Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: DentaQuest*
Type of Product Line: DHMO
Effective Date: Beginning on or after 01/01/2026

Name of Product: Dental HMO Covered CA Individual
Plan Phone #: 1-855-425-4164
Plan Website: www.caldental.net

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.CALDENTAL.NET OR CALL 1-855-425-4164.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable
Orthodontia	None	Not Applicable

- **There is no deductible, however an office visit co-pay may apply.**
- 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.

**Dental benefits are provided by California Dental Network. California Dental Network does business as DentaQuest. Throughout this Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC), California Dental Network is referred to as DentaQuest.*

- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not applicable
Lifetime Maximum for Orthodontia	None	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.
- **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. **There is no waiting period.**

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	$0.00	Not Covered	Limited to once every six months, per provider.
Bitewing X-ray	Preventive & Diagnostic	$0.00	Not Covered	Covered once per date of service.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Cleaning	Preventive & Diagnostic	$0.00	Not Covered	Limited to once every six months.
Filling	Basic	$30.00	Not Covered	
Extraction, Erupted Tooth or Exposed Root	Basic	$65.00	Not Covered	
Root Canal	Major	$300.00	Not Covered	A benefit once per tooth for initial root canal therapy treatment. Please consult Your Evidence of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Scaling and Root Planing	Basic	$55.00	Not Covered	A benefit for patients aged 13 or older; each once per quadrant every 24 months. Please consult Your Evidence of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Ceramic Crown	Major	$300.00	Not Covered	Please consult Your Evidence of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Removable Partial Denture	Major	$300.00	Not Covered	Each a benefit once in a five- year period, when replacing a permanent front tooth/ teeth and/or the arch lacks posterior balanced occlusion. Please consult Your Evidence of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Extraction, Erupted Tooth with Bone Removal	Major	$120.00	Not Covered	Covered when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial bone or sectioning of the tooth. Please consult Your Evidence of Coverage for a Detailed Description of Coverage Benefits and Limitations.
Orthodontia	Orthodontia	$350.00	Not Covered	Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate, and facial growth management cases for patients under the age of 21 and shall be prior authorized.

				Please consult Your Evidence of Coverage for a Detailed Description of Coverage Benefits and Limitations.

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-rays) 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: $1300 Out-of-network: $1,750
Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Deductible	In-network: None Out-of-network: Not Applicable	Deductible	In-network: None Out-of-network: Not Applicable	Deductible	In-network: None Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not applicable
Patient Cost (copayment or coinsurance)	In-network: $0.00 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $30.00 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $300.00 Out-of-network: $1,750

In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $0.00 Out-of-network: $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	In-network: $30.00 Out-of-network: $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	In-network: $300.00 Out-of-network: $1,750
Summary of what is not covered or subject to a limitation:	Full mouth series x-rays limited to once in 36 months. Prophylaxis (teeth cleaning) is limited to once every 6 months.			Summary of what is not covered or subject to a limitation:	