

UnitedHealthcare Dental HMO Plan 2026 Summary of Benefits and Coverage

A lifetime of healthy smiles starts with good dental care, and the Publix Group Dental Plan provides dental benefits at an affordable cost. This summary lists the most common covered services. The complete Schedule of Benefits, including the applicable exclusions and limitations for each plan, and a provider locator are available by visiting the UnitedHealthcare Dental website. Visit publix.org and log in to PASSport to find associate pay period deductions for all coverage tiers and a link to the provider website. You also may call UnitedHealthcare Dental toll-free at 1-800-815-8119. ID cards are issued to new enrollees in the dental plan.

Network Provider¹

Out-of-Network Provider²

CALENDAR YEAR DEDUCTIBLE (CYD)

Per Individual
Per Family Aggregate

None
None

None
None

CALENDAR YEAR MAXIMUM BENEFIT

No maximum

No maximum

PREVENTIVE & DIAGNOSTIC SERVICES

Office Visit
Initial Exam
X-Rays (bitewings)
Semi-Annual Cleanings (limit 2 per calendar year)
Sealant — Per Tooth (children under 16 years old — molars without cavities only)

Patient Pays:

No charge
No charge
No charge
No charge
No charge

Reimbursement:

\$20
\$20
\$25
\$35
\$20

BASIC SERVICES

One Surface White Filling
Two Surface White Filling
Periodontal Scaling and Root Planing
Single Tooth Extraction
Surgical Removal of Erupted Tooth

Patient Pays:

\$37 Anterior/\$70 Posterior
\$45 Anterior/\$85 Posterior
\$55
\$25
\$105

Reimbursement:

\$15 Anterior only
\$20 Anterior only
Not covered
Not covered
Not covered

MAJOR SERVICES

Porcelain to Metal Crown/Bridge (per unit)
Molar Root Canal Therapy

Patient Pays:

\$175 + Lab³
\$325

Reimbursement:

Not covered
Not covered

ORTHODONTIC SERVICES

Consultation
Evaluation
Records/Treatment Planning for up to 24 Months Routine
Orthodontic Treatment (child)
Orthodontic Treatment (adult)
Retainer (post-orthodontic treatment)

Patient Pays:

No charge
\$35
\$250
\$1,500
\$2,000
\$300

Reimbursement:

Not covered
Not covered
Not covered
Not covered
Not covered
Not covered

¹ You may receive specialist services (Oral Surgeon, Endodontist, Orthodontist, Periodontist or Pediatric Dentist) by going directly to a participating specialist with no referral and receive a 25% reduction off the specialist's usual and customary fee; or you may obtain prior written authorization from the plan and receive specialty treatment by an approved participating specialist for a fixed copayment. Please refer to the Specialty Care Referral Policy in the Certificate of Coverage for details.

² Out-of-Network reimbursements are available for preventive, diagnostic and certain basic services. Please refer to the Schedule of Benefits for details.

³ Please refer to the Schedule of Benefits for details.



ACCESS + SPBX

Schedule of Benefits

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

- No Waiting Periods
- No Deductibles
- Out-of-Network Preventive & Diagnostic Reimbursement

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

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

Members can choose a participating provider at
myuhcdental.com

Member Services Department: 1-800-815-8119

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

CODE	DESCRIPTION	COPAY/REIMBURSEMENT
APPOINTMENTS		
D0120	*Periodic oral evaluation - established patient	\$0 /\$20
D0140	Limited oral evaluation - problem focused	\$0 /\$20
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0 /\$20
D0150	*Comprehensive oral evaluation - new or established patient	\$0 /\$20
D0160	*Detailed and extensive oral evaluation - problem focused, by report	\$0 /\$20
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0 /\$20
D0180	Comprehensive periodontal evaluation - new or established patient	\$0 /\$20
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$0 /\$20
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$0 /\$20
D9440	Office visit - after regularly scheduled hours	\$0 /\$20
D9450	Case presentation, detailed and extensive treatment planning	\$0 /\$20
RADIOGRAPHY / DIAGNOSTIC DENTISTRY		
D0210	*Intraoral - complete series (including bitewings)	\$0 /\$25
D0220	Intraoral - periapical first radiographic images	\$0 /\$4
D0230	Intraoral - periapical each additional radiographic images	\$0 /\$2
D0240	Intraoral - occlusal radiographic images	\$0
D0270	*Bitewing - single radiographic images	\$0 /\$10
D0272	*Bitewings - two radiographic images	\$0 /\$15
D0273	*Bitewings - three radiographic images	\$0 /\$20
D0274	*Bitewings - four radiographic images	\$0 /\$23
D0277	*Vertical bitewings - 7 to 8 radiographic images	\$32 /\$25
D0310	Sialography	\$150
D0320	Temporomandibular joint arthrograph, including injection	\$250
D0321	Other temporomandibular joint radiographic images, by report	\$150
D0322	Tomographic survey	\$150
D0330	*Panoramic radiographic images	\$50 /\$25
D0340	Cephalometric radiographic images	\$162
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	\$20 /\$15
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	\$152
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	\$142
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla,	\$142



