PO Box 30779

Salt Lake City, UT 84130-0779

800-955-4137

Solstice Member Certificate

Group Dental

Notice: Any benefits in this certificate will apply to an Employee only if: (a) he/she has elected that benefit; or (b) he/she has a confirmation letter and/or a Solstice identification card, which shows his/her election of that benefit.

Solstice certifies that under the terms and conditions of the Contract issued to the Policyholder, the Policyholder became covered as of the effective date indicated on the identification card received.

This certificate along with the Group Contract and Schedule of Benefits summarizes the provisions, limitations, and exclusions of the Contract issued to the Policyholder, and are subject to the terms of the Contract.

All periods of time under the Contract will begin and end at 12:01 a.m. local time at the Policyholder's address.

Michael D. Flax

President

Solstice Benefits, Inc.
A licensed PLHSO under Chapter 636 F.S.

Important Information About Your Dental Plan

When you elected dental benefits for yourself and your Dependents, you elected the following plan option provided by Solstice:

- Solstice S200

Details of the benefits under each of the above options are described in separate Schedules of Benefits which are made part of the Member certificate.

When electing an option initially or when changing options as described below, the following rules apply:

- You and your Dependents may enroll for only one of the options.
- Your Dependents will be insured only if you are insured and only for the same option.
- You may elect to change options for yourself and your Dependents during any open enrollment period.

Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - A decision by Solstice not to authorize payment for specialty referrals on the basis of necessity of appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements:

- It must be consistent with the symptoms, diagnosis or treatment of the condition present.
- It must conform to commonly accepted standards throughout the dental field.
- It must not be used primarily for the convenience of the member or provider of care.
- It must not exceed the scope duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Request for payment authorizations that are declined by Solstice based upon the above will be the responsibility of the member at the Dentist's Usual Fees. A licensed Dentist will make any such denial.

Contract Fees - The fees contained in the Network Specialty Dentist agreement with Solstice.

Covered Services - The dental procedures listed on your patient Schedule of Benefits.

Dental Office - Your selected office of Network General Dentist(s).

Dental Plan - Managed dental care plan offered through the Group Contract between Solstice and your Group.

Dental Service Area - The geographical area designated by Solstice within which it shall provide benefits and arrange for dental care services.

Dependent - Your lawful spouse or domestic partner (with 6+ months history) or your unmarried child (including newborns, adopted children - from moment of birth if agreement is entered into, stepchildren, a

child for whom you must provide dental coverage under a court order; or a Dependent child who resides in your home as a result of court order or administrative placement) who is:

(1) Less than 26 years old.

(2) Any age if he or she is both:

- Incapable of self-sustaining employment due to mental or physical disability.
- Reliant upon you for maintenance and support.

For a child who falls into category (2) above, you will need to furnish Solstice with evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 26 and once a year thereafter during his or her term of coverage.

Coverage for Dependents living outside of the Solstice service area are subject to the availability of an approved network where the Dependent resides.

This definition of Dependent applies unless it is modified by your Group Contract.

Employee - An Employee of the Group who meets eligibility rules of Solstice as set out in the Group Contract, as prescribed by the Group (specifically including any minimum number of hours worked during a week and waiting period) and as set out in the Group enrollment application.

Employee Waiting Period - The time period in which an Employee must wait before being eligible for benefits.

Group - An employer, labor union or other organization that has entered into a Group Contract with Solstice for managed dental services on your behalf.

Group Contract/Policy - The entire Group Contract/Policy consists of the following:

- Part A - General Contract Provisions.
- Part B - Member Certificate/Benefit Provisions.
- Part C - Schedule of Benefits.
- Part D - All applications including, but not limited to, the Policyholder's application.
- Part E - Any endorsements, amendments and/or riders to any or all of the above.

Member/Subscriber/You/Insured - An Employee or Employee's Dependent enrolled in a dental plan in accordance with the Contract.

Network Dentist - A licensed Dentist who has signed an agreement with Solstice to provide general dentistry or specialty care services to you. The term includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - A licensed Dentist who has signed an agreement with Solstice under which he or she agrees to provide general dental care services to you.

Network Specialty Dentist - A licensed Dentist who has signed an agreement with Solstice under which he or she agrees to provide specialized dental care services upon payment authorization by Solstice.

Patient Copayment - The amount you owe your Network Dentist for any dental procedure listed on your patient Schedule of Benefits.

