VSP Advantage Plan℠

Created for United Teacher of Dade

The VSP Advantage Plan is a basic full-service plan that offers choice, flexibility, and value through a VSP Advantage Network Provider.

Save up to $3,000

With Exclusive Member Extras, members can save more than $3,000 with special offers and deals through VSP and other leading industry brands.

Get up to $250 back

Members can save big with VSP exclusive mail-in rebates on eligible popular contact lens brands like Bausch + Lomb.

$1,000 savings on LASIK

Members can save up to $1,000 on LASIK at Lasik***Plus***, NVISION Eye Center, TLC Laser Eye Centers and The LASIK Vision Institute.

LEARN MORE. VISIT VSP.COM/OFFERS

Benefits through a VSP Network Provider

Exam Services

- Comprehensive WellVision Exam® covered in full*
- Routine retinal screening covered after a no more than $39 copay

Lenses

- Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses are covered in full*

Lens Enhancements

- Most popular lens enhancements are covered after a copay, saving our members an average of 20-25%

Lens Enhancement	***Single Vision***	***Multifocal***
Anti-reflective coating	$41	$41
Polycarbonate - Adult	$35	$35
Polycarbonate - Children	Covered	Covered
Standard Progressive	N/A	Covered
Tints	Covered	Covered
Scratch-resistant coating	Covered	Covered

Prices above reflect standard lens enhancement selections; premium or custom lens enhancements may also be available at an additional cost

Frame

- Frames covered in full* up to the retail allowance of **$180**
- Featured frame brands, including bebe, Calvin Klein, Cole Haan, Dragon, Flexon, Longchamp, Nike, and more are covered up to the enhanced featured frame allowance of **$200.**
  Featured frame brands subject to change
- 20% off any amount above the retail allowance
- Members can choose from all frames available on the market today

VSP Advantage Plan℠

Additional Pairs of Glasses

- Within 12 months of exam: 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP doctor

Elective Contact Lenses

- **Contact lens exam (fitting and evaluation):** Standard and Premium fits are covered in full after copay. Member receives 15% off of contact lens exam services and member's copay will never exceed **$60**
- Prescription contact lens materials are covered in full up to the retail allowance of **$180** (in lieu of frame & lenses)
- Members can choose from any available prescription contact lens materials

Essential Medical Eye Care

- Supplemental medical coverage for specialty eyecare services and conditions, such as pink eye, and other urgent eyecare needs
- $20 exam copay

VSP Laser VisionCare℠ Program

- Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, Custom PRK, LASIK, Custom LASIK, SMILE, and Contoura

Discounts are only available from VSP-contracted facilities. Also custom LASIK coverage only available using wavefront technology, other LASIK procedures may be performed at an additional cost to the member

Out-of-Network Schedule

We offer a generous reimbursement schedule for services from other providers

Exam	$ 40
Lenses:	
Single vision	$ 30
Lined bifocal	$ 50
Lined trifocal	$ 60
Lenticular	$ 75
Frame	$ 50
Elective contact lenses (in lieu of lenses and frame)	$100
Medically Necessary	$210

Solstice

Solstice Vision Plan

Clear 10 Benefits Summary

In-Network Procedures	Member Co-Payment	Benefit
Eye Exam	$4.00	One exam every 12 months
Single Lenses	$10.00	One standard pair (plastic or clear glass) every 12 months
Bifocal Lenses	$10.00	
Trifocal Lenses	$10.00	
Lens Options *(tint, UV, anti-scratch coat, anti-reflective, progressive, polycarbonate, hi-index, photogray, transitions, polaroid)*	20% Discount	None
Frames*	$79.00 Retail allowance after $10.00 co-payment	Frames every 12 months
Contact Lenses*	$85.00 Allowance**	Contact lenses every 12 months
Medically Necessary Contact Lenses	Paid In Full	

* Once a year benefit for either frames or contacts.
** Allowance is for exam, fitting, evaluation, follow-up care and materials.

More Options

> Receive benefits immediately upon the coverage effective date
> Annual deductible – NONE
> Claim forms to submit – NONE
> Waiting periods - NONE
> Multilingual representatives
> The member co-payments listed are guaranteed to be a 20-45% discount and are offered by a participating Solstice Provider.
> The patient/member is ultimately responsible for verification as to the accuracy and appropriateness of all fees applicable.
> Benefit for contacts or frames are a once a year benefit (Ex: one year frames the following year contacts).

Leading–Edge Technology

> Employer internet services: Manage eligibility, receive electronic bills, make payments online, and access standard reporting options
> Employee online self-service: Search for network vision providers, request ID card, view benefit
> Interactive Voice Response (IVR) system available 24 hours a day, 7 days a week
> Toll-free customer service line
> You can locate participating vision providers at www.SolsticeBenefits.com or via our secure member portal, www.MySolstice.net

Sales@SolsticeBenefits.com or contact us at 877.760.2247
P.O. Box 19199 | Plantation, FL, 33318

Solstice

Solstice Benefits*Booster*

What is Benefits*Booster*?

Benefits*Booster* is an Increasing Calendar Year Maximum feature included in select Solstice dental plans that puts dental care decisions directly in the hands of the consumer. Members are encouraged to seek care through an awards-based framework that allows them to carry forward part of their unused calendar year maximum.

Highlights of the Solstice Benefits*Booster*

- No penalty if dental services are not used in the year
- Carry forward unused balances
- Competitor's award balance accepted
- Award balance may be used for out-of-network claims

How does Benefits*Booster* work?

Benefits*Booster* is designed for dental plans with deductibles and annual maximums and can be utilized by groups who are either fully insured or ASO. It is administered at the member level, giving each member an opportunity to earn their own awards. Members must use their dental benefit at least once per year, and can qualify for an additional bonus if a member utilizes all in network providers.