Underwritten by Solstice, Inc.
Administered by
Dental Benefit Providers, Inc.



CODE	DESCRIPTION	COPAY/REIMBURSEMENT
D0367	*Cone beam CT capture and interpretation with field of view of both jaws, with or without	\$187
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	\$142
D0369	*Maxillofacial MRI capture and interpretation	\$192
D0370	*Maxillofacial ultrasound capture and interpretation	\$172
D0371	*Sialoendoscopy capture and interpretation	\$172
D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	\$152
D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	\$142
D0382	*Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without	\$142
D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	\$187
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	\$142
D0385	*Maxillofacial MRI image capture	\$172
D0386	*Maxillofacial ultrasound image capture	\$172
D0393	*Treatment simulation using 3D image volume	\$12
D0394	*Digital subtraction of two or more images or image volumes of the same modality	\$12
D0395	*Fusion of two or more 3D image volumes of one or more modalities	\$12
D0415	Collection of microorganisms for culture and sensitivity	\$0
D0425	Caries susceptibility tests	\$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$75
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	\$0
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	\$0
D0502	Other oral pathology procedures, by report	\$0
D0601	Caries risk assessment and documentation, with a finding of low risk	\$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	\$0
D0603	Caries risk assessment and documentation, with a finding of high risk	\$0
PREVENTIVE DENTISTRY		
D1110	*Prophylaxis - adult	\$0 /\$35
D1110	Prophylaxis - adult additional	\$25^
D1120	*Prophylaxis - child	\$0 /\$25
D1120	Prophylaxis - child additional	\$25^
D1206	Topical fluoride varnish	\$0
D1208	*Topical application of fluoride - excluding varnish	\$0 /\$10
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	*Sealant - per tooth	\$0 /\$20
D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	\$0
D1510	*Space maintainer - fixed - unilateral	\$0 /\$50
D1516	*Space maintainer - fixed - bilateral, maxillary	\$0 /\$75
D1517	*Space maintainer - fixed - bilateral, mandibular	\$0 /\$75
D1520	*Space maintainer - removable - unilateral	\$0 /\$50
D1526	*Space maintainer - removable - bilateral, maxillary	\$0 /\$75
D1527	*Space maintainer - removable - bilateral, mandibular	\$0 /\$75
D1550	*Re-cementation or re-bond space maintainer	\$15
D1555	Removal of fixed space maintainer	\$22
RESTORATIVE DENTISTRY		
D2140	Amalgam - one surface, primary or permanent	\$16 /\$15
D2150	Amalgam - two surfaces, primary or permanent	\$22 /\$20

