Prepared For: Insurafy-NY Small Group Plans
Maximum Eligible:50 / Minimum Participating:2

2020 Effective Dates

Plan	Plan 11029	Plan 11040	S500B	IC 4
Employee	$34.51	$66.33	$19.15	$7.39
Employee+Spouse	$69.01	$132.67	$38.29	$12.93
Employee+Child(ren)	$78.42	$150.76	$43.52	$16.04
Employee+Family	$109.79	$211.06	$60.92	$20.33

Product Type:	Dental PPO	Dental EPO	Vision PPO
Rate Period:	12 Months	12 Months	12 Months
Rate Type:	Voluntary	Voluntary	Voluntary
Book Rate Area:	New York 3 Digit Zip Areas: 100-119	New York	New York

All Plans: If less than 15 subscribers enroll with a group, an ACH/EFT Authorization Form must be completed and automatic ACH/EFT must be the method of payment to avoid a $10 monthly administration fee. A NYS-45 Form must be submitted for groups with less than 15 enrolled subscribers.

Minimum Rate Type Contribution and Participation Requirements:	**Non Contributory**	- Employer pays 100% of Employee and Dependent premium.
		- 100% participation is required, excluding valid waivers.
	Contributory	- Employer pays 100% of Employee premium or 50% across all tiers
		- 70% participation is required, excluding valid waivers.
	Voluntary	- Minimum of 2 enrolled employees.
		- At least 1 employee must be non owner/non partner W2 employee

	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	N/A	N/A

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	N/A	

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)	80%	80%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	80%	80%	Limited to one (1) time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	80%	80%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	80%	80%	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	80%	80%	
Anesthetics	80%	80%	General Anesthesia: When clinically necessary.
Adjunctive Services	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	50%	50%	Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	Not Covered	Not Covered	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.

	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)*	$2000 per person per Calendar Year	$2000 per person per Calendar Year	N/A	N/A

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	N/A	

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)	80%	80%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	80%	80%	Limited to one (1) time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	80%	80%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	80%	80%	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	80%	80%	
Anesthetics	80%	80%	General Anesthesia: When clinically necessary.
Adjunctive Services	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	50%	50%	Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	Not Covered	Not Covered	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 80th Percentile of Usual and Customary Charge.

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.

B**ITEWING 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.

Solstice
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Plantation, FL 33318
Telephone: 877-760-2247
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www.mysolstice.net

S500B
Dental Plan Schedule of Benefits

Members of the S500B Dental Plan are eligible to receive benefits immediately upon the effective date of coverage with:

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

The member co-payments listed are offered by a participating general in-network general dentists. The member receives:

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

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

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

The following Member Copayments apply when a Participating Dentist who is a General Dentist performs the services. An "*" or a "†" denotes limitations and/or additional fees on certain benefits. See the Limitations and Additional Fees section below for details.

CODE	DESCRIPTION	MEMBER COPAY
	CLINICAL ORAL EVALUATIONS	
D0120	*Periodic oral evaluation - established patient	No charge
D0140	Limited oral evaluation - problem focused	No charge
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge
D0150	*Comprehensive oral evaluation - new or established patient	No charge
D0160	*Detailed and extensive oral evaluation - problem focused, by report	No charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge
D0171	Re-evaluation – post-operative office visit	No charge
D0180	*Comprehensive periodontal evaluation - new or established patient	No charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	25.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No charge
D9440	Office visit - after regularly scheduled hours	30.00
D9450	Case presentation, detailed and extensive treatment planning	No charge
D9986	Missed appointment	25.00
	DIAGNOSTIC IMAGING	
D0210	*Intraoral - complete series of radiographic images	No charge
D0220	Intraoral - periapical first radiographic image	4.00
D0230	Intraoral - periapical each additional radiographic image	2.00
D0240	Intraoral - occlusal radiographic image	No charge
D0250	Extra-oral – 2d projection radiographic image created using a stationary radiation source, and detector	No charge
D0251	*Extra-oral posterior dental radiographic image	No charge
D0270	*Bitewing - single radiographic image	No charge
D0272	*Bitewings - two radiographic images	No charge
D0273	*Bitewings - three radiographic images	No charge
D0274	*Bitewings - four radiographic images	No charge
D0277	*Vertical bitewings - 7 to 8 radiographic images	27.00
D0310	Sialography	150.00
D0320	Temporomandibular joint arthrogram, including injection	250.00
D0321	Other temporomandibular joint radiographic images, by report	150.00
D0322	Tomographic survey	150.00
D0330	*Panoramic radiographic image	45.00
D0340	2d cephalometric radiographic image – acquisition, measurement and analysis	100.00
D0350	2d oral/facial photographic image obtained intra-orally or extra-orally	20.00

