EssentialSmile Ohio - Total Care

P.O. Box 19199
Plantation, FL 33318
Telephone: 855.574.1284
Fax: 954.370.1701
www.mysmile365.com

Members can search for a Network Provider at
www.solsticecare.com/provider-search.aspx
Member Services: 1.855.574.1284

The Copayments listed on this Schedule of Benefits apply when a Participating Provider who is a General Dentist performs the Covered Services. **You are responsible for requesting Preauthorization for treatment of malignancies, cysts or neoplasms, general anesthesia, IV sedation , crowns, bridges, prosthetics, and Network Specialist Dentist**

Symbol Legend	† Procedures that are not eligible at a Specialist ^ Adult Copayments that do not include the cost of material and laboratory fees.
COST-SHARING	Member Responsibility for Cost-Sharing
Deductible Covered Individuals Nineteen (19) years of age and under (Applies to all classes) Adult	 $30 $0
Out-of Pocket Limit One (1) Per Covered Individual Nineteen (19) years of age and under More than One (1) Covered Individual Nineteen (19) years of age and under	 $450 $900

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
APPOINTMENTS				
D0120	Periodic oral evaluation- established patient	1 Every 6 Months	$0	$0
D0140	Limited oral evaluation - problem focused	1 Every 6 Months	$0	$0

Underwritten by UnitedHealthcare of Ohio, Inc.
Administered by Solstice of New York, Inc.

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D0150	Comprehensive oral evaluation-new or established patient	1 Every 6 Months	$0	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report		$0	$10
D0180	Comprehensive periodontal evaluation	1 Every 6 Months	$0	$10
D9110	Palliative (emergency) treatment of dental pain-minor procedure		$40	$40
D9310	Consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician		$25	$25
RADIOGRAPHY / DIAGNOSTIC DENTISTRY				
D0210	Intraoral-complete series of radiographic images	1 Every 60 Months	$0	$0
D0220	Intraoral-periapical first radiographic image		$0	$0
D0230	Intraoral-periapical each additional radiographic image		$0	$3
D0240	Intraoral-occlusal radiographic image		$0	$8
D0270	Bitewing - single radiographic image	1 Set Every 6 Months	$0	$0
RADIOGRAPHY / DIAGNOSTIC DENTISTRY CONT.				
D0272	Bitewings - two radiographic image	1 Set Every 6 Months	$0	$0
D0273	Bitewings - three radiographic image	1 Set Every 6 Months	$0	$0
D0274	Bitewings - four radiographic image	1 Set Every 6 Months	$0	$0
D0277	Vertical Bitewings - 7 To 8 radiographic image	1 Set Every 6 Months	$0	$0
D0330	Panoramic radiographic image	1 Every 60 Months	$0	$20
D0340	2D Cephalometric radiographic image- acquisition, measurement and analysis		$125	$120
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally		$31	$26
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw		Not Covered	$147
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible		Not Covered	$137
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium		Not Covered	$137
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium		Not Covered	$182
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures		Not Covered	$137
D0369	Maxillofacial MRI capture and interpretation		Not Covered	$187
D0370	Maxillofacial ultrasound capture and interpretation		Not Covered	$167
D0371	Sialoendoscopy capture and interpretation		Not Covered	$167
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw		Not Covered	$157

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible		Not Covered	$137
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium		Not Covered	$137
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium		Not Covered	$182
D0384	Cone beam CT image capture for TMJ series including two or more exposures		Not Covered	$137
D0385	Maxillofacial MRI image capture		Not Covered	$167
D0386	Maxillofacial ultrasound image capture		Not Covered	$167
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		$125	$125
D0393	Treatment simulation using 3D image volume		Not Covered	$7
D0394	Digital subtraction of two or more images or image volumes of the same modality		Not Covered	$7
D0395	Fusion of two or more 3D image volumes of one or more modalities		Not Covered	$7
D0415	Collection of microorganisms for culture and sensitivity		Not Covered	$0
D0425	Caries susceptibility tests		Not Covered	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures		Not Covered	$70
D0460	Pulp vitality tests		Not Covered	$0
D0470	Diagnostic casts		$55	$50
PREVENTIVE DENTISTRY				
D1110	Prophylaxis- adult	Dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive (6) months	$0	$0
D1120	Prophylaxis- child	Dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive (6) months	$0	$0

