Solstice

DHMO DENTAL & VISION

HEALTH WELLNESS & EDUCATION ASSOCIATION

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S700B
Dental Plan Schedule of Benefits

Members of the S700B Dental Plan are eligible to receive benefits immediately upon the Effective Date of coverage with:

- No waiting Periods
- No deductibles or maximums
- No claim forms to submit

The Member Co-payments listed are offered by a Network General Dentists. The Member receives:

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

Members can locate a participating provider at
www.SolsticeBenefits.com
Member Services Department: 1.877.760.2247

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

The following Member Co-payments apply when a Network General Dentist performs services. An "*" denotes limitations on certain Benefits (see "Exclusions/Limitations").

CODE	DESCRIPTION	MEMBER COPAY
	CLINICAL ORAL EVALUATIONS	
D0120	*Periodic oral evaluation - established patient	0
D0140	Limited oral evaluation - problem focused	0
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	*Comprehensive oral evaluation - new or established patient	0
D0160	*Detailed and extensive oral evaluation - problem focused, by report	0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0
D0171	Re-evaluation – post-operative office visit	0
D0180	*Comprehensive periodontal evaluation - new or established patient	0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	25
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	0
D9440	Office visit - after regularly scheduled hours	35
D9450	Case presentation, subsequent to detailed and extensive treatment planning	0
D9986	Missed appointment	25
	DIAGNOSTIC IMAGING	
D0210	*Intraoral – comprehensive series of radiographic images	0
D0220	Intraoral - periapical first radiographic image	4
D0230	Intraoral - periapical each additional radiographic image	2
D0240	Intraoral - occlusal radiographic image	0
D0250	Extra-oral – 2d projection radiographic image created using a stationary radiation source, and detector	0
D0251	*Extra-oral posterior dental radiographic image	0
D0270	*Bitewing - single radiographic image	0
D0272	*Bitewings - two radiographic images	0
D0273	*Bitewings - three radiographic images	0
D0274	*Bitewings - four radiographic images	0
D0277	*Vertical bitewings - 7 to 8 radiographic images	29
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 image	50
D0340	2d cephalometric radiographic image – acquisition, measurement and analysis	125
D0350	2d oral/facial photographic image obtained intra-orally or extra-orally	20
D0364	*Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	169
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	149
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	139
D0367	*Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	139
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	184

CODE	DESCRIPTION	MEMBER COPAY
D0369	*Maxillofacial MRI capture and interpretation	139
D0370	*Maxillofacial ultrasound capture and interpretation	189
D0371	*Sialoendoscopy capture and interpretation	169
D0372	*Intraoral tomosynthesis – comprehensive series of radiographic images	0
D0373	*Intraoral tomosynthesis – bitewing radiographic image	0
D0374	Intraoral tomosynthesis – periapical radiographic image	4
D0380	*Cone beam CT image capture with limited field of view – less than one whole jaw	169
D0381	*Cone beam CT image capture with field of view of one full dental arch – mandible	149
D0382	*Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	139
D0383	*Cone beam CT image capture with field of view of both jaws; with or without cranium	139
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	184
D0385	*Maxillofacial MRI image capture	139
D0386	*Maxillofacial ultrasound image capture	169
D0387	*Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0
D0388	*Intraoral tomosynthesis – bitewing radiographic image – image capture only	0
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	4
D0393	*Virtual treatment simulation using 3d image volume or surface scan	9
D0394	*Digital subtraction of two or more images or image volumes of the same modality	9
D0395	*Fusion of two or more 3d image volumes of one or more modalities	9
	TESTS AND EXAMINATIONS	
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	65
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
	ORAL PATHOLOGY LABORATORY	
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 transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	0
D0502	Other oral pathology procedures, by report	0
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	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
D0701	*Panoramic radiographic image – image capture only	50
D0702	*2-D cephalometric radiographic image – image capture only	125
D0703	*2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	20
D0705	*Extra-oral posterior dental radiographic image – image capture only	0
D0706	*Intraoral – occlusal radiographic image – image capture only	0
D0707	*Intraoral – periapical radiographic image – image capture only	2
D0708	*Intraoral – bitewing radiographic image – image capture only	0
D0709	*Intraoral – comprehensive series of radiographic images – image capture only	0
D0801	*3D dental surface scan – direct	9
D0802	*3D dental surface scan – indirect	9
D0803	*3D facial surface scan – direct	9
D0804	*3D facial surface scan – indirect	9
	DENTAL PROPHYLAXIS	
D1110	*Prophylaxis - adult	0
D1110	Additional prophylaxis - adult	20
D1120	*Prophylaxis - child	0
D1120	Additional prophylaxis - child	20
	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)	
D1206	*Topical application of fluoride varnish	15
D1208	*Topical application of fluoride – excluding varnish	0
D9910	*Application of desensitizing medicament	20
	OTHER PREVENTIVE SERVICES	
D1301	Immunization counseling	0
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
D1352	*Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	0
D1353	Sealant repair – per tooth	0