Maximum Benefit	Claim Threshold	Carryover Amount	Network Bonus	Increase Limit	Maximum Benefit Limit
$500	$250	$125	$100	$500	$1,000
$1,000	$500	$250	$100	$1,000	$2,000
$1,250	$500	$250	$100	$1,250	$2,500
$1,500	$750	$400	$100	$1,500	$3,000
$2,000	$1,000	$500	$100	$1,500	$3,500
$2,500	$1,250	$600	$100	$1,875	$4,375
$3,000	$1,500	$700	$100	$2,250	$5,250

There are some limitations to the program:

- New groups sold, and new hires made, in the last three months of the benefit period (October, November or December) will have participation deferred until the 1st month of the next full benefit period
- If a member chooses to terminate coverage, but returns prior to a six-month break in coverage with the same employer, participation will be reinstated without penalty or loss of any previously accumulated award balance, provided the employer still offers a dental plan with Benefits*Booster*. Award balance is considered depleted once the six-month window has passed or when consumer purchases another plan without the Benefits*Booster* feature.

9/4/12

Dental PPO Summary of Benefits Effective 9/1/2024

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$25	$25	$0	$0
Family Annual Calendar Year Deductible	$75	$75	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	Unlimited Maximum per person per Calendar Year	Unlimited Maximum per person per Calendar Year	$1500 per person per Lifetime	$1500 per person per Lifetime

Annual deductible applies to preventive and diagnostic services	No (In Network)	No (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	No	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	Children up to 19 Years Old	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	100%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	100%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	100%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	100%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	90%	90%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	90%	90%	Limited to one (1) time per tooth per lifetime.
Anesthetics	90%	90%	General Anesthesia: When clinically necessary.
Adjunctive Services	90%	90%	
MAJOR SERVICES			
Oral Surgery (includes surgical extractions)	60%	60%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	60%	60%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	60%	60%	Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	60%	60%	
Inlays/Onlays/Crowns	60%	60%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	60%	60%	Full Denture/Partial Denture/Bridges: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	60%	60%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

*The network percentage of benefits is based on the discounted fees negotiated with the provider.

**Out of-Network benefits are based on the participating provider contracted fees.

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits your Certificate of Coverage/benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Limitations, Non-Covered Services, and Exclusions

General Limitations

ALTERNATE BENEFIT – 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 $300; please consult your dentist.

BASIC RESTORATIONS – Multiple restorations on one (1) surface will be treated as a single filling. BITEWING RADIOGRAPHS are limited to one (1) series of films per consecutive twelve (12) months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS are limited to one (1) time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANINGS) are limited to

(2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.

EXTRAORAL RADIOGRAPHS are limited to two (2) films per consecutive twelve (12) months.

FLUORIDE TREATMENTS are limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.

FULL OR PARTIAL DENTURES are limited to one (1) time every consecutive sixty (60) months. No additional allowances for precision or semi-precision attachments.

FULL-MOUTH DEBRIDEMENT is limited to one (1) time per consecutive thirty-six (36) months.

GENERAL ANESTHESIA, IV SEDATION are covered when necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.

MAJOR RESTORATIONS – Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one (1) time per consecutive sixty (60) months from initial or subsequent placement.

OCCLUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control habitual grinding.

ORAL EVALUATIONS - Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if not in conjunction with other exams.

ORTHODONTIC SERVICES – When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

PERIODONTAL MAINTENANCE is limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance procedures in any twelve (12) consecutive months.

PERIODONTAL SURGERY – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) pins per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have had root canal therapy.

RELINING, REBASING AND TISSUE CONDITIONING DENTURES are limited to relining/rebasing performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) time per consecutive thirty-six (36) months.
REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) time per consecutive six (6) months.

REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for twelve (12) continuous months.

REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12), continuous months.

SEALANTS are limited to Covered Persons under the age of sixteen (16) years and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.

SCALING AND ROOT PLANING is limited to one (1) time per quadrant per consecutive twenty-four (24) months. Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report, is not covered when performed on the same day as root planing and scaling.

SEDATIVE FILLINGS are 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.

SPACE MAINTAINERS are limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.

Non-Covered Services

The following are NOT covered under the plan:

1. Dental Services that are not Reasonable and/or Necessary.
2. Hospital or other facility charges.
3. Reconstructive surgery to the mouth or jaw.
4. Any Procedures not directly associated with dental disease.
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are considered 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 Experimental, Investigational or Unproven in the treatment of that particular condition.
7. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
10. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
11. If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
12. If damage or breakage was directly related to provider error, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. 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. Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
14. Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hours notice.
15. Expenses for dental procedures begun before enrollment under the plan.
16. Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Attachments to conventional removable prosthesis 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. Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
19. Occlusal guards used as safety items or for sports-related activities.
20. Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
21. Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
22. Acupuncture, acupressure, and other forms of alternative treatment, whether or not
23. Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
24. Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.
25. Inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.
26. Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
27. Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
28. Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

1. Illness, accident, treatment or medical condition arising out of:
   - i. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
   - ii. service in the Armed Forces or units auxiliary thereto;
   - iii. suicide, attempted suicide or intentionally self-inflicted injury;
   - iv. aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and,
   - v. with respect to blanket insurance, interscholastic sports.
2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
3. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;
4. Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
5. ILLEGAL OCCUPATION: Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
6. INTOXICANTS AND NARCOTICS: Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Dental PPO Summary of Benefits Effective 9/1/2024

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$50	$50	$0	$0
Family Annual Calendar Year Deductible	$150	$150	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	$1500 per person per Calendar Year	$1500 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime

Annual deductible applies to preventive and diagnostic services	No (In Network)	No (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	Yes	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	Children up to 19 Years Old	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	100%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	100%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	100%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	100%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	90%	80%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	90%	80%	Limited to one (1) time per tooth per lifetime.
Anesthetics	90%	80%	General Anesthesia: When clinically necessary.
Adjunctive Services	90%	80%	
MAJOR SERVICES			
Oral Surgery (includes surgical extractions)	60%	50%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	60%	50%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	60%	50%	Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	60%	50%	
Inlays/Onlays/Crowns	60%	50%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	60%	50%	Full Denture/Partial Denture/Bridges: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	60%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

*The network percentage of benefits is based on the discounted fees negotiated with the provider.