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D1206	Topical application of fluoride varnish	Limited To 2 Every 12 Months	$0	$11
D1208	Topical application of fluoride- excluding varnish	Limited To 2 Every 12 Months	$0	$10
D1351	Sealant - per tooth	1 Sealant Per Unrestored Permanent Tooth Every 36 Months	$0	$24
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	1 Sealant Per Permanent Tooth Every 36 Months	$10	$24
D1510	Space maintainer-fixed -unilateral	Limited to children under age 19	$0	$0
D1516	Space maintainer – fixed – bilateral, maxillary	Limited to children under age 19	$0	$0
D1517	Space maintainer – fixed – bilateral, mandibular	Limited to children under age 19	$0	$0
D1520	Space maintainer-removable -unilateral	Limited to children under age 19	$0	$0
D1526	Space maintainer – removable – bilateral, maxillary	Limited to children under age 19	$0	$0
D1527	Space maintainer – removable – bilateral, mandibular	Limited to children under age 19	$0	$0
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	Limited to children under age 19	$30	$30
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	Limited to children under age 19	$30	$30
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	Limited to children under age 19	$30	$30
RESTORATIVE DENTISTRY				
D2140	Amalgam-one surface primary or permanent		$56	$56
D2150	Amalgam-two surfaces primary or permanent		$65	$65
D2160	Amalgam-three surfaces primary or permanent		$85	$85
D2161	Amalgam-four or more surfaces primary or permanent		$109	$109
D2330	Resin-based composite- one surface, anterior		$65	$65
D2331	Resin-based composite- two surfaces, anterior		$84	$84
D2332	Resin-based composite- three surfaces, anterior		$102	$102
D2335	Resin-based composite- four or more surfaces or involving incisal angle (anterior)		$124	$124
D2510	Inlay-metallic-one surface		$350	$380
D2520	Inlay-metallic-two surfaces		$350	$420
D2530	Inlay-metallic-three or more surfaces		$350	$465
D2542	Onlay -metallic – two surfaces		$350	$505
D2543	Onlay - metallic - three surfaces		$350	$545
D2544	Onlay - metallic - four or more surfaces		$350	$560

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D2642	Onlay - porcelain/ceramic - two surfaces		$350	$310^
D2643	Onlay - porcelain/ceramic - three surfaces		$350	$375^
D2740	Crown-porcelain/ceramic substrate	Limited To 1 Per Tooth Every 60 Months	$350	$260^
RESTORATIVE DENTISTRY CONT.				
D2750	Crown- porcelain fused to high noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$255^
D2751	Crown- porcelain fused to predominantly base metal	Limited To 1 Per Tooth Every 60 Months	$350	$290^
D2752	Crown- porcelain fused to noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$250^
D2780	Crown 3/4 cast high noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$240^
D2781	Crown 3/4 cast predominantly base metal	Limited To 1 Per Tooth Every 60 Months	$350	$290^
D2783	Crown 3/4 porcelain/ceramic	Limited To 1 Per Tooth Every 60 Months	$350	$260^
D2790	Crown-full cast high noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$210^
D2791	Crown-full cast predominantly base metal	Limited To 1 Per Tooth Every 60 Months	$350	$235^
D2792	Crown-full cast noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$250^
D2794	Crown – titanium	Limited To 1 Per Tooth Every 60 Months	$350	$250^
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		$36	$36
D2920	Re-cement or re-bond crown		$36	$36
D2929	Prefabricated porcelain/ceramic crown – primary tooth	Limited To 1 Per Tooth Every 60 Months	$119	$54^
D2930	Prefabricated stainless steel crown- primary tooth	Limited To 1 Per Tooth Every 60 Months	$110	$60
D2931	Prefabricated stainless steel crown- permanent tooth	Limited To 1 Per Tooth Every 60 Months	$110	$60
D2940	Protective restoration		$32	$32
D2950	Crown buildup, including any pins when required	Limited To 1 Per Tooth Every 60 Months	$90	$40
D2951	Pin retention- per tooth, in addition to restoration		$24	$24
D2954	Prefabricated post and core in addition to crown	Limited To 1 Per Tooth Every 60 Months	$140	$90
D2980	Crown repair necessitated by restorative material failure		$95	$45
D2981	Inlay repair necessitated by restorative material failure		$95	$95
D2982	Onlay repair necessitated by restorative material failure		$95	$95