Policyholder - Your Group/employer that has elected to sponsor this dental coverage and administrate it.

Premiums/Prepayment Fees - Fees that your Group remits to Solstice, on your behalf, during the term of your Group Contract.

Schedule of Benefits - List of services covered under your dental plan and how much they cost you.

Solstice Benefits - The Solstice Benefits, Inc. organization that provides dental benefits in Florida.

Usual and Customary Fee - The customary fee that an individual Dentist most frequently charges for a given dental service.

Introduction To Your Solstice Dental Plan

Welcome to the Solstice Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Solstice or its designee for administrative purposes and is to be considered in full satisfaction of all Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and pertinent Florida Statutes.

Eligibility - When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must make written application for the Dental Plan on an approved Solstice application form and be able to seek treatment for covered services within a Solstice Dental Service Area. Other eligibility requirements may be determined by your Group as set forth in your Group Contract. There will be at least one open enrollment period of not less than 30 days every 18 months unless Solstice and your Group mutually agree to a period of time shorter than 18 months.

You the Employee

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract). If you are subject to an Employee Waiting Period, then this must be completed prior to eligibility which would commence on the first of the month following such completion.

Your Dependents

Your Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption (from moment of birth if agreement is entered into), placement, or court or administrative order. All enrollments must be done through approved Solstice forms. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce.

New Born/Adopted Children Coverage

If you have family coverage, a newborn child and/or an adopted child is automatically covered during the first 31 days of life/placement in the home or date of entry of an order granting you custody. If you wish to continue coverage beyond the first 31 days, your baby needs to be enrolled in the Dental Plan by

submitting an approved application and you need to begin to pay Premiums/Prepayment Fees, if any additional are due, during that period.

Family and Medical Leave Act of 1993

Under the Family and Medical Leave Act of 1993 (FMLA), you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for payment to your Group the portion of the premium/prepayment fees, if any, which you would have paid if you had not taken the leave. You may be entitled to FMLA leave for any of the following reasons:

- The birth of a child, and to care for such child.
- The placement of a child with you for adoption or foster care.
- To care for your seriously ill spouse, child, or parent.
- A serious health condition which makes you unable to perform your job functions.

The Policyholder shall be responsible for the determination of your eligibility, rights, or length of leave period for FMLA.

Initial Term

The Group Contract shall be in effect commencing at 12.01am on the effective date set forth in the certificate of coverage and shall extend for a minimum of 12 months thereafter.

Renewal Term(s)

The Group Contract is renewable at the option of the Group and Solstice at the end of the initial term for an additional 12 months (renewal term) and each renewal term may be renewed at the Group's option for an additional 12 months, subject to Solstice's right to modify/change, or amend the coverage and/or the premium rates applicable for the renewal term. Any such changes/amendments shall be subject to the Group's acceptance and shall be made part of the Group Contract. Solstice will offer renewal terms a minimum of 45 days in advance of the Group's anniversary date for signature by an authorized officer of Solstice. The agreement shall be deemed accepted and approved without the Group's signature if the first premium due for the new contract year is paid to Solstice on or before the first day of the month of the new contract year.

Member/Dependent Disenrollment from the Dental Plan - Termination of Benefits

Except as otherwise provided in the sections titled Extension of Benefits and Continuation of Benefits (COBRA), or in your Group Contract, disenrollment from the Dental Plan/Termination of benefits and coverage will be as follows:

Member

- The day the Policy terminates;
- The day your employment terminates;
- The last day of the grace period which was enacted due to lack of premium paid in the month prior;
- The last day of the month in which eligibility requirements are no longer met;

- The day you are no longer actively at work due to a labor dispute, including but not limited to, any strike, work slowdown or lockout;
- The day the Insured enters the armed forces of any country or international authority on a full time basis;
- Upon 60 days notice from Solstice due to permanent breakdown of the Dentist/patient relationship as determined by Solstice after at least three opportunities to utilize dental offices have failed;
- Upon 60 days notice by Solstice due to fraud or misuse of dental services and/or dental offices;
- Upon 60 days notice by Solstice due to continued lack of a dental office in your service area;
- The last day of the month after voluntary disenrollment; or
- Upon any condition cited in the Group Contract.

