Summary of Dental Benefits & Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: MediExcel Dental Plan
Type of Product Line: DHMO
Effective Date: 01/01/2025–12/31/2025

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

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	This benefit is limited to two oral evaluations per calendar year. For more information about dental limitations and exceptions, consult your Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.

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 Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.
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 Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.
Filling	Basic	$25	Not Covered	
Extraction, Erupted Tooth or Exposed Root	Basic	$65	Not Covered	
Root Canal	Major	$140	Not Covered	For more information about dental limitations and exceptions, consult your Dental Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.
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 Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.

Common Dental Procedures	Category	In-Network	Out-of- Network	Benefit Limitations and Exclusions
Ceramic Crown	Major	$190	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 Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.
Removable Partial Denture	Major	$160	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 Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.
Extraction, Erupted Tooth with Bone Removal	Basic	$25	Not Covered	
Orthodontia	Orthodontia	$1,200 (under 18) $1,400 (18 and over)	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 Dental Plan Combined Evidence of Coverage & Disclosure Form, within the section called Your Dental Benefits.

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
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: $25** **Out-of-network: $200**	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network: $190** **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.