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D2983	Veneer repair necessitated by restorative material failure		$95	$95
D2990	Resin infiltration of incipient smooth surface lesions	Limited to 1 in 36 months	$29	$29
ENDODONTICS SERVICES				
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service	$65	$65
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service	$75	$75
D3230	Pupal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)	Limited to once per tooth per lifetime	$157	$157
D3240	Pupal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	Limited to once per tooth per lifetime	$200	$200
D3310	Endodontic therapy, anterior tooth (excluding final restoration)		$350	$395
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)		$350	$478
D3330	Endodontic therapy, molar (excluding final restoration)		$350	$643
D3346	Retreatment of previous root canal therapy - anterior		$350	$505
D3347	Retreatment of previous root canal therapy - bicuspid		$350	$643
D3348	Retreatment of previous root canal therapy - molar		$350	$753
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		$160	$160
D3352	Apexification/recalcification - interim medication replacement		$90	$90
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)		$235	$235
D3355	Pulpal regeneration - initial visit		$350	$500
D3356	Pulpal regeneration - interim medication replacement		$300	$350
D3357	Pulpal regeneration - completion of treatment		$350	$600
D3410	Apicoectomy - anterior		$350	$385
D3421	Apicoectomy - bicuspid (first root)		$350	$413
D3425	Apicoectomy - molar (first root)		$350	$495
D3426	Apicoectomy (each additional root)		$176	$176

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D3430	Retrograde filling - per root		$95	$95
D3450	Root amputation-per root		$235	$235
D3920	Hemisection (including any root removal), not including root canal therapy		$205	$205
PERIODONTIC SERVICES				
D4210	Gingivectomy/Gingivoplasty-four or more contiguous teeth or bounded spaces per quadrant	Limited To 1 Every 36 Months	$350	$418
D4211	Gingivectomy/Gingivoplasty- one to three teeth per quadrant	Limited To 1 Every 36 Months	$149	$149
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Limited To 1 Every 36 Months	$65	$65
D4240	Gingival flap procedure including root planing-four or more contiguous teeth or bounded spaces per quadrant	Limited To 1 Every 36 Months	$325	$325
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$325	$325
D4249	Clinical crown lengthening- hard tissue		$350	$460
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$350	$786
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$350	$786
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	Limited To 1 Every 36 Months	$350	$450
D4270	Pedicle soft tissue graft procedure		$350	$447
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft		$350	$550
D4277	Free soft tissue graft procedure (including recipient and donor sites), first tooth, implant, or edentulous tooth position in graft		$350	$554
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		$350	$554
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Limited To (1) per quadrant per 24 Months	$150	$150†
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Limited To (1) per quadrant per 24 Months	$80	$80†