Dependent

- The day the Policy terminates;
- The date on which the Policy is changed to end Dependent insurance;
- The date on which a Dependent ceases to be a Dependent as defined in the Policy;
- The last day of a period for which the required premium payment for the cost of the Dependent is remitted;
- The day you request that the insurance for the Dependent be terminated;
- The day the Dependent enters the armed forces of any country or international authority on a full time basis;
- Upon all notices available by Solstice to the Member as stated in the Member termination provisions above; or
- When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

Extension of Benefits

Coverage for a specific dental procedure (other than orthodontics) which was started before your disenrollment or your Group's termination from the Dental Plan will be extended for a maximum of 90 days from the disenrollment/termination date. Your provider, by contract, is obligated to complete any and all procedures begun during the Dental Plan coverage period at the original contracted fees. Should this treatment be considered complex dentistry (ex. full mouth rehabilitation involving 6 or more crowns to be fabricated at the same time, periodontal therapy, etc.) as determined by the Solstice dental director, a decision will be rendered as to the additional time period that the provider needs to complete the original dental treatment plan.

Coverage for orthodontic treatment which was started before Member disenrollment or Group termination will be extended to the end of the quarter or for 90 days after Member disenrollment or Group termination whichever is later, unless such action was prompted due to nonpayment of premiums in which case coverage ceases immediately.

Subrogation

When benefits have been paid under the Policy for any loss caused by a third party, Solstice has the right to be reimbursed from any recovery the Insured obtains as a result of the alleged negligence. Solstice is entitled to any recovery even if such recovery does not fully satisfy the judgment, settlement, or underlying claim for damages or fully compensate the Insured. If the Insured is not fully compensated, Solstice shall be reimbursed on a pro-rata basis.

Solstice may take whatever legal action it sees fit against a third party to recover the benefits paid under the Policy. This will not affect the Insured's right to pursue other forms of recovery, unless the Insured or his/her legal representative consent otherwise.

The Insured shall advise Solstice of a claim or suit against a third party or insurance carrier within 60 days of the action. Solstice has the right to the Insured's full cooperation. All procedures and provisions relating to the right of subrogation shall not be in conflict with any applicable Florida Statute or the decisions of courts of competent jurisdiction which eliminate or restrict such rights.

Continuation of Benefits (COBRA)

For groups with 20 or more Employees, federal law requires the employer to offer continuation of benefits coverage for an Employee or Dependent after termination of employment or reduction of work hours, for any reason other than gross misconduct. Such reasons (qualifying event) include the following:

- The Employee's death;
- Termination of the Employee's employment (except for gross misconduct) or a reduction of hours below the minimum for eligibility;
- The Employee's divorce or legal separation;
- The Employee becoming eligible for benefits under Medicare; and
- A Dependent child ceasing to be eligible under the terms of the Policy.

The maximum period of continued coverage for the Employee and his/her Dependents as a result of termination and/or reduction of hours is 18 months from the date of such event. The maximum period of continued coverage as a result of any qualifying event other than termination and/or reduction is 36 months from the date of the event.

It is the responsibility of the Employee or Dependent to notify the Policyholder of a qualifying event other than termination and/or reduction of hours within 60 days of such event and make known his/her right for extension of benefits.

It is the responsibility of the employer to provide continued coverage, however it is the responsibility of the Employee/Dependent to remit the premium for such coverage within 45 days after such election. Subsequent payments must be made to the employer within 10 days of the Group's premium due date.

Termination of the extended coverage will end at the earliest of the following dates:

- The end of the maximum period of continued coverage set forth;
- The date on which the Employer ceases to provide any group plan;

- If an Employee/Dependent fails to make a premium payment when due, the last day of the period of coverage for which premiums have been paid; and
- The date on which the Employee/Dependent becomes covered under any other group dental plan or becomes eligible for benefits under Medicare.

Coordination of Benefits

If you or your Dependents have other coverage, indemnity or otherwise, through your spouse's employer or other sources, applicable coordination of benefits rules will determine which coverage is primary or secondary. In most cases:

- The plan covering you as an Employee is primary for you.
- The plan covering your spouse as an Employee is primary for him/her.
- Your children are covered as primary by the plan of the parent whose birthday occurs earlier in the year.
- Utilizing two dental benefits cannot result in reimbursement for more than 100% of the charge of the service rendered.

Grace Period

A grace period of 31 days will be allowed for the payment of any premium except the first premium due to enact the Policy. The Policy stays in force during a grace period. Full payment must be received by the 31st day of such a grace period. The Policy terminates at the end of the grace period with no further coverage.