**Out of-Network benefits are based on the participating provider contracted fees.

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits your Certificate of Coverage/benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Limitations, Non-Covered Services, and Exclusions

General Limitations

ALTERNATE BENEFIT – 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 $300; please consult your dentist.

BASIC RESTORATIONS – Multiple restorations on one (1) surface will be treated as a single filling.
BITEWING RADIOGRAPHS are limited to one (1) series of films per consecutive twelve (12) months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS are limited to one (1) time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANINGS) are limited to

(2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.

EXTRAORAL RADIOGRAPHS are limited to two (2) films per consecutive twelve (12) months.

FLUORIDE TREATMENTS are limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.

FULL OR PARTIAL DENTURES are limited to one (1) time every consecutive sixty (60) months. No additional allowances for precision or semi-precision attachments.

FULL-MOUTH DEBRIDEMENT is limited to one (1) time per consecutive thirty-six (36) months.

GENERAL ANESTHESIA, IV SEDATION are covered when necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.

MAJOR RESTORATIONS – Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one (1) time per consecutive sixty (60) months from initial or subsequent placement.

OCCLUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control habitual grinding.

ORAL EVALUATIONS - Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if not in conjunction with other exams.

ORTHODONTIC SERVICES – When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

PERIODONTAL MAINTENANCE is limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance procedures in any twelve (12) consecutive months.

PERIODONTAL SURGERY – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) pins per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have had root canal therapy.

RELINING, REBASING AND TISSUE CONDITIONING DENTURES are limited to relining/rebasing performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) time per consecutive thirty-six (36) months.
REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) time per consecutive six (6) months.

REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for twelve (12) continuous months.

REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12), continuous months.

SEALANTS are limited to Covered Persons under the age of sixteen (16) years and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.

SCALING AND ROOT PLANING is limited to one (1) time per quadrant per consecutive twenty-four (24) months. Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report, is not covered when performed on the same day as root planing and scaling.

SEDATIVE FILLINGS are 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.

SPACE MAINTAINERS are limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.

Non-Covered Services

The following are NOT covered under the plan:

1. Dental Services that are not Reasonable and/or Necessary.
2. Hospital or other facility charges.
3. Reconstructive surgery to the mouth or jaw.
4. Any Procedures not directly associated with dental disease.
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are considered 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 Experimental, Investigational or Unproven in the treatment of that particular condition.
7. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
10. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
11. If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
12. If damage or breakage was directly related to provider error, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. 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. Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
14. Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hours notice.
15. Expenses for dental procedures begun before enrollment under the plan.
16. Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Attachments to conventional removable prosthesis 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. Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
19. Occlusal guards used as safety items or for sports-related activities.
20. Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
21. Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
22. Acupuncture, acupressure, and other forms of alternative treatment, whether or
23. Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
24. Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.
25. Inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.
26. Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
27. Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
28. Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

1. Illness, accident, treatment or medical condition arising out of:
   - i. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
   - ii. service in the Armed Forces or units auxiliary thereto;
   - iii. suicide, attempted suicide or intentionally self-inflicted injury;
   - iv. aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and,
   - v. with respect to blanket insurance, interscholastic sports.
2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
3. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;
4. Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
5. ILLEGAL OCCUPATION: Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
6. INTOXICANTS AND NARCOTICS: Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

P.O. Box 19199
Plantation, FL 33318
Telephone: 877-760-2247
Fax: 954-370-1701

S200B Access+

Members of S200B Access+ dental plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No Waiting Periods
- No Deductibles
- Out-of-Network Services covered at a Schedule Reimbursement to the member

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

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

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

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 benefits are payable under the Policy. An "*" or a "†" denotes limitations and/or additional fees on certain benefits. See the Limitations and Additional Fees section below for details. A “^” indicate copays for additional services.

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
	APPOINTMENTS		
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	$20
D0150	*Comprehensive oral evaluation - new or established patient	$0	$20
D0160	*Detailed and extensive oral evaluation - problem focused, by report	$0	$20
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	$20
D0171	Re-evaluation – post-operative office visit	$0	
D0180	*Comprehensive periodontal evaluation - new or established patient	$0	$20
	RADIOGRAPHY / DIAGNOSTIC DENTISTRY		
D0210	*Intraoral - complete series of radiographic images	$0	$25
D0220	Intraoral - periapical first radiographic image	$4	$4
D0230	Intraoral - periapical each additional radiographic image	$2	$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	$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	$20	$25
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	$35	$25
D0340	2d cephalometric radiographic image – acquisition, measurement and analysis	$75	
D0350	2d oral/facial photographic image obtained intra-orally or extra-orally	$20	$15
D0364	*Cone beam ct capture and interpretation with limited field of view – less than one whole jaw	$140	
D0365	*Cone beam ct capture and interpretation with field of view of one full dental arch – mandible	$130	
D0366	*Cone beam ct capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	$130	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D0367	*Cone beam ct capture and interpretation with field of view of both jaws; with or without cranium	$175	
D0368	*Cone beam ct capture and interpretation for tmj series including two or more exposures	$130	
D0369	*Maxillofacial mri capture and interpretation	$180	
D0370	*Maxillofacial ultrasound capture and interpretation	$160	
D0371	*Sialoendoscopy capture and interpretation	$160	
D0380	*Cone beam ct image capture with limited field of view – less than one whole jaw	$140	
D0381	*Cone beam ct image capture with field of view of one full dental arch – mandible	$130	
D0382	*Cone beam ct image capture with field of view of one full dental arch – maxilla, with or without cranium	$130	
D0383	*Cone beam ct image capture with field of view of both jaws; with or without cranium	$175	
D0384	*Cone beam ct image capture for tmj series including two or more exposures	$130	
D0385	*Maxillofacial mri image capture	$160	
D0386	*Maxillofacial ultrasound image capture	$160	
D0393	*Treatment simulation using 3d image volume	$0	
D0394	*Digital subtraction of two or more images or image volumes of the same modality	$0	
D0395	*Fusion of two or more 3d image volumes of one or more modalities	$0	
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	
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	$35	$25
D0702	*2-D cephalometric radiographic image – image capture only	$75	
D0703	*2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	$20	$15
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	$2
D0708	*Intraoral – bitewing radiographic image – image capture only	$0	$10
D0709	*Intraoral – complete series of radiographic images – image capture only	$0	$25
D0999	Unspecified diagnostic procedure, by report	$0	
	PREVENTIVE DENTISTRY		
D1110	*Prophylaxis - adult	$0	$35
D1110	Prophylaxis - adult additional	$15^	
D1120	*Prophylaxis - child	$0	$25
D1120	Prophylaxis - child additional	$15^	
D1206	*Topical application of fluoride varnish	$5	
D1208	*Topical application of fluoride – excluding varnish	$0	$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	
D1353	Sealant repair – per tooth	$0	
D1354	*Interim caries arresting medicament application – per tooth	$20	
D1355	Caries preventive medicament application – per tooth	$20	
D1510	*Space maintainer - fixed - unilateral	$0	$50
D1516	*Space maintainer – fixed – bilateral, maxillary	$0	$75