CODE	DESCRIPTION	MEMBER COPAY
D0364	*Cone beam ct capture and interpretation with limited field of view – less than one whole jaw	147.00
D0365	*Cone beam ct capture and interpretation with field of view of one full dental arch – mandible	137.00
D0366	*Cone beam ct capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	137.00
D0367	*Cone beam ct capture and interpretation with field of view of both jaws; with or without cranium	182.00
D0368	*Cone beam ct capture and interpretation for tmj series including two or more exposures	137.00
D0369	*Maxillofacial mri capture and interpretation	187.00
D0370	*Maxillofacial ultrasound capture and interpretation	167.00
D0371	*Sialoendoscopy capture and interpretation	167.00
D0380	*Cone beam ct image capture with limited field of view – less than one whole jaw	147.00
D0381	*Cone beam ct image capture with field of view of one full dental arch – mandible	137.00
D0382	*Cone beam ct image capture with field of view of one full dental arch – maxilla, with or without cranium	137.00
D0383	*Cone beam ct image capture with field of view of both jaws; with or without cranium	182.00
D0384	*Cone beam ct image capture for tmj series including two or more exposures	137.00
D0385	*Maxillofacial mri image capture	167.00
D0386	*Maxillofacial ultrasound image capture	167.00
D0393	*Treatment simulation using 3d image volume	7.00
D0394	*Digital subtraction of two or more images or image volumes of the same modality	7.00
D0395	*Fusion of two or more 3d image volumes of one or more modalities	7.00
	TESTS AND EXAMINATIONS	
D0415	Collection of microorganisms for culture and sensitivity	No charge
D0425	Caries susceptibility tests	No charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	65.00
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts	No charge
	ORAL PATHOLOGY LABORATORY	
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No charge
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	No charge
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	No charge
D0502	Other oral pathology procedures, by report	No charge
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	No charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge
	DENTAL PROPHYLAXIS	
D1110	*Prophylaxis - adult	No charge
D1110	Additional prophylaxis - adult	15.00
D1120	*Prophylaxis - child	No charge
D1120	Additional prophylaxis - child	15.00
	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)	
D1206	*Topical application of fluoride varnish	10.00
D1208	*Topical application of fluoride – excluding varnish	No charge
D9910	*Application of desensitizing medicament	20.00
	OTHER PREVENTIVE SERVICES	
D1310	Nutritional counseling for control of dental disease	No charge
D1320	Tobacco counseling for the control and prevention of oral disease	No charge
D1330	Oral hygiene instructions	No charge
D1351	*Sealant - per tooth	No charge
D1352	*Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No charge
D1353	Sealant repair – per tooth	No charge
D1354	*Interim caries arresting medicament application – per tooth	20.00
	SPACE MAINTAINERS (PASSIVE APPLIANCES)	
D1510	*Space maintainer - fixed - unilateral	No charge
D1516	*Space maintainer – fixed – bilateral, maxillary	No charge
D1517	*Space maintainer – fixed – bilateral, mandibular	No charge
D1520	*Space maintainer - removable - unilateral	No charge
D1526	*Space maintainer – removable – bilateral, maxillary	No charge
D1527	*Space maintainer – removable – bilateral, mandibular	No charge
D1550	Re-cement or re-bond space maintainer	10.00
D1555	Removal of fixed space maintainer	10.00
D1575	Distal shoe space maintainer – fixed – unilateral	No charge