The information below outlines the utilization of your coverage and will help you to better understand how to make the best use of your Dental Plan. Your particular Schedule of Benefits are attached to your certificate which outlines each specific procedure covered, applicable Patient Copayments to these services, exclusions and limitations. Please refer to this document each and every time that you use your Dental Plan.

Member Services

If you have any questions or concerns about the Dental Plan, our Member Services representatives are just a toll-free phone call away. They can give you information on dental offices in your area; explain certain dental services and their applicable copayments, second opinion or consultation; act as your liaison with your dental office; or explain your benefits. To contact Member Services from any location, call 1-800-955-4137.

Premiums

Your Group remits a monthly fee to Solstice for Members participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your benefits representative for information regarding any part of the fee to be withheld from your salary to be paid by you to the Group or the amount that the Group is paying on your behalf.

Other Charges - Patient Charges

Your Schedule of Benefits lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you while others require a Patient Copayment that is your responsibility to be paid at the time that the service is rendered. There are no deductibles and no annual dollar limits for services covered by your Dental Plan. Your Dentist receives supplemental payments from Solstice towards some "no charge" services as well as some services requiring Patient Copayments.

Your Network General Dentist should tell you about patient charges for covered services, the amount you must pay for non-covered services and the dental office's payment policies. It is possible that the dental office may add late charges to overdue balances or charges for broken appointments.

Your Schedule of Benefits is subject to annual change in accordance with your Group Contract. Solstice will provide written notice to your Group of any change in patient charges at least 45 days prior to such change. You will be responsible for the patient charges listed on the Schedule of Benefits that is in effect on the date a procedure is started.

Choice of Network Dentist

You and your Dependents can select a Dental Office once enrolled in the Dental Plan. The benefits of the Dental Plan are available only at a Network dental office within the Dental Service Area, except in the case of an emergency or when Solstice authorizes a payment for specialty referrals. Should you wish to change your Network Dentist or your Network Dentist elects to terminate their contract with Solstice, you have several help options:

- Contact Member Services at 1-800-955-4137;
- Request and/or review our printed Network Dentist Directory; or
- Visit us at www.myuhcdental.com.and utilize our Network Dentist search feature.

It is you and your Dependent's responsibility to review the Network Dentist directory to ascertain whether there is sufficient Network Dentists in your service area. Solstice will make every effort to establish and maintain an adequate choice of Network Dentists throughout the state, however claims no responsibility should Network representation be diminished or eliminated through attrition of Network Dentists from the Solstice Network. Should all Network Dentists in a given service area elect to terminate after having been active at the time of your enrollment in the Dental Plan, Solstice may tell you if you may obtain covered services at a particular non-Network Dentist on a temporary/emergency basis. In this situation, Solstice may pay the non-Network Dentist the difference, if any, between his or her usual fee and the applicable patient charge.

You may receive a description of the process used to analyze the qualifications and credentials of Network Dentists upon request.

Emergency Dental Care - Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe that his or her condition requires immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. Please contact your Network General Dentist if you have an emergency in your service area.

Emergency Care Away From Home

If you have an emergency while you are out of your service area, you may receive emergency covered services as defined above from any General Dentist. Typical routine emergency services may be emergency examination, x-rays, extraction, prescription, or other palliative care to relieve immediate pain, infection and bleeding. Routine restorative procedures or definitive treatment (e.g. root canal) which might be the final therapy necessary to correct the clinical situation creating the patient symptoms are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency care there will be up to $100.00 reimbursement towards the abatement of pain.

Emergency Care After Hours

There is a patient charge listed on your Schedule of Benefits for the emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

Benefit Limitations, Exclusions and Exceptions

Limitations on Covered Services

Listed below are limitations on services covered by your Dental Plan:

- Frequency/Age - The frequency of certain covered services, specifically preventive and diagnostic procedures such as cleanings, x-rays, are limited. Your patient Schedule of Benefits lists these limitations on frequency and age.
- Specialty Care - All Members of Dental Plans 500, 500A, 500AP, 700, 800, 800A, 800AP, Premium 300, Premium 300A, and Premium 300AP may seek treatment from a contracted Solstice dental specialist without a referral from Solstice and/or your General Dentist (we encourage the involvement of your General Dentist so that proper coordination of treatment be considered in your dental therapy). The Solstice dental specialist will provide a 25% reduction off of his/her usual and customary fee.