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D2160 Amalgam - three surfaces, primary or permanent	\$26 /\$25
D2161 Amalgam - four or more surfaces, primary or permanent	\$30 /\$25
D2330 Resin-based composite - one surface, anterior	\$37 /\$15
D2331 Resin-based composite - two surfaces, anterior	\$45 /\$20
D2332 Resin-based composite - three surfaces, anterior	\$55 /\$25
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$87 /\$25
D2390 Resin-based composite crown, anterior	\$130
D2391 Resin-based composite - one surface, posterior	\$70
D2392 Resin-based composite - two surfaces, posterior	\$85
D2393 Resin-based composite - three surfaces, posterior	\$100
D2394 Resin-based composite - four or more surfaces, posterior	\$122
D2410 Gold foil - one surface	\$75
D2420 Gold foil - two surfaces	\$95
D2430 Gold foil - three surfaces	\$125
D2510 Inlay - metallic - one surface	\$115
D2520 Inlay - metallic - two surfaces	\$125
D2530 Inlay - metallic - three or more surfaces	\$150
D2542 Onlay - metallic-two surfaces	\$325
D2543 Onlay - metallic-three surfaces	\$340
D2544 Onlay - metallic-four or more surfaces	\$350
D2610 Inlay - porcelain/ceramic - one surface	\$275*
D2620 Inlay - porcelain/ceramic - two surfaces	\$300*
D2630 Inlay - porcelain/ceramic - three or more surfaces	\$325*
D2642 Onlay - porcelain/ceramic - two surfaces	\$360*
D2643 Onlay - porcelain/ceramic - three surfaces	\$390*
D2644 Onlay - porcelain/ceramic - four or more surfaces	\$400*
D2650 Inlay - resin-based composite - one surface	\$237
D2651 Inlay - resin-based composite - two surfaces	\$250
D2652 Inlay - resin-based composite - three or more surfaces	\$275
D2662 Onlay - resin-based composite - two surfaces	\$247
D2663 Onlay - resin-based composite - three surfaces	\$267
D2664 Onlay - resin-based composite - four or more surfaces	\$287
D2710 *Crown - resin-based composite (indirect)	\$195
D2712 *Crown - ¾ resin-based composite (indirect)	\$195
D2720 *Crown- resin with high noble metal	\$290*
D2721 *Crown - resin with predominantly base metal	\$290*
D2722 *Crown - resin with noble metal	\$290*
D2740 *Crown - porcelain/ceramic substrate	\$165*
D2750 *Crown - porcelain fused to high noble metal	\$165*
D2751 *Crown - porcelain fused to predominantly base metal	\$165*
D2752 *Crown - porcelain fused to noble metal	\$165*
D2780 *Crown - 3/4 cast high noble metal	\$290*
D2781 *Crown - 3/4 cast predominantly base metal	\$290*
D2782 *Crown - 3/4 cast noble metal	\$290*
D2783 *Crown - 3/4 porcelain/ceramic	\$290*
D2790 *Crown - full cast high noble metal	\$175*
D2791 *Crown - full cast predominantly base metal	\$175*
D2792 *Crown - full cast noble metal	\$175*
D2794 *Crown - titanium	\$290*
D2799 Provisional Crown - further treatment or completion of diagnosis necessary prior to final impression	\$125
D2910 Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	\$15
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$20
D2920 Re-cement or re-bond crown	\$20

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D2921 Reattachment of tooth fragment, incisal edge or cusp	\$27
D2929 Prefabricated porcelain/ceramic crown - primary tooth	\$54*
D2930 Prefabricated stainless steel crown - primary tooth	\$52
D2931 Prefabricated stainless steel crown - permanent tooth	\$85
D2932 Prefabricated resin crown	\$95
D2933 Prefabricated stainless steel crown with resin window	\$145
D2940 Protective restoration	\$20
D2941 Interim therapeutic restoration - primary dentition	\$20
D2949 Restorative foundation for an indirect restoration	\$20
D2950 Core buildup, including any pins	\$50
D2951 Pin retention - per tooth, in addition to restoration	\$20
D2952 Post and core in addition to crown, indirectly fabricated	\$97
D2953 Each additional indirectly fabricated post - same tooth	\$95
D2954 Prefabricated post and core in addition to crown	\$97
D2955 Post removal	\$37
D2957 Each additional prefabricated post - same tooth	\$30
D2960 Labial veneer (resin laminate) - chairside	\$200
D2961 Labial veneer (resin laminate) - laboratory	\$255*
D2962 Labial veneer (porcelain laminate) - laboratory	\$310*
D2971 Additional procedures to construct new crown under existing partial denture framework	\$45
D2975 Coping	\$95
D2980 Crown repair necessitated by restorative material failure	\$95
D2981 Inlay repair necessitated by restorative material failure	\$95
D2982 Onlay repair necessitated by restorative material failure	\$95
D2983 Veneer repair necessitated by restorative material failure	\$95
D2990 Resin infiltration of incipient smooth surface lesions	\$29
ENDODONTIC SERVICES	
D3110 Pulp cap - direct (excluding final restoration)	\$32
D3120 Pulp cap - indirect (excluding final restoration)	\$32
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$40
D3221 Pulpal debridement, primary and permanent teeth	\$95
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$75
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$65
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$57
D3310 Endodontic therapy, anterior tooth (excluding final restoration)	\$150
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)	\$250
D3330 Endodontic therapy, molar (excluding final restoration)	\$325
D3331 Treatment of root canal obstruction; non-surgical access	\$85
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$75
D3333 Internal root repair of perforation defects	\$125
D3346 Retreatment of previous root canal therapy - anterior	\$375
D3347 Retreatment of previous root canal therapy - bicuspid	\$425
D3348 Retreatment of previous root canal therapy - molar	\$500
D3351 Apexification/recalcification	\$90
D3352 Apexification/recalcification - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.)	\$90
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.)	\$90
D3410 Apicoectomy - anterior	\$235
D3421 Apicoectomy - bicuspid (first root)	\$315
D3425 Apicoectomy - molar (first root)	\$347
D3426 Apicoectomy (each additional root)	\$102
D3427 Periradicular surgery without apicoectomy	\$235