CODE	DESCRIPTION	MEMBER COPAY
	AMALGAMS RESTORATIONS (INCLUDING POLISHING)	
D2140	Amalgam - one surface, primary or permanent	No charge
D2150	Amalgam - two surfaces, primary or permanent	No charge
D2160	Amalgam - three surfaces, primary or permanent	No charge
D2161	Amalgam - four or more surfaces, primary or permanent	No charge
	RESIN BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-based composite - one surface, anterior	25.00
D2331	Resin-based composite - two surfaces, anterior	35.00
D2332	Resin-based composite - three surfaces, anterior	45.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	75.00
D2390	Resin-based composite crown, anterior	105.00
D2391	Resin-based composite - one surface, posterior	55.00
D2392	Resin-based composite - two surfaces, posterior	70.00
D2393	Resin-based composite - three surfaces, posterior	85.00
D2394	Resin-based composite - four or more surfaces, posterior	105.00
	GOLD FOIL RESTORATIONS	
D2410	Gold foil - one surface	70.00
D2420	Gold foil - two surfaces	92.00
D2430	Gold foil - three surfaces	120.00
	INLAY/ONLAY RESTORATIONS	
D2510	Inlay - metallic - one surface	85.00
D2520	Inlay - metallic - two surfaces	96.00
D2530	Inlay - metallic - three or more surfaces	120.00
D2542	Onlay - metallic - two surfaces	290.00
D2543	Onlay - metallic - three surfaces	300.00
D2544	Onlay - metallic - four or more surfaces	330.00
D2610	Inlay - porcelain/ceramic - one surface	250.00*
D2620	Inlay - porcelain/ceramic - two surfaces	275.00*
D2630	Inlay - porcelain/ceramic - three or more surfaces	300.00*
D2642	Onlay - porcelain/ceramic - two surfaces	335.00*
D2643	Onlay - porcelain/ceramic - three surfaces	365.00*
D2644	Onlay - porcelain/ceramic - four or more surfaces	375.00*
D2650	Inlay - resin-based composite - one surface	195.00
D2651	Inlay - resin-based composite - two surfaces	220.00
D2652	Inlay - resin-based composite - three or more surfaces	255.00
D2662	Onlay - resin-based composite - two surfaces	230.00
D2663	Onlay - resin-based composite - three surfaces	250.00
D2664	Onlay - resin-based composite - four or more surfaces	280.00
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	*Crown - resin-based composite (indirect)	195.00
D2712	*Crown - ¾ resin-based composite (indirect)	195.00
D2720	*Crown - resin with high noble metal	240.00*
D2721	*Crown - resin with predominantly base metal	240.00*
D2722	*Crown - resin with noble metal	240.00*
D2740	*Crown - porcelain/ceramic	240.00*
D2750	*Crown - porcelain fused to high noble metal	240.00*
D2751	*Crown - porcelain fused to predominantly base metal	240.00*
D2752	*Crown - porcelain fused to noble metal	240.00*
D2780	*Crown - 3/4 cast high noble metal	240.00*
D2781	*Crown - 3/4 cast predominantly base metal	240.00*
D2782	*Crown - 3/4 cast noble metal	240.00*
D2783	*Crown - 3/4 porcelain/ceramic	240.00*
D2790	*Crown - full cast high noble metal	240.00*
D2791	*Crown - full cast predominantly base metal	220.00*
D2792	*Crown - full cast noble metal	220.00*
D2794	*Crown - titanium	240.00*
D2799	*Provisional crown– further treatment or completion of diagnosis necessary prior to final impression	125.00
	OTHER RESTORATIVE SERVICES	
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	10.00
D2920	Re-cement or re-bond crown	10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp	10.00
D2929	*Prefabricated porcelain/ceramic crown – primary tooth	41.00*
D2930	Prefabricated stainless steel crown - primary tooth	40.00
D2931	Prefabricated stainless steel crown - permanent tooth	40.00
D2932	Prefabricated resin crown	92.00
D2933	Prefabricated stainless steel crown with resin window	140.00
D2940	Protective restoration	10.00
D2941	Interim therapeutic restoration – primary dentition	10.00
D2949	Restorative foundation for an indirect restoration	20.00
D2950	Core buildup, including any pins when required	40.00
D2951	Pin retention - per tooth, in addition to restoration	12.00
D2952	Post and core in addition to crown, indirectly fabricated	85.00
D2953	Each additional indirectly fabricated post - same tooth	95.00
D2954	Prefabricated post and core in addition to crown	75.00
D2955	Post removal	25.00
D2957	Each additional prefabricated post - same tooth	30.00
D2960	Labial veneer (resin laminate) - chairside	200.00