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D1517	*Space maintainer – fixed – bilateral, mandibular	$0	$75
D1520	*Space maintainer - removable - unilateral	$0	$50
D1526	*Space maintainer – removable – bilateral, maxillary	$0	$75
D1527	*Space maintainer – removable – bilateral, mandibular	$0	$75
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10	
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10	
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10	
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10	
D1557	Removal of fixed bilateral space maintainer - maxillary	$10	
D1558	Removal of fixed bilateral space maintainer - mandibular	$10	
D1575	Distal shoe space maintainer – fixed – unilateral	$0	
	RESTORATIVE DENTISTRY		
D2140	Amalgam - one surface, primary or permanent	$0	$15
D2150	Amalgam - two surfaces, primary or permanent	$0	$20
D2160	Amalgam - three surfaces, primary or permanent	$0	$25
D2161	Amalgam - four or more surfaces, primary or permanent	$0	$25
D2330	Resin-based composite - one surface, anterior	$20	$15
D2331	Resin-based composite - two surfaces, anterior	$32	$20
D2332	Resin-based composite - three surfaces, anterior	$40	$25
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$70	$25
D2390	Resin-based composite crown, anterior	$100	
D2391	Resin-based composite - one surface, posterior	$45	
D2392	Resin-based composite - two surfaces, posterior	$65	
D2393	Resin-based composite - three surfaces, posterior	$80	
D2394	Resin-based composite - four or more surfaces, posterior	$95	
D2410	Gold foil - one surface	$65	
D2420	Gold foil - two surfaces	$90	
D2430	Gold foil - three surfaces	$120	
D2510	Inlay - metallic - one surface	$80	
D2520	Inlay - metallic - two surfaces	$90	
D2530	Inlay - metallic - three or more surfaces	$115	
D2542	Onlay - metallic - two surfaces	$250	
D2543	Onlay - metallic - three surfaces	$270	
D2544	Onlay - metallic - four or more surfaces	$290	
D2610	Inlay - porcelain/ceramic - one surface	$225*	
D2620	Inlay - porcelain/ceramic - two surfaces	$250*	
D2630	Inlay - porcelain/ceramic - three or more surfaces	$275*	
D2642	Onlay - porcelain/ceramic - two surfaces	$310*	
D2643	Onlay - porcelain/ceramic - three surfaces	$340*	
D2644	Onlay - porcelain/ceramic - four or more surfaces	$350*	
D2650	Inlay - resin-based composite - one surface	$180	
D2651	Inlay - resin-based composite - two surfaces	$200	
D2652	Inlay - resin-based composite - three or more surfaces	$250	
D2662	Onlay - resin-based composite - two surfaces	$225	
D2663	Onlay - resin-based composite - three surfaces	$245	
D2664	Onlay - resin-based composite - four or more surfaces	$275	
D2710	*Crown - resin-based composite (indirect)	$195	
D2712	*Crown - ¾ resin-based composite (indirect)	$195	
D2720	*Crown - resin with high noble metal	$195*	
D2721	*Crown - resin with predominantly base metal	$195*	
D2722	*Crown - resin with noble metal	$195*	
D2740	*Crown - porcelain/ceramic	$195*	
D2750	*Crown - porcelain fused to high noble metal	$195*	
D2751	*Crown - porcelain fused to predominantly base metal	$195*	
D2752	*Crown - porcelain fused to noble metal	$195*	
D2753	*Crown - porcelain fused to titanium and titanium alloys	$195*	
D2780	*Crown - 3/4 cast high noble metal	$195*	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D2781	*Crown - 3/4 cast predominantly base metal	$195*	
D2782	*Crown - 3/4 cast noble metal	$195*	
D2783	*Crown - 3/4 porcelain/ceramic	$195*	
D2790	*Crown - full cast high noble metal	$195*	
D2791	*Crown - full cast predominantly base metal	$195*	
D2792	*Crown - full cast noble metal	$195*	
D2794	*Crown - titanium	$195*	
D2799	*Provisional crown– further treatment or completion of diagnosis necessary prior to final impression	$125	
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	$10	
D2920	Re-cement or re-bond crown	$10	
D2921	Reattachment of tooth fragment, incisal edge or cusp	$10	
D2928	*Prefabricated porcelain/ceramic crown – permanent tooth	$34*	
D2929	*Prefabricated porcelain/ceramic crown – primary tooth	$34*	
D2930	Prefabricated stainless steel crown - primary tooth	$35	
D2931	Prefabricated stainless steel crown - permanent tooth	$40	
D2932	Prefabricated resin crown	$90	
D2933	Prefabricated stainless steel crown with resin window	$135	
D2940	Protective restoration	$5	
D2941	Interim therapeutic restoration – primary dentition	$5	
D2949	Restorative foundation for an indirect restoration	$20	
D2950	Core buildup, including any pins when required	$35	
D2951	Pin retention - per tooth, in addition to restoration	$10	
D2952	Post and core in addition to crown, indirectly fabricated	$80	
D2953	Each additional indirectly fabricated post - same tooth	$95	
D2954	Prefabricated post and core in addition to crown	$75	
D2955	Post removal	$20	
D2957	Each additional prefabricated post - same tooth	$30	
D2960	Labial veneer (resin laminate) - direct	$200	
D2961	Labial veneer (resin laminate) - indirect	$225*	
D2962	Labial veneer (porcelain laminate) - indirect	$350*	
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	
D2990	Resin infiltration of incipient smooth surface lesions	$29	
	ENDODONTIC SERVICES		
D3110	Pulp cap - direct (excluding final restoration)	$10	
D3120	Pulp cap - indirect (excluding final restoration)	$10	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$20	
D3221	Pulpal debridement, primary and permanent teeth	$95	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$75	
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)	$100	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$175	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$210	
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	
D3346	Retreatment of previous root canal therapy - anterior	$250	
D3347	Retreatment of previous root canal therapy - premolar	$285	
D3348	Retreatment of previous root canal therapy - molar	$350	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$90	
D3352	Apexification/recalcification – interim medication replacement	$90	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$90	
D3410	Apicoectomy - anterior	$96	
D3421	Apicoectomy - premolar (first root)	$300	
D3425	Apicoectomy - molar (first root)	$150	
D3426	Apicoectomy (each additional root)	$75	
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	$32	
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	$25	
D3430	Retrograde filling - per root	$55	
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	$85	
D3460	Endodontic endosseous implant	$535	
D3470	Intentional reimplantation (including necessary splinting)	$175	
D3471	Surgical repair of root resorption – anterior	$96	
D3472	Surgical repair of root resorption – premolar	$300	
D3473	Surgical repair of root resorption – molar	$150	
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$96	
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$96	
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$96	
D3910	Surgical procedure for isolation of tooth with rubber dam	$95	
D3920	Hemisection (including any root removal), not including root canal therapy	$80	
D3950	Canal preparation and fitting of preformed dowel or post	$75	
	PERIODONTIC SERVICES		
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	$66	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$40	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$163	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$150	
D4245	Apically positioned flap	$150	
D4249	Clinical crown lengthening – hard tissue	$175	
