Solstice S500B/D1067

SCHEDULE OF BENEFITS

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

- No Waiting Periods
- No Deductibles and Maximums
- No Claim Forms to Submit

The member co-payments listed are offered by a participating 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.myuhc.com
Member Services Department: 800-955-4137

The member is ultimately responsible for verifications of the accuracy and appropriateness of all fees applicable to any denta benefit provided by a network provider. We urge all of our members to verify all fees for proposed treatment via the “Schedul of Benefits” and/or with our Member Services Department prior to treatment.

The following Member co-payments apply when a participating General Dentist performs services. An “*” denotes limitations on certain benefits (see “Exclusions/Limitations”).

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120*	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145*	ORAL EVAL PT<3 AND COUNSEL	$0
D0150*	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160*	DTL&EXT ORAL EVAL - PROB FOCUS RPT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0180*	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210*	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$4
D0230	INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$2
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRAORAL - FIRST RADIOGRAPHIC IMAGE	$0
D0260	EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE	$0
D0270*	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272*	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273*	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274*	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277*	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$27
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$150
D0310	RADIOGRAPHS -SIALOGRAPHY	$150
D0320	TMJ - Including injection	$250
D0321	RADIOGRAPHS - TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES	$150
D0322	RADIOGRAPHS OTHER TEMPOROMANDIBULAR FILMS	$150
D0330*	PANORAMIC RADIOGRAPHIC IMAGE	$45
D0340	RADIOGRAPHS - CEPHALOMETRIC RADIOGRAPHIC IMAGE	$100
D0350	RADIOGRAPHS - ORAL.FACIAL IMAGES	$20
D0364*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$147
D0365*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$137
D0366*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIE OF ONE FULL DENTAL ARCH-MAXILLA	$137
D0367*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$182

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ADA	DESCRIPTION	MEMBER PAYS
D0368*	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$137
D0369*	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$187
D0370*	MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	$167
D0371*	SIALOENDOSCOPY AND CAPTURE AND INTERPRETATION	$167
D0380*	CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$147
D0381*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$137
D0382*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$137
D0383*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS	$182
D0384*	CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$137
D0385*	MAXILLOFACIAL MRI IMAGE CAPTURE	$167
D0386*	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$167
D0393*	SIMULATION USING 3D IMAGES	$7
D0394*	DIGITAL SUBTRACTION OF IMAGES	$7
D0395*	FUSION OF TWO OR MORE 3D IMAGES	$7
D0415	COLLECT MICROORAGNISMS CULT & SENS	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$65
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	$0
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	$0
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	$0
D0480	PROCESSING AND INTERP OF EXFOLIATIVE CYTOLOGICAL SMEARS, INCL PREP AND TRANS OF WRITTEN REPORT	$0
D0486	ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE, MICCROSCOPIS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0502	OTHER ORAL PATHOLOGY PROCEDURES	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
PREVENTIVE SERVICES		
D1110*	PROPHYLAXIS - ADULT	$0
D1110*	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$15
D1120*	PROPHYLAXIS - CHILD	$0
D1120*	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$15
D1206*	TOP FLUORIDE VARNISH	$10
D1208*	TOPICAL APPLICATION OF FLUORIDE	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351*	SEALANT - PER TOOTH	$0
D1352*	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOT	$0
D1510*	SPACE MAINTAINER - FIXED-UNILATERAL	$0
D1515*	SPACE MAINTAINER - FIXED-BILATERAL	$0
D1520*	SPACE MAINTAINER - REMOVABLE-UNI	$0
D1525*	SPACE MAINTAINER - REMOVABLE-BIL	$0
D1550	RECEMENTATION OF SPACE MAINTAINER	$10
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$10
RESTORATIVE SERVICES		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$0
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$0
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$0
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$25
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$35