CODE	DESCRIPTION	MEMBER COPAY
D2961	Labial veneer (resin laminate) - laboratory	225.00*
D2962	Labial veneer (porcelain laminate) - laboratory	350.00*
D2971	Additional procedures to construct new crown under existing partial denture framework	45.00
D2975	Coping	95.00
D2980	Crown repair necessitated by restorative material failure	95.00
D2981	Inlay repair necessitated by restorative material failure	95.00
D2982	Onlay repair necessitated by restorative material failure	95.00
D2983	Veneer repair necessitated by restorative material failure	95.00
D2990	Resin infiltration of incipient smooth surface lesions	29.00
	PULP CAPPING	
D3110	Pulp cap - direct (excluding final restoration)	20.00
D3120	Pulp cap - indirect (excluding final restoration)	20.00
	PULPOTOMY	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	25.00
D3221	Pulpal debridement, primary and permanent teeth	95.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	75.00
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	40.00
	ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES & FOLLOW-UP CARE)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	100.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	185.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	225.00
D3331	Treatment of root canal obstruction; non-surgical access	85.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75.00
D3333	Internal root repair of perforation defects	125.00
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	280.00
D3347	Retreatment of previous root canal therapy - premolar	305.00
D3348	Retreatment of previous root canal therapy - molar	380.00
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	90.00
D3352	Apexification/recalcification – interim medication replacement	90.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	90.00
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - anterior	96.00
D3421	Apicoectomy - premolar (first root)	305.00
D3425	Apicoectomy - molar (first root)	320.00
D3426	Apicoectomy (each additional root)	80.00
D3427	Periradicular surgery without apicoectomy	96.00
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	37.00
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	32.00
D3430	Retrograde filling - per root	60.00
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	150.00
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	150.00
D3450	Root amputation - per root	100.00
D3460	Endodontic endosseous implant	542.00
D3470	Intentional reimplantation (including necessary splinting)	175.00
	OTHER ENDODONTIC PROCEDURES	
D3910	Surgical procedure for isolation of tooth with rubber dam	95.00
D3920	Hemisection (including any root removal), not including root canal therapy	85.00
D3950	Canal preparation and fitting of preformed dowel or post	75.00
	SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	175.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	72.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	43.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	187.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	175.00
D4245	Apically positioned flap	150.00
D4249	Clinical crown lengthening – hard tissue	175.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	375.00

CODE	DESCRIPTION	MEMBER COPAY
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	325.00
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	450.00
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	325.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	325.00
D4266	Guided tissue regeneration - resorbable barrier, per site	325.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	325.00
D4268	Surgical revision procedure, per tooth	No charge
D4270	Pedicle soft tissue graft procedure	240.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	300.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	120.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	502.00
D4276	Combined connective tissue and double pedicle graft, per tooth	65.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	215.00
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	75.00
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	268.00
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	392.00
	NON SURGICAL PERIODONTAL SERVICE	
D4320	Provisional splinting - intracoronal	115.00
D4321	Provisional splinting - extracoronal	105.00
D4341	*Periodontal scaling and root planing - four or more teeth per quadrant	45.00†
D4342	*Periodontal scaling and root planing - one to three teeth per quadrant	35.00†
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	35.00†
D4355	*Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	35.00†
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	45.00†

CODE	DESCRIPTION	MEMBER COPAY
	OTHER PERIODONTAL SERVICES	
D4910	*Periodontal maintenance	45.00
D4910	Additional Periodontal maintenance procedures	100.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	25.00
D4921	Gingival irrigation – per quadrant	15.00
D4999	Unspecified periodontal procedure, by report	No charge
	COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5110	*Complete denture - maxillary	260.00*
D5120	*Complete denture - mandibular	260.00*
D5130	*Immediate denture - maxillary	280.00*
D5140	*Immediate denture - mandibular	280.00*
	PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5211	*Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	260.00*
D5212	*Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	260.00*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	280.00*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	280.00*
D5221	*Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	280.00*
D5222	*Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	280.00*
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	300.00*
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	300.00*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	280.00*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	280.00*
D5282	*Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	240.00*
D5283	*Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	240.00*
	ADJUSTMENTS TO DENTURES	
D5410	Adjust complete denture - maxillary	10.00
D5411	Adjust complete denture - mandibular	10.00
D5421	Adjust partial denture - maxillary	15.00
D5422	Adjust partial denture - mandibular	15.00
	REPAIRS TO COMPLETE DENTURES	
D5511	*Repair broken complete denture base, mandibular	15.00*
D5512	*Repair broken complete denture base, maxillary	15.00*

