDC

Plan Phone #: 1-800-445-9090

Effective Date: 1/1/2025

Plan Website: www.myuhc.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE 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 AT www.myuhc.com OR CALL 1-800-445-9090.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

	In-Network		Out-of-Network	
Dental	Per Individual:	$0	Per Individual:	Not Applicable
	Per Family:	$0	Per Family:	Not Applicable

- **There is no deductible.**
- 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 have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Not Applicable	Not Applicable
Lifetime Maximum for Orthodontia	Not Applicable	Not Applicable

- **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.
- **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 for all or certain dental treatments. There is 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	Not Covered	Limited to 2 times per consecutive 12 months
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	Limited to 1 series of films per calendar year
Cleaning	Preventive & Diagnostic	$0	Not Covered	Limited to 2 times per consecutive 12 months.
Filling	Basic	$0	Not Covered	Multiple restorations on one surface will be treated as a single filling.
Extraction, Erupted Tooth or Exposed Root	Basic	$0	Not Covered	Limited to 1 time per tooth per lifetime
Root Canal	Basic	$0	Not Covered	Limited to 1 time per tooth per lifetime
Scaling and Root Planing	Basic	$0	Not Covered	Limited to 1 time per quadrant per consecutive 24 months.
Ceramic Crown	Major	$0	Not Covered	Limited to 1 time per tooth per consecutive 60 months.
Removable Partial Denture	Major	$0	Not Covered	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments
Extraction, Erupted Tooth with bone Removal	Major	$0	Not Covered	Limited to 1 time per tooth per lifetime
Orthodontia	Orthodontia	$750	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 policy to other dental policies you may be considering. Your actual cost 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 Visit**	**Sam's Visit**	**Sam's Visit**	**Maria's Visit**	**Maria's Visit**
Total Cost of Care	In-network: $250 Out-of-network: $450	Total Cost of Care	In-network: $150 Out-of-network: $250	Total Cost of Care	In-network: $950 Out-of-network: $1,400
Deductible	In-network: Per Indiv: $0 Per Family: $0 Out-of-network: Per Indiv: Not Applicable Per Family: Not Applicable	Deductible	In-network: Per Indiv: $0 Per Family: $0 Out-of-network: Per Indiv: Not Applicable Per Family: Not Applicable	Deductible	In-network: Per Indiv: $0 Per Family: $0 Out-of-network: Per Indiv: Not Applicable Per Family: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: $450	In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: $250	In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: $1,400
Summary of what is not covered or subject to a limitation:	Limited to 2 times per consecutive 12 months	Summary of what is not covered or subject to a limitation:	Multiple restorations on one surface will be treated as a single filling.	Summary of what is not covered or subject to a limitation:	Limited to 1 time per tooth per consecutive 60 months.