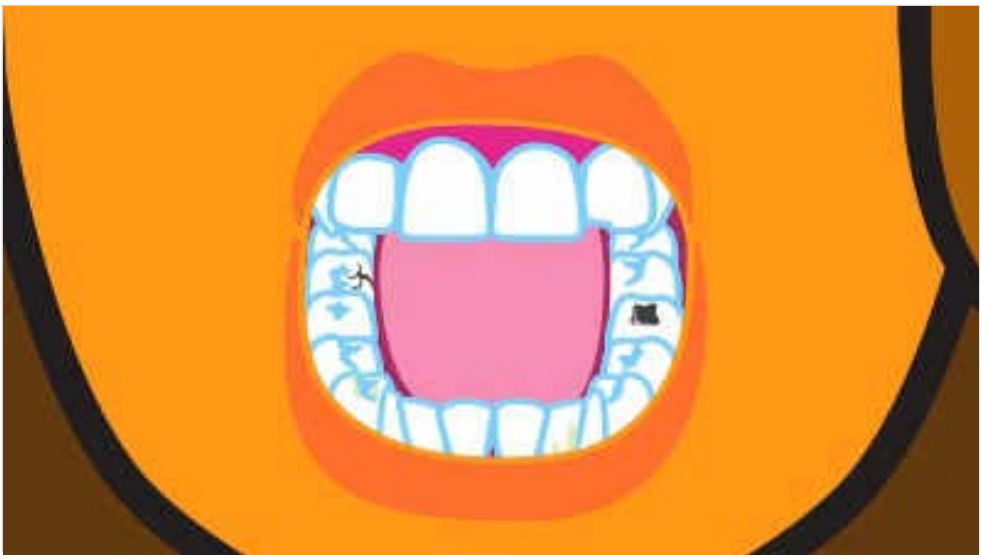
UHC Access+ Dental

UnitedHealthcare Solstice Dental Health Maintenance Organization, or DHMO, is a network of Provider Groups who have agreed to offer specific services at negotiated rates to participating members. There are many reasons to consider selecting one of the UnitedHealthcare Solstice DHMO plans, a Standard and a High Plan.

Click to play Dental Video:



UnitedHealthcare Solstice DHMO Plans

You do not need to select a dental facility at the time of enrolment; you elect your dentist at the time of service by selecting a participating provider and verifying their participation in the plan prior to the dental visit. Additionally, these plans provide you with certain services with set reimbursements when accessing care from non-participating providers.

The member pays a copayment at participating providers, however, most diagnostic and preventive care iscovered at no cost. Additionally, there are no deductibles, and no claim forms are needed. The plans also provide reimbursement for services provided by an out-of-network provider for preventive and diagnostic services. Additionally the plan offers a 25% discount on all procedure codes not listed in the following pages.

The patient/Member is ultimately responsible for verifications to the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our Members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with UnitedHealthcare Solstice DHMO Member Services Department prior to treatment.

>> Benefit Eligibility Note:

- **All M-DCPS groups are eligible to enroll in the UHC Access+ Dental offered by the School Board.**
- **Current COBRA participants may only continue to enroll in UHC Access+ Dental if you were previously enrolled in vision.**
- **See eligibility section for more details.**

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

UHC Access+ Dental

Why choose a UnitedHealthcare Solstice DHMO plan?

The Dental Health Maintenance Organization, or DHMO, is a network of Provider Groups who have agreed to offer specific services at negotiated rates to participating members. There are many reasons to consider selecting one of the UnitedHealthcare Solstice DHMO plans:

- No deductibles
- No waiting periods
- No office visits copays
- No claim forms to submit
- Out-of-Network Preventive and Diagnostic Reimbursement (25 procedure codes only)
- No annual benefit dollar maximums
- Coverage for pre-existing conditions
- No primary dentist selection required
- Ability to change dentist at any time
- Specialist coverage at same general dentist copay level with authorization, or self-referral for a 25% discount
- Defined copayment on over 400 procedures codes
- Implant coverage at copayment level through network of implant specialists
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included
- 25% discount on all procedure codes not listed

Am I eligible for this coverage?

You may elect to enroll in the dental plan if you are an active, benefit-eligible employee working a minimum of 20 hours per week on a regularly scheduled basis.

Who is an eligible dependent for this coverage?

Eligible dependents for the dental plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and stepchildren under you or your spouse's legal guardianship until the end of the calendar year in which the child reaches age 26
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

NOTE: Children may be covered under this plan until the end of the calendar year in which the child reaches age 26, provided he/she is unmarried and resides in your home and depends upon you for support, or is registered as a full-time or part-time student. Children with a mental or physical handicap are also eligible for coverage beyond the age of 26.

How do I select or change my dental provider?

You may select a dental provider from the many offices in the Solstice network without prior authorization. Visit www.myuhcdental.com or call Member Services at phone number 1.800.955.4137 to choose a participating provider for the first time or to make changes. If you would like to keep the dentist you have under your prior plan and are now changing plans, you may maintain that same dentist as long as they are part of the UnitedHealthcare Solstice network.

How do I make an appointment with my UnitedHealthcare Solstice dentist?

To schedule an appointment, you simply call the dental office and identify yourself as a UnitedHealthcare Solstice member on or after your effective date of coverage.

When you see your dentist for the first time, you may be required to undergo an oral examination including diagnostic X-rays, before your routine cleaning is done. After the dentist has completed the evaluation, you should request a written treatment plan of care the dentist is recommending including the 4-digit ADA code for each treatment. Review this treatment plan and compare it with your Schedule of Benefits. It should match! For help analyzing your treatment plan and charges, you can call UnitedHealthcare Dental member services at 1.800.955.4137.

What if I need the services of a Specialist?

Should you need to use the services of a Specialist such as an Oral Surgeon, Endodontist, Periodontist, Orthodontist, Prosthodontist, or Pediatric Dentist, you may receive this care in either one of two ways:

- You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's reasonable and customary fees or
- You need to get prior written authorization from Solstice Benefits and receive specialty treatment by an approved specialist at the copayments listed in the schedule of benefits.

What if I need services from an Implantologist (Implants)?

Members seeking implant treatment should refer to their participating implantologist, a select network of providers. Not all providers perform the implant procedures at the copay listed on the Schedule of Benefits. Please refer to the provider listing at www.myuhcdental.com under “find a physician.”

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UHC Access+ Dental

UHC Solstice Access+ High DHMO

What if I require dental services while I'm traveling out of state?

If you need the services of a dentist specifically for the relief of pain while traveling out of the state of Florida, UnitedHealthcare Solstice will reimburse up to $100.00 per occurrence. You should mail your receipt and treatment information from the dental office to UnitedHealthcare Dental Claims Unit.

What if I need a Pedodontist for my child?

With the DHMO plans you can choose a participating dentist that best satisfies the needs of each individual. Children are covered at the Pediatric Dentist up to age 16 and do not require a referral from as General Dentist. Visits to the participating Pediatric Dentist for covered routine preventive and diagnostic dental work (exams, X-rays, cleanings, fluoride, sealants, and space maintainers) are allowed without a pre-authorization. However, if additional treatment is needed, you may need pre-authorization. For additional treatment, you may receive this care in either of two ways: 1) You may go directly to a participating Pediatric Dentist and receive a 25% reduction off the provider's Usual and Customary fee; or 2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating specialist at the listed copayments. With the open access provider network, you have the option to select a Pedodontist for your child without a pre-authorization or you may choose to have your child see a General Dentist.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to Member Services at phone number 1.800.955.4137.