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	$325	
D4266	Guided tissue regeneration - resorbable barrier, per site	$325	
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$325	
D4268	Surgical revision procedure, per tooth	$0	
D4270	Pedicle soft tissue graft procedure	$235	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$280	
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$100	
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 double 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	$250	
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	
D4320	Provisional splinting - intracoronal	$100	
D4321	Provisional splinting - extracoronal	$100	
D4341	*Periodontal scaling and root planing - four or more teeth per quadrant	$36†	
D4342	*Periodontal scaling and root planing - one to three teeth per quadrant	$29†	
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$35†	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D4355	*Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$35†	
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$45†	
D4910	*Periodontal maintenance	$40	
D4910	Additional Periodontal maintenance procedure	$100^	
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$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	$210*	
D5140	*Immediate denture - mandibular	$210*	
D5211	*Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$210*	
D5212	*Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$210*	
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$220*	
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$220*	
D5221	*Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$230*	
D5222	*Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$230*	
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240*	
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240*	
D5225	*Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$220*	
D5226	*Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$220*	
D5282	*Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$235*	
D5283	*Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$235*	
D5410	Adjust complete denture - maxillary	$8	
D5411	Adjust complete denture - mandibular	$8	
D5421	Adjust partial denture - maxillary	$10	
D5422	Adjust partial denture - mandibular	$10	
D5511	*Repair broken complete denture base, mandibular	$15*	
D5512	*Repair broken complete denture base, maxillary	$15*	
D5520	*Replace missing or broken teeth - complete denture (each tooth)	$10*	
D5611	*Repair resin partial denture base, mandibular	$15*	
D5612	*Repair resin partial denture base, maxillary	$15*	
D5621	*Repair cast partial framework, mandibular	$30*	
D5622	*Repair cast partial framework, maxillary	$30*	
D5630	*Repair or replace broken retentive clasping materials – per tooth	$15*	
D5640	*Replace broken teeth - per tooth	$10*	
D5650	*Add tooth to existing partial denture	$30*	
D5660	*Add clasp to existing partial denture - per tooth	$30*	
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	$100*	
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	$100*	
D5710	*Rebase complete maxillary denture	$75*	
D5711	*Rebase complete mandibular denture	$75*	
D5720	*Rebase maxillary partial denture	$75*	
D5721	*Rebase mandibular partial denture	$75*	
D5730	*Reline complete maxillary denture (direct)	$45*	
D5731	*Reline complete mandibular denture (direct)	$45*	
D5740	*Reline maxillary partial denture (direct)	$45*	
D5741	*Reline mandibular partial denture (direct)	$45*	
D5750	*Reline complete maxillary denture (indirect)	$35*	
D5751	*Reline complete mandibular denture (indirect)	$35*	
D5760	*Reline maxillary partial denture (indirect)	$35*	
D5761	*Reline mandibular partial denture (indirect)	$35*	
D5810	*Interim complete denture (maxillary)	$220*	
D5811	*Interim complete denture (mandibular)	$220*	
D5820	*Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$220*	
D5821	*Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$220*	
D5850	Tissue conditioning, maxillary	$25	
D5851	Tissue conditioning, mandibular	$25	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D5862	Precision attachment, by report	$150	
D5899	Unspecified removable prosthodontic procedure, by report	$0	
D5982	Surgical stent	$100*	
D5987	Commissure splint	$100*	
D5988	Surgical splint	$100*	
	IMPLANT SUPPORTED PROSTHETICS		
D6010	*Surgical placement of implant body: endosteal implant	$950	
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$950	
D6056	*Prefabricated abutment – includes modification and placement	$385	
D6057	*Custom fabricated abutment – includes placement	$495	
D6058	*Abutment supported porcelain/ceramic crown	$695	
D6059	*Abutment supported porcelain fused to metal crown (high noble metal)	$695	
D6060	*Abutment supported porcelain fused to metal crown (predominantly base metal)	$695	
D6061	*Abutment supported porcelain fused to metal crown (noble metal)	$695	
D6062	*Abutment supported cast metal crown (high noble metal)	$695	
D6063	*Abutment supported cast metal crown (predominantly base metal)	$695	
D6064	*Abutment supported cast metal crown (noble metal)	$695	
D6065	*Implant supported porcelain/ceramic crown	$695	
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$695	
D6067	*Implant supported metal crown (titanium, titanium alloy, high noble metal)	$695	
D6068	*Abutment supported retainer for porcelain/ceramic fpd	$695	
D6069	*Abutment supported retainer for porcelain fused to metal fpd (high noble metal)	$695	
D6070	*Abutment supported retainer for porcelain fused to metal fpd (predominantly base metal)	$695	
D6071	*Abutment supported retainer for porcelain fused to metal fpd (noble metal)	$695	
D6072	*Abutment supported retainer for cast metal fpd (high noble metal)	$695	
D6073	*Abutment supported retainer for cast metal fpd (predominantly base metal)	$695	
D6074	*Abutment supported retainer for cast metal fpd (noble metal)	$695	
D6075	*Implant supported retainer for ceramic fpd	$695	
D6076	*Implant supported retainer for porcelain fused to metal fpd (titanium, titanium alloy, or high noble metal)	$695	
D6077	*Implant supported retainer for cast metal fpd (titanium, titanium alloy, or high noble metal)	$695	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$180	
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	$36†	
D6082	*Implant supported crown - porcelain fused to predominantly base alloys	$695	
D6083	*Implant supported crown - porcelain fused to noble alloys	$695	
D6084	*Implant supported crown - porcelain fused to titanium and titanium alloys	$695	
D6085	Provisional implant crown	$125	
D6086	*Implant supported crown - predominantly base alloys	$695	
D6087	*Implant supported crown - noble alloys	$695	
D6088	*Implant supported crown - titanium and titanium alloys	$695	
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	
D6094	*Abutment supported crown - (titanium)	$695	
D6095	Repair implant abutment, by report	$220	
D6096	Remove broken implant retaining screw	$500	
D6097	*Abutment supported crown - porcelain fused to titanium and titanium alloys	$695	
D6098	*Implant supported retainer - porcelain fused to predominantly base alloys	$695	
D6099	*Implant supported retainer for FPD - porcelain fused to noble alloys	$695	
D6100	Implant removal, by report	$700	
D6110	*Implant /abutment supported removable denture for edentulous arch – maxillary	$1200	
