Summary of Dental Benefits & Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: MediExcel Dental Plan
Type of Product Line: DHMO
Effective Date: 01/01/2022–12/31/2022

Name of Product: D200
Plan Phone #: 1-619-365-4346
Plan Website: www.mediexcel.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS ONLY A SUMMARY 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 COVERED BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE AT www.mediexcel.com OR CALL 1-619-365-4346.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Covered

- **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 are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not Covered
Lifetime Maximum for Orthodontia	None	Not Covered

- **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. **Your dental benefits plan has 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	No charge	Not Covered	Benefit is limited to two oral evaluations per calendar year. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-19.

Common Dental Procedures	Category	In-Network	Out-of- Network	Benefit Limitations and Exclusions
Bitewing X-ray	Preventive & Diagnostic	No charge	Not Covered	Bitewing x-rays are limited to no more than one series of four films in any six-month period. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-18.
Cleaning (Adult)	Preventive & Diagnostic	No charge	Not Covered	Benefit is limited to two cleanings per calendar year. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-18.
Filling	Basic	$20	Not Covered	
Extraction, Erupted Tooth or Exposed Root	Basic	$30	Not Covered	
Root Canal	Major	$50	Not Covered	For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-20.
Scaling and Root Planing	Basic	$30	Not Covered	Periodontal maintenance is allowed following active periodontal therapy once every six months. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-20.

Common Dental Procedures	Category	In-Network	Out-of- Network	Benefit Limitations and Exclusions
Ceramic Crown	Major	$50	Not Covered	Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-19.
Removable Partial Denture	Major	$63	Not Covered	Replacement of an existing appliance only if the appliance is over five years old. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-21.
Extraction, Erupted Tooth with Bone Removal	Basic	$15	Not Covered	
Orthodontia	Orthodontia	$1,400	Not Covered	Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/ rebandings on different teeth during the covered course of treatment are Benefits. For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-23.

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 (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:** $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:** Not Applicable **Out-of-network:** Not Applicable	**Deductible**	**In-network:** Not Applicable **Out-of-network:** Not Applicable	**Deductible**	**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	**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:** 100%	**Patient Cost (copayment or coinsurance)**	**In-network:** $20 **Out-of-Network:** 100%	**Patient Cost (copayment or coinsurance)**	**In-network:** $50 **Out-of-network:** 100%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	**In-network:** **$0** **Out-of-network:** **$550**	**In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** **$20** **Out-of-network:** **$200**	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** **$50** **Out-of-network:** **$1,750**
Summary of what is not covered or subject to a limitation:	Cleanings are limited to two per calendar year. Bitewing x-rays are limited to no more than one series of four films in any six-month period. Full Mouth x-rays are limited to once every 24 consecutive months. Fluoride Treatments are covered with up to two treatments per calendar year, up to the 18th birthday.	**Summary of what is not covered or subject to a limitation:**	Cosmetic dental care is not covered. Replacement of amalgam restorations with different materials, solely to eliminate the presence of amalgam is not covered. **Out-of-Network:** Not covered.	**Summary of what is not covered or subject to a limitation:**	Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years. Porcelain crowns, porcelain fused to metal or resin with metal type crowns for children under 16 years of age are not covered. **Out-of-Network:** Not covered.

MediExcel Health Plan
Dental HMO Plan

Dental Plan 200

Benefit Summary

THIS MATRIX IS ONLY A SUMMARY AND IS INTENDED TO HELP YOU COMPARE COVERAGE BENEFITS. FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS, PLEASE CONSULT YOUR *EVIDENCE OF COVERAGE* AND PLAN CONTRACT.

Using Your Dental Plan

Your Plan grants you access to a network of dental providers without deductibles or the filing of claim forms. To schedule an appointment, including referrals for consultation and emergency services, contact MediExcel's Member Line toll-free at (855) 633-4392.