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D3428 Bone graft in conjunction with periradicular surgery - per tooth, single site	\$47
D3429 Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	\$42
D3430 Retrograde filling - per root	\$82
D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	\$150
D3432 Guided tissue regeneration in conjunction with periradicular	\$150
D3450 Root amputation - per root	\$170
D3460 Endodontic endosseous implant	\$549
D3470 Intentional reimplantation (including necessary splinting)	\$175
D3910 Surgical procedure for isolation of tooth with rubber dam	\$95
D3920 Hemisection (including any root removal), not including root canal therapy	\$112
D3950 Canal preparation and fitting of preformed dowel or post	\$75
PERIODONTIC SERVICES	
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per	\$150
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per	\$75
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$65
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$217
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$207
D4245 Apically positioned flap	\$150
D4249 Clinical crown lengthening - hard tissue	\$245
D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$375
D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	\$325
D4263 Bone replacement graft - first site in quadrant	\$450
D4264 Bone replacement graft - each additional site in quadrant	\$325
D4265 Biologic materials to aid in soft and osseous tissue regeneration	\$325
D4266 Guided tissue regeneration - resorbable barrier, per site	\$325
D4268 Surgical revision procedure, per tooth	\$0
D4270 Pedicle soft tissue graft procedure	\$310
D4273 Autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$417
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$132
D4275 Soft tissue allograft	\$502
D4276 Combined connective tissue and double pedicle graft, per tooth	\$65
D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	\$215
D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	\$75
D4320 Provisional splinting - intracoronal	\$115
D4321 Provisional splinting - extracoronal	\$105
D4341 Periodontal scaling and root planing - four or more teeth per quadrant	\$75+
D4342 Periodontal scaling and root planing - one to three teeth per quadrant	\$55+
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis	\$60+
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$60+
D4910 *Periodontal maintenance	\$72
D4910 Periodontal maintenance	\$100^
D4920 Unscheduled dressing change (by someone other than treating dentist)	\$25
D4921 Gingival irrigation - per quadrant	\$15
PROSTHODONTICS REMOVABLE	
D5110 *Complete denture - maxillary	\$325*
D5120 *Complete denture - mandibular	\$325*
D5130 *Immediate denture - maxillary	\$325*
D5140 *Immediate denture - mandibular	\$325*
D5211 *Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$325*
D5212 *Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$325*