CODE	DESCRIPTION	MEMBER COPAY
D1354	*Application of caries arresting medicament – per tooth	20
D1355	Caries preventive medicament application – per tooth	20
	SPACE MAINTAINERS (PASSIVE APPLIANCES)	
D1510	*Space maintainer - fixed, unilateral - per quadrant	0
D1516	*Space maintainer – fixed – bilateral, maxillary	0
D1517	*Space maintainer – fixed – bilateral, mandibular	0
D1520	*Space maintainer - removable, unilateral - per quadrant	0
D1526	*Space maintainer – removable – bilateral, maxillary	0
D1527	*Space maintainer – removable – bilateral, mandibular	0
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	15
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	15
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	15
D1556	Removal of fixed unilateral space maintainer - per quadrant	15
D1557	Removal of fixed bilateral space maintainer - maxillary	15
D1558	Removal of fixed bilateral space maintainer - mandibular	15
D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant	0
	AMALGAMS RESTORATIONS (INCLUDING POLISHING)	
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
	RESIN BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-based composite - one surface, anterior	30
D2331	Resin-based composite - two surfaces, anterior	37
D2332	Resin-based composite - three surfaces, anterior	50
D2335	Resin-based composite - four or more surfaces (anterior)	80
D2390	Resin-based composite crown, anterior	115
D2391	Resin-based composite - one surface, posterior	65
D2392	Resin-based composite - two surfaces, posterior	75
D2393	Resin-based composite - three surfaces, posterior	90
D2394	Resin-based composite - four or more surfaces, posterior	115
	GOLD FOIL RESTORATIONS	
D2410	Gold foil - one surface	75
D2420	Gold foil - two surfaces	95
D2430	Gold foil - three surfaces	125
	INLAY/ONLAY RESTORATIONS	
D2510	Inlay - metallic - one surface	225
D2520	Inlay - metallic - two surfaces	235
D2530	Inlay - metallic - three or more surfaces	245
D2542	Onlay - metallic - two surfaces	325
D2543	Onlay - metallic - three surfaces	340
D2544	Onlay - metallic - four or more surfaces	350
D2610	Inlay - porcelain/ceramic - one surface	275*
D2620	Inlay - porcelain/ceramic - two surfaces	300*
D2630	Inlay - porcelain/ceramic - three or more surfaces	325*
D2642	Onlay - porcelain/ceramic - two surfaces	360*
D2643	Onlay - porcelain/ceramic - three surfaces	390*
D2644	Onlay - porcelain/ceramic - four or more surfaces	400*
D2650	Inlay - resin-based composite - one surface	200
D2651	Inlay - resin-based composite - two surfaces	220
D2652	Inlay - resin-based composite - three or more surfaces	260
D2662	Onlay - resin-based composite - two surfaces	240
D2663	Onlay - resin-based composite - three surfaces	260
D2664	Onlay - resin-based composite - four or more surfaces	283
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	*Crown - resin-based composite (indirect)	195
D2712	*Crown - ¾ resin-based composite (indirect)	195
D2720	*Crown - resin with high noble metal	245*
D2721	*Crown - resin with predominantly base metal	245*
D2722	*Crown - resin with noble metal	245*
D2740	*Crown - porcelain/ceramic	245*
D2750	*Crown - porcelain fused to high noble metal	245*
D2751	*Crown - porcelain fused to predominantly base metal	245*
D2752	*Crown - porcelain fused to noble metal	245*
D2753	*Crown - porcelain fused to titanium and titanium alloys	245*
D2780	*Crown - 3/4 cast high noble metal	245*
D2781	*Crown - 3/4 cast predominantly base metal	245*
D2782	*Crown - 3/4 cast noble metal	245*
D2783	*Crown - 3/4 porcelain/ceramic	245*
D2790	*Crown - full cast high noble metal	245*
D2791	*Crown - full cast predominantly base metal	245*
D2792	*Crown - full cast noble metal	245*
D2794	*Crown - titanium and titanium alloys	245*
D2799	*Interim crown– further treatment or completion of diagnosis necessary prior to final impression	125
	OTHER RESTORATIVE SERVICES	
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	20
D2920	Re-cement or re-bond crown	15
D2921	Reattachment of tooth fragment, incisal edge or cusp	15
D2928	*Prefabricated porcelain/ceramic crown – permanent tooth	49*
D2929	*Prefabricated porcelain/ceramic crown – primary tooth	49*