PLAN FEATURES	IN-NETWORK PROVIDERS
Calendar Year Deductible	$0
Annual Benefit Maximum	None

ADA CODE	COVERED SERVICES	COPAY
	DIAGNOSTIC SERVICES	
D0120	Oral Evaluations	$0
D0210	Full Mouth Series X-rays	$0
D0220	Periapical X-ray Film	$0
D0230	Each Additional Film	$0
D0460	Pulp Vitality Test	$0
D1130	Emergency Oral Examinations	$0
	PREVENTIVE SERVICES	
D1110	Cleaning (Prophylaxis) – Adult	$0
D1120	Cleaning (Prophylaxis) – Child	$0
D1203	Fluoride - Child	$0
D1204	Fluoride - Adult	$0
- Diagnostic and Preventive services may be subject to age and frequency limitations. See your Evidence of Coverage for details.		
	SPACE MAINTAINERS	
D1510	Space Maintainer – Fixed Unilateral	$20
D1520	Space Maintainer – Removable Unilateral	$25
	RESTORATIVE SERVICES	
	PRIMARY OR PERMANENT TEETH	
D2140	Amalgam (Cavity) – 1 Surf Primary of Permanent	$5
D2150	Amalgam (Cavity) – 2 Surf Primary of Permanent	$8
D2160	Amalgam (Cavity) – 3 Surf Primary of Permanent	$10
D2161	Amalgam (Cavity) – 4+ Surf Primary of Permanent	$10
D2210	Silicate Cement – Per Restoration	$15
D2310	Acrylic or Plastic Restoration, Anterior	$15
D2330	Resin-Based Composite 1 Surf, Anterior	$20
D2331	Resin-Based Composite 2 Surf, Anterior	$20
D2332	Resin-Based Composite 3 Surf, Anterior	$25
D2335	Resin-Based Composite 4+ Surf, Anterior	$25

	CROWNS/BRIDGES	
D2740	Crown – Porcelain/Ceramic Substrate	$50
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$50
D2753	Crown – Acrylic	$45
D2754	Crown – Acrylic with Metal	$45
D2791	Crown – Full Cast Predominantly Base Metal	$15
D2810	Crown – 3/4	$50
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$5
D2920	Recement Crown	$5
D2930	Prefab, Stainless Steel Crown – Primary Tooth	$15
D2931	Prefab, Stainless Steel Crown – Permanent Tooth	$15
D2950	Core Buildup, Including Any Pins	$35
D2952	Post & Core in Addition to Crown	$40
D6211	Pontic – Cast Predominantly Base Metal	$60
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	$70
D6251	Pontic – Resin with Predominantly Base Metal	$60
- Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontic under one treatment plan. - Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost of the gold/high noble metal.		
	ENDODONTIC SERVICES	
D3110	Pulp Cap – Direct (excluding final restoration)	$5
D3120	Pulp Cap – Indirect (excluding final restoration)	$10
D3220	Therapeutic Pulpotomy (excluding final restoration)	$10
D3310	Root Canal Therapy – Anterior (excluding final restoration)	$30
D3320	Root Canal Therapy – Bicuspid (excluding final restoration)	$40
D3330	Root Canal Therapy – Molar (excluding final restoration)	$50
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$50
D3410	Apicoectomy/Periradicular Surgery – Anterior	$50
D3411	Apicoectomy/per tooth, each additional root	$50
D3430	Retrograde Filling – Per Root	$60
D3940	Recalcification	$5
D3999	Culturing Canal	$5
	PERIODONTICS SERVICES	
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth – Per Quadrant	$25
D4211	Gingivectomy or Gingivoplasty – 1-3 Teeth – Per Tooth	$8
D4220	Gingival Curettage – Per Quadrant	$18
D4250	Mucogingival Surgery – Per Quadrant	$36
D4260	Osseous Surgery – 4 or More Teeth – Per Quadrant	$36
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth – Per Quadrant	$30
D9110	Palliative (Emergency) Treatment	$5
	PROSTHODONTICS - REMOVABLE	
D5110	Complete Denture – Maxillary	$63
D5120	Complete Denture – Mandibular	$63
D5130	Immediate Denture – Maxillary	$63
D5140	Immediate Denture – Mandibular	$63
D5211	Maxillary Partial Denture – Resin Base (including retentive/clasping materials, rests and teeth)	$63
D5212	Mandibular Partial Denture – Resin Base (including retentive/clasping materials, rests and teeth)	$63
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$63
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$63
D5410	Adjust Complete Denture – Maxillary	$10
D5411	Adjust Complete Denture – Mandibular	$10