Pre-Treatment Plans

Your dental plan covers an extensive array of dental procedures at either a fixed copayment or at a discount off the dentist's normal charges. It is highly recommended that prior to having dental work started; you request a pre-treatment plan or estimate, from your dentist on all treatment over $500. Should you have any questions regarding your treatment plan, you can always refer to your schedule of benefits or call UnitedHealthcare Dental so we can ensure that you receive the maximum benefit from your dental plan.

SCHEDULE OF BENEFITS

Members of the Solstice Access+ S1000A HIGH dental plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No waiting periods
- No deductibles
- No claim forms to submit
- Out-of-network preventive and diagnostic reimbursement

The Member copayments listed are offered by a participating in-network provider. The Member receives:

The Member receives:

- Most diagnostic & preventive care at no charge
- Cosmetic and orthodontia treatment covered

Members can choose a participating provider at www.myuhcdental.com

Member Services Department: 1.800.955.4137

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The following Member copayments apply when a participating General Dentist performs services. An "*" denotes limitation on certain benefits (see "Exclusions/Limitations").

Code	Description	Copay/Reimbursement
D0120	*Periodic oral evaluation - established patient	$0/$20
D0140	Limited oral evaluation - problem focused	$0/$20
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0/$25
D0150	*Comprehensive oral evaluation - new or established patient	$0/$30
D0160	*Detailed and extensive oral evaluation - problem focused, by report	$0/$30
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0/$15
D0180	Comprehensive periodontal evaluation - new or established patient	$10/$15
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0

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Radiography / Diagnostic Dentistry

D0210	*Intraoral - complete series (including bitewings)	$0/$25
D0220	Intraoral - periapical first radiographic images	$0/$4
D0230	Intraoral - periapical each additional radiographic images	$0/$2
D0240	Intraoral - occlusal radiographic images	$0
D0260	Extraoral - each additional radiographic images	$0
D0270	*Bitewing - single radiographic images	$0/$10
D0272	*Bitewings - two radiographic images	$0/$15
D0273	*Bitewings - three radiographic images	$0/$20
D0274	*Bitewings - four radiographic images	$0/$23
D0277	*Vertical bitewings - 7 to 8 radiographic images	$0/$25
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic images	$150
D0310	Sialography	$150
D0320	Temporomandibular joint arthrogram, including injection	$250
D0321	Other temporomandibular joint radiographic images, by report	$150
D0322	Tomographic survey	$150
D0330	*Panoramic radiographic images	$0/$25
D0340	Cephalometric radiographic images	$75
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0/$15
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	$150
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$140
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$140
D0367	*Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	$190
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	$140
D0369	*Maxillofacial MRI capture and interpretation	$190
D0370	*Maxillofacial ultrasound capture and interpretation	$170
D0371	*Sialoendoscopy capture and interpretation	$170
D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	$150
D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	$140
D0382	*Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	$140
D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	$190
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	$140
D0385	*Maxillofacial MRI image capture	$170
D0386	*Maxillofacial ultrasound image capture	$170
D0393	*Treatment simulation using 3D image volume	$10
D0394	*Digital subtraction of two or more images or image volumes of the same modality	$10
D0395	*Fusion of two or more 3D image volumes of one or more modalities	$10
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0

Preventive Dentistry

D1110	*Prophylaxis - adult	$0/$35
D1110	Prophylaxis - adult additional	$20
D1120	*Prophylaxis - child	$0/$25
D1120	Prophylaxis - child additional	$20
D1206	Topical fluoride varnish	$0
D1208	*Topical application of fluoride - excluding varnish	$17/$10
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	*Sealant - per tooth	$5/$20
D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0
D1510	*Space maintainer - fixed - unilateral	$45/$50
D1515	*Space maintainer - fixed - bilateral	$45/$75

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D1520	*Space maintainer - removable - unilateral	$85/$50
D1525	*Space maintainer - removable - bilateral	$85/$75
D1550	*Re-cementation or re-bond space maintainer	$5
D1555	Removal of fixed space maintainer	$5

Restorative Dentistry

D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$70
D2391	Resin-based composite - one surface, posterior	$60
D2392	Resin-based composite - two surfaces, posterior	$80
D2393	Resin-based composite - three surfaces, posterior	$90
D2394	Resin-based composite - four or more surfaces, posterior	$120
D2410	Gold foil - one surface	$65
D2420	Gold foil - two surfaces	$90
D2430	Gold foil - three surfaces	$120
D2510	Inlay - metallic - one surface	$95
D2520	Inlay - metallic - two surfaces	$105
D2530	Inlay - metallic - three or more surfaces	$130
D2542	Onlay - metallic-two surfaces	$230
D2543	Onlay - metallic-three surfaces	$230
D2544	Onlay - metallic-four or more surfaces	$230
D2610	Inlay - porcelain/ceramic - one surface	$230*
D2620	Inlay - porcelain/ceramic - two surfaces	$230*
D2630	Inlay - porcelain/ceramic - three or more surfaces	$230*
D2642	Onlay - porcelain/ceramic - two surfaces	$230*
D2643	Onlay - porcelain/ceramic - three surfaces	$230*
D2644	Onlay - porcelain/ceramic - four or more surfaces	$230*
D2650	Inlay - resin-based composite - one surface	$230
D2651	Inlay - resin-based composite - two surfaces	$230
D2652	Inlay - resin-based composite - three or more surfaces	$230
D2662	Onlay - resin-based composite - two surfaces	$230
D2663	Onlay - resin-based composite - three surfaces	$230
D2664	Onlay - resin-based composite - four or more surfaces	$230
D2710	*Crown - resin-based composite (indirect)	$230
D2712	*Crown - ¾ resin-based composite (indirect)	$230
D2720	*Crown- resin with high noble metal	$230*
D2721	*Crown - resin with predominantly base metal	$230*
D2722	*Crown - resin with noble metal	$230*
D2740	*Crown - porcelain/ceramic substrate	$280*
D2750	*Crown - porcelain fused to high noble metal	$280*
D2751	*Crown - porcelain fused to predominantly base metal	$280*
D2752	*Crown - porcelain fused to noble metal	$280*
D2780	*Crown - 3/4 cast high noble metal	$230*
D2781	*Crown - 3/4 cast predominantly base metal	$230*
D2782	*Crown - 3/4 cast noble metal	$230*
D2783	*Crown - 3/4 porcelain/ceramic	$230*
D2790	*Crown - full cast high noble metal	$280*
D2791	*Crown - full cast predominantly base metal	$280*
D2792	*Crown - full cast noble metal	$280*
D2794	*Crown - titanium	$230*
D2799	Provisional Crown - further treatment or completion of diagnosis necessary prior to final impression	$0
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	$10
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$10
D2921	Reattachment of tooth fragment, incisal edge or cusp	$15
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$50*
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$35
D2933	Prefabricated stainless steel crown with resin window	$35
D2940	Protective restoration	$10
D2941	Interim therapeutic restoration - primary dentition	$15
D2949	Restorative foundation for an indirect restoration	$20
D2950	Core buildup, including any pins	$45
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$60
D2953	Each additional indirectly fabricated post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$60
D2955	Post removal	$10
D2957	Each additional prefabricated post - same tooth	$30
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300*
D2962	Labial veneer (porcelain laminate) - laboratory	$350*
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2975	Coping	$100
D2980	Crown repair necessitated by restorative material failure	$0
D2981	Inlay repair necessitated by restorative material failure	$100
D2982	Onlay repair necessitated by restorative material failure	$100
D2983	Veneer repair necessitated by restorative material failure	$100
D2990	Resin infiltration of incipient smooth surface lesions	$30

