Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Anthem Blue Cross Life and Health Insurance Company
Plan Name: Essential Choice PPO
Policy Type: PPO
Insurer Phone #: 844-729-1565
Effective Date: Beginning on or after 01/01/2027
Insurer 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 INSURER WEBSITE AT www.anthem.com/ca **OR CALL** 844-729-1565.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	$50 per individual/$150 per family	$100 per individual/$300 per family

- **The deductible applies to all services except Preventive and Diagnostic when In-Network, and applies to all services when Out-of-Network.**
- 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	$1,000	Yes, the cost-sharing will be higher. Contact your Plan.
Lifetime Maximum for Orthodontia	Not covered	Not covered

- **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. **24 month waiting period for replacement of teeth missing prior to member's effective date.**

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	20% Deductible does not apply	30%	2 per 12 months For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage.
Bitewing X-ray	Preventive & Diagnostic	20% Deductible does not apply	30%	1 per 12 months

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage.
Cleaning	Preventive & Diagnostic	20% Deductible does not apply	30%	2 per 12 months For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage.
Filling	Basic	20%	40%	1 per 24 months per tooth/surface For Limitations and Exclusions, refer to the Covered Services; Basic Restorative Services section of your Certificate of Coverage.
Simple Extraction	Basic	20%	40%	1 per lifetime per tooth For Limitations and Exclusions, refer to the Covered Services; Basic Restorative Services section of your Certificate of Coverage.
Root Canal	Major	50%	50%	1 per lifetime per tooth For Limitations and Exclusions, refer to the Covered Services; Endodontic Services section of your Certificate of Coverage.
Scaling and Root Planing	Major	50%	50%	1 per 24 months per quadrant For Limitations and Exclusions, refer to the Covered Services; Periodontal Services section of your Certificate of Coverage.
Ceramic Crown	Major	50%	50%	1 per 60 months per tooth For Limitations and Exclusions, refer to the Covered Services; Major Restorative Services section of your Certificate of Coverage.
Removable Partial Denture	Major	50%	50%	1 per 60 months per tooth

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				For Limitations and Exclusions, refer to the Covered Services; Prosthodontic Services section of your Certificate of Coverage.
Orthodontia	Orthodontia	Not covered	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 policy to other dental policies 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: $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: Not applicable Out-of-network: $100	Deductible	In-network: $50 Out-of-network: $100	Deductible	In-network: $50 Out-of-network: $100
Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan.	Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan.	Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan.
Patient Cost (copayment or	In-network: 20%	Patient Cost (copayment or	In-network: 20%	Patient Cost (copayment or	In-network: 50%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
coinsurance)	Out-of-network: 30%	coinsurance)	Out-of-network: 40%	coinsurance)	Out-of-network: 50%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $50 **Out-of-network:** $205	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $70 **Out-of-network:** $160	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $500 **Out-of-network:** $750
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.	Summary of what is not covered or subject to a limitation:	Covered 1 per 24 months per tooth/surface.	Summary of what is not covered or subject to a limitation:	Covered 1 per 60 months per tooth.