Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Anthem Blue Cross Life and Health Insurance Company
Type of Product Line: DHMO
Effective Date: Beginning on or after 01/01/2027

Name of Product: Dental Net 3000D
Plan Phone #: 800-627-0004
Plan Website: www.anthem.com/ca

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.anthem.com/ca **OR CALL** 800-627-0004.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	None
Orthodontia	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 have not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Not applicable	Not applicable
Lifetime or Annual 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 No 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 & Diagnostic	$0	Not Covered	2 per 12 months. For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	2 sets per 12 months. For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Cleaning	Preventive & Diagnostic	$0	Not Covered	2 per 12 months. For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Filling	Basic	$20	Not Covered	No limitations. For Limitations and Exclusions, refer to the Covered Services; Restorative Services section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Extraction, Erupted Tooth or Exposed Root	Basic	$5	Not Covered	1 per lifetime per tooth. For Limitations and Exclusions, refer to the Covered Services; Oral Surgery Services section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Root Canal	Basic	$225	Not Covered	1 per lifetime per tooth.

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
				For Limitations and Exclusions, refer to the Covered Services; Endodontic Services section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Scaling and Root Planing	Basic	$45	Not Covered	1 per 24 months per quadrant. For Limitations and Exclusions, refer to the Covered Services; Periodontic Services section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Ceramic Crown	Major	$235	Not Covered	1 per tooth per 60 months. For Limitations and Exclusions, refer to the Covered Services; Prosthodontic Services section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Removable Partial Denture	Major	$235	Not Covered	1 per 60 months. For Limitations and Exclusions, refer to the Covered Services; Prosthodontic Services section of your Certificate of Coverage. For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Extraction, Erupted Tooth with Bone Removal	Major	$90	Not Covered	1 per lifetime per tooth. For Limitations and Exclusions, refer to the Covered Services; Oral Surgery Services section of your Certificate of Coverage.

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
				For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage.
Orthodontia	Orthodontia	$1895	Not Covered	Adult and Dependent Children Coverage. For Limitations and Exclusions, refer to the Covered Services; Orthodontics section of your Certificate of Coverage.

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: 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: 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: $5 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $70 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $240 Out-of-network: $1750
In this example,	**In-network:** $5	**In this example,**	**In-network:** $70	**In this example,**	**In-network:** $240

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Dana would pay (includes copays/coinsurance and deductible, if applicable):	**Out-of-network:** $550	**Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**Out-of-network:** $200	**Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**Out-of-network:** $1750
Summary of what is not covered or subject to a limitation:	Exam covered 2 per 12 months. X-ray covered 1 per 36 months. Cleaning covered 2 per 12 months. Every time you visit your participating dental office, you are responsible to pay a $5 office visit fee, whether dental services are or are not performed.	Summary of what is not covered or subject to a limitation:	No limitations. Every time you visit your participating dental office, you are responsible to pay a $5 office visit fee, whether dental services are or are not performed.	Summary of what is not covered or subject to a limitation:	1 per tooth per 60 months. Every time you visit your participating dental office, you are responsible to pay a $5 office visit fee, whether dental services are or are not performed.