



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: D100
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

Table with 3 columns: Deductible, In-Network, Out-of-Network. Row 1: 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

- J **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.
- J **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
<i>Bitewing X-ray</i>	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.
<i>Cleaning (Adult)</i>	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.
<i>Filling</i>	Basic	\$25	Not Covered	
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	\$65	Not Covered	
<i>Root Canal</i>	Major	\$140	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.
<i>Scaling and Root Planing</i>	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
<i>Ceramic Crown</i>	Major	\$190	Not Covered	<p>Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years.</p> <p>For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-19.</p>
<i>Removable Partial Denture</i>	Major	\$160	Not Covered	<p>Replacement of an existing appliance only if the appliance is over five years old.</p> <p>For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-21.</p>
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	\$25	Not Covered	
<i>Orthodontia</i>	Orthodontia	\$1,400	Not Covered	<p>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.</p> <p>For more information about dental limitations and exceptions, consult your 2022 Dental Plan Combined Evidence of Coverage & Disclosure Form on Page EOC-23.</p>

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: \$25 Out-of-Network: 100%	Patient Cost (copayment or coinsurance)	In-network: \$190 Out-of-network: 100%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
<p>In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):</p>	<p>In-network: \$0</p> <p>Out-of-network: \$550</p>	<p>In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):</p>	<p>In-network: \$25</p> <p>Out-of-network: \$200</p>	<p>In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):</p>	<p>In-network: \$190</p> <p>Out-of-network: \$1,750</p>
<p>Summary of what is not covered or subject to a limitation:</p>	<p>Cleanings are limited to two per calendar year.</p> <p>Bitewing x-rays are limited to no more than one series of four films in any six-month period.</p> <p>Full Mouth x-rays are limited to once every 24 consecutive months.</p> <p>Fluoride Treatments are covered with up to two treatments per calendar year, up to the 18th birthday.</p>	<p>Summary of what is not covered or subject to a limitation:</p>	<p>Cosmetic dental care is not covered.</p> <p>Replacement of amalgam restorations with different materials, solely to eliminate the presence of amalgam is not covered.</p> <p>Out-of-Network: Not covered.</p>	<p>Summary of what is not covered or subject to a limitation:</p>	<p>Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five years.</p> <p>Porcelain crowns, porcelain fused to metal or resin with metal type crowns for children under 16 years of age are not covered.</p> <p>Out-of-Network: Not covered.</p>



Dental Plan 100

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		
D0120	Oral Evaluations	\$0
D0210	Full Mouth Series X-rays	\$0
D0220	Periapical X-ray Film	\$0
D0460	Pulp Vitality Test	\$0
PREVENTIVE		
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	\$30
D1520	Space Maintainer – Removable Unilateral	\$30
RESTORATIVE		
PRIMARY OR PERMANENT TEETH		
D2140	Amalgam (Cavity) – 1 Surf Primary of Permanent	\$10
D2150	Amalgam (Cavity) – 2 Surf Primary of Permanent	\$12
D2160	Amalgam (Cavity) – 3 Surf Primary of Permanent	\$15
D2161	Amalgam (Cavity) – 4 or more Surf Primary of Permanent	\$15
D2330	Resin-Based Composite 1 Surf, Anterior	\$25
D2331	Resin-Based Composite 2 Surf, Anterior	\$25
D2332	Resin-Based Composite 3 Surf, Anterior	\$30
D2335	Resin-Based Composite 4 or more Surf, Anterior	\$30
CROWNS/BRIDGES		
D2740	Crown – Porcelain/Ceramic Substrate	\$190
D2751	Crown – Porcelain Fused to Predominantly Base Metal	\$160