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ADA	DESCRIPTION	MEMBER PAYS
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$45
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$75
D2390	RESIN COMPOS CROWN ANTERIOR	$105
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	$55
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	$70
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	$85
D2394	RESIN COMPOS - 4/MORE SURFACES POST	$105
D2410	GOLD FOIL - ONE SURFACE	$70
D2420	GOLD FOIL - TWO SURFACES	$92
D2430	GOLD FOIL - THREE SURFACES	$120
D2510	INLAY - METALLIC - ONE SURFACE	$85
D2520	INLAY - METALLIC - TWO SURFACES	$96
D2530	INLAY - METALLIC - 3/MORE SURFACES	$120
D2542	ONLAY - METALLIC - TWO SURFACES	$290
D2543	ONLAY METALLIC THREE SURFACES	$300
D2544	ONLAY METALLIC FOUR OR MORE SURF	$330
D2610*	INLAY - PORCELN/CERAMIC - 1 SURFACE	$250
D2620*	INLAY - PORCELN/CERAMIC - 2 SURF	$275
D2630*	INLAY - PORCELN/CERAM - 3/MORE SURF	$300
D2642*	ONLAY - PORCELN/CERAMIC - 2 SURF	$335
D2643*	ONLAY - PORCELN/CERAMIC - 3 SURF	$365
D2644*	ONLAY - PORCELN/CERAM - 4/MORE SURF	$375
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$195
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$220
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$255
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$230
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$250
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	$280
D2710*	CROWN RESINBASED COMPOSITE INDIRECT	$195
D2712*	CROWN 3/4 RESNBASED COMPOS INDIRECT	$195
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$240
D2721*	CROWN - RESIN W/PREDOM BASE METAL	$240
D2722*	CROWN - RESIN WITH NOBLE METAL	$240
D2740*	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$240
D2750*	CROWN - PORCELN FUSED HI NOBLE METL	$240
D2751*	CROWN-PORCELN FUSD PREDOM BASE METL	$240
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$240
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$240
D2781*	CROWN - 3/4 CAST PREDOM BASE METL	$240
D2782*	CROWN - 3/4 CAST NOBLE METAL	$240
D2783*	CROWN - 3/4 PORCELAIN/CERAMIC	$240
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$240
D2791*	CROWN - FULL CAST PREDOM BASE METL	$220
D2792*	CROWN - FULL CAST NOBLE METAL	$220
D2794*	CROWN TITANIUM	$240
D2799*	PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOS NECESSARY PRIOR TO FINAL IMPRESSION	$125
D2910	RECEMENT INLAY ONLAY/PART COV REST	$10
D2915	RECEMENT CAST/PREFAB POST & CORE	$10
D2920	RECEMENT CROWN	$10
D2921	REATTACHMENT OF TOOTH FRAGMENT	$10
D2929*	PREFABRICATED PORCELAIN CROWN- PRIMARY	$41
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	$40
D2931	PRFABR STAINLESS STEEL CROWN-PERM	$40
D2932	PREFABRICATED RESIN CROWN	$92
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	$140
D2940	SEDATIVE FILLING	$10
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$10

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ADA	DESCRIPTION	MEMBER PAYS
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION	$20
D2950	CORE BUILDUP INCLUDING ANY PINS	$40
D2951	PIN RETN - PER TOOTH ADDITION REST	$12
D2952	POST & CORE ADD CROWN INDIRECT FAB	$85
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$95
D2954	PREFABR POST&CORE ADDITION CROWN	$75
D2955	POST REMOVAL	$25
D2957	EA ADD PREFABR POST - SAME TOOTH	$30
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$200
D2961*	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$225
D2962*	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$350
D2970	TEMPORARY CROWN	$75
D2971	ADD PROC NEW CROWN XST PART DENTURE	$45
D2975	COPING	$95
D2980	CROWN REPAIR	$95
D2981	INLAY REPAIR	$95
D2982	ONLAY REPAIR	$95
D2983	VENEER REPAIR	$95
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$29
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$20
D3120	PULP CAP - INDIRECT	$20
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	$25
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	$95
D3222	PARTIAL PULPOTOMY	$75
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	$45
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$40
D3310	ANTERIOR	$100
D3320	BICUSPID	$185
D3330	MOLAR	$225
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$75
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$125
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$280
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$305
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$380
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	$90
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	$90
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	$90
D3410	APICOECTOMY SURG - ANT	$96
D3421	APICOECTOMY SURG-BICUSPID	$305
D3425	APICOECTOMY SURG - MOLAR	$320
D3426	APICOECTOMY SURGERY	$80
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$96
D3428	BONE GRAFT WITH PERIRADICULAR SURGERY - PER TOOTH	$37
D3429	BONE GRAFT WITH PERIRADICULAR SURGERY - EACH ADDITIONAL TOOTH	$32
D3430	RETROGRADE FILLING - PER ROOT	$60
D3431	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$150
D3432	GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE	$150
D3450	ROOT AMPUTATION - PER ROOT	$100
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$542
D3470	INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$175
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$95
D3920	HEMISECTION NOT INCL RC THERAPY	$85
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$75
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$175
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$72