CODE	DESCRIPTION	MEMBER COPAY
D2930	Prefabricated stainless steel crown - primary tooth	45
D2931	Prefabricated stainless steel crown - permanent tooth	55
D2932	Prefabricated resin crown	95
D2933	Prefabricated stainless steel crown with resin window	145
D2940	Protective restoration	15
D2949	Restorative foundation for an indirect restoration	20
D2950	Core buildup, including any pins when required	70
D2951	Pin retention - per tooth, in addition to restoration	15
D2952	Post and core in addition to crown, indirectly fabricated	88
D2953	Each additional indirectly fabricated post - same tooth	95
D2954	Prefabricated post and core in addition to crown	75
D2955	Post removal	30
D2957	Each additional prefabricated post - same tooth	30
D2960	Labial veneer (resin laminate) - direct	200
D2961	Labial veneer (resin laminate) - indirect	255*
D2962	Labial veneer (porcelain laminate) - indirect	390*
D2971	Additional procedures to construct new crown under existing partial denture framework	45
D2975	Coping	95
D2980	Crown repair necessitated by restorative material failure	95
D2981	Inlay repair necessitated by restorative material failure	95
D2982	Onlay repair necessitated by restorative material failure	95
D2983	Veneer repair necessitated by restorative material failure	95
D2989	Excavation of a tooth resulting in the determination of non-restorability	125
D2990	Resin infiltration of incipient smooth surface lesions	29
D2991	Application of hydroxyapatite regeneration medicament – per tooth	0
	PULP CAPPING	
D3110	Pulp cap - direct (excluding final restoration)	25
D3120	Pulp cap - indirect (excluding final restoration)	25
	PULPOTOMY	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	30
D3221	Pulpal debridement, primary and permanent teeth	95
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	75
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	50
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50

CODE	DESCRIPTION	MEMBER COPAY
	ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES & FOLLOW-UP CARE)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	110
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	195
D3330	Endodontic therapy, molar tooth (excluding final restoration)	245
D3331	Treatment of root canal obstruction; non-surgical access	85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75
D3333	Internal root repair of perforation defects	125
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	300
D3347	Retreatment of previous root canal therapy - premolar	350
D3348	Retreatment of previous root canal therapy - molar	440
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	90
D3352	Apexification/recalcification – interim medication replacement	90
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	90
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - anterior	100
D3421	Apicoectomy - premolar (first root)	315
D3425	Apicoectomy - molar (first root)	340
D3426	Apicoectomy (each additional root)	95
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	47
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	42
D3430	Retrograde filling - per root	75
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	150
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	150
D3450	Root amputation - per root	110
D3460	Endodontic endosseous implant	545
D3470	Intentional reimplantation (including necessary splinting)	175
D3471	Surgical repair of root resorption – anterior	100
D3472	Surgical repair of root resorption – premolar	315
D3473	Surgical repair of root resorption – molar	340
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	100
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	100
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	100