CODE	DESCRIPTION	MEMBER COPAY
D5520	*Replace missing or broken teeth - complete denture (each tooth)	10.00*
	REPAIRS TO PARTIAL DENTURES	
D5611	*Repair resin partial denture base, mandibular	15.00*
D5612	*Repair resin partial denture base, maxillary	15.00*
D5621	*Repair cast partial framework, mandibular	30.00*
D5622	*Repair cast partial framework, maxillary	30.00*
D5630	*Repair or replace broken retentive clasping materials – per tooth	15.00*
D5640	*Replace broken teeth - per tooth	10.00*
D5650	*Add tooth to existing partial denture	30.00*
D5660	*Add clasp to existing partial denture - per tooth	30.00*
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	100.00*
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	100.00*
D5710	*Rebase complete maxillary denture	75.00*
D5711	*Rebase complete mandibular denture	75.00*
D5720	*Rebase maxillary partial denture	75.00*
D5721	*Rebase mandibular partial denture	75.00*
D5730	*Reline complete maxillary denture (chairside)	45.00*
D5731	*Reline complete mandibular denture (chairside)	45.00*
D5740	*Reline maxillary partial denture (chairside)	45.00*
D5741	*Reline mandibular partial denture (chairside)	45.00*
D5750	*Reline complete maxillary denture (laboratory)	35.00*
D5751	*Reline complete mandibular denture (laboratory)	35.00*
D5760	*Reline maxillary partial denture (laboratory)	35.00*
D5761	*Reline mandibular partial denture (laboratory)	35.00*
	INTERIM PROSTHESIS	
D5810	*Interim complete denture (maxillary)	250.00*
D5811	*Interim complete denture (mandibular)	250.00*
D5820	*Interim partial denture (maxillary)	250.00*
D5821	*Interim partial denture (mandibular)	250.00*
	OTHER REMOVABLE PROSTHESIS	
D5850	Tissue conditioning, maxillary	25.00
D5851	Tissue conditioning, mandibular	25.00
D5862	Precision attachment, by report	150.00
D5899	Unspecified removable prosthodontic procedure, by report	No charge
	NON-CLINICAL PROCEDURES	
D5982	Surgical stent	145.00*
D5987	Commissure splint	145.00*
D5988	Surgical splint	145.00*
	PRE-SURGICAL SERVICES	
D6190	Radiographic/surgical implant index, by report	235.00

CODE	DESCRIPTION	MEMBER COPAY
	SURGICAL SERVICES	
D6010	*Surgical placement of implant body: endosteal implant	1000.00
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	1000.00
D6100	Implant removal, by report	700.00
	IMPLANT SUPPORTED PROSTHETICS	
D6056	*Prefabricated abutment – includes modification and placement	435.00
D6057	*Custom fabricated abutment – includes placement	545.00
D6058	*Abutment supported porcelain/ceramic crown	745.00
D6059	*Abutment supported porcelain fused to metal crown (high noble metal)	745.00
D6060	*Abutment supported porcelain fused to metal crown (predominantly base metal)	745.00
D6061	*Abutment supported porcelain fused to metal crown (noble metal)	745.00
D6062	*Abutment supported cast metal crown (high noble metal)	745.00
D6063	*Abutment supported cast metal crown (predominantly base metal)	745.00
D6064	*Abutment supported cast metal crown (noble metal)	745.00
D6065	*Implant supported porcelain/ceramic crown	745.00
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	745.00
D6067	*Implant supported metal crown (titanium, titanium alloy, high noble metal)	745.00
D6068	*Abutment supported retainer for porcelain/ceramic fpd	745.00
D6069	*Abutment supported retainer for porcelain fused to metal fpd (high noble metal)	745.00
D6070	*Abutment supported retainer for porcelain fused to metal fpd (predominantly base metal)	745.00
D6071	*Abutment supported retainer for porcelain fused to metal fpd (noble metal)	745.00
D6072	*Abutment supported retainer for cast metal fpd (high noble metal)	745.00
D6073	*Abutment supported retainer for cast metal fpd (predominantly base metal)	745.00
D6074	*Abutment supported retainer for cast metal fpd (noble metal)	745.00
D6075	*Implant supported retainer for ceramic fpd	745.00
D6076	*Implant supported retainer for porcelain fused to metal fpd (titanium, titanium alloy, or high noble metal)	745.00
D6077	*Implant supported retainer for cast metal fpd (titanium, titanium alloy, or high noble metal)	745.00
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	45.00†
D6085	Provisional implant crown	125.00
D6094	*Abutment supported crown - (titanium)	745.00