Endodontic Services

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0

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D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3221	Pulpal debridement, primary and permanent teeth	$45
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$30
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$35
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$80
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$115
D3330	Endodontic therapy, molar (excluding final restoration)	$200
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy - anterior	$135
D3347	Retreatment of previous root canal therapy - bicuspid	$175
D3348	Retreatment of previous root canal therapy - molar	$275
D3351	Apexification/recalcification	$65
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy - anterior	$95
D3421	Apicoectomy - bicuspid (first root)	$95
D3425	Apicoectomy - molar (first root)	$95
D3426	Apicoectomy (each additional root)	$60
D3427	Periradicular surgery without apicoectomy	$100
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$50
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$45
D3430	Retrograde filling - per root	$40
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$150
D3432	Guided tissue regeneration in conjunction with periradicular	$150
D3450	Root amputation - per root	$95
D3460	Endodontic endosseous implant	$550
D3470	Intentional reimplantation (including necessary splinting)	$175
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15

Periodontic Services

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$40
D4212	Gingivectormy or gingivoplasty to allow access for restorative procedure, per tooth	$50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$120
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$295
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$210
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$215
D4267	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$255
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$245
D4273	Subepithelial connective tissue graft procedures, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4275	Soft tissue allograft	$380
D4276	Combined connective tissue and double pedicle graft, per tooth	$70
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$220
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$80
D4320	Provisional splinting - intracoronal	$95
D4321	Provisional splinting - extracoronal	$85
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$40†

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D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30†
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40†
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$45†
D4910	*Periodontal maintenance	$30
D4910	Periodontal maintenance Additional	$55
D4920	Unscheduled dressing change (by someone other than treating dentist)	$20
D4921	Gingival irrigation - per quadrant	$15
D4999	Unspecified periodontal procedure, by report	$0

Prosthodontics Removable

D5110	*Complete denture - maxillary	$210*
D5120	*Complete denture - mandibular	$210*
D5130	*Immediate denture - maxillary	$225*
D5140	*Immediate denture - mandibular	$225*
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$240*
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$240*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365*
D5281	*Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$250*
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5510	*Repair broken complete denture base	$15*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	$15*
D5610	*Repair resin denture base	$15*
D5620	*Repair cast framework	$30*
D5630	*Repair or replace broken clasp	$15*
D5640	*Replace broken teeth - per tooth	$15*
D5650	*Add tooth to existing partial denture	$30*
D5660	*Add clasp to existing partial denture	$35*
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	$165*
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	$165*
D5710	*Rebase complete maxillary denture	$60*
D5711	*Rebase complete mandibular denture	$60*
D5720	*Rebase maxillary partial denture	$60*
D5721	*Rebase mandibular partial denture	$60*
D5730	*Reline complete maxillary denture (chairside)	$35*
D5731	*Reline complete mandibular denture (chairside)	$35*
D5740	*Reline maxillary partial denture (chairside)	$35*
D5741	*Reline mandibular partial denture (chairside)	$35*
D5750	*Reline complete maxillary denture (laboratory)	$35*
D5751	*Reline complete mandibular denture (laboratory)	$35*
D5760	*Reline maxillary partial denture (laboratory)	$35*
D5761	*Reline mandibular partial denture (laboratory)	$35*
D5810	*Interim Complete denture (maxillary)	$230*
D5811	*Interim complete denture (mandibular)	$230*
D5820	*Interim partial denture (maxillary)	$60*
D5821	*Interim partial denture (mandibular)	$60*
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$160
D5899	Unspecified removable prosthodontic procedure, by report	$0
D5982	Surgical stent	$150*
D5987	Commissure splint	$150*
D5988	Surgical splint	$150*

*Implant Supported Prosthetics

D6190	Radiographic/surgical implant index, by report	$235
D6010	*Surgical placement of implant body; endosteal implant	$950
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$950
D6100	Implant removal, by report	$700
D6056	*Prefabricated abutment – includes placement	$400
D6057	*Customer abutment – includes placement	$600
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$950
D6055	Dental implant supported connecting bar	$1,800
D6110	*implant /abutment supported removable denture for edentulous arch – maxillary	$1,200
D6111	*implant /abutment supported removable denture for edentulous arch – mandibular	$1,200
D6112	*implant /abutment supported removable denture for partially edentulous arch – maxillary	$940
D6113	*implant /abutment supported removable denture for partially edentulous arch – mandibular	$940
D6114	*implant /abutment supported fixed denture for edentulous arch – maxillary	$3,800
D6115	*implant /abutment supported fixed denture for edentulous arch – mandibular	$3,800

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D6116	*implant /abutment supported fixed denture for partially edentulous arch – maxillary	$2,200
D6117	*Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$2,200
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis, and abutments and reinsertion of prosthesis	$180
D6090	Repair implant supported prosthesis, by report	$400
D6095	Repair implant abutment, by report	$220
D6092	Recement implant/abutment supported crown	$45
D6093	Recement implant/abutment supported fixed partial denture	$65

Prosthodontics Fixed

D6205	Pontic - indirect resin based composite	$750
D6210	*Pontic - cast high noble metal	$280*
D6211	*Pontic - cast predominantly base metal	$280*
D6212	*Pontic - cast noble metal	$280*
D6214	*Pontic - titanium	$280*
D6240	*Pontic - porcelain fused to high noble metal	$280*
D6241	*Pontic - porcelain fused to predominantly base metal	$280*
D6242	*Pontic - porcelain fused to noble metal	$280*
D6245	*Pontic - porcelain/ceramic	$280*
D6250	*Pontic - resin with high noble metal	$250*
D6251	*Pontic - resin with predominantly base metal	$230*
D6252	*Pontic - resin with noble metal	$230*
D6253	Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No charge
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$200*
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$375*
D6600	Inlay - porcelain/ceramic, two surfaces	$230*
D6601	Inlay - porcelain/ceramic, three or more surfaces	$230*
D6602	Inlay - cast high noble metal, two surfaces	$230*
D6603	Inlay - cast high noble metal, three or more surfaces	$230*
D6604	Inlay - cast predominantly base metal, two surfaces	$230*
D6605	Inlay - cast predominantly base metal, three or more surfaces	$230*
D6606	Inlay - cast noble metal, two surfaces	$230*
D6607	Inlay - cast noble metal, three or more surfaces	$230*
D6608	Onlay -porcelain/ceramic, two surfaces	$230*
D6609	Onlay - porcelain/ceramic, three or more surfaces	$230*
D6610	Onlay - cast high noble metal, two surfaces	$230*
D6611	Onlay - cast high noble metal, three or more surfaces	$230*
D6612	Onlay - cast predominantly base metal, two surfaces	$230*
D6613	Onlay - cast predominantly base metal, three or more surfaces	$230*
D6614	Onlay - cast noble metal, two surfaces	$230*
D6615	Onlay - cast noble metal, three or more surfaces	$230*
D6624	*Inlay - titanium	$250*
D6634	*Onlay - titanium	$250*
D6710	*Crown - indirect resin based composite	$230*
D6720	*Crown - resin with high noble metal	$230*
D6721	*Crown - resin with predominantly base metal	$230*
D6722	*Crown - resin with noble metal	$230*
D6740	*Crown - porcelain/ceramic	$230*
D6750	*Crown - porcelain fused to high noble metal	$230*
D6751	*Crown - porcelain fused to predominantly base metal	$230*
D6752	*Crown - porcelain fused to noble metal	$230*
D6780	*Crown - 3/4 cast high noble metal	$230*
D6781	*Crown - 3/4 cast predominantly base metal	$230*
D6782	*Crown - 3/4 cast noble metal	$230*
D6783	*Crown - 3/4 porcelain/ceramic	$230*
D6790	*Crown - full cast high noble metal	$230*
D6791	*Crown - full cast predominantly base metal	$230*
D6792	*Crown - full cast noble metal	$230*
D6793	Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$130
D6794	*Crown - titanium	$230*
D6930	Re-cement or re-bond fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6980	Fixed partial denture repair necessitated by restorative material failure	$45

