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.**