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Limited To 1 Per Lifetime	$90	$90†
D4910	Periodontal Maintenance	Sharing with dental prophylaxis, periodontal maintenance procedure is limited to 2 times in any consecutive (6) months	$100	$100
PROSTHODONTICS- REMOVABLE				
D5110	Complete denture- maxillary	Limited To 1 Every 60 Months	$350	$455^
D5120	Complete denture- mandibular	Limited To 1 Every 60 Months	$350	$455^
D5130	Immediate denture- maxillary	Limited To 1 Every 60 Months	$350	$525^
D5140	Immediate denture- mandibular	Limited To 1 Every 60 Months	$350	$525^
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Limited To 1 Every 60 Months	$350	$350^
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	Limited To 1 Every 60 Months	$350	$350^
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Limited To 1 Every 60 Months	$350	$575^
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Limited To 1 Every 60 Months	$350	$575^
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	Limited To 1 Every 60 Months	$350	$195^
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	Limited To 1 Every 60 Months	$350	$195^
D5410	Adjust complete denture - maxillary		$30	$30^
D5411	Adjust complete denture- mandibular		$30	$30^
D5421	Adjust partial denture- maxillary		$30	$30^
D5422	Adjust partial denture- mandibular		$30	$30^
D5511	Repair broken complete denture base, mandibular		$110	$60^
D5512	Repair broken complete denture base, maxillary		$110	$60^
D5520	Replace missing or broken teeth- complete denture (each tooth)		$90	$40^
D5611	Repair resin partial denture base, mandibular		$85	$35^
D5612	Repair resin partial denture base, maxillary		$85	$35^
D5621	Repair cast partial framework, mandibular		$90	$40^
D5622	Repair cast partial framework, maxillary		$90	$40^
D5630	Repair or replace broken clasp- per tooth		$110	$60^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D5640	Replace broken teeth-per tooth		$90	$40^
D5650	Add tooth to existing partial denture		$100	$50^
D5660	Add clasp to existing partial denture- per tooth		$125	$75^
D5710	Rebase complete maxillary denture	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$280	$230^
D5720	Rebase maxillary partial denture	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$250	$200^
D5721	Rebase mandibular partial denture	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$250	$200^
D5730	Reline complete maxillary denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$155	$105^
D5731	Reline complete mandibular denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$155	$105^
D5740	Reline maxillary partial denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$130	$80^
D5741	Reline mandibular partial denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$130	$80^
D5750	Reline complete maxillary denture (indirect)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$235	$185^
D5751	Reline complete mandibular denture (indirect)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$235	$185^
D5760	Reline maxillary partial denture (indirect)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$200	$150^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D5761	Reline mandibular partial denture (indirect)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$200	$150^
D5850	Tissue conditioning, maxillary		$75	$75
D5851	Tissue conditioning, mandibular		$75	$75
IMPLANT SERVICES-				
D6010	Surgical placement of implant body: endosteal implant	Limited To 1 Per Tooth Every 60 Months	$350	$1,050
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	Limited To 1 Per Tooth Every 60 Months	$350	$1,050
D6040	Surgical placement: eposteal	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6050	Surgical placement: transosteal	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6055	Connecting bar – implant supported or abutment supported	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6056	Prefabricated abutment- includes modification and placement	Limited To 1 Per Tooth Every 60 Months	$350	$475
D6057	Custom fabricated abutment – includes placement	Limited To 1 Per Tooth Every 60 Months	$350	$595
D6058	Abutment supported porcelain/ceramic crown	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6062	Abutment supported cast metal crown (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6063	Abutment supported cast metal crown (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6064	Abutment supported cast metal crown (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6065	Implant supported porcelain/ceramic crown	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6068	Abutment supported retainer for porcelain/ceramic FPD	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6075	Implant supported retainer for ceramic FPD	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	Limited To 1 Per Tooth Every 60 Months	$180	$180
D6090	Repair implant supported prosthesis, by report	Limited To 1 Per Tooth Every 60 Months	$350	$400
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	Limited To 1 Per Tooth Every 60 Months	$160	Not Covered
D6095	Repair implant abutment, by report	Limited To 1 Per Tooth Every 60 Months	$220	$220
D6100	Surgical removal of implant body	Limited To 1 Per Tooth Every 60 Months	$128	$600
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure		$350	Not Covered
D6104	Bone graft at time of implant placement		$350	Not Covered
D6190	Radiographic/surgical implant index, by report	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
PROSTHODONTICS- FIXED				
D6210	Pontic-cast high noble metal	1 Every 60 Months	$350	$210^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D6211	Pontic-cast predominantly base metal	1 Every 60 Months	$350	$240^
D6212	Pontic-cast noble metal	1 Every 60 Months	$350	$200^
D6214	Pontic - titanium	1 Every 60 Months	$350	$250^
D6240	Pont- porcelain fused to high noble metal	1 Every 60 Months	$350	$255^
D6241	Pont- porcelain fused to predominantly base metal	1 Every 60 Months	$350	$290^
D6242	Pont- porcelain fused to noble metal	1 Every 60 Months	$350	$250^
D6245	Pontic- porcelain/ceramic	1 Every 60 Months	$350	$300^
D6545	Retainer- cast metal for resin bonded fixed prosthesis	1 Every 60 Months	$350	$185^
D6548	Retainer- porcelain/ceramic for resin bonded fixed prosthesis	1 Every 60 Months	$350	$330^
D6602	Inlay- cast high noble metal, two surfaces	1 Every 60 Months	$350	$340^
D6603	Inlay- cast high noble metal ,three or more surfaces	1 Every 60 Months	$350	$442
D6609	Onlay- porcelain/ceramic, three or more surfaces	1 Every 60 Months	$350	$513^
D6611	Onlay- cast high noble metal, three or more surfaces	1 Every 60 Months	$350	$489
D6613	Onlay- cast predominantly base metal, three or more surfaces	1 Every 60 Months	$350	$459
D6740	Retainer Crown- porcelain/ceramic	1 Every 60 Months	$350	$260^
D6750	Retainer Crown- porcelain fused to high noble metal	1 Every 60 Months	$350	$255^
D6751	Retainer Crown- porcelain fused to predominantly base metal	1 Every 60 Months	$350	$290^
PROSTHODONTICS- FIXED				
D6752	Retainer Crown- porcelain fused to noble metal	1 Every 60 Months	$350	$250^
D6780	Retainer Crown-3/4 cast high noble metal	1 Every 60 Months	$350	$265^
D6781	Retainer Crown 3/4 cast predominantly base metal	1 Every 60 Months	$350	$290^
D6782	Retainer Crown 3/4 cast noble metal	1 Every 60 Months	$350	$250^
D6783	Retainer Crown - 3/4 porcelain/ceramic	1 Every 60 Months	$350	$260^
D6790	Retainer Crown-full cast high noble metal	1 Every 60 Months	$350	$255^
D6791	Retainer Crown-full cast predominantly base metal	1 Every 60 Months	$350	$290^
D6792	Retainer Crown-full cast noble metal	1 Every 60 Months	$350	$250^
D6930	Re-cement or re-bond fixed partial denture		$65	$65
D6980	Fixed partial denture repair necessitated by restorative material failure		$95	$95
ORAL SURGERY				
D7140	Extraction erupted tooth or exposed root (elevation and/or forceps removal)		$83	$83
D7210	Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		$156	$156
D7220	Removal of impacted tooth- soft tissue		$200	$200
D7230	Removal of impacted tooth- partially bony		$262	$262
D7240	Removal of impacted tooth- completely bony		$312	$312
D7241	Removal of impacted tooth- completely bony, unusual surgical complications		$350	$375