CODE	DESCRIPTION	MEMBER COPAY
	OTHER ENDODONTIC PROCEDURES	
D3910	Surgical procedure for isolation of tooth with rubber dam	95
D3920	Hemisection (including any root removal), not including root canal therapy	90
D3921	Decoronation or submergence of an erupted tooth	30
D3950	Canal preparation and fitting of preformed dowel or post	75
	SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	175
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	81
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	49
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	195
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	185
D4245	Apically positioned flap	150
D4249	Clinical crown lengthening – hard tissue	230
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	375
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	325
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	450
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	325
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	82
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	325
D4267	Guided tissue regeneration, natural teeth - nonresorbable barrier, per site (includes membrane removal)	325
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	250
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	335
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	125
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	502
D4276	Combined connective tissue and pedicle graft, per tooth	65
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	215
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	75
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	299
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	392
D4286	Removal of non-resorbable barrier	20
	NON SURGICAL PERIODONTAL SERVICE	
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	115
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	105
D4341	*Periodontal scaling and root planing - four or more teeth per quadrant	50†
D4342	*Periodontal scaling and root planing - one to three teeth per quadrant	43†
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	50†
D4355	*Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50†
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	60†
	OTHER PERIODONTAL SERVICES	
D4910	*Periodontal maintenance	50
D4910	Additional Periodontal maintenance procedures	100
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	25
D4921	Gingival irrigation with a medical agent – per quadrant	15
D4999	Unspecified periodontal procedure, by report	0
	COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5110	*Complete denture - maxillary	325*
D5120	*Complete denture - mandibular	325*
D5130	*Immediate denture - maxillary	350*
D5140	*Immediate denture - mandibular	350*
	PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5211	*Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	400*
D5212	*Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	400*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	425*

CODE	DESCRIPTION	MEMBER COPAY
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	425*
D5221	*Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	420*
D5222	*Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	420*
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	445*
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	445*
D5225	*Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	425*
D5226	*Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	425*
D5227	*Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	425*
D5228	*Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	425*
D5282	*Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	245*
D5283	*Removable unilateral partial denture – one piece cast metal (including rententive/clasping materias, rests, and teeth), mandibular	245*
	ADJUSTMENTS TO DENTURES	
D5410	Adjust complete denture - maxillary	15
D5411	Adjust complete denture - mandibular	15
D5421	Adjust partial denture - maxillary	15
D5422	Adjust partial denture - mandibular	15
	REPAIRS TO COMPLETE DENTURES	
D5511	*Repair broken complete denture base, mandibular	35*
D5512	*Repair broken complete denture base, maxillary	35*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	35*
	REPAIRS TO PARTIAL DENTURES	
D5611	*Repair resin partial denture base, mandibular	35*
D5612	*Repair resin partial denture base, maxillary	35*
D5621	*Repair cast partial framework, mandibular	35*
D5622	*Repair cast partial framework, maxillary	35*
D5630	*Repair or replace broken retentive clasping materials – per tooth	35*
D5640	*Replace broken teeth - per tooth	35*
D5650	*Add tooth to existing partial denture	35*
D5660	*Add clasp to existing partial denture - per tooth	35*
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	155*
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	155*
D5710	*Rebase complete maxillary denture	135*
D5711	*Rebase complete mandibular denture	135*
D5720	*Rebase maxillary partial denture	155*
D5721	*Rebase mandibular partial denture	155*
D5725	*Rebase hybrid prosthesis	155*
D5730	*Reline complete maxillary denture (direct)	65*
D5731	*Reline complete mandibular denture (direct)	65*
D5740	*Reline maxillary partial denture (direct)	65*
D5741	*Reline mandibular partial denture (direct)	65*
D5750	*Reline complete maxillary denture (indirect)	85*
D5751	*Reline complete mandibular denture (indirect)	85*
D5760	*Reline maxillary partial denture (indirect)	85*
D5761	*Reline mandibular partial denture (indirect)	85*
D5765	*Soft liner for complete or partial removable denture – indirect	69*
	INTERIM PROSTHESIS	
D5810	*Interim complete denture (maxillary)	250*
D5811	*Interim complete denture (mandibular)	250*
D5820	*Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary	175*
D5821	*Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular	175*
	OTHER REMOVABLE PROSTHESIS	
D5850	Tissue conditioning, maxillary	20
D5851	Tissue conditioning, mandibular	20
D5862	Precision attachment, by report	150
D5899	Unspecified removable prosthodontic procedure, by report	0
	NON-CLINICAL PROCEDURES	
D5982	Surgical stent	150*
D5987	Commissure splint	150*
D5988	Surgical splint	150*
	PRE-SURGICAL SERVICES	
D6190	Radiographic/surgical implant index, by report	235
D6198	Remove interim implant component	700
	SURGICAL SERVICES	
D6010	*Surgical placement of implant body: endosteal implant	1010
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	1010
D6100	Surgical removal of implant body	700
	IMPLANT SUPPORTED PROSTHETICS	
D6056	*Prefabricated abutment – includes modification and placement	440
D6057	*Custom fabricated abutment – includes placement	550
D6058	*Abutment supported porcelain/ceramic crown	750
D6059	*Abutment supported porcelain fused to metal crown (high noble metal)	750
D6060	*Abutment supported porcelain fused to metal crown (predominantly base metal)	750
D6061	*Abutment supported porcelain fused to metal crown (noble metal)	750
D6062	*Abutment supported cast metal crown (high noble metal)	750