CODE	DESCRIPTION	MEMBER COPAY
D6110	*Implant /abutment supported removable denture for edentulous arch – maxillary	1250.00
D6111	*Implant /abutment supported removable denture for edentulous arch – mandibular	1250.00
D6112	*Implant /abutment supported removable denture for partially edentulous arch – maxillary	990.00
D6113	*Implant /abutment supported removable denture for partially edentulous arch – mandibular	990.00
D6114	*Implant /abutment supported fixed denture for edentulous arch – maxillary	3850.00
D6115	*Implant /abutment supported fixed denture for edentulous arch – mandibular	3850.00
D6116	*Implant /abutment supported fixed denture for partially edentulous arch – maxillary	2250.00
D6117	*Implant /abutment supported fixed denture for partially edentulous arch – mandibular	2250.00
D6118	*Implant/abutment supported interim fixed denture for edentulous arch – mandibular	1800.00
D6119	*Implant/abutment supported interim fixed denture for edentulous arch – maxillary	1800.00
	OTHER IMPLANT SERVICES	
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	180.00
D6090	Repair implant supported prosthesis, by report	400.00
D6092	Re-cement or re-bond implant/abutment supported crown	45.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	65.00
D6095	Repair implant abutment, by report	220.00
D6096	Remove broken implant retaining screw	500.00
	FIXED PARTIAL DENTURE PONTICS	
D6205	*Pontic - indirect resin based composite	745.00
D6210	*Pontic - cast high noble metal	220.00*
D6211	*Pontic - cast predominantly base metal	220.00*
D6212	*Pontic - cast noble metal	220.00*
D6214	*Pontic - titanium	240.00*
D6240	*Pontic - porcelain fused to high noble metal	240.00*
D6241	*Pontic - porcelain fused to predominantly base metal	240.00*
D6242	*Pontic - porcelain fused to noble metal	240.00*
D6245	*Pontic - porcelain/ceramic	240.00*
D6250	*Pontic - resin with high noble metal	240.00*
D6251	*Pontic - resin with predominantly base metal	240.00*
D6252	*Pontic - resin with noble metal	240.00*
D6253	*Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	No charge
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	235.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	240.00*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	240.00*
D6602	Retainer inlay - cast high noble metal, two surfaces	240.00*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	240.00*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	240.00*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	240.00*
D6545	Retainer - cast metal for resin bonded fixed prosthesis	235.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	240.00*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	240.00*
D6602	Retainer inlay - cast high noble metal, two surfaces	240.00*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	240.00*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	240.00*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	240.00*
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6710	*Retainer crown - indirect resin based composite	240.00*
D6720	*Retainer crown - resin with high noble metal	240.00*
D6721	*Retainer crown - resin with predominantly base metal	240.00*
D6722	*Retainer crown - resin with noble metal	240.00*
D6740	*Retainer crown - porcelain/ceramic	240.00*
D6750	*Retainer crown - porcelain fused to high noble metal	240.00*
D6751	*Retainer crown - porcelain fused to predominantly base metal	240.00*
D6752	*Retainer crown - porcelain fused to noble metal	240.00*
D6780	*Retainer crown - 3/4 cast high noble metal	240.00*
D6781	*Retainer crown - 3/4 cast predominantly base metal	240.00*
D6782	*Retainer crown - 3/4 cast noble metal	240.00*
D6783	*Retainer crown - 3/4 porcelain/ceramic	240.00*
D6790	*Retainer crown - full cast high noble metal	220.00*
D6791	*Retainer crown - full cast predominantly base metal	220.00*
D6792	*Retainer crown - full cast noble metal	220.00*
D6793	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
D6794	*Retainer crown - titanium	240.00*

CODE	DESCRIPTION	MEMBER COPAY
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Re-cement or re-bond fixed partial denture	10.00
D6940	Stress breaker	125.00
D6950	Precision attachment	195.00
D6980	Fixed partial denture repair necessitated by restorative material failure	80.00
	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)	
D7111	Extraction, coronal remnants – primary tooth	45.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	25.00
	OTHER SURGICAL PROCEDURES	
D7220	Removal of impacted tooth - soft tissue	40.00
D7230	Removal of impacted tooth - partially bony	60.00
D7240	Removal of impacted tooth - completely bony	75.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	128.00
D7250	Removal of residual tooth roots (cutting procedure)	25.00
D7251	Coronectomy – intentional partial tooth removal	270.00
D7260	Oroantral fistula closure	160.00
D7261	Primary closure of a sinus perforation	275.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	100.00
D7280	Exposure of an unerupted tooth	125.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00
D7283	Placement of device to facilitate eruption of impacted tooth	80.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	115.00
D7286	Incisional biopsy of oral tissue-soft	75.00
D7287	Exfoliative cytological sample collection	65.00
D7288	Brush biopsy - transepithelial sample collection	25.00
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	30.00
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	20.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	20.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50.00