D2791	Crown – Full Cast Predominantly Base Metal	\$50
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	\$15
D2920	Recement Crown	\$15
D2930	Prefab, Stainless Steel Crown – Primary Tooth	\$35
D2931	Prefab, Stainless Steel Crown – Permanent Tooth	\$40
D2950	Core Buildup, including any Pins	\$40
D2952	Post & Core in addition to Crown	\$45
D6211	Pontic – Cast Predominantly Base Metal	\$120
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	\$100
D6251	Pontic – Resin with Predominantly Base Metal	\$120
<p>- 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.</p>		
ENDODONTICS		
D3110	Pulp Cap – Direct (excluding final restoration)	\$30
D3120	Pulp Cap – Indirect (excluding final restoration)	\$30
D3220	Therapeutic Pulpotomy (excluding final restoration)	\$20
D3310	Root Canal Therapy – Anterior (excluding final restoration)	\$100
D3320	Root Canal Therapy – Bicuspid (excluding final restoration)	\$100
D3330	Root Canal Therapy – Molar (excluding final restoration)	\$140
D3346	Retreatment of Previous Root Canal Therapy – Anterior	\$160
D3410	Apicoectomy/Periradicular Surgery – Anterior	\$120
D3430	Retrograde Filling – Per Root	\$70
PERIODONTICS		
D4210	Gingivectomy or Gingivoplasty – 4 or more Teeth – Per Quadrant	\$80
D4211	Gingivectomy or Gingivoplasty – 1-3 Teeth – Per Tooth	\$50
D4260	Osseous Surgery (Incl. flap entry & closure) – 4 or more Teeth Per Quadrant	\$80
D4341	Periodontal Scaling and Root Planing – 4 or more Teeth – Per Quadrant	\$30
REMOVABLE PROSTHODONTICS		
D5110	Complete Denture – Maxillary	\$210
D5120	Complete Denture – Mandibular	\$210
D5130	Immediate Denture – Maxillary	\$210
D5140	Immediate Denture – Mandibular	\$210
D5211	Maxillary Partial Denture – Resin Base (including retentive/clasping materials, rests and teeth)	\$160
D5212	Mandibular Partial Denture – Resin Base (including retentive/clasping materials, rests and teeth)	\$160
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	\$200
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	\$200
D5410	Adjust Complete Denture – Maxillary	\$30
D5411	Adjust Complete Denture – Mandibular	\$30
D5421	Adjust Partial Denture – Maxillary	\$30
D5422	Adjust Partial Denture - Mandibular	\$30
REPAIRS TO PROSTHETICS		
D5510	Repair Broken Complete Denture Base	\$30
D5520	Replace Missing or Broken Teeth – Complete Denture (each tooth)	\$30
D5610	Repair Resin Denture Base	\$30
D5630	Repair or Replace Broken Retentive/Clasping Materials – Per Tooth	\$30
D5640	Replace Broken Teeth – Per Tooth	\$30
D5650	Add Tooth or Existing Partial Denture (\$5 each additional tooth)	\$30
D5660	Add Clasp to Existing Partial Denture	\$25
D5730	Reline Complete Maxillary Denture (Chairside)	\$30
D5731	Reline Complete Mandibular Denture (Chairside)	\$30
D5740	Reline Maxillary Partial Denture (Chairside)	\$30

D5741	Reline Mandibular Partial Denture (Chairside)	\$30
D5750	Reline Complete Maxillary Denture (Lab)	\$45
D5751	Reline Complete Mandibular Denture (Lab)	\$45
D5760	Reline Maxillary Partial Denture (Lab)	\$45
D5761	Reline Mandibular Partial Denture (Lab)	\$45
D5820	Interim Partial Denture (Maxillary)	\$45
ORAL SURGERY		
D7210	Surgical Removal of Erupted Tooth	\$25
D7220	Removal of Impacted Tooth – Soft Tissue	\$65
D7230	Removal of Impacted Tooth – Partially Bony	\$75
D7240	Removal of Impacted Tooth – Completely Bony	\$120
D7310	Alveoloplasty in Conjunction with Extractions – 4 or more Teeth or Tooth Spaces – Per Quadrant	\$25
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	\$30
D7960	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	\$40
MISCELLANEOUS		
D9110	Palliative (Emergency) Treatment of Dental Pain – minor procedure	\$20
D9440	Office Visit – after regularly scheduled hours	\$10
D9999	Broken Appointment (notified less than 24 hours before appointment time)	\$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 this 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 at (855) 633-4392 for additional questions.**