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D5213 *Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$325*
D5214 *Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$325*
D5225 *Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$507*
D5226 *Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$507*
D5282 *Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	\$260*
D5283 *Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	\$260*
D5410 Adjust complete denture - maxillary	\$19
D5411 Adjust complete denture - mandibular	\$19
D5421 Adjust partial denture - maxillary	\$19
D5422 Adjust partial denture - mandibular	\$19
D5510 *Repair broken complete denture base	\$20*
D5520 *Replace missing or broken teeth - complete denture (each tooth)	\$20*
D5610 *Repair resin denture base	\$20
D5630 *Repair or replace broken clasp	\$20*
D5640 *Replace broken teeth - per tooth	\$20*
D5650 *Add tooth to existing partial denture	\$35*
D5660 *Add clasp to existing partial denture	\$87*
D5670 *Replace all teeth and acrylic on cast metal framework (maxillary)	\$205*
D5671 *Replace all teeth and acrylic on cast metal framework (mandibular)	\$205*
D5710 *Rebase complete maxillary denture	\$187*
D5711 *Rebase complete mandibular denture	\$187*
D5720 *Rebase maxillary partial denture	\$162*
D5721 *Rebase mandibular partial denture	\$162*
D5730 *Reline complete maxillary denture (chairside)	\$55*
D5731 *Reline complete mandibular denture (chairside)	\$55*
D5740 *Reline maxillary partial denture (chairside)	\$55*
D5741 *Reline mandibular partial denture (chairside)	\$55*
D5750 *Reline complete maxillary denture (laboratory)	\$40*
D5751 *Reline complete mandibular denture (laboratory)	\$40*
D5760 *Reline maxillary partial denture (laboratory)	\$40*
D5761 *Reline mandibular partial denture (laboratory)	\$40*
D5810 *Interim Complete denture (maxillary)	\$250*
D5811 *Interim complete denture (mandibular)	\$250*
D5820 *Interim partial denture (maxillary)	\$167*
D5821 *Interim partial denture (mandibular)	\$167*
D5850 Tissue conditioning, maxillary	\$35
D5851 Tissue conditioning, mandibular	\$35
D5862 Precision attachment, by report	\$150
D5899 Unspecified removable prosthodontic procedure, by report	\$0
D5982 Surgical stent	\$155*
D5987 Commissure splint	\$155*
D5988 Surgical splint	\$155*
IMPLANT SUPPORTED PROSTHETICS	
D6190 Radiographic/surgical implant index, by report	\$235
D6010 *Surgical placement of implant body; endosteal implant	\$1,050
D6012 *Surgical placement of interim implant body for transitional prosthesis: endosteal implant	\$1,050
D6100 Implant removal, by report	\$700
D6056 *Prefabricated abutment – includes placement	\$475
D6057 *Custom abutment – includes placement	\$595
D6066 *Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$795
D6110 *Implant /abutment supported removable denture for edentulous arch – maxillary	\$1,300
D6111 *Implant /abutment supported removable denture for edentulous arch – mandibular	\$1,300
D6112 *Implant /abutment supported removable denture for partially edentulous arch – maxillary	\$1,040

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D6113 *Implant /abutment supported removable denture for partially edentulous arch – mandibular	\$1,040
D6114 *Implant /abutment supported fixed denture for edentulous arch – maxillary	\$3,900
D6115 *Implant /abutment supported fixed denture for edentulous arch – mandibular	\$3,900
D6116 *Implant /abutment supported fixed denture for partially edentulous arch – maxillary	\$2,300
D6117 *Implant /abutment supported fixed denture for partially edentulous arch – mandibular	\$2,300
D6080 Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis,	\$180
D6090 Repair implant supported prosthesis, by report	\$400
D6095 Repair implant abutment, by report	\$220
D6092 Recement implant/abutment supported crown	\$45
D6093 Recement implant/abutment supported fixed partial denture	\$65
PROSTHODONTICS FIXED	
D6205 Pontic - indirect resin based composite	\$795
D6210 *Pontic - cast high noble metal	\$175*
D6211 *Pontic - cast predominantly base metal	\$175*
D6212 *Pontic - cast noble metal	\$175*
D6214 *Pontic - titanium	\$290*
D6240 *Pontic - porcelain fused to high noble metal	\$175*
D6241 *Pontic - porcelain fused to predominantly base metal	\$175*
D6242 *Pontic - porcelain fused to noble metal	\$290*
D6245 *Pontic - porcelain/ceramic	\$290*
D6250 *Pontic - resin with high noble metal	\$290*
D6251 *Pontic - resin with predominantly base metal	\$290*
D6252 *Pontic - resin with noble metal	\$290*
D6253 Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	\$0
D6545 Retainer - cast metal for resin bonded fixed prosthesis	\$180
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis	\$225*
D6600 Inlay - porcelain/ceramic, two surfaces	\$290*
D6601 Inlay - porcelain/ceramic, three or more surfaces	\$290*
D6602 Inlay - cast high noble metal, two surfaces	\$290*
D6603 Inlay - cast high noble metal, three or more surfaces	\$290*
D6604 Inlay - cast predominantly base metal, two surfaces	\$290*
D6605 Inlay - cast predominantly base metal, three or more surfaces	\$290*
D6606 Inlay - cast noble metal, two surfaces	\$290*
D6607 Inlay - cast noble metal, three or more surfaces	\$290*
D6608 Onlay -porcelain/ceramic, two surfaces	\$290*
D6609 Onlay - porcelain/ceramic, three or more surfaces	\$290*
D6610 Onlay - cast high noble metal, two surfaces	\$290*
D6611 Onlay - cast high noble metal, three or more surfaces	\$290*
D6612 Onlay - cast predominantly base metal, two surfaces	\$290*
D6613 Onlay - cast predominantly base metal, three or more surfaces	\$290*
D6614 Onlay - cast noble metal, two surfaces	\$290*
D6615 Onlay - cast noble metal, three or more surfaces	\$290*
D6624 *Inlay - titanium	\$290*
D6634 *Onlay - titanium	\$290*
D6710 *Crown - indirect resin based composite	\$290*
D6720 *Crown - resin with high noble metal	\$290*
D6750 *Crown - porcelain fused to high noble metal	\$175*
D6751 *Crown - porcelain fused to predominantly base metal	\$175*
D6752 *Crown - porcelain fused to noble metal	\$175*
D6790 *Crown - full cast high noble metal	\$175*
D6791 *Crown - full cast predominantly base metal	\$175*
D6792 *Crown - full cast noble metal	\$175*
D6793 Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final	\$125
D6930 Re-cement or re-bond fixed partial denture	\$15