CODE	DESCRIPTION	MEMBER COPAY
D6063	*Abutment supported cast metal crown (predominantly base metal)	750
D6064	*Abutment supported cast metal crown (noble metal)	750
D6065	*Implant supported porcelain/ceramic crown	750
D6066	*Implant supported crown - porcelain fused to high noble alloys	750
D6067	*Implant supported crown - high noble alloys	750
D6068	*Abutment supported retainer for porcelain/ ceramic fpd	750
D6069	*Abutment supported retainer for porcelain fused to metal fpd (high noble metal)	750
D6070	*Abutment supported retainer for porcelain fused to metal fpd (predominantly base metal)	750
D6071	*Abutment supported retainer for porcelain fused to metal fpd (noble metal)	750
D6072	*Abutment supported retainer for cast metal fpd (high noble metal)	750
D6073	*Abutment supported retainer for cast metal fpd (predominantly base metal)	750
D6074	*Abutment supported retainer for cast metal fpd (noble metal)	750
D6075	*Implant supported retainer for ceramic fpd	750
D6076	*Implant supported retainer for FPD - porcelain fused to high noble alloys	750
D6077	*Implant supported retainer for metal FPD - high noble alloys	750
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	50†
D6082	*Implant supported crown - porcelain fused to predominantly base alloys	750
D6083	*Implant supported crown - porcelain fused to noble alloys	750
D6084	*Implant supported crown - porcelain fused to titanium and titanium alloys	750
D6085	Interim implant crown	125
D6086	*Implant supported crown - predominantly base alloys	750
D6087	*Implant supported crown - noble alloys	750
D6088	*Implant supported crown - titanium and titanium alloys	750
D6088	*Implant supported crown - titanium and titanium alloys	750
D6089	Accessing and retorquing loose implant screw - per screw	50
D6097	*Abutment supported crown - porcelain fused to titanium and titanium alloys	750
D6098	*Implant supported retainer - porcelain fused to predominantly base alloys	750
D6099	*Implant supported retainer for FPD - porcelain fused to noble alloys	750
D6105	Removal of implant body not requiring bone removal nor flap elevation	700
D6106	*Guided tissue regeneration – resorbable barrier, per implant	325
D6107	*Guided tissue regeneration – non-resorbable barrier, per implant	325
D6110	*Implant /abutment supported removable denture for edentulous arch – maxillary	1255
D6111	*Implant /abutment supported removable denture for edentulous arch – mandibular	1255
D6112	*Implant /abutment supported removable denture for partially edentulous arch – maxillary	995
D6113	*Implant /abutment supported removable denture for partially edentulous arch – mandibular	995
D6114	*Implant /abutment supported fixed denture for edentulous arch – maxillary	3855
D6115	*Implant /abutment supported fixed denture for edentulous arch – mandibular	3855
D6116	*Implant /abutment supported fixed denture for partially edentulous arch – maxillary	2255
D6117	*Implant /abutment supported fixed denture for partially edentulous arch – mandibular	2255
D6118	*Implant/abutment supported interim fixed denture for edentulous arch – mandibular	1804
D6119	*Implant/abutment supported interim fixed denture for edentulous arch – maxillary	1804
D6120	*Implant supported retainer – porcelain fused to titanium and titanium alloys	750
D6121	*Implant supported retainer for metal FPD – predominantly base alloys	750
D6122	*Implant supported retainer for metal FPD – noble alloys	750
D6123	*Implant supported retainer for metal FPD – titanium and titanium alloys	750
	OTHER IMPLANT SERVICES	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	180
D6090	Repair implant supported prosthesis, by report	400
D6092	Re-cement or re-bond implant/abutment supported crown	45
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	65
D6096	Remove broken implant retaining screw	500
D6193	*Systems perspective: Bundle frequency with D6051, D6056, D6057	550
	FIXED PARTIAL DENTURE PONTICS	
D6205	*Pontic - indirect resin based composite	750
D6210	*Pontic - cast high noble metal	245*
D6211	*Pontic - cast predominantly base metal	245*
D6212	*Pontic - cast noble metal	245*
D6214	*Pontic - titanium and titanium alloys	245*
D6240	*Pontic - porcelain fused to high noble metal	245*
D6241	*Pontic - porcelain fused to predominantly base metal	245*
D6242	*Pontic - porcelain fused to noble metal	245*
D6243	*Pontic - porcelain fused to titanium and titanium alloys	245*
D6245	*Pontic - porcelain/ceramic	245*
D6250	*Pontic - resin with high noble metal	245*
D6251	*Pontic - resin with predominantly base metal	245*