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D4212	GINGIVECT/PLSTY WITH REST PROC/TOOTH	$43
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$187
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$175
D4245	APICALLY POSITIONED FLAP	$150
D4249	CLIN CROWN LEN - HARD TISSUE	$175
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$375
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$325
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$450
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	$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	$240
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, PER TOOTH	$300
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$120
D4275	SOFT TISSUE ALLOGRAFT	$502
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH	$65
D4277	FREE SOFT TISSUE GRAFT-1ST TOOTH	$215
D4278	FREE SOFT TISSUE GRAFT-ADD TOOTH	$75
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$115
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$105
D4341†*	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$45
D4342†	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$35
D4355†*	FULL MOUTH DEBRID COMP EVAL&DX	$35
D4381†*	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEA VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$45
D4910*	PERIODONTAL MAINTENANCE	$45
D4920	UNSCHEDULED DRESSING CHANGE	$25
D4921	GINGIVAL IRRIGATION - PER QUADRANT	$15
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110*	COMPLETE DENTURE - MAXILLARY	$260
D5120*	COMPLETE DENTURE - MANDIBULAR	$260
D5130*	IMMEDIATE DENTURE - MAXILLARY	$280
D5140*	IMMEDIATE DENTURE - MANDIBULAR	$280
D5211*	MAX PARTIAL DENTURE - RESIN BASE	$260
D5212*	MAND PARTIAL DENTUR - RESIN BASE	$260
D5213*	MAX PART DENTUR-CAST METL W/RSN	$280
D5214*	MAND PART DENTUR- CAST METL W/RSN	$280
D5225*	MAXILLARY PARTIAL DENTURE FLEX BASE	$280
D5226*	MANDIBULAR PART DENTURE FLEX BASE	$280
D5281*	REMV UNI PART DENTUR-1 PC CAST METL	$240
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$10
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$10
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$15
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$15
D5510*	REPAIR BROKEN COMPLETE DENTURE BASE	$15
D5520*	REPL MISS/BROKEN TEETH-CMPL DENTUR	$10
D5610*	REPAIR RESIN DENTURE BASE	$15
D5620*	REPAIR CAST FRAMEWORK	$30
D5630*	REPAIR OR REPLACE BROKEN CLASP	$15
D5640*	REPLACE BROKEN TEETH - PER TOOTH	$10
D5650*	ADD TOOTH EXISTING PARTIAL DENTURE	$30
D5660*	ADD CLASP EXISTING PARTIAL DENTURE	$30
D5670*	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$100
D5671*	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$100
D5710*	REBASE COMPLETE MAXILLARY DENTURE	$75

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D5711*	REBASE COMPLETE MANDIBULAR DENTURE	$75
D5720*	REBASE MAXILLARY PARTIAL DENTURE	$75
D5721*	REBASE MANDIBULAR PARTIAL DENTURE	$75
D5730*	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$45
D5731*	RELINE CMPL MAND DENTURE CHAIRSIDE	$45
D5740*	RELINE MAXIL PART DENTURE CHAIRSIDE	$45
D5741*	RELINE MAND PART DENTURE CHAIRSIDE	$45
D5750*	RELINE CMPL MAXIL DENTURE LAB	$35
D5751*	RELINE CMPL MAND DENTRUE LABORATORY	$35
D5760*	RELINE MAXIL PART DENTURE LAB	$35
D5761*	RELINE MAND PART DENTURE LABORATORY	$35
D5810*	INTERIM COMPLETE DENTURE (MAXILLARY)	$250
D5811*	INTERIM COMPLETE DENTURE (MANDIBULAR)	$250
D5820*	INTERIM PARTIAL DENTURE MAXILLARY	$250
D5821*	INTERIM PARTIAL DENTURE MANDIBULAR	$250
D5850	TISSUE CONDITIONING MAXILLARY	$25
D5851	TISSUE CONDITIONING MANDIBULAR	$25
D5862	PRECISION ATTACHMENT, BY REPORT	$150
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	$0
IMPLANT SERVICES		
D6010*	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,000
D6056*	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$435
D6057*	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$545
D6058*	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$745
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$745
D6060*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$745
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE META	$745
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$745
D6063*	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$745
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$745
D6065*	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$745
D6066*	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$745
D6067*	IMPLANT SUPPORTED METAL CROWN	$745
D6068*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$745
D6069*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$745
D6070*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$745
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$745
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE META	$745
D6073*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$745
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$745
D6075*	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$745
D6076*	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$745
D6077*	IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	$745
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$180
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$400
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN	$45
D6093	RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$65
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	$745
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$220
D6100	IMPLANT REMOVAL, BY REPORT	$700
D6190		$235
FIXED PROSTHODONTIC SERVICES		
D6205*	PONTIC- INDIRECT RESIN BASED COMPOSITE	$745