  Should your dental plan be the 500, 500A, 500AP, or 700 and the services of an Orthodontic specialist be necessary, you may receive this 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 usual and customary fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating Orthodontic specialist at the listed copayments.

  Should your Dental Plan be the S200, S200A, S200AP, S500, S500A, S500AP, S700, S700A, S700AP, S800A, or S800AP, you have one of two options:

  1. You may seek treatment from a contracted Solstice dental specialist without a referral from Solstice and/or your general dentist. The Solstice dental specialist will provide a 25% reduction off of his/her usual and customary fee.

     or

  2. You may elect to obtain prior written authorization from Solstice and receive specialty treatment by an approved Solstice S-plan specialist (which may or may not be on the list of Solstice dental specialists) at the listed co-payments on your Schedule of Benefits should they appear there.

  Though it is the intent to provide easy access for Solstice Members to its S-Plan dental specialists, Solstice is not obligated to provide the required dental specialist within a specific radius or geographic area. The following general limitations apply:

- Pediatric Dentistry - Coverage for referral to a pediatric Dentist ends on your child's 16th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 16th birthday.
- Oral Surgery - Surgical removal of impacted 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 dentist's or specialist's 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.
- There are certain procedure codes listed in your Schedule of Benefits that are not eligible under S-Plan reimbursement. These services are noted by an "iron cross".

Please refer to the section "Specialty Care Protocol" for a review of the authorization procedure.

Orthodontics

The following definitions apply:

- Orthodontic Treatment Plan and Records- The preparation of orthodontic records and a treatment plan by the orthodontist(models, x-rays, etc.).
- Interceptive/Transitional Orthodontic Treatment- Treatment prior to full eruption of the permanent teeth, frequently a first phase prior to comprehensive therapy.
- Comprehensive Orthodontic Treatment- Treatment after eruption of most permanent teeth(i.e. braces).
- Retention(Post Treatment Stabilization) - The period following comprehensive treatment where you may wear an appliance to maintain and stabilize the new position of the teeth.

The Solstice orthodontic benefit allows for a total of 24 months of orthodontic treatment whether it be entirely "comprehensive" or 12 months of "Interceptive" and 12 months of Comprehensive, etc. The patient charge for your entire orthodontic case, including retention, will be based upon the appropriate Schedule of Benefits in effect on the date of your visit for treatment plan and records. Factors that could alter the total charge might be the type of brackets utilized (ceramic, clear, lingual vs metal), required surgery, appliances to guide minor tooth movement, harmful habit appliances, as well as the evaluation of the difficulty or case type of the orthodontic treatment and/or the degree to which the treatment plan deviates from a "typical" or normal case difficulty as discerned entirely by the Orthodontist. Solstice bears no liability towards treatment unable to be completed due to a terminated status or a treatment planned case, originally thought to be completed within 24 months, at the end of which, more therapy is evident to achieve a satisfactory result as discerned by the Orthodontist.

If you/your Dependent is in the middle of orthodontia treatment of any type at the time of initial enrollment, you must contact Solstice to see if you are eligible for reimbursement under the orthodontia benefit.

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 not listed on the Schedule of Benefits are charged to you, the Member/Dependent, at a 25% discount of the provider's usual and customary fee.

- Services provided by a non-Network General Dentist or Dental Specialist without Solstice Benefit's prior approval, except emergencies.
- 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 listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice Benefits.
- 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 associated with the placement or prosthodontic restoration of a dental implant.
- Services considered to be unnecessary 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 neoplasm's.
- A broken appointment fee up to $20 maybe charged by the dental office if 24 hour prior notice is not given.
- 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.
- Surgical removal of impacted 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 dentist's or specialist's 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.

Pre-existing Conditions

There are no pre-existing conditions. Should any be added as an addendum to the Contract upon renewal, pre-existing conditions will not be excluded, for a condition which occurs 3 months prior to the effective date, for more than two years.

Exceptions

Within each particular Schedule of Benefits, there may be additional copayments, fees, surcharges that apply to services that present with a Patient Copayment (e.g. precious metal copayment when undergoing crown restoration therapy, complex rehabilitation/multiple crowns of 6 or more requiring a $30.00 surcharge). Please review your entire Schedule of Benefits to determine whether such additional charges apply.