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D6940 Stress breaker	\$125
D6950 Precision attachment	\$195
D6980 Fixed partial denture repair necessitated by restorative material failure	\$80
ORAL SURGERY	
D7111 Extraction, coronal remnants - deciduous tooth	\$45
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$25
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$105
D7220 Removal of impacted tooth - soft tissue	\$85
D7230 Removal of impacted tooth - partially bony	\$90
D7240 Removal of impacted tooth - completely bony	\$135
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications	\$157
D7250 Surgical removal of residual tooth roots (cutting procedure)	\$40
D7251 Coronectomy - intentional partial tooth removal	\$270
D7260 Oroantral fistula closure	\$160
D7261 Primary closure of a sinus perforation	\$275
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$95
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	\$100
D7280 Surgical access of an unerupted tooth	\$125
D7282 Mobilization of erupted or malpositioned tooth to aid eruption	\$125
D7283 Placement of device to facilitate eruption of impacted tooth	\$80
D7285 Incisional biopsy of oral tissue-hard (bone, tooth)	\$155
D7286 Incisional biopsy of oral tissue-soft	\$100
D7287 Exfoliative cytological sample collection	\$85
D7288 Brush biopsy - transepithelial sample collection	\$25
D7291 Transseptal fibrotomy/supra crestal fibrotomy, by report	\$40
D7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$40
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$40
D7320 Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant	\$157
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$157
D7340 Vestibuloplasty - ridge extension (secondary epithelialization)	\$370
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$990
D7410 Excision of benign lesion up to 1.25 cm	\$25
D7411 Excision of benign lesion greater than 1.25 cm	\$50
D7412 Excision of benign lesion, complicated	\$55
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$65
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$95
D7471 Removal of lateral exostosis (maxilla or mandible)	\$95
D7472 Removal of torus palatinus	\$65
D7473 Removal of torus mandibularis	\$95
D7485 Surgical reduction of osseous tuberosity	\$95
D7510 Incision and drainage of abscess - intraoral soft tissue	\$20
D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$20
D7520 Incision and drainage of abscess - extraoral soft tissue	\$20
D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$20
D7910 Suture of recent small wounds up to 5 cm	\$35
D7921 Collection and application of autologous blood concentrate product	\$125
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	\$350
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach	\$800
D7952 Sinus augmentation via a vertical approach	\$350
D7953 Bone replacement graft for ridge preservation – per site	\$100
D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure	\$112
D7963 Frenuloplasty	\$112

