

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Anthem Blue Cross Life and Health Insurance Company

Name of Product: Dental Net 2000C

Type of Product Line: DHMO

Plan Phone #: 800-627-0004

Effective Date: Beginning on or after 03/01/2023

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

| <u>Deductible</u> | <u>In-Network</u> | <u>Out-of-Network</u> |
|--------------------------|--------------------------|------------------------------|
| 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

| <u>Maximums</u> | <u>In-Network</u> | <u>Out-of-Network</u> |
|--|--------------------------|------------------------------|
| 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.

| <u>Common Dental Procedures</u> | <u>Category</u> | <u>In-Network</u> | <u>Out-of-Network</u> | <u>Benefit Limitations and Exclusions</u> |
|--|-------------------------|--------------------------|------------------------------|--|
| <i>Oral Exam</i> | Preventive & Diagnostic | \$0 | Not Covered | 2 per calendar year. 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. |

| <u>Common Dental Procedures</u> | <u>Category</u> | <u>In-Network</u> | <u>Out-of-Network</u> | <u>Benefit Limitations and Exclusions</u> |
|--|-------------------------|--------------------------|------------------------------|---|
| <i>Bitewing X-ray</i> | 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. |
| <i>Cleaning</i> | Preventive & Diagnostic | \$0 | Not Covered | 2 per calendar year. 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. |
| <i>Filling</i> | Basic | \$0 | 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. |
| <i>Extraction, Erupted Tooth or Exposed Root</i> | 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. |
| <i>Root Canal</i> | Basic | \$130 | Not Covered | No limitations. |

| <u>Common Dental Procedures</u> | <u>Category</u> | <u>In-Network</u> | <u>Out-of-Network</u> | <u>Benefit Limitations and Exclusions</u> |
|--|------------------------|--------------------------|------------------------------|--|
| | | | | 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. |
| <i>Scaling and Root Planing</i> | Basic | \$20 | Not Covered | 1 per calendar year 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. |
| <i>Ceramic Crown</i> | Major | \$95 | Not Covered | 1 per tooth per 5 calendar years. 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. |
| <i>Removable Partial Denture</i> | Major | \$130 | Not Covered | 1 per 5 calendar years. 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. |
| <i>Extraction, Erupted Tooth with Bone Removal</i> | Major | \$60 | 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. |

| <u>Common Dental Procedures</u> | <u>Category</u> | <u>In-Network</u> | <u>Out-of-Network</u> | <u>Benefit Limitations and Exclusions</u> |
|--|------------------------|--------------------------|------------------------------|--|
| | | | | For Office Visit Fee, refer to the Your Financial Responsibility section of your Certificate of Coverage. |
| <i>Orthodontia</i> | 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.

| <u>Dana Has a Dental Appointment with a New Dentist</u> | <u>Sam Needs a Tooth Filled</u> | <u>Maria Needs a Crown</u> |
|--|--|-------------------------------------|
| New patient exam, x-rays (full-mouth x-ray) and cleaning | Resin-based composite – one surface, posterior | Crown – porcelain/ceramic substrate |

| <u>Dana's Visit</u> | <u>Dana's Cost</u> | <u>Sam's Visit</u> | <u>Sam's Cost</u> | <u>Maria's Visit</u> | <u>Maria's Cost</u> |
|---|--|---|--|---|--|
| 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: \$0 Out-of-network: \$550 | Patient Cost (copayment or coinsurance) | In-network: \$10 Out-of-network: \$200 | Patient Cost (copayment or coinsurance) | In-network: \$95 Out-of-network: \$1750 |
| In this example, | In-network: \$0 | In this example, | In-network: \$10 | In this example, | In-network: \$95 |

| <u>Dana's Visit</u> | <u>Dana's Cost</u> | <u>Sam's Visit</u> | <u>Sam's Cost</u> | <u>Maria's Visit</u> | <u>Maria's Cost</u> |
|--|---|---|------------------------------|---|-----------------------------------|
| 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 calendar year. X-ray covered 1 in 36 months. Cleaning covered 2 per calendar year. | Summary of what is not covered or subject to a limitation: | No limitations. | Summary of what is not covered or subject to a limitation: | 1 per tooth per 5 calendar years. |