CODE	DESCRIPTION	MEMBER COPAY
D6252	*Pontic - resin with noble metal	245*
D6253	*Interim pontic - further treatment or completion of diagnosis necessary prior to final impression	0
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ ONLAYS	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	390
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	245*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	245*
D6602	Retainer inlay - cast high noble metal, two surfaces	245*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	245*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	245*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	245*
D6606	Retainer inlay - cast noble metal, two surfaces	245*
D6607	Retainer inlay - cast noble metal, three or more surfaces	245*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	245*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	245*
D6610	Retainer onlay - cast high noble metal, two surfaces	245*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	245*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	245*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	245*
D6614	Retainer onlay - cast noble metal, two surfaces	245*
D6615	Retainer onlay - cast noble metal, three or more surfaces	245*
D6624	Retainer inlay - titanium	245*
D6634	Retainer onlay - titanium	245*
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6710	*Retainer crown - indirect resin based composite	245*
D6720	*Retainer crown - resin with high noble metal	245*
D6721	*Retainer crown - resin with predominantly base metal	245*
D6722	*Retainer crown - resin with noble metal	245*
D6740	*Retainer crown - porcelain/ceramic	245*
D6750	*Retainer crown - porcelain fused to high noble metal	245*
D6751	*Retainer crown - porcelain fused to predominantly base metal	245*
D6752	*Retainer crown - porcelain fused to noble metal	245*
D6753	*Retainer crown - porcelain fused to titanium and titanium alloys	245*
D6780	*Retainer crown - 3/4 cast high noble metal	245*
D6781	*Retainer crown - 3/4 cast predominantly base metal	245*
D6782	*Retainer crown - 3/4 cast noble metal	245*
D6783	*Retainer crown - 3/4 porcelain/ceramic	245*
D6784	*Retainer crown ¾ - titanium and titanium alloys	245*
D6790	*Retainer crown - full cast high noble metal	245*
D6791	*Retainer crown - full cast predominantly base metal	245*
D6792	*Retainer crown - full cast noble metal	245*
D6793	*Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	125
D6794	*Retainer crown - titanium and titanium alloys	245*
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Re-cement or re-bond fixed partial denture	15
D6940	Stress breaker	125
D6950	Precision attachment	195
D6980	Fixed partial denture repair necessitated by restorative material failure	80
	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)	
D7111	Extraction, coronal remnants – primary tooth	50
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	30
	OTHER SURGICAL PROCEDURES	
D7220	Removal of impacted tooth - soft tissue	50
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	135
D7250	Removal of residual tooth roots (cutting procedure)	40
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	270
D7260	Oroantral fistula closure	160
D7261	Primary closure of a sinus perforation	275
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	Exposure of an unerupted tooth	125
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125
D7283	Placement of device to facilitate eruption of impacted tooth	80
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	125
D7286	Incisional biopsy of oral tissue-soft	85
D7287	Exfoliative cytological sample collection	75
D7288	Brush biopsy - transepithelial sample collection	25
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	40
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	40