Oral Surgery

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30
D7220	Removal of impacted tooth - soft tissue	$45
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$80
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35
D7251	Cronectomy - intentional partial tooth removal	$270
D7260	Oroantral fistula closure	$140
D7261	Primary closure of a sinus perforation	$280
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	$100
D7280	Surgical access of an unerupted tooth	$85

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D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$0
D7286	Incisional biopsy of oral tissue-soft	$0
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$70
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$370
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$990
D7410	Excision of benign lesion up to 1.25 cm	$30
D7411	Excision of benign lesion greater than 1.25 cm	$50
D7412	Excision of benign lesion, complicated	$60
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$65
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$95
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$25
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7520	Incision and drainage of abscess - extraoral soft tissue	$30
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7910	Suture of recent small wounds up to 5 cm	$25
D7921	Collection and application of autologous blood concentrate product	$130
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogeneous or nonautogeneous, by report	$350
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$800
D7952	Sinus augmentation via a vertical approach	$350
D7953	Bone replacement graft for ridge preservation – per site	$100
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$40
D7963	Frenuloplasty	$40
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of Pericoronal Gingiva	$35
D7972	Surgical reduction of fibrous tuberosity	$130

Orthodontic

D8010	Limited orthodontic treatment of the primary dentition	$1000
D8020	Limited orthodontic treatment of the transitional dentition	$1000
D8030	Limited orthodontic treatment of the adolescent dentition	$1000
D8040	Limited orthodontic treatment of the adult dentition	$1000
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1800
D8090	Comprehensive orthodontic treatment of the adult dentition	$1800
D8210	Removable appliance therapy	$103
D8220	Fixed appliance therapy	$103
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
D8999	Unspecified orthodontic procedure, by report	$250

Miscellaneous

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous moderate (conscious) sedation/analgesia – first 30 minutes	$150
D9242	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	$45

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

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D9248	Non-intravenous moderate (conscious) sedation	$15
D9610	Therapeutic parenteral drug, single administration	$15
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$0
D9940	*Occlusal guard, by report	$85
D9942	Repair and/or reline of Occlusal guard	$40
D9950	Occlusion analysis - mounted case	$75
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching - per arch - performed in office	$125
D9973	External bleaching - per tooth	$30
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$240

Specialty Services

1. This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice.
2. Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.
3. The participating General Dentist you select may not perform all procedures listed. The copayments shown apply to participating General Dentists.
4. Should the services of a specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating specialist at the listed copayments. Please refer to the Specialty Care Referral Policy in your Member handbook.
5. Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member copay.
6. Members seeking implant treatment should refer to their participating implantologist, a select network of providers. Not all providers perform the implant procedures at the copay listed on the Schedule of Benefits. Please refer to the provider listing at www.myuhc.com under "find a physician."

Exclusions

1. Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
2. Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the Member's dental health or experimental in nature, as determined by the participating Solstice dentist.
3. Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
4. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
5. Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
6. Dental procedures initiated prior to the Member's eligibility under this benefit plan or started after the Member's termination from the plan.
7. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member, including but not limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.
8. D9972 Excludes bleaching material for home use.

Limitations

1. Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.
2. All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
4. Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period.
5. Sealants are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
6. Space maintainers and all adjustments are limited to children under the age of 16.

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7. Harmful habit appliances are limited to one (1) time per person under the age of 16.
8. General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
9. New dentures include one (1) reline within the first six (6) months
10. Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
11. When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
12. Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows:

- High noble metal (precious) up to $145.00
- Titanium metal up to $120 (covered with proof of allergy to other metals)
- Noble metal (semi-precious) up to $120.00
- Predominantly base metal (non-precious) up to $55.00
- Crown laboratory fees up to $155.00
- Laboratory fees on dentures up to $225.00
- Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00
- Denture repair laboratory fees up to $50.00
- All ceramic and/or porcelain crown material fees up to $155.00

13. Copayments marked by "†" are not eligible at a specialist.
14. Either D0210 or D0330 are reimbursable one (1) time every five (5) consecutive years.
15. Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
16. D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.
17. All denture adjustment fees are for dentures which were not fabricated at the present office; all denture adjustment for new dentures made within 12 months are at no fee to the member.
18. Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
19. A broken appointment fee up to $20 may be charged by the dental office if 24 hour prior notice is not given.
20. Surgical removal of wisdom teeth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off the general dentists' or specialists' usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
21. Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho copay plus the difference in cost for the enhanced treatment.
22. Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
23. D0364-D0395 is limited to one (1) time per sixty(60) months, covered only in a dental setting and not in a radiographic imaging center

ACCESS+ S1500A STANDARD SCHEDULE OF BENEFITS

Members of the Solstice Access+ S1500A HIGH dental plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No waiting periods
- No deductibles
- No claim forms to submit
- Out-of-network preventive and diagnostic reimbursement

The Member copayments listed are offered by a participating in-network provider. The Member receives:

The Member receives:

- Most diagnostic & preventive care at no charge
- Cosmetic and orthodontia treatment covered

Members can choose a participating provider at www.myuhcdental.com

Member Services Department: 1.800.955.4137

The patient/Member is ultimately responsible for verifications to the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our Members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following Member copayments apply when a participating General Dentist performs services. An "*" denotes limitation on certain benefits (see "Exclusions/Limitations").