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D6210*	PONTIC - CAST HIGH NOBLE METAL	$220
D6211*	PONTIC - CAST PREDOM BASE METAL	$220
D6212*	PONTIC - CAST NOBLE METAL	$220
D6214*	PONTIC TITANIUM	$240
D6240*	PONTIC-PORCELN FUSED HI NOBLE METL	$240
D6241*	PONTIC-PORCLN FUSD PREDOM BASE METL	$240
D6242*	PONTIC - PORCELN FUSED NOBLE METAL	$240
D6245*	PONTIC - PORCELAIN/CERAMIC	$300
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$240
D6251*	PONTIC RESIN W/PREDOM BASE METAL	$240
D6252*	PONTIC RESIN W/NOBLE METAL	$240
D6253*	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOS NECESSARY PRIOR TO FINAL IMPRESSION	$0
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	$180
D6548*	RET-PORC/CER FOR RESIN BONDED FIXED PROS	$225
D6600*	INLAY-PORCELAIN/CERAMIC 2 SURFACES	$240
D6601*	INLAY - PORCELN/CERAMIC 3/MORE SURF	$240
D6602*	INLAY - CAST HI NOBLE METAL 2 SURF	$240
D6603*	INLAY-CAST HI NOBLE METL 3/> SURF	$240
D6604*	INLAY-CAST PREDOM BASE METL 2 SURF	$240
D6605*	INLAY-CAST PREDOM BASE METL 3/>SURF	$240
D6606*	INLAY - CAST NOBLE METAL 2 SURFACES	$240
D6607*	INLAY - CAST NOBLE METL 3/MORE SURF	$240
D6608*	ONLAY - PORCELN/CERAMIC 2 SURFACES	$240
D6609*	ONLAY - PORCELN/CERAMIC 3/MORE SURF	$240
D6610*	ONLAY - CAST HI NOBLE METAL 2 SURF	$240
D6611*	ONLAY-CAST HI NOBLE METL 3/> SURF	$240
D6612*	ONLAY-CAST PREDOM BASE METL 2 SURF	$240
D6613*	ONLAY-CAST PREDOM BASE METL 3/>SURF	$240
D6614*	ONLAY - CAST NOBLE METAL 2 SURFACES	$240
D6615*	ONLAY - CAST NOBLE METL 3/MORE SURF	$240
D6624*	INLAY TITANIUM	$240
D6634*	ONLAY TITANIUM	$240
D6710*	CROWN-INDIRECT RESIN BASED OCMPOSITE	$240
D6720*	CROWN - RESIN WITH HIGH NOBLE METAL	$240
D6721*	CROWN RESIN PREDOM BASE METL-DENTUR	$240
D6722*	CROWN - RESIN WITH NOBLE METAL	$240
D6740*	CROWN - PORCELAIN/CERAMIC	$240
D6750*	CRWN PORCLN FUSD HI NOBL MTL-DENTUR	$240
D6751*	CROWN-PORCELN FUSD PREDOM BASE METL	$240
D6752*	CROWN - PORCELAIN FUSED NOBLE METAL	$240
D6780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$240
D6781*	CROWN-3/4 CAST PREDOM BASED METAL	$240
D6782*	CROWN 3/4 CAST NOBLE METAL-DENTURE	$240
D6783*	CROWN 3/4 PORCELAIN/CERAMIC-DENTURE	$240
D6790*	CROWN FULL CAST HI NOBL METL-DENTUR	$220
D6791*	CROWN FULL CAST BASE METAL-DENTURE	$220
D6792*	CROWN FULL CAST NOBLE METAL-DENTURE	$220
D6793*	PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$125
D6794*	CROWN TITANIUM	$240
D6930	RECEMENT FIXED PARTIAL DENTURE	$10
D6940	STRESS BREAKER	$125
D6950	PRECISION ATTACHMENT	$195
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$80
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$45
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$10
D7210	SURG REMOVAL ERUPTED TOOTH	$25