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D7250	Removal of residual tooth roots (cutting procedure)		$156	$156
D7251	Cronectomy- intentional partial tooth removal		$270	$270
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		$350	$357
D7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)		$215	$215
D7280	Exposure of an unerupted tooth		$350	$370
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		$131	$131
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		$54	$54
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		$207	$207
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		$93	$93
D7471	Removal lateral exostosis (maxilla or mandible)		$265	$265
D7510	Incision and drainage of abscess- intraoral soft tissue		$124	$124
D7910	Suture of recent small wounds up to 5cm		$35	$35
D7921	Collection and application of autologous blood concentrate product	Limited to one (1) in 36 months	$125	$125
D7953	Bone replacement graft for ridge preservation - per site		$100	$100
D7971	Excision of pericoronal gingiva		$150	$150
ORTHODONTIA- Children Under Age 19				
D8010	Limited orthodontic treatment of the primary dentition	Medically Necessary Only	$350	Not Covered
D8020	Limited orthodontic treatment of the transitional dentition	Medically Necessary Only	$350	Not Covered
D8030	Limited orthodontic treatment of the adolescent dentition	Medically Necessary Only	$350	Not Covered
ORTHODONTIA- CONT.				
D8070	Comprehensive orthodontic treatment of the transitional dentition	Medically Necessary Only	$350	Not Covered
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Medically Necessary Only	$350	Not Covered
D8210	Removable appliance therapy	Medically Necessary Only	$350	$350
D8220	Fixed appliance therapy	Medically Necessary Only	$236	$236