Code	Description	Copay/Reimbursement
D0120	*Periodic oral evaluation - established patient	$0/$20
D0140	Limited oral evaluation - problem focused	$0/$20
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0/$25
D0150	*Comprehensive oral evaluation - new or established patient	$0/$30
D0160	*Detailed and extensive oral evaluation - problem focused, by report	$0/$30
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0/$15

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D0180	Comprehensive periodontal evaluation - new or established patient	$20/$15
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$5
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0

Radiography / Diagnostic Dentistry

D0210	*Intraoral - complete series (including bitewings)	$0/$25
D0220	Intraoral - periapical first radiographic images	$0/$4
D0230	Intraoral - periapical each additional radiographic images	$0/$2
D0240	Intraoral - occlusal radiographic images	$0
D0260	Extraoral - each additional radiographic images	$0
D0270	*Bitewing - single radiographic images	$0/$10
D0272	*Bitewings - two radiographic images	$0/$15
D0273	*Bitewings - three radiographic images	$0/$20
D0274	*Bitewings - four radiographic images	$0/$23
D0277	*Vertical bitewings - 7 to 8 radiographic images	$0/$25
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic images	$150
D0310	Sialography	$150
D0320	Temporomandibular joint arthrogram, including injection	$250
D0321	Other temporomandibular joint radiographic imagess, by report	$150
D0322	Tomographic survey	$150
D0330	*Panoramic radiographic images	$0/$25
D0340	Cephalometric radiographic images	$75
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0/$15
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	$150
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$140
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$140
D0367	*Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	$190
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	$140
D0369	*Maxillofacial MRI capture and interpretation	$190
D0370	*Maxillofacial ultrasound capture and interpretation	$170
D0371	*Sialoendoscopy capture and interpretation	$170
D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	$150
D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	$140
D0382	*Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	$140
D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	$190
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	$140
D0385	*Maxillofacial MRI image capture	$170
D0386	*Maxillofacial ultrasound image capture	$170
D0393	*Treatment simulation using 3D image volume	$10
D0394	*Digital subtraction of two or more images or image volumes of the same modality	$10
D0395	*Fusion of two or more 3D image volumes of one or more modalities	$10
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0

Preventive Dentistry

D1110	*Prophylaxis - adult	$0/$30
D1110	Prophylaxis - adult additional	$35
D1120	*Prophylaxis - child	$0/$20
D1120	Prophylaxis - child additional	$35
D1206	Topical fluoride varnish	$0

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

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D1208	*Topical application of fluoride - excluding varnish	$17/$10
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	*Sealant - per tooth	$0/$20
D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0
D1510	*Space maintainer - fixed - unilateral	$65/$50
D1515	*Space maintainer - fixed - bilateral	$65/$75
D1520	*Space maintainer - removable - unilateral	$105/$50
D1525	*Space maintainer - removable - bilateral	$105/$75
D1550	*Re-cementation or re-bond space maintainer	$15
D1555	Removal of fixed space maintainer	$15

Restorative Dentistry

D2140	Amalgam - one surface, primary or permanent	$20
D2150	Amalgam - two surfaces, primary or permanent	$25
D2160	Amalgam - three surfaces, primary or permanent	$30
D2161	Amalgam - four or more surfaces, primary or permanent	$35
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$65
D2391	Resin-based composite - one surface, posterior	$75
D2392	Resin-based composite - two surfaces, posterior	$85
D2393	Resin-based composite - three surfaces, posterior	$95
D2394	Resin-based composite - four or more surfaces, posterior	$120
D2410	Gold foil - one surface	$65
D2420	Gold foil - two surfaces	$90
D2430	Gold foil - three surfaces	$120
D2510	Inlay - metallic - one surface	$155
D2520	Inlay - metallic - two surfaces	$165
D2530	Inlay - metallic - three or more surfaces	$190
D2542	Onlay - metallic-two surfaces	$370
D2543	Onlay - metallic-three surfaces	$370
D2544	Onlay - metallic-four or more surfaces	$370
D2610	Inlay - porcelain/ceramic - one surface	$370*
D2620	Inlay - porcelain/ceramic - two surfaces	$370*
D2630	Inlay - porcelain/ceramic - three or more surfaces	$370*
D2642	Onlay - porcelain/ceramic - two surfaces	$370*
D2643	Onlay - porcelain/ceramic - three surfaces	$370*
D2644	Onlay - porcelain/ceramic - four or more surfaces	$370
D2650	Inlay - resin-based composite - one surface	$370
D2651	Inlay - resin-based composite - two surfaces	$370
D2652	Inlay - resin-based composite - three or more surfaces	$370
D2662	Onlay - resin-based composite - two surfaces	$370
D2663	Onlay - resin-based composite - three surfaces	$370
D2664	Onlay - resin-based composite - four or more surfaces	$370
D2710	*Crown - resin-based composite (indirect)	$370
D2712	*Crown - ¾ resin-based composite (indirect)	$370*
D2720	*Crown- resin with high noble metal	$370*
D2721	*Crown - resin with predominantly base metal	$370*
D2722	*Crown - resin with noble metal	$370*
D2740	*Crown - porcelain/ceramic substrate	$370*
D2750	*Crown - porcelain fused to high noble metal	$370*
D2751	*Crown - porcelain fused to predominantly base metal	$370*
D2752	*Crown - porcelain fused to noble metal	$370*
D2780	*Crown - 3/4 cast high noble metal	$370*
D2781	*Crown - 3/4 cast predominantly base metal	$370*
D2782	*Crown - 3/4 cast noble metal	$370*
D2783	*Crown - 3/4 porcelain/ceramic	$370*
D2790	*Crown - full cast high noble metal	$370*
D2791	*Crown - full cast predominantly base metal	$370*
D2792	*Crown - full cast noble metal	$370*
D2794	*Crown - titanium	$370*
D2799	Provisional Crown - further treatment or completion of diagnosis necessary prior to final impression	$0
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	$15
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$15
D2921	Reattachment of tooth fragment, incisal edge or cusp	$15
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$50
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$45
D2933	Prefabricated stainless steel crown with resin window	$45
D2940	Protective restoration	$0
D2941	Interim therapeutic restoration - primary dentition	$15
D2949	Restorative foundation for an indirect restoration	$20
D2950	Core buildup, including any pins	$60
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$60
D2953	Each additional indirectly fabricated post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$10
D2957	Each additional prefabricated post - same tooth	$30
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300*
D2962	Labial veneer (porcelain laminate) - laboratory	$350*
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2975	Coping	$100
D2980	Crown repair necessitated by restorative material failure	$0

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D2981	Inlay repair necessitated by restorative material failure	$100
D2982	Onlay repair necessitated by restorative material failure	$100
D2983	Veneer repair necessitated by restorative material failure	$100
D2990	Resin infiltration of incipient smooth surface lesions	$30

Endodontic Services

D3110	Pulp cap - direct (excluding final restoration)	$5
D3120	Pulp cap - indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40
D3221	Pulpal debridement, primary and permanent teeth	$60
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$200
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$210
D3330	Endodontic therapy, molar (excluding final restoration)	$310
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$110
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy - anterior	$230
D3347	Retreatment of previous root canal therapy - bicuspid	$280
D3348	Retreatment of previous root canal therapy - molar	$325
D3351	Apexification/recalcification	$70
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$70
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3410	Apicoectomy - anterior	$190
D3421	Apicoectomy - bicuspid (first root)	$95
D3425	Apicoectomy - molar (first root)	$95
D3426	Apicoectomy (each additional root)	$80
D3427	Periradicular surgery without apicoectomy	$100
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$50
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$45
D3430	Retrograde filling - per root	$60
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$150
D3432	Guided tissue regeneration in conjunction with periradicular	$150
D3450	Root amputation - per root	$110
D3460	Endodontic endosseous implant	$550
D3470	Intentional reimplantation (including necessary splinting)	$175
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15

Periodontic Services

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$180
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$55
D4212	Gingivectormy or gingivoplasty to allow access for restorative procedure, per tooth	$50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$170
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$130
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$160
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$330
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$248
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$215
D4267	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$255
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$250
D4273	Subepithelial connective tissue graft procedures, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4275	Soft tissue allograft	$380
D4276	Combined connective tissue and double pedicle graft, per tooth	$70