CODE	DESCRIPTION	MEMBER COPAY
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	40
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	60
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	60
	VESTIBULOPLASTY	
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
	SURGICAL EXCISION OF SOFT TISSUE LESIONS	
D7410	Excision of benign lesion up to 1.25 cm	25
D7411	Excision of benign lesion greater than 1.25 cm	50
D7412	Excision of benign lesion, complicated	55
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
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
D7509	Marsupialization of odontogenic cyst	65
	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	95
D7472	Removal of torus palatinus	95
D7473	Removal of torus mandibularis	95
D7485	Reduction of osseous tuberosity	95
	SURGICAL INCISION	
D7510	Incision and drainage of abscess - intraoral soft tissue	20
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20
D7520	Incision and drainage of abscess - extraoral soft tissue	20
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20
	REPAIR OF TRAUMATIC WOUNDS	
D7910	Suture of recent small wounds up to 5 cm	35
	OTHER REPAIR PROCEDURES	
D7921	Collection and application of autologous blood concentrate product	125
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, 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
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	325
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	325
D7961	Buccal / labial frenectomy (frenulectomy)	105
D7962	Lingual frenectomy (frenulectomy)	105
D7963	Frenuloplasty	105
D7970	Excision of hyperplastic tissue - per arch	140
D7971	Excision of pericoronal gingiva	102
D7972	Surgical reduction of fibrous tuberosity	125
	LIMITED ORTHODONTIC TREATMENT	
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	1350
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive orthodontic treatment of the transitional dentition	2200
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2250
D8090	Comprehensive orthodontic treatment of the adult dentition	2350
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	*Removable appliance therapy	103
D8220	*Fixed appliance therapy	103
	OTHER ORTHODONTIC SERVICES	
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
D8681	Removable orthodontic retainer adjustment	0
D8698	Re-cement or re-bond fixed retainer – maxillary	0
D8699	Re-cement or re-bond fixed retainer – mandibular	0
D8999	Unspecified orthodontic procedure, by report	250
	UNCLASSIFIED TREATMENT	
D9110	Palliative treatment of dental pain - per visit	0
D9120	Fixed partial denture sectioning	0
	ANESTHESIA	
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 in conjunction with operative or surgical procedures	0
D9222	Deep sedation/general anesthesia – first 15 minutes	50
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	50
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	20
D9239	Intravenous moderate (conscious) sedation/ analgesia- first 15 minutes	65