Genetic, Handicapped and Communicable Disease Conditions

Solstice, in compliance with Florida Statutes and Florida Administrative Code, does not consider Members with the following conditions subject to limited, altered, or denied coverage, by virtue of these specific conditions alone:

- HIV.
- Handicapped children.
- Genetic information absent of a condition requiring diagnosis.

Solstice, in the course of its business, complies with the following Florida Statues/Administrative Codes:

- 636.016
- 4-203.025
- 636.0201
- 636.022
- 627.431

Grievance Procedures - What To Do If There Is A Problem

Most problems can be resolved between you and your Dentist. We suggest that you discuss your questions and/or concerns with your Dentist first in the hopes of continuing to maintain an easy working relationship. However, we want you to be completely satisfied with the Dental Plan. That's why we've established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

Informal Grievance Procedure

Begin with the Solstice Member Services Department which can be reached at 1-800-955-4137. We're here to listen and to help. If you have a concern about your dental office or the Dental Plan, you may call the toll-free number and explain your concern to one of the Member Services representatives. Many questions/concerns are able to be addressed at the time of your first phone call by reviewing your Dental Plan, normal Solstice procedures as described in this certificate, and interpreting what might appear to be complicated typical dental office procedure. If necessary, and only under your direction, we will contact your dental provider for you to gain necessary treatment information. We will evaluate such information as it pertains to your concern and get back to you as soon as possible, usually by the end of the next business day. Should you consider this informal grievance procedure unsatisfactory, Solstice employs a two level "Appeals" process for any disputes and/or concerns.

Level One Complaint-Appeal

Even though it is not necessary, it is always assumed that you have attempted to have your concern(s) addressed through our informal process prior to utilizing the "Level One" formal process. To initiate a "Level One" complaint or appeal towards the findings of an informal query, you must submit a request for review of such a complaint/appeal within one year of the occurrence, to include the following information:

- The letter should be labeled as a "Level One" complaint/Appeal.
- Patient identifying information.
- Dental provider identifying information.
- The date(s) of the experience.
- Description of the intended dental service.
- The nature of the deviation.
- The patient financial obligation toward the dental provider, if any.
- The overall temperament/attitude of the Dentist and his/her auxiliaries.
- A review of your attempt, if any, to clarify/correct the provider deviation.
- A review of the provider's attempt, if any, to clarify/correct the deviation.
- A review of the Informal grievance process by yourself and Solstice if one had occurred.

The above letter should be addressed to:

Appeals Coordinator

PO Box 30569

Salt Lake City, UT 84130-0569

If you are unable or choose not to submit a written request, you may ask Member Services/Appeals Coordinator to register your request by calling the toll-free number 1-800-955-4137 at which time the Member Services representative will fill out a formal grievance form. Once completed, this formal grievance form will be mailed to you for your signature to be returned to Solstice for action.

Your "Level One" request will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

We will respond with a decision within 15 calendar days after we receive your request. If the review cannot be completed before 15 days, we will notify you on or before the 15th day of the reason for the delay. The review will be completed within 15 calendar days after that. If you are not satisfied with our decision, you may request a second level review.

Level Two Appeal

To initiate a level two appeal, you must submit your request in writing to Solstice within 60 days after receipt of Solstice Benefit's level one decision.

Second level reviews will be conducted by Solstice Benefit's Appeals Committee, which consists of a minimum of 3 people. Anyone involved in the prior decision may not vote on the Appeal's Committee. For appeals involving dental necessity or clinical appropriateness, the Committee will include at least one Dentist. If specialty care is in dispute, the Committee will consult with a Dentist in the same or similar specialty as the care under consideration, as determined by Solstice.

Solstice will acknowledge your appeal in writing within 5 business days and schedule a committee review. The acknowledgement will include the name, address, and telephone number of the Appeals Coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 after the receipt of your initial request.

You may present your situation to the Committee in person or by conference call. Please advise Solstice 5 days in advance if you or your representative plans to be present. The location of the review will be at the Solstice home office address or at a location within your service area that is mutually convenient. You will be notified in writing of the Committee decision within 5 business days after the Committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

Expedited Appeals

You may request that the complaint or appeal resolution be expedited if the timeframes under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Solstice will respond orally with a decision within 72 hours, followed up in writing within two business days of the decision.