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D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$220
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$80
D4320	Provisional splinting - intracoronal	$95
D4321	Provisional splinting - extracoronal	$85
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$60†
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$45†
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$50†
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60†
D4910	*Periodontal maintenance	$50
D4910	Periodontal maintenance Additional	$60
D4920	Unscheduled dressing change (by someone other than treating dentist)	$20
D4921	Gingival irrigation - per quadrant	$15
D4999	Unspecified periodontal procedure, by report	$0

Prosthodontics Removable

D5110	*Complete denture - maxillary	$375*
D5120	*Complete denture - mandibular	$375*
D5130	*Immediate denture - maxillary	$375*
D5140	*Immediate denture - mandibular	$375*
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$375*
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$375*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$480*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$480*
D5281	*Removable unilateral partial denture - one piece cast metal (including clasps and teeth	$360*
D5410	Adjust complete denture - maxillary	$20
D5411	Adjust complete denture - mandibular	$20
D5421	Adjust partial denture - maxillary	$20
D5422	Adjust partial denture - mandibular	$20
D5510	*Repair broken complete denture base	$30*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	$30*
D5610	*Repair resin denture base	$30*
D5620	*Repair cast framework	$50*
D5630	*Repair or replace broken clasp	$30*
D5640	*Replace broken teeth - per tooth	$30*
D5650	*Add tooth to existing partial denture	$45*
D5660	*Add clasp to existing partial denture	$70*
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	$165*
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	$165*
D5710	*Rebase complete maxillary denture	$125*
D5711	*Rebase complete mandibular denture	$125*
D5720	*Rebase maxillary partial denture	$125*
D5721	*Rebase mandibular partial denture	$125*
D5730	*Reline complete maxillary denture (chairside)	$65*
D5731	*Reline complete mandibular denture (chairside)	$65*
D5740	*Reline maxillary partial denture (chairside)	$65*
D5741	*Reline mandibular partial denture (chairside)	$65*
D5750	*Reline complete maxillary denture (laboratory)	$50*
D5751	*Reline complete mandibular denture (laboratory)	$50*
D5760	*Reline maxillary partial denture (laboratory)	$50*
D5761	*Reline mandibular partial denture (laboratory)	$50*
D5810	*Interim Complete denture (maxillary)	$230*
D5811	*Interim complete denture (mandibular)	$230*
D5820	*Interim partial denture (maxillary)	$160*
D5821	*Interim partial denture (mandibular)	$170*
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
D5862	Precision attachment, by report	$160
D5899	Unspecified removable prosthodontic procedure, by report	$0
D5982	Surgical stent	$150*
D5987	Commissure splint	$150*
D5988	Surgical splint	$150*

*Implant Supported Prosthetics

D6190	Radiographic/surgical implant index, by report	$235
D6010	*Surgical placement of implant body; endosteal implant	$950
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$950
D6100	Implant removal, by report	$700
D6056	*Prefabricated abutment – includes placement	$400
D6057	*Customer abutment – includes placement	$600
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$950
D6055	Dental implant supported connecting bar	$1,800
D6110	*implant /abutment supported removable denture for edentulous arch – maxillary	$1,200
D6111	*implant /abutment supported removable denture for edentulous arch – mandibular	$1,200

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

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D6112	*implant /abutment supported removable denture for partially edentulous arch – maxillary	$940
D6113	*implant /abutment supported removable denture for partially edentulous arch – mandibular	$940
D6114	*implant /abutment supported fixed denture for edentulous arch – maxillary	$3,800
D6115	*implant /abutment supported fixed denture for edentulous arch – mandibular	$3,800
D6116	*implant /abutment supported fixed denture for partially edentulous arch – maxillary	$2,200
D6117	*Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$2,200
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis, and abutments and reinsertion of prosthesis	$180
D6090	Repair implant supported prosthesis, by report	$400
D6095	Repair implant abutment, by report	$220
D6092	Recement implant/abutment supported crown	$45
D6093	Recement implant/abutment supported fixed partial denture	$65

Prosthodontics Fixed

D6205	Pontic - indirect resin based composite	$750
D6210	*Pontic - cast high noble metal	$370*
D6211	*Pontic - cast predominantly base metal	$370*
D6212	*Pontic - cast noble metal	$370*
D6214	*Pontic - titanium	$370*
D6240	*Pontic - porcelain fused to high noble metal	$370*
D6241	*Pontic - porcelain fused to predominantly base metal	$370*
D6242	*Pontic - porcelain fused to noble metal	$370*
D6245	*Pontic - porcelain/ceramic	$370*
D6250	*Pontic - resin with high noble metal	$370*
D6251	*Pontic - resin with predominantly base metal	$370*
D6252	*Pontic - resin with noble metal	$370*
D6253	Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No charge
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$370*
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$375*
D6600	Inlay - porcelain/ceramic, two surfaces	$370*
D6601	Inlay - porcelain/ceramic, three or more surfaces	$370*
D6602	Inlay - cast high noble metal, two surfaces	$370*
D6603	Inlay - cast high noble metal, three or more surfaces	$370*
D6604	Inlay - cast predominantly base metal, two surfaces	$370*
D6605	Inlay - cast predominantly base metal, three or more surfaces	$370*
D6606	Inlay - cast noble metal, two surfaces	$370*
D6607	Inlay - cast noble metal, three or more surfaces	$370*
D6608	Onlay -porcelain/ceramic, two surfaces	$370*
D6609	Onlay - porcelain/ceramic, three or more surfaces	$370*
D6610	Onlay - cast high noble metal, two surfaces	$370*
D6611	Onlay - cast high noble metal, three or more surfaces	$370*
D6612	Onlay - cast predominantly base metal, two surfaces	$370*
D6613	Onlay - cast predominantly base metal, three or more surfaces	$370*
D6614	Onlay - cast noble metal, two surfaces	$370*
D6615	Onlay - cast noble metal, three or more surfaces	$370*
D6624	*Inlay - titanium	$250*
D6634	*Onlay - titanium	$250*
D6710	*Crown - indirect resin based composite	$370*
D6720	*Crown - resin with high noble metal	$370*
D6721	*Crown - resin with predominantly base metal	$370*
D6722	*Crown - resin with noble metal	$370*
D6740	*Crown - porcelain/ceramic	$370*
D6750	*Crown - porcelain fused to high noble metal	$370*
D6751	*Crown - porcelain fused to predominantly base metal	$370*
D6752	*Crown - porcelain fused to noble metal	$370*
D6780	*Crown - 3/4 cast high noble metal	$370*
D6781	*Crown - 3/4 cast predominantly base metal	$370*
D6782	*Crown - 3/4 cast noble metal	$370*
D6783	*Crown - 3/4 porcelain/ceramic	$370*
D6790	*Crown - full cast high noble metal	$370*
D6791	*Crown - full cast predominantly base metal	$370*
D6792	*Crown - full cast noble metal	$370*
D6793	Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$130
D6794	*Crown - titanium	$370*
D6930	Re-cement or re-bond fixed partial denture	$15
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6980	Fixed partial denture repair necessitated by restorative material failure	$45

Oral Surgery

D7111	Extraction, coronal remnants - deciduous tooth	$20
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$20
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth - soft tissue	$75
D7230	Removal of impacted tooth - partially bony	$85
D7240	Removal of impacted tooth - completely bony	$135
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	$65
D7251	Cronectomy - intentional partial tooth removal	$270
D7260	Oroantral fistula closure	$140