D6111	*Implant /abutment supported removable denture for edentulous arch – mandibular	$1200	
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	$3800	
D6115	*Implant /abutment supported fixed denture for edentulous arch – mandibular	$3800	
D6116	*Implant /abutment supported fixed denture for partially edentulous arch – maxillary	$2200	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D6117	*Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$2200	
D6118	*Implant/abutment supported interim fixed denture for edentulous arch – mandibular	$1760	
D6119	*Implant/abutment supported interim fixed denture for edentulous arch – maxillary	$1760	
D6120	*Implant supported retainer – porcelain fused to titanium and titanium alloys	$695	
D6121	*Implant supported retainer for metal FPD – predominantly base alloys	$695	
D6122	*Implant supported retainer for metal FPD – noble alloys	$695	
D6123	*Implant supported retainer for metal FPD – titanium and titanium alloys	$695	
D6190	Radiographic/surgical implant index, by report	$235	
	PROSTHODONTICS FIXED		
D6205	*Pontic - indirect resin based composite	$695	
D6210	*Pontic - cast high noble metal	$195*	
D6211	*Pontic - cast predominantly base metal	$195*	
D6212	*Pontic - cast noble metal	$195*	
D6214	*Pontic - titanium	$195*	
D6240	*Pontic - porcelain fused to high noble metal	$195*	
D6241	*Pontic - porcelain fused to predominantly base metal	$195*	
D6242	*Pontic - porcelain fused to noble metal	$195*	
D6243	*Pontic - porcelain fused to titanium and titanium alloys	$195*	
D6245	*Pontic - porcelain/ceramic	$195*	
D6250	*Pontic - resin with high noble metal	$195*	
D6251	*Pontic - resin with predominantly base metal	$195*	
D6252	*Pontic - resin with noble metal	$195*	
D6253	*Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	$0	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$180	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$225*	
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$195*	
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$195*	
D6602	Retainer inlay - cast high noble metal, two surfaces	$195*	
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$195*	
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$195*	
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$195*	
D6606	Retainer inlay - cast noble metal, two surfaces	$195*	
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195*	
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$195*	
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$195*	
D6610	Retainer onlay - cast high noble metal, two surfaces	$195*	
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$195*	
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$195*	
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$195*	
D6614	Retainer onlay - cast noble metal, two surfaces	$195*	
D6615	Retainer onlay - cast noble metal, three or more surfaces	$195*	
D6624	Retainer inlay - titanium	$195*	
D6634	Retainer onlay - titanium	$195*	
D6710	*Retainer crown - indirect resin based composite	$195*	
D6720	*Retainer crown - resin with high noble metal	$195*	
D6721	*Retainer crown - resin with predominantly base metal	$195*	
D6722	*Retainer crown - resin with noble metal	$195*	
D6740	*Retainer crown - porcelain/ceramic	$195*	
D6750	*Retainer crown - porcelain fused to high noble metal	$195*	
D6751	*Retainer crown - porcelain fused to predominantly base metal	$195*	
D6752	*Retainer crown - porcelain fused to noble metal	$195*	
D6753	*Retainer crown - porcelain fused to titanium and titanium alloys	$195*	
D6780	*Retainer crown - 3/4 cast high noble metal	$195*	
D6781	*Retainer crown - 3/4 cast predominantly base metal	$195*	
D6782	*Retainer crown - 3/4 cast noble metal	$195*	
D6783	*Retainer crown - 3/4 porcelain/ceramic	$195*	
D6784	*Retainer crown ¾ - titanium and titanium alloys	$195*	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D6790	*Retainer crown - full cast high noble metal	$195*	
D6791	*Retainer crown - full cast predominantly base metal	$195*	
D6792	*Retainer crown - full cast noble metal	$195*	
D6793	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$125	
D6794	*Retainer crown - titanium	$195*	
D6930	Re-cement or re-bond fixed partial denture	$10	
D6940	Stress breaker	$125	
D6950	Precision attachment	$125	
D6980	Fixed partial denture repair necessitated by restorative material failure	$80	
	ORAL SURGERY		
D7111	Extraction, coronal remnants – primary tooth	$45	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$25	
D7220	Removal of impacted tooth - soft tissue	$40	
D7230	Removal of impacted tooth - partially bony	$55	
D7240	Removal of impacted tooth - completely bony	$63	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$100	
D7250	Removal of residual tooth roots (cutting procedure)	$25	
D7251	Coronectomy – intentional partial tooth removal	$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)	$115	
D7286	Incisional biopsy of oral tissue-soft	$60	
D7287	Exfoliative cytological sample collection	$50	
D7288	Brush biopsy - transepithelial sample collection	$25	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$30	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$20	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$20	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
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	$25	
D7411	Excision of benign lesion greater than 1.25 cm	$50	
D7412	Excision of benign lesion, complicated	$55	
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)	$95	
D7472	Removal of torus palatinus	$95	
D7473	Removal of torus mandibularis	$95	
D7485	Reduction of osseous tuberosity	$95	
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	
D7910	Suture of recent small wounds up to 5 cm	$35	
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	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D7961	Buccal / labial frenectomy (frenulectomy)	$50	
D7962	Lingual frenectomy (frenulectomy)	$50	
D7963	Frenuloplasty	$50	
D7970	Excision of hyperplastic tissue - per arch	$140	
D7971	Excision of pericoronal gingiva	$102	
D7972	Surgical reduction of fibrous tuberosity	$125	
	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	$1350	
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1800	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1850	
D8090	Comprehensive orthodontic treatment of the adult dentition	$1950	
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	
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	
	MISCELLANEOUS		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0	
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 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	
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$65	
D9248	Non-intravenous conscious sedation	$15	
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	$25	
D9450	Case presentation, detailed and extensive treatment planning	$0	
D9610	Therapeutic parenteral drug, single administration	$15	
D9630	Drugs or medicaments dispensed in the office for home use	$15	
D9910	*Application of desensitizing medicament	$20	
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$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	
D9950	Occlusion analysis - mounted case	$75	
D9951	Occlusal adjustment - limited	$25	
D9952	Occlusal adjustment - complete	$75	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	
D9986	Missed appointment	$25	
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	

