

**Attachment A  
Deductibles, Maximums and Contract Benefit Levels**

**Contractholder:** County of San Bernardino  
**Group Number:** 18760      **Effective Date:** January 1, 2018

**LOW PLAN - TEXAS**

<b>Deductibles &amp; Maximums</b>	
<b>Annual Deductibles</b>	\$50 per Enrollee each Calendar Year \$150 per family each Calendar Year
Deductibles waived for	Diagnostic and Preventive Services
<b>Annual Maximum</b>	\$1,000 per Enrollee per Calendar Year
Annual Maximum waived for	Diagnostic and Preventive Services

<b>Contract Benefit Levels</b>		
<b>Dental Service Category</b>	<b>Delta Dental PPO Provider<sup>†</sup></b>	<b>Delta Dental Premier and Non-Delta Dental Providers<sup>†</sup></b>
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services:		
<b>Diagnostic and Preventive Services</b>	100%	100%
<b>Basic Services</b>	80%	80%
<b>Major Services</b>	50%	50%

<sup>†</sup> Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

**Waiting Periods:**

Benefits for Crowns/Onlays, and Prosthodontics are limited to Enrollees who have been enrolled in the Contract for 12 consecutive months. Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date of Coverage reported by the Contractholder for said Primary Enrollee.