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D7261	Primary closure of a sinus perforation	$280
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$80
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	$100
D7280	Surgical access of an unerupted tooth	$100
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$150
D7286	Incisional biopsy of oral tissue-soft	$60
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$100
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$370
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$990
D7410	Excision of benign lesion up to 1.25 cm	$30
D7411	Excision of benign lesion greater than 1.25 cm	$50
D7412	Excision of benign lesion, complicated	$60
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$65
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$95
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$35
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess - extraoral soft tissue	$35
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7910	Suture of recent small wounds up to 5 cm	$25
D7921	Collection and application of autologous blood concentrate product	$130
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogeneous or nonautogeneous, by report	$350
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$800
D7952	Sinus augmentation via a vertical approach	$350
D7953	Bone replacement graft for ridge preservation – per site	$100
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$90
D7963	Frenuloplasty	$90
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of Pericoronal Gingiva	$40
D7972	Surgical reduction of fibrous tuberosity	$130

Orthodontic

D8010	Limited orthodontic treatment of the primary dentition	$1095
D8020	Limited orthodontic treatment of the transitional dentition	$1095
D8030	Limited orthodontic treatment of the dolescent dentition	$1095
D8040	Limited orthodontic treatment of the adult dentition	$1095
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2095
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2095
D8090	Comprehensive orthodontic treatment of the adult dentition	$2095
D8210	Removable appliance therapy	$103
D8220	Fixed appliance therapy	$103
D8660	Pre-orthodontic treatment examination to monitor growth and development	$35
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$250
D8999	Unspecified orthodontic procedure, by report	$250

Miscellaneous

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$15
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$150

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D9221	Deep sedation/general anesthesia – each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous moderate (conscious) sedation/analgesia – first 30 minutes	$150
D9242	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	$45
D9248	Non-intravenous moderate (conscious) sedation	$15
D9610	Therapeutic parenteral drug, single administration	$15
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$0
D9940	*Occlusal guard, by report	$85
D9942	Repair and/or reline of Occlusal guard	$40
D9950	Occlusion analysis - mounted case	$75
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching - per arch - performed in office	$125
D9973	External bleaching - per tooth	$30
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$240

Specialty Services

1. This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice.
2. Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.
3. The participating General Dentist you select may not perform all procedures listed. The copayments shown apply to participating General Dentists.
4. Should the services of a specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating specialist at the listed copayments. Please refer to the Specialty Care Referral Policy in your Member handbook.
5. Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member copay.
6. Members seeking implant treatment should refer to their participating implantologist, a select network of providers. Not all providers perform the implant procedures at the copay listed on the Schedule of Benefits. Please refer to the provider listing at www.myuhcdental.com under "find a physician.
7. **Exclusions:**
   - Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
   - Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the Member's dental health or experimental in nature, as determined by the participating Solstice dentist.
   - Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
   - Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
   - Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
   - Dental procedures initiated prior to the Member's eligibility under this benefit plan or started after the Member's termination from the plan.
   - Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member, including but not limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.
   - D9972 Excludes bleaching material for home use.

Limitations

1. Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.
2. All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
4. Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period.
5. Sealants are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
6. Space maintainers and all adjustments are limited to children

under the age of 16.

7. Harmful habit appliances are limited to one (1) time per person under the age of 16.
8. General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
9. New dentures include one (1) reline within the first six (6) months
10. Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
11. When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
12. Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows:
    - High noble metal (precious) up to $145.00
    - Titanium metal up to $120 (covered with proof of allergy to other metals)
    - Noble metal (semi-precious) up to $120.00
    - Predominantly base metal (non-precious) up to $55.00
    - Crown laboratory fees up to $155.00
    - Laboratory fees on dentures up to $225.00
    - Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00
    - Denture repair laboratory fees up to $50.00
    - All ceramic and/or porcelain crown material fees up to $155.00
13. Copayments marked by "†" are not eligible at a specialist.
14. Either D0210 or D0330 are reimbursable one (1) time every five (5) consecutive years.
15. Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
16. D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.
17. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.
18. Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
19. A broken appointment fee up to $20 may be charged by the dental office if 24 hour prior notice is not given.
20. Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists' or specialists' usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
21. Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Orthodontic copay plus the difference in cost for the enhanced treatment.
22. Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
23. D0364-D0395 is limited to one (1) time per sixty(60) months, covered only in a dental setting and not in a radiographic imaging center.

UHC PPO Plans

UnitedHealthcare (UHC) PPO Plans

Click here for the Dental Presentation: [LINK PENDING]

UnitedHealthcare PPO Plans

UnitedHealthcare PPO Plans are traditional indemnity plans, you have the choice of two plans, a Standard PPO Plan or the High PPO Plan. You save money and receive a higher level of coverage when choosing a participating dentist, these dentists have agreed to a discounted fee schedule resulting in a lower out-of-pocket expense to the member.

Why choose a UnitedHealthcare dental PPO plan?

Whether you select the Standard PPO Plan or the High PPO Plan, you can see any dentist or specialist in or outside the UnitedHealthcare national network. However, you can save money by choosing a dentist who is part of the network because network dentists agree to discount their services by 20-30% for UnitedHealthcare dental members.

Preventive care such as exams and cleanings are covered at little or no cost to you. The plan also covers Oral Cancer screenings each year for adult members. There is also a Pregnancy Dental Benefit designed to cover extra visits for dental cleanings and gum treatments, if needed, during pregnancy and the first three months after the baby is born.

Am I eligible for this coverage?

You may elect to enroll in the dental plan if you are an active, benefit-eligible employee working a minimum of 20 hours per week on a regularly scheduled basis.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and stepchildren to the end of the calendar year they reach age 26
- Children older than age 26 will remain covered under this plan only if proof is submitted that he/she suffers from a physical handicap or mental retardation, provided the child remains chiefly dependent upon you for support.
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

How do I select my dental provider?

You may select a dental provider who is part of the large national UnitedHealthcare network. Visit www.myuhcdental.com and click on Find a Dentist under Links and Tools to choose a network doctor or make changes. If you would like to keep the dentist you have under your prior plan and are now changing plans, you may maintain that same dentist provided they are part of the UnitedHealthcare network.

How can I make an appointment with my dentist?

To schedule an appointment, you may call a dentist you've selected through the UnitedHealthcare network or any other licensed dentist on or after your effective date of coverage. Be sure to bring your ID card each time you visit your dentist.

How are my dental visits paid for?

When you see a network dentist, you don't need to worry about claim forms. Your dentist will bill UnitedHealthcare who will pay them directly. If you see a dentist who is not part of the network, the dentist may bill you and you can then send the claim to UnitedHealthcare.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to the UnitedHealthcare Member Services at 1.877.816.3596.

UHC PPO Plans

UHC PPO Standard

Standard PPO Plan – PIN31

The Standard Plan is a low-cost option, which allows you and each of your covered family members to use a provider of your choice; however, you'll receive a higher level of coverage when you choose a participating network provider. The Standard Plan includes a copay schedule that applies to the various in-network dental procedures. You do NOT have to satisfy an annual calendar year deductible if you seek services from an in-network dental provider. If you use an out-of-network provider fees are subject to Maximum Allowable Charges (MAC).