EXCLUSIONS, LIMITATIONS, AND ADDITIONAL FEES

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 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 an approved 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 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.

Limitations and Additional Fees

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.

17 D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.

18 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.

19 Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.

20 A broken appointment fee up to $20.00 may be charged by the dental office if 24-hour prior notice is not given.

21 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% o 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 25% reduction off of the doctor's usual and customary fees.

22 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.

23 Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.

24 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.

25 Copayments marked by "^" are additional benefits utilized after the original limitation.

P.O. Box 19199
Plantation, FL 33318
Telephone: 877-760-2247
Fax: 954-370-1701

S700B Access+

Members of S700B Access+ dental plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No Waiting Periods
- No Deductibles
- Out-of-Network Services covered at a Schedule Reimbursement to the member

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

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

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

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 benefits are payable under the Policy. An "*" or a "†" denotes limitations and/or additional fees on certain benefits. See the Limitations and Additional Fees section below for details. A “^” indicate copays for additional services.

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
	APPOINTMENTS		
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	$20
D0150	*Comprehensive oral evaluation - new or established patient	$0	$20
D0160	*Detailed and extensive oral evaluation - problem focused, by report	$0	$20
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	$20
D0171	Re-evaluation – post-operative office visit	$0	
D0180	*Comprehensive periodontal evaluation - new or established patient	$0	$20
	RADIOGRAPHY / DIAGNOSTIC DENTISTRY		
D0210	*Intraoral - complete series of radiographic images	$0	$25
D0220	Intraoral - periapical first radiographic image	$4	$4
D0230	Intraoral - periapical each additional radiographic image	$2	$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	$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	$29	$25
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	$25
D0340	2d cephalometric radiographic image – acquisition, measurement and analysis	$125	
D0350	2d oral/facial photographic image obtained intra-orally or extra-orally	$20	$15
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	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	
D0369	*Maxillofacial mri capture and interpretation	$139	
D0370	*Maxillofacial ultrasound capture and interpretation	$189	
D0371	*Sialoendoscopy capture and interpretation	$169	
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	
D0393	*Treatment simulation using 3d image volume	$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	
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	
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	$25
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	$15
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	$2
D0708	*Intraoral – bitewing radiographic image – image capture only	$0	$10
D0709	*Intraoral – complete series of radiographic images – image capture only	$0	$25
D0999	Unspecified diagnostic procedure, by report	$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 application of fluoride varnish	$15	
D1208	*Topical application of fluoride – excluding varnish	$0	$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	
D1353	Sealant repair – per tooth	$0	
D1354	*Interim caries arresting medicament application – per tooth	$20	
D1355	Caries preventive medicament application – per tooth	$20	
D1510	*Space maintainer - fixed - unilateral	$0	$50
D1516	*Space maintainer – fixed – bilateral, maxillary	$0	$75

