MediExcel Health Plan
Dental HMO Plan

Dental Plan 100

Benefit Summary

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Using Your Dental Plan

You will have access to a network of dental providers without paying deductibles or filling out claim forms. To make an appointment, simply call MediExcel Health Plan for your dental care appointments, including referrals for consultation with plan specialists and emergency services. If you have any questions, please call Member Services at (855) 633-4392.

PLAN FEATURES	IN-NETWORK PROVIDERS
Calendar Year Deductible	No Deductible
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
D0460	Pulp Vitality Test	$0
	PREVENTIVE SERVICES	
D1110	Deep Cleaning – Adult	$0
D1120	Deep Cleaning - 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 SERVICES	
	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+ Surf Primary of Permanent	$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	$180
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$150
D2791	Crown – Full Cast Predominantly Base Metal	$50
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$10
D2920	Recement Crown	$10
D2930	Prefab, Stainless Steel Crown – Primary Tooth	$35
D2931	Prefab, Stainless Steel Crown – Permanent Tooth	$35
D2950	Core Buildup, Including Any Pins	$25
D2952	Post & Core in Addition to Crown	$30
D6211	Pontic – Cast Predominantly Base Metal	$120
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	$100
D6251	Pontic – Resin With Predominantly Base Metal	$120
- Full mouth rehabilitation 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 for gold/high noble metal.		
	ENDODONTIC SERVICES	
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	$60
	PERIODONTICS SERVICES	
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth – Per Quadrant	$80
D4211	Gingivectomy or Gingivoplasty – 1-3 Teeth – Per Tooth	$40
D4260	Osseous Surgery – 4 or More Teeth – Per Quadrant	$80
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth – Per Quadrant	$30
	PROSTHODONTICS - REMOVABLE	
D5110	Complete Denture – Maxillary	$190
D5120	Complete Denture – Mandibular	$190
D5130	Immediate Denture – Maxillary	$170
D5140	Immediate Denture – Mandibular	$170
D5211	Maxillary Partial Denture – Resin Base (including any conventional clasps, rests and teeth)	$150
D5212	Mandibular Partial Denture – Resin Base (including any conventional clasps, rests and teeth)	$150
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$150
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$150

D5281	Removable Unilateral Partial Denture – One Piece Cast Metal (including clasps and teeth)	$150
D5410	Adjust Complete Denture – Maxillary	$25
D5411	Adjust Complete Denture – Mandibular	$25
D5421	Adjust Partial Denture – Maxillary	$25
D5422	Adjust Partial Denture - Mandibular	$25
	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 Clasp	$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	$20
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)	$40
	ORAL SURGERY SERVICES	
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
	MISC	
D9110	Palliative (Emergency) Treatment of Dental Pain – minor procedure	$20
D9951	Occlusal Adjustment – Limited	$15
D9952	Occlusal Adjustment - Complete	$30
	ORTHODONTICS	
D8080	Comprehensive Orthodontic Treatment - Adolescent	$1,200
D8090	Comprehensive Orthodontic Treatment - Adult	$1,400

	PLAN EXCLUSIONS AND LIMITATIONS*	

Some Services Not Covered Under the Plan Are:

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 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 a nonparticipating 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. You may also call Member Services at (855) 633-4392 if you have any questions.**

Dental Rates

Tier 3	Tier 4
EE+ $5.00	EE $5.00
EE+1 $12.00	ES $12.00
EE+2+ $19.00	EC $15.00
	EF $19.00

- **NO minimum employer contribution**
- **NO minimum participation**