Benefit	**In-Network**	**Out-of-Network**
Individual Annual Deductible	$0	$50
Family Annual Deductible	$0	$150 (applies to Classes I, II and III)
Maximum (the sum of all Network and Non-network benefits will not exceed the Annual Maximum)	$1,500 per person per calendar year	$1,500 per person per calendar year
Lifetime Orthodontic Maximum	$1,500 per person per Lifetime	$1,500 per person per Lifetime
Waiting Period	None	
Diagnostic and Preventive Services	**In-Network** **Miami-Dade County (Area 2)**	**Out-of-Network*** **
	EMPLOYEE PAYS	PLAN PAYS
Periodic Exam	$0	90% of MAC
Radiographs (bitewings)	$0	90% of MAC
Prophylaxis (Cleaning)	$15	90% of MAC
Fluoride Treatment	$0	90% of MAC
Basic Services		
Amalgam - 2 Surfaces	$45	60% of MAC
Sealants	$10	60% of MAC
Space Maintainers - Unilateral	$100	60% of MAC
Periodontics- Maintenance	$35	60% of MAC
Major Services		
General Anesthesia	$120	30% of MAC
Simple Extractions	$45	30% of MAC
Oral Surgery - Surgical Removal of Erupted tooth	$90	30% of MAC
Endodontics Anterior Root Canal Bicuspid Root Canal Molar Root Canal	 $265 $315 $425	30% of MAC
Crowns/Onlays* - Metal Porcelain	$390	30% of MAC

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.
**Miami-Dade County (Area 2) consist of zip codes that begin with digits 330-332, 338, 341-342 and 349. If you do not reside in a zip code that begins with these digits, please contact UnitedHealthcare Member Services at 1.877.816.3596 for more accurate in-network schedule of benefits copay.
***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

UHC PPO Plans

UHC PPO Standard

Benefits Continued	In-Network	Out-of-Network
Major Services Continued		
Inlays	$295	30% of MAC
Periodontic-Scaling and Root Planing (per quadrant)	$75	30% of MAC
Complete Dentures	$485	30% of MAC
Partial Dentures – Resin Base	$375	30% of MAC
Fixed Partial Dentures Pontics (Bridges)*	$375	30% of MAC
Orthodontic Services		
Diagnose or correct misalignment of teeth or bite (Adult and Child)	$2,100	50% of MAC

*Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.
**Miami-Dade County (Area 2) consist of zip codes that begin with digits 330-332, 338, 341-342 and 349. If you do not reside in a zip code that begins with these digits, please contact UnitedHealthcare Member Services at 1.877.816.3596 for more accurate in-network schedule of benefits copay.
***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

UHC PPO Plans

UHC PPO High

PPO High Plan – 0P542

The High Plan is designed for those individuals who have more extensive dental needs. This option allows you and each of your covered family members to use a provider of your choice; however, you'll receive a higher level of coverage when you choose a participating network provider. If you use an out-of-network provider fees are subject to Maximum Allowable Charges (MAC).

Benefit	**In-Network**	**Out-of-Network**
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150 (applies to Classes II and III)	$150 (applies to Classes I, II and III)
Maximum (the sum of all Network and Non-network benefits will not exceed the Annual Maximum)	$1,500 per person per calendar year	$1,500 per person per calendar year
Lifetime Orthodontic Maximum	$1,500 per person per Lifetime	$1,500 per person per Lifetime
Waiting Period	None	
Diagnostic and Preventive Services	**In-Network****	**Out-of-Network*****
	PLAN PAYS	PLAN PAYS
Periodic Exam	100%	100% of MAC
Radiographs (bitewings)	100%	100% of MAC
Prophylaxis (Cleaning)	100%	100% of MAC
Fluoride Treatment (Preventive)	100%	100% of MAC
Sealants	100%	100% of MAC
Space Maintainers	100%	100% of MAC
Basic Services		
Restorations (Amalgams or Composites)*	80%	80% of MAC
General Anesthesia	80%	80% of MAC
Emergency Treatment	80%	80% of MAC
Simple Extractions	80%	80% of MAC
Periodontics Periodontics - Non-Surgical Periodontics - Maintenance	 80% 80%	 80% of MAC 80% of MAC
Endodontics - Pulpotomy	80%	80% of MAC
Major Services		
Oral Surgery (incl. surgical extractions)	50%	50% of MAC
Periodontics Periodontics – Surgical Periodontics – Osseus Surgery	 50% 50%	 50% of MAC 50% of MAC

If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern.

UHC PPO Plans

UHC PPO High

Benefits Continued	In-Network	Out-of-Network
Major Services Continued		
Endodontics – Other	50%	50% of MAC
Inlays/Onlays/Crowns*	50%	50% of MAC
Dentures and other Removable Prsothetics	50%	50% of MAC
Fixed Partial Dentures (Bridges)*	50%	50% of MAC
Orthodontic Services		
Diagnose or correct misalignment of teeth or bite (Adult and Child)	50%	50% of MAC

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.
**The network percentage of benefits is based on the discounted fees negotiated with the provider.
***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographical area in which the expenses are incurred.

Pre-Treatment Plans for PPO Plans

It is highly recommended that prior to having dental work started; you request a pre-treatment plan or estimate, from your dentist on all treatment over $500. Should you have any questions regarding your treatment plan, you can always refer PPO plans benefits description above or call UnitedHealthcare Dental so we can ensure that you receive the maximum benefit from your dental plan.

Dental benefits can be found at www.myuhcdental.com.

The information you need is all in one place. When you sign in at www.myuhcdental.com, you can quickly find answers and complete important tasks 24 hours a day:

- Locate a dentist
- Review your coverage
- Compare costs with the Treatment Cost Calculator
- Check your dental claims
- Get answers to the most frequently asked questions
- Learn about oral health and dental treatment
- Request a dental ID card

UHC PPO Plans

UHC PPO High

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment, and

D. Not excluded as described in the Section entitled. General Exclusions.

General Limitations:

1. PERIODIC ORAL EVALUATION Limited to two times per consecutive 12 months.
2. COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to onetime per consecutive 36 months.
3. BITEWING RADIOGRAPHS Limited to one series of films per calendar year.
4. EXTRAORAL RADIOGRAPHS Limited to two films per calendar year.
5. DENTAL PROPHLYAXIS Limited to two times per consecutive 12 months.
6. FLUORIDE TREATMENTS Limited to covered persons under the age of 19 years, and limited to two times per consecutive 12 months.
7. SPACE MAINTAINERS Limited to covered persons under the age of 19 years, limited to one per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. Sealants Limited to covered persons under the age of 19 years, and once per first or second permanent molar every consecutive 60 months.
9. RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
10. PIN RETENTION Limited to two pins per tooth; not covered in addition to cast restoration.
11. INLAYS AND ONLAYS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. CROWNS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. POST AND CORES Covered only for teeth that have had root canal therapy.
14. SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. SCALING AND ROOT PLANING Limited to one time per quadrant per consecutive 24 months.
16. ROOT CANAL THERAPY Limited to one time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Limited to four times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. FULL DENTURES Limited to one time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to one time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than six months after the initial insertion. Limited to one time per consecutive 12 months.
21. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per consecutive six months.
22. PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. FULL MOUTH DEBRIDEMENT Limited to one time every consecutive 36 months.
24. GENERAL ANESTHESIA Covered only when clinically necessary.
25. OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
26. PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to one quadrant or site per consecutive 36 months per surgical area.
27. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

UHC PPO Plans

UHC PPO High

General Exclusions:

The following are not covered:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
25. Foreign Services are not Covered unless required as an Emergency.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.