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT

D8660	Pre-orthodontic treatment examination to monitor growth and development	Medically Necessary Only	$63	Not Covered
D8670	Periodic orthodontic treatment visit	Medically Necessary Only	$35	Not Covered
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Medically Necessary Only	$15	$300
ORTHODONTIA- Adult (Cosmetic)				
D8040	Limited orthodontic treatment of the adult dentition	Adult Only	Not Covered	$1,350
D8090	Comprehensive orthodontic treatment of the adult dentition	Adult Only	Not Covered	$3,700
MISCELLANEOUS SERVICES				
D9222	Deep sedation/general anesthesia – first 15 minutes		$65	$65
D9223	Deep sedation/ general anesthesia- each 15 minute increment		$65	$65
D9239	Intravenous moderate (conscious) sedation/analgesia –first 15 minutes		$55	$55
D9243	Intravenous moderate (conscious) sedation/analgesia- each 15 minute increment		$55	$55
D9610	Therapeutic parenteral drug, single administration		$25	$25
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report		$39	$39
D9944	Occlusal guard – hard appliance, full arch	1 In 12 Months For Patients 13 And Older	$350	$350
D9945	Occlusal guard – soft appliance, full arch	1 In 12 Months For Patients 13 And Older	$350	$350
D9946	Occlusal guard – hard appliance, partial arch	1 In 12 Months For Patients 13 And Older	$350	$350
D9995	Teledentistry – synchronous; real-time encounter		$30	$30
D9995	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		$30	$30

Benefit Limitations, Exclusions and Exceptions

Limitations on Covered Services

- X-rays (D0210 or D0330) are limited to one (1) time every sixty (60) months.
- X-rays (D0270-D0277) are payable only when other inclusive films have not been taken within the last consecutive six (6) months.

- Any oral evaluation excluding problem focused exams (D0140) is limited to one (1) time per consecutive six (6) months.
- Comprehensive exams (D0150, D0180) are only covered one (1) time per 6 months, if and only if the patient is considered to be a new or established patient.
- Placement of fixed bridges or dentures are limited to one (1) bridge every 60 months.
- Removable complete, partial or immediate dentures are limited to one (1) upper and one (1) lower appliance every 60 months. All removable dentures include six (6) months follow up care; and additional services include insertion of identification slips, repairs, relines and rebases
- Specialty Care Preauthorization - All Members must obtain Preauthorization from Solstice before seeking treatment from a Network Specialty Dentist. To request Preauthorization, you must call us at the number on your ID card, or the number listed in the Member Services section of this Certificate. You must contact us to request Preauthorization at least 2 weeks prior to a planned service. After receiving your request, we will review the reasons for your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and therapeutic guidelines. If You fail to seek Preauthorization for benefits subject to this section, you may be responsible for the cost of the dental services you receive.
- Pediatric Dentistry - Coverage for a pediatric Network Specialty Dentist ends on your Child's 16th birthday; however, exceptions for medical reasons may be considered on an individual basis. Preauthorization for pediatric dentistry is required regardless of your Child's age. Your Network General Dentist will provide care after your Child's 16th birthday.

Exclusions of Your Dental Plan

Listed below are the services or expenses which are NOT Covered under your Dental Plan and which are your responsibility.

- Services provided by a non-Network Dentist without Solstice's prior approval, except in emergencies, as described in the Emergency Dental Care – Reimbursement section of this Certificate.
- Services related to an injury or illness paid under worker's compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services relating to injuries which are intentionally self-inflicted.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- General anesthesia or IV sedation is available when Medically Necessary and previously approved by Solstice.
- Prescription drugs.
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ") unless TMJ therapy is specifically listed on your Schedule of Benefits or specified as an orthodontic benefit.
- Dental procedures initiated prior to the Member's eligibility under this Dental Plan or initiated after the Member's termination from the Dental Plan.
- Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Services considered not to be Medically Necessary or experimental in nature.
- Any inpatient/outpatient hospitalization, including any associated incremental charges for dental services/medical services performed in a hospital.
- Treatment of malignancies, cysts or neoplasms without Preauthorization.
- Services to the extent you or your enrolled Dependent is compensated under any group medical plan, no-fault auto insurance policy, or an insured motorist policy.

- 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 and or general anesthetics.

Exceptions

- Within each particular Schedule of Benefits, there may be additional Copayments, fees, surcharges that apply to services that present with a Copayment (e.g. precious metal Copayment when undergoing crown restoration therapy, complex rehabilitation/multiple crowns of six (6) or more requiring a $30.00 surcharge).