# 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 12/01/2023
**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 | $50 per individual/$150 per family |

- **The deductible applies to all services except Preventive, Diagnostic, and Orthodontia.**
- 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 | $1,500 | Yes, the cost-sharing will be higher. Contact your Plan. |
| Lifetime Maximum for Orthodontia | $1,000 | $1,000 |

- **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 | 0% Deductible does not apply | 30% Deductible does not apply | 2 per 12 months<br>For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage. |
| *Bitewing X-ray* | Preventive & Diagnostic | 0% Deductible does not apply | 30% Deductible does not apply | 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 | 0%<br>Deductible does not apply | 30%<br>Deductible does not apply | 2 per 12 months<br>For Limitations and Exclusions, refer to the Covered Services; Preventive Care section of your Certificate of Coverage. |
| *Filling* | Basic | 10% | 50% | 1 per 24 months per tooth/surface<br>For Limitations and Exclusions, refer to the Covered Services; Basic Restorative Services section of your Certificate of Coverage. |
| *Simple Extraction* | Basic | 10% | 50% | 1 per lifetime per tooth<br>For Limitations and Exclusions, refer to the Covered Services; Basic Restorative Services section of your Certificate of Coverage. |
| *Root Canal* | Basic | 10% | 50% | 1 per lifetime per tooth<br>For Limitations and Exclusions, refer to the Covered Services; Endodontic Services section of your Certificate of Coverage. |
| *Scaling and Root Planing* | Basic | 10% | 50% | 1 per 24 months per quadrant<br>For Limitations and Exclusions, refer to the Covered Services; Periodontal Services section of your Certificate of Coverage. |
| *Ceramic Crown* | Major | 40% | 50% | 1 per 60 months per tooth<br>For Limitations and Exclusions, refer to the Covered Services; Major Restorative Services section of your Certificate of Coverage. |
| *Removable Partial Denture* | Major | 40% | 50% | 1 per 60 months per tooth<br>24 month waiting period for replacement of teeth missing prior to member's effective date. |

| 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 | 50% | 50% | Dependent Children Coverage<br>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 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<br>Out-of-network: $450 | Total Cost of Care | In-network: $150<br>Out-of-network: $250 | Total Cost of Care | In-network: $950<br>Out-of-network: $1,400 |
| Deductible | In-network: Not applicable<br><br>Out-of-network: Not applicable | Deductible | In-network: $50<br><br>Out-of-network: $50 | Deductible | In-network: $50<br><br>Out-of-network: $50 |
| Annual Maximum (Plan Will Pay) | In-network: $1,500<br><br>Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan. | Annual Maximum (Plan Will Pay) | In-network: $1,500<br><br>Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan. | Annual Maximum (Plan Will Pay) | In-network: $1,500<br><br>Out-of-network: Yes, the cost-sharing will be higher. Contact your Plan. |
| Patient Cost (copayment or | In-network: 0% | Patient Cost (copayment or | In-network: 10% | Patient Cost (copayment or | In-network: 40% |

| 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: 50% | coinsurance) | Out-of-network: 50% |
| **In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):** | **In-network:** $0<br><br>**Out-of-network:** $135 | **In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):** | **In-network:** $60<br><br>**Out-of-network:** $150 | **In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):** | **In-network:** $410<br><br>**Out-of-network:** $725 |
| 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. |