CODE	DESCRIPTION	MEMBER COPAY
	VESTIBULOPLASTY	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	370.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	990.00
	SURGICAL EXCISION OF SOFT TISSUE LESIONS	
D7410	Excision of benign lesion up to 1.25 cm	25.00
D7411	Excision of benign lesion greater than 1.25 cm	50.00
D7412	Excision of benign lesion, complicated	55.00
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	65.00
	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	95.00
D7472	Removal of torus palatinus	95.00
D7473	Removal of torus mandibularis	95.00
D7485	Reduction of osseous tuberosity	95.00
	SURGICAL INCISION	
D7510	Incision and drainage of abscess - intraoral soft tissue	20.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
D7520	Incision and drainage of abscess - extraoral soft tissue	20.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
	REPAIR OF TRAUMATIC WOUNDS	
D7910	Suture of recent small wounds up to 5 cm	35.00
	OTHER REPAIR PROCEDURES	
D7921	Collection and application of autologous blood concentrate product	125.00
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	350.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	800.00
D7952	Sinus augmentation via a vertical approach	350.00
D7953	Bone replacement graft for ridge preservation - per site	100.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	90.00
D7963	Frenuloplasty	90.00
D7970	Excision of hyperplastic tissue - per arch	140.00
D7971	Excision of pericoronal gingiva	102.00
D7972	Surgical reduction of fibrous tuberosity	125.00

CODE	DESCRIPTION	MEMBER COPAY
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited orthodontic treatment of the primary dentition	1000.00
D8020	Limited orthodontic treatment of the transitional dentition	1000.00
D8030	Limited orthodontic treatment of the adolescent dentition	1000.00
D8040	Limited orthodontic treatment of the adult dentition	1350.00
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive orthodontic treatment of the transitional dentition	2000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2050.00
D8090	Comprehensive orthodontic treatment of the adult dentition	2150.00
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	*Removable appliance therapy	103.00
D8220	*Fixed appliance therapy	103.00
	OTHER ORTHODONTIC SERVICES	
D8660	Pre-orthodontic treatment examination to monitor growth and development	35.00
D8670	Periodic orthodontic treatment visit	No charge
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	300.00
D8681	Removable orthodontic retainer adjustment	No charge
D8693	Re-cement or re-bond fixed retainer	No charge
D8999	Unspecified orthodontic procedure, by report	250.00
	UNCLASSIFIED TREATMENT	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	No charge
D9120	Fixed partial denture sectioning	No charge
	ANESTHESIA	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	No charge
D9211	Regional block anesthesia	No charge
D9212	Trigeminal division block anesthesia	No charge
D9215	Local anesthesia in conjunction with operative or surgical procedures	No charge
D9222	Deep sedation/general anesthesia – first 15 minutes	50.00
D9223	Deep sedation/general anesthesia – each subsequent 15-minute increment	50.00
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	20.00
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	65.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment	65.00
D9248	Non-intravenous conscious sedation	15.00
	DRUGS	
D9610	Therapeutic parenteral drug, single administration	15.00
D9630	Drugs or medicaments dispensed in the office for home use	15.00
	MISCELLANEOUS SERVICES	
D9910	*Application of desensitizing medicament	20.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No charge
D9932	Cleaning and inspection of removable complete denture, maxillary	No charge
D9933	Cleaning and inspection of removable complete denture, mandibular	No charge
D9934	Cleaning and inspection of removable partial denture, maxillary	No charge
D9935	Cleaning and inspection of removable partial denture, mandibular	No charge
D9942	Repair and/or reline of occlusal guard	40.00
D9943	Occlusal guard adjustment	25.00
D9944	*Occlusal guard – hard appliance, full arch	250.00
D9945	*Occlusal guard – soft appliance, full arch	250.00
D9946	*Occlusal guard – hard appliance, partial arch	250.00
D9950	Occlusion analysis - mounted case	75.00
D9951	Occlusal adjustment - limited	25.00
D9952	Occlusal adjustment - complete	95.00
D9973	External bleaching - per tooth	30.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	240.00
D9991	Dental case management – addressing appointment compliance barriers	No charge
D9992	Dental case management – care coordination	No charge
D9993	Dental case management – motivational interviewing	No charge
D9994	Dental case management – patient education to improve oral health literacy	No charge