CODE	DESCRIPTION	MEMBER COPAY
D9243	Intravenous moderate (conscious) sedation/ analgesia – each subsequent 15 minute increment	65
D9248	Non-intravenous conscious sedation	15
	DRUGS	
D9610	Therapeutic parenteral drug, single administration	15
D9630	Drugs or medicaments dispensed in the office for home use	15
	MISCELLANEOUS SERVICES	
D9910	*Application of desensitizing medicament	20
D9911	Application of desensitizing resin for cervical and/ or root surface, per tooth	0
D9912	Pre-visit patient screening	0
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	0
D9932	Cleaning and inspection of removable complete denture, maxillary	0
D9933	Cleaning and inspection of removable complete denture, mandibular	0
D9934	Cleaning and inspection of removable partial denture, maxillary	0
D9935	Cleaning and inspection of removable partial denture, mandibular	0
D9942	Repair and/or reline of occlusal guard	40
D9943	Occlusal guard adjustment	25
D9944	*Occlusal guard – hard appliance, full arch	250
D9945	*Occlusal guard – soft appliance, full arch	250
D9946	*Occlusal guard – hard appliance, partial arch	250
D9947	Custom sleep apnea appliance fabrication and placement	1900
D9948	Adjustment of custom sleep apnea appliance	85
D9949	Repair of custom sleep apnea appliance	88
D9950	Occlusion analysis - mounted case	75
D9951	Occlusal adjustment - limited	30
D9952	Occlusal adjustment - complete	100
D9953	Reline custom sleep apnea appliance (indirect)	65
D9972	External bleaching - per arch - performed in office	150
D9973	External bleaching - per tooth	30
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	240
D9991	Dental case management – addressing appointment compliance barriers	0
D9992	Dental case management – care coordination	0
D9993	Dental case management – motivational interviewing	0
D9994	Dental case management – patient education to improve oral health literacy	0
D9997	Dental case management - patients with special health care needs	0

CODE	DESCRIPTION	MEMBER COPAY

Specialty Services

1. This Member Schedule of Benefits applies when listed dental services are performed by a Network 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 Network General Dentist's Usual and Customary fee less 25%.
3. The Network General Dentist you select may not perform all procedures listed. The Co-payments shown apply to Network General Dentists.
4. Should the services of a Network Specialty Dentist (NSD) (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 NSD 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 a NSD at the listed Co-payments. 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 NSD 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 Co-payment.
6. Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.solsticebenefits.com under "Locate A Provider."

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 Provider."
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 Service 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.

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 (D1351 or D1352) 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, D0251, 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. 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.
20. Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
21. Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
22. 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.

Solstice HealthPlans, Inc. is a licensed Prepaid Limited Health Service Organization pursuant to Part I of Chapter 636, F.S.

Solstice Vision Plan SV 6
Summary of Benefits

BENEFIT FREQUENCY

Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses instead of Eyeglasses	Once every 12 months

IN-NETWORK SERVICES

COPAYS

Exam(s)	$10.00
Eyeglasses (lenses and frame)	$25.00
Contact lenses instead of Eyeglasses	$25.00

FRAME BENEFIT

Frame allowance	$100.00

LENS OPTIONS (Covered in full with your plan)

Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19)

CONTACT LENS BENEFIT

Elective contact lenses	
Formulary contact lenses- The fitting/evaluation fees, contact lenses and up to two follow-up visits are covered in full after copay	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider
Non-Formulary contact lenses- An allowance is applied toward the purchase of contact lenses outside the Formulary. Contact lens copay is waived	$100.00
Necessary contact lenses[1]	Covered in full after copay (if applicable).

OUT-OF-NETWORK REIMBURSEMENTS (COPAYS DO NOT APPLY)

Exam(s)	Up to $40.00
Frames	Up to $45.00
Eyeglass lenses[2]	Up to $40.00 - $80.00
Elective Contacts instead of Eyeglasses	Up to $100.00
Necessary Contacts instead of Eyeglasses[1]	Up to $210.00

1. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.
2. Out-of-Network reimbursements for Eyeglass Lenses will vary by lens type: Single Vision up to $40, Lined Bifocal and Progressive up to $60, Trifocal up to $80, Lenticular up to $80.

IMPORTANT TO REMEMBER

IN-NETWORK

- Patient lens options which are not covered-in-full may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details.

CHOICE AND ACCESS OF VISION CARE PROVIDERS

Solstice Vision plans, powered by UnitedHealthcare, offer a vision program through national network including both private practice and retail chain providers. Please refer to your Certificate of Coverage for a full explanation of benefits. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - Participant pays all billed charges to the provider, and Solstice Vision plans, powered by UnitedHealthcare, reimburse the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

CUSTOMER SERVICE IS AVAILABLE TOLL-FREE AT (800) 638-3120
MONDAY - FRIDAY (FROM 8:00 A.M. - 11:00 P.M. ET), SATURDAY (FROM 9:00 A.M. - 6:30 P.M. ET)

DISCLAIMER

READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA, or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher that if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.