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ADA	DESCRIPTION	MEMBER PAYS
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$40
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$60
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$75
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$128
D7250	SURG REMOVAL RESIDUAL TOOTH ROOTS	$25
D7260	OROANTRAL FISTULA CLOSURE	$160
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$275
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$50
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)	$100
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$125
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$125
D7283	PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH	$80
D7285	BIOPSY OF ORAL TISSUE HARD	$115
D7286	BIOPSY OF ORAL TISSUE SOFT	$75
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$65
D7288	BRUSH BIOPSY	$25
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$30
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$20
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$20
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$50
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$50
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$370
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$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	$95
D7472	REMOVAL OF TORUS PALATINUS	$95
D7473	REMOVAL OF TORUS MANDIBULARIS	$95
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$95
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$20
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$20
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$20
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$35
D7921	COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT	$125
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES - 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
D7960	FRENULECTOMY SEPARATE PROCEDURE	$90
D7963	FRENULOPLASTY	$90
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$140
D7971	EXCISION OF PERICORONAL GINGIVA	$102
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$125
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$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 ANES	$0

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ADA	DESCRIPTION	MEMBER PAYS
D9215	LOCAL ANESTHESIA	$0
D9220	DP SEDATION/GEN ANES-1ST 30 MIN	$125
D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	$15
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$20
D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	$125
D9242	IV CONSC SEDAT/ANALG-EA ADD 15 MIN	$55
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$15
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$25
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$30
D9450	CASE PRSATION DTL&EXT TX PLANNING	$0
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	$15
D9630	OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT	$15
D9910*	APPLICATION OF DESENSITIZING MEDICAMENT	$20
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9940*	OCCLUSAL GUARD BY REPORT	$250
D9942	REPAIR AND/OR RELINE OCCCLUSAL GUARDS	$40
D9950	OCCLUSAL ANALYSIS - MOUNTED CASE	$75
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$25
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$95
D9973	EXTERNAL BLEACHING-PER TOOTH	$30
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$240
ORTHODONTIC SERVICES		
D8010		$1,000
D8020	LTD ORTHO TREAT OF THE TRANS DENTITION	$1,000
D8030	LTD ORTHO TREAT OF THE ADOLESC DENTITION	$1,000
D8040	LTD ORTHO TREAT OF THE ADULT DENTITION	$1,350
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$2,000
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$2,050
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$2,150
D8210	REMOVABLE APPLIANCE THERAPY	$103
D8220	FIXED APPLIANCE THERAPY	$103
D8660	PRE-ORTHODONTIC TREATMENT VISIT	$35
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$300
D8693	REBONDING OR RECEMENTING FIXED RETAINER	$0

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UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Either D0210 or D0330 are reimbursable one (1) time every five (5) consecutive years.
2.	BITEWING RADIOGRAPHS	D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the l six (6) months.
3.	FLUORIDE TREATMENTS	Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period for children under the age o 16.
4.	SPACE MAINTAINERS	Space maintainers and all adjustments are limited to children under the age of 16.
5.	SEALANTS OCCLUSAL	Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This only allowed for unrestored permanent molar teeth for children under the age of 16.
6.	GUARDS GENERAL	Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
7.	ANESTHESIA	General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
8.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	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
9.	ORAL EVALUATION	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.
10.	BITEWINGS X-RAYS	All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
11.	CROWNS, FIXED BRIDGES, AND IMPLANTS	When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge o $30.00 per unit.
12.	THIRD-MOLAR ("WISDOM TEETH") EXTRACTIONS	'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.
13.	SPECIALTY SERVICES	a) This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice. b) 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%. c) The participating General Dentist you select may not perform all procedures listed. The copayments shown apply to participating General Dentists. d) Should the services of a specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a participating specialis with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtai prior written authorization from Solstice and receive specialty treatment by an approved participating specialis at the listed copayments. Please refer to the Specialty Care Referral Policy in your Member handbook. e) Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usu 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-pay. f) Members seeking implant treatment should refer to their participating implantologist, a select network of providers. Not all providers perform the implant procedures at the copay listed on the Schedule of Benefits.
14.	PROPHYLAXIS AND PERIODONTAL MAINTENANCE	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.
15.	HARMFUL HABIT APPLIANCES	Harmful habit appliances are limited to one (1) time per person under the age of 16.
16.	DENTURES	New dentures include one (1) reline within the first six (6) months.
17.	REPLACEMENT OF CROWNS, IMPLANTS, AND FIXED BRIDGES OR DENTURES	Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive fi (5) years.
18.	COST OF MATERIAL AND LAB 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 allerg 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 repai laboratory fees up to $50.00- All ceramic and/or porcelain crown material fees up to $155.00
19.	X-RAYS	Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can obtained for a $15 fee.
20.	EMERGENCY TREATMENT	Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
21.	ORTHO	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.

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EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

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 limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

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