ADDITIONAL FEES

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

SPECIALTY SERVICES

1. The Schedule of Benefits applies when listed Dental Services are performed by a Participating General Dentist, unless otherwise authorized by Solstice.
2. Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.
3. The Participating General Dentist you select may not perform all Dental Procedures listed. The Copayments shown apply to Participating Dentists who do perform these Dental Services. Therefore, you are encouraged to secure availability of the scheduled Dental Services with your Participating General Dentist.
4. Should the services of a Specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care by going directly to a Participating Specialist with no referral and receive a 25% reduction off the Provider's usual and customary fee; or your Provider may obtain written authorization from Solstice and You may receive specialty treatment by an approved Participating Specialist at the listed Copayments.
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 Network Specialty Dentist 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 non-participating dentist or dentist specialist without preauthorization from Solstice.
2. 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.
3. We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational.
4. We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges. In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary.
5. Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and preauthorization from Solstice.
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

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 for endodontic procedures do not include the cost of the final restoration.
13. Copayments marked by "†" are not eligible at a specialist.
14. Either D0210, D0251, or D0330 are reimbursable one (1) time every five (5) consecutive years.
15. Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
16. D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.
17. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.
18. Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
19. A broken appointment fee up to $20.00 may be charged by the dental office if 24-hour prior notice is not given.
20. Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
21. Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
22. Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
23. D0364-D0395 is limited to one (1) time per sixty (60) months, covered only in a dental setting and not in a radiographic imaging center.

IMPORTANT DISCLAIMER

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. For a complete listing of your coverage, including specialty services, non covered services, 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 and your Certificate of Coverage/ benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions 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.

Solstice

Solstice Vision Plan IC 4

In-Network Benefits		Plan Design Options
Frequency – Once Every:		**IC 4 Designer**
Eye Examination inclusive of Dilation (when professionally indicated)		12 Months
Spectacle Lenses		12 Months
Frame		24 months
Contact Lens Evaluation, Fitting & Follow-Up Care		12 Months
Contact Lenses (in lieu of eyeglasses)		12 Months
Copayments		
Eye Examination		$10
Spectacle Lenses		$25
Contact Lens Evaluation, Fitting & Follow-Up Care		$25
Eyeglass Benefit - Frame	**Average Retail Value**	
Non-Collection Frame Allowance (Retail):	**Up to $150**	Up to $130 Plus a 20% discount on any overage [1]
Davis Vision Frame Collection[2] (in lieu of Allowance):		
Fashion level	**Up to $125**	Included
Designer level	**Up to $175**	Included
Premier level	**Up to $225**	$25 copayment
Eyeglass Benefit - Spectacle Lenses	**Average Retail Value**	**Member Charges**
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	**$60-$120**	Included
Tinting of Plastic Lenses	**$20**	Included
Scratch-Resistant Coating	**$25-$40**	Included
Polycarbonate Lenses (Children [3]/ Adults)	**$60-$75**	$0 or $30
Ultraviolet Coating	**$25-$30**	$12
Anti-Reflective (AR) Coating (Standard/Premium/Ultra)	**$50-$125**	$35 / $48 / $60
Progressive Lenses (Standard / Premium / Ultra[4])	**$150-$300**	$50 / $90 / $140
Intermediate-Vision Lenses	**$150-$175**	$30
High-Index Lenses	**$90-$150**	$55
Polarized Lenses	**$95-$110**	$75
Plastic Photosensitive Lenses	**$95-$150**	$65
Scratch Protection Plan: Single Vision | Multifocal Lenses		$20|$40
Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $130 Plus a 15% discount on any overage[1]
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Included
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Up to $60 with an additional 15% discount off any overage
Collection Contact Lenses [2] (in lieu of Allowance): Materials		
- Disposable		4 boxes / multi-packs
- Planned Replacement: up to		2 boxes / multi-packs
- Evaluation, Fitting & Follow-up Care		Included
Medically Necessary Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care		Included

Out-of-Network Reimbursement Schedule: up to

Eye Examination: $40	Single Vision Lenses: $40	Trifocal Lenses: $80	Elective Contact Lenses: $105
Frame: $50	Bifocal/Progressive Lenses: $60	Lenticular Lenses: $100	Medically Necessary CL: $225

[1] Additional discounts not applicable at Walmart or Sam's Club locations.
[2] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.
[3] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
[4] Category includes digital free-form progressive lenses.

One-year eyeglass breakage warranty included