D5421	Adjust Partial Denture – Maxillary	$10
D5422	Adjust Partial Denture - Mandibular	$10
	REPAIRS TO PROSTHETICS	
D5510	Repair Broken Complete Denture Base	$15
D5520	Replace Missing or Broken Teeth – Complete Denture (each tooth)	$10
D5610	Repair Resin Denture Base	$20
D5630	Repair or Replace Broken Retentive/Clasping Materials – per tooth	$20
D5640	Replace Broken Teeth – Per Tooth	$10
D5650	Add Tooth or Existing Partial Denture ($5 each additional tooth)	$15
D5660	Add Clasp to Existing Partial Denture	$5
D5730	Reline Complete Maxillary Denture (Chairside)	$15
D5731	Reline Complete Mandibular Denture (Chairside)	$15
D5740	Reline Maxillary Partial Denture (Chairside)	$15
D5741	Reline Mandibular Partial Denture (Chairside)	$15
D5750	Reline Complete Maxillary Denture (Lab)	$18
D5751	Reline Complete Mandibular Denture (Lab)	$18
D5760	Reline Maxillary Partial Denture (Lab)	$18
D5761	Reline Mandibular Partial Denture (Lab)	$18
D5820	Interim Partial Denture (Maxillary)	$10
D6930	Recement Bridge	$10
	ORAL SURGERY SERVICES	
D7110	Single Tooth	$8
D7120	Each Additional Tooth	$8
D7210	Surgical Removal of Erupted Tooth	$15
D7220	Removal of Impacted Tooth – Soft Tissue	$30
D7230	Removal of Impacted Tooth – Partially Bony	$35
D7240	Removal of Impacted Tooth – Completely Bony	$50
D7285	Biopsy of Oral Tissue – Hard	$0
D7286	Biopsy of Oral Tissue – Soft	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces – Per Quadrant	$15
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	$0
D7960	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$25
	MISCELLANEOUS	
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	$5
D9215	Local Anesthesia	$0
D9310	Consultation (Diagnostic Service by Additional Dentist)	$0
D9430	Post-Operative Visit	$0
D9440	Office Visit – After Hours	$10
D9999	Broken Appointment (less than 24 hours)	$10
	ORTHODONTICS	
D8080	Comprehensive Orthodontic Treatment - Adolescent	$1,200
D8090	Comprehensive Orthodontic Treatment - Adult	$1,400
	PLAN EXCLUSIONS AND LIMITATIONS*	

***Services that May Not Be Covered Under the Plan:**

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Plan; or
   (b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury
3. Services not listed in the Dental Care Benefit Summary that applies, unless otherwise specified in the Evidence of Coverage.

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances

that have been damaged due to abuse, misuse or neglect.

5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance.

6. Those for or in connection with services, procedures, drugs or other supplies that are determined by MediExcel Health Plan to be experimental or still under clinical investigation by health professionals.

7. Those of any of the following services:
   (a) An appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;
   (c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.

8. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

9. Services given by an out-of-network dental provider.

10. Those for a crown, cast or processed restoration unless:
    (a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; - or-
    (b) The tooth is an abutment to a covered partial denture or fixed bridge.

11. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Evidence of Coverage.

12. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Evidence of Coverage.

13. Services needed solely in connection with non-covered services.

14. Any exclusion above will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.

***This is a partial list of exclusions and limitations, others may apply. Please check your Evidence of Coverage for details. Contact MediExcel's Member Line toll-free at (855) 633-4392 for additional questions.**