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D1517	*Space maintainer – fixed – bilateral, mandibular	$0	$75
D1520	*Space maintainer - removable - unilateral	$0	$50
D1526	*Space maintainer – removable – bilateral, maxillary	$0	$75
D1527	*Space maintainer – removable – bilateral, mandibular	$0	$75
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	$0	
	RESTORATIVE DENTISTRY		
D2140	Amalgam - one surface, primary or permanent	$0	$15
D2150	Amalgam - two surfaces, primary or permanent	$0	$20
D2160	Amalgam - three surfaces, primary or permanent	$0	$25
D2161	Amalgam - four or more surfaces, primary or permanent	$0	$25
D2330	Resin-based composite - one surface, anterior	$30	$15
D2331	Resin-based composite - two surfaces, anterior	$37	$20
D2332	Resin-based composite - three surfaces, anterior	$50	$25
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$80	$25
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	
D2410	Gold foil - one surface	$75	
D2420	Gold foil - two surfaces	$95	
D2430	Gold foil - three surfaces	$125	
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	
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*	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	$245*	
D2799	*Provisional crown– further treatment or completion of diagnosis necessary prior to final impression	$125	
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*	
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	
D2941	Interim therapeutic restoration – primary dentition	$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	
D2990	Resin infiltration of incipient smooth surface lesions	$29	
	ENDODONTIC SERVICES		
D3110	Pulp cap - direct (excluding final restoration)	$25	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
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	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$50	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$50	
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	
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	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$90	
D3352	Apexification/recalcification – interim medication replacement	$90	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$90	
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	
D3910	Surgical procedure for isolation of tooth with rubber dam	$95	
D3920	Hemisection (including any root removal), not including root canal therapy	$90	
D3950	Canal preparation and fitting of preformed dowel or post	$75	
	PERIODONTIC SERVICES		
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	$325	
D4266	Guided tissue regeneration - resorbable barrier, per site	$325	
D4267	Guided tissue regeneration - 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 double 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	
D4320	Provisional splinting - intracoronal	$115	
D4321	Provisional splinting - extracoronal	$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†	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D4355	*Full mouth debridement to enable a comprehensive oral 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†	
D4910	*Periodontal maintenance	$50	
D4910	Additional Periodontal maintenance procedure	$100^	
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$25	
D4921	Gingival irrigation – per quadrant	$15	
D4999	Unspecified periodontal procedure, by report	$0	
	PROSTHODONTICS REMOVABLE		
D5110	*Complete denture - maxillary	$325*	
D5120	*Complete denture - mandibular	$325*	
D5130	*Immediate denture - maxillary	$350*	
D5140	*Immediate denture - mandibular	$350*	
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 any conventional clasps, rests and teeth)	$425*	
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$425*	
D5221	*Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$420*	
D5222	*Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$420*	
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$445*	
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, 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*	
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 retentive/clasping materials, rests, and teeth), mandibular	$245*	
D5410	Adjust complete denture - maxillary	$15	
D5411	Adjust complete denture - mandibular	$15	
D5421	Adjust partial denture - maxillary	$15	
D5422	Adjust partial denture - mandibular	$15	
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*	
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*	
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*	
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*	
D5850	Tissue conditioning, maxillary	$20	
D5851	Tissue conditioning, mandibular	$20	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
D5862	Precision attachment, by report	$150	
D5899	Unspecified removable prosthodontic procedure, by report	$0	
D5982	Surgical stent	$150*	
D5987	Commissure splint	$150*	
D5988	Surgical splint	$150*	
	IMPLANT SUPPORTED PROSTHETICS		
D6010	*Surgical placement of implant body: endosteal implant	$1010	
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$1010	
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	
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 porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$750	
D6067	*Implant supported metal crown (titanium, titanium alloy, high noble metal)	$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 porcelain fused to metal fpd (titanium, titanium alloy, or high noble metal)	$750	
D6077	*Implant supported retainer for cast metal fpd (titanium, titanium alloy, or high noble metal)	$750	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$180	
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	Provisional 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	
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	
D6094	*Abutment supported crown - (titanium)	$750	
D6095	Repair implant abutment, by report	$220	
D6096	Remove broken implant retaining screw	$500	
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	
D6100	Implant removal, by report	$700	
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	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	
D6190	Radiographic/surgical implant index, by report	$235	
	PROSTHODONTICS FIXED		
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	$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*	
D6252	*Pontic - resin with noble metal	$245*	
D6253	*Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	$0	
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*	
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*	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$125	
D6794	*Retainer crown - titanium	$245*	
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	
	ORAL SURGERY		
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	
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	$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	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$40	
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	
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	$25	
D7411	Excision of benign lesion greater than 1.25 cm	$50	
D7412	Excision of benign lesion, complicated	$55	
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)	$95	
D7472	Removal of torus palatinus	$95	
D7473	Removal of torus mandibularis	$95	
D7485	Reduction of osseous tuberosity	$95	
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	
D7910	Suture of recent small wounds up to 5 cm	$35	
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	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	
	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	$1350	
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	
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	
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	
	MISCELLANEOUS		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0	
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 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	
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$65	
D9248	Non-intravenous conscious sedation	$15	
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, detailed and extensive treatment planning	$0	
D9610	Therapeutic parenteral drug, single administration	$15	
D9630	Drugs or medicaments dispensed in the office for home use	$15	
D9910	*Application of desensitizing medicament	$20	
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$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	
D9950	Occlusion analysis - mounted case	$75	
D9951	Occlusal adjustment - limited	$30	
D9952	Occlusal adjustment - complete	$100	

CODE	DESCRIPTION	INN COPAY	OON REIMBURSEMENT
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	
D9986	Missed appointment	$25	
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	

EXCLUSIONS, LIMITATIONS, AND ADDITIONAL FEES

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 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 an approved 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 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.

Limitations and Additional Fees

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.

17 D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.

18 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.

19 Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.

20 A broken appointment fee up to $20.00 may be charged by the dental office if 24-hour prior notice is not given.

21 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% o 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 25% reduction off of the doctor's usual and customary fees.

22 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.

23 Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.

24 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.

25 Copayments marked by "^" are additional benefits utilized after the original limitation.