CODE DESCRIPTION	COPAY/REIMBURSEMENT
D7970 Excision of hyperplastic tissue - per arch	\$140
D7971 Excision of Pericoronal Gingiva	\$102
D7972 Surgical reduction of fibrous tuberosity	\$125
ORTHODONTIC	
D8010 Limited orthodontic treatment of the primary dentition	\$1,375
D8020 Limited orthodontic treatment of the transitional dentition	\$1,375
D8030 Limited orthodontic treatment of the adolescent dentition	\$1,375
D8040 Limited orthodontic treatment of the adult dentition	\$1,800
D8070 Comprehensive orthodontic treatment of the transitional dentition	\$1,500
D8080 Comprehensive orthodontic treatment of the adolescent dentition	\$1,500
D8090 Comprehensive orthodontic treatment of the adult dentition	\$2,000
D8210 Removable appliance therapy	\$103
D8220 Fixed appliance therapy	\$103
D8660 Pre-orthodontic treatment examination to monitor growth and development	\$35
D8670 Periodic orthodontic treatment visit	\$0
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$300
D8693 Re-cement or re-bond fixed retainer	\$0
D8999 Unspecified orthodontic procedure, by report	\$250
MISCELLANEOUS	
D9110 Palliative (emergency) treatment of dental pain - minor procedure	\$0
D9120 Fixed partial denture sectioning	\$0
D9210 Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9211 Regional block anesthesia	\$0
D9212 Trigeminal division block anesthesia	\$0
D9215 Local anesthesia	\$0
D9222 Deep sedation/general anesthesia – first 15 minutes	\$50
D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment	\$50
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide	\$20
D9239 Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	\$65
D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$65
D9248 Non-intravenous moderate (conscious) sedation	\$15
D9610 Therapeutic parenteral drug, single administration	\$15
D9630 Other drugs and/or medicaments, by report	\$15
D9910 *Application of desensitizing medicament	\$0
D9930 Treatment of complications (post- surgical) - unusual circumstances, by report	\$0
D9942 Repair and/or relines of Occlusal guard	\$40
D9944 *Occlusal guard - hard appliance, full arch	\$250
D9945 *Occlusal guard - soft appliance, full arch	\$250
D9946 *Occlusal guard - hard appliance, partial arch	\$250
D9950 Occlusion analysis - mounted case	\$75
D9951 Occlusal adjustment - limited	\$30
D9952 Occlusal adjustment - complete	\$137
D9972 External bleaching - per arch - performed in office	\$150
D9973 External bleaching - per tooth	\$30
D9975 External bleaching for home application, per arch; includes materials and fabrication of custom trays	\$240

EXCLUSIONS AND LIMITATIONS

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 you may obtain prior written authorization from Solstice and receive specialty treatment by an approved Participating Specialist at the listed Copayments. Please refer to the Specialty Care Referral Policy in your Certificate of Coverage
- 5 Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member Co-payment.
- 6 Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.solsticebenefits.com under "Locate A Provider."

Exclusions

- 1 Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
- 2 Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the Member's dental health or experimental in nature, as determined by the participating Solstice dentist.
- 3 Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
- 4 Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
- 5 Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
- 6 Dental procedures initiated prior to the Member's eligibility under this benefit plan or started after the Member's termination from the plan.
- 7 Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member, including but not limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

Limitations

- 1 Any oral evaluation (excluding problem) is limited to twice per calendar year; 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 twice per calendar year. 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) time per calendar year.
- 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 crowns, implants, 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 '*' 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"
- 14 Copayments marked by "+" are not eligible at a specialist.
- 15 Either D0210, D0251, or D0330 are reimbursable one (1) time every five (5) consecutive years.
- 16 Copies of X-rays can be obtained for \$2 per periapical image up to a maximum of \$30. Panoramic X-ray can be obtained for a \$15 fee.
- 17 D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.

- 18 All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12
months are at no fee to the member.
- 19 Emergency treatment is available for palliative treatment for the abatement of pain up to \$100.00 per occurrence.
- 20 A broken appointment fee up to \$20.00 may be charged by the dental office if 24-hour prior notice is not given.
- 21 Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be
covered at 25% 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.
- 22 Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in
cost for the enhanced treatment.
- 23 Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual
grinding/Bruxism.
- 24 D0364 – D0395 is limited to one (1) time per sixty (60) months, covered only in a dental setting and not in a
radiographic imaging center.
- 25 Copayments marked by “^” are additional benefits utilized after the original limitation.



Underwritten by Solstice, Inc.
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Dental Benefit Providers, Inc.