Appeals to the State

You have the right to contact your state's Department of Insurance or Health for assistance at any time. Such contact can be made at the following address:

Department of Financial Services

200 East Gaines Street

Tallahassee, Florida 32399

1-800-342-2672

Arbitration

As a Solstice enrollee, you acknowledge that any/all grievances, upon your request, may be placed in an arbitration process so that an agreeable resolution may be established. All arbitration processes will not preclude review pursuant to Rule 4-191.081 of the Florida Administrative Code and shall be conducted pursuant to Chapter 682 of the Florida Statues.

Solstice will not cancel or refuse to renew coverage because you or your Dependent has filed a complaint or appealed a decision made by Solstice. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

ACCESS+ S1000A HIGH

SCHEDULE OF BENEFITS

Members of the Solstice ACCESS+ S1000A HIGH dental plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No Waiting Periods
- No Deductibles
- No Claim Forms to Submit
- Out-of-Network Preventive and 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

www.myuhcdental.com

Member Services Department: 800-955-4137

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

The following Member copayments apply when a participating General Dentist performs services. An "*" denotes limitation on certain benefits (see "Exclusions/Limitations").

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/$25
D0150	*Comprehensive oral evaluation - new or established patient	$0/$30
D0160	*Detailed and extensive oral evaluation - problem focused, by report	$0/$30
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0/$15
D0180	Comprehensive periodontal evaluation - new or established patient	$10/$15
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0

Code	Description	Copay/ Reimbursement
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
	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
D0260	Extraoral - each additional 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	$0/$25
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic images	$150
D0310	Sialography	$150
D0320	Temporomandibular joint arthrogram, including injection	$250
D0321	Other temporomandibular joint radiographic imagess, by report	$150
D0322	Tomographic survey	$150
D0330	*Panoramic radiographic images	$0/$25
D0340	Cephalometric radiographic images	$75
D0350	2D oral/facial photographic image obtainedintra-orally or extra-orally	$0/$15
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	$150
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$140
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$140
D0367	*Cone beam CT capture and interpretation with field of vie of both jaws, with or without cranium	$190
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	$140
D0369	*Maxillofacial MRI capture and interpretation	$190
D0370	*Maxillofacial ultrasound capture and interpretation	$170
D0371	*Sialoendoscopy capture and interpretation	$170
D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	$150
D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	$140
D0382	*Cone Beam CT image capture with field of view of one full dental arch -	$140

Code	Description	Copay/ Reimbursement
	maxilla, with or without cranium	
D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	$190
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	$140
D0385	*Maxillofacial MRI image capture	$170
D0386	*Maxillofacial ultrasound image capture	$170
D0393	*Treatment simulation using 3D image volume	$10
D0394	*Digital subtraction of two or more images or image volumes of the same modality	$10
D0395	*Fusion of two or more 3D image volumes of one or more modalities	$10
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	$50
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	$20
D1120	*Prophylaxis - child	$0/$25
D1120	Prophylaxis - child additional	$20
D1206	Topical fluoride varnish	$0
D1208	*Topical application of fluoride - excluding varnish	$17/$10
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0

Code	Description	Copay/ Reimbursement
D1330	Oral hygiene instructions	$0
D1351	*Sealant - per tooth	$5/$20
D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0
D1510	*Space maintainer - fixed - unilateral	$45/$50
D1515	*Space maintainer - fixed - bilateral	$45/$75
D1520	*Space maintainer - removable - unilateral	$85/$50
D1525	*Space maintainer - removable - bilateral	$85/$75
D1550	*Re-cementation or re-bond space maintainer	$5
D1555	Removal of fixed space maintainer	$5
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$70
D2391	Resin-based composite - one surface, posterior	$60
D2392	Resin-based composite - two surfaces, posterior	$80
D2393	Resin-based composite - three surfaces, posterior	$90
D2394	Resin-based composite - four or more surfaces, posterior	$120
D2410	Gold foil - one surface	$65
D2420	Gold foil - two surfaces	$90
D2430	Gold foil - three surfaces	$120
D2510	Inlay - metallic - one surface	$95
D2520	Inlay - metallic - two surfaces	$105
D2530	Inlay - metallic - three or more surfaces	$130
D2542	Onlay - metallic-two surfaces	$230
D2543	Onlay - metallic-three surfaces	$230
D2544	Onlay - metallic-four or more surfaces	$230
D2610	Inlay - porcelain/ceramic - one surface	$230*
D2620	Inlay - porcelain/ceramic - two surfaces	$230*
D2630	Inlay - porcelain/ceramic - three or more surfaces	$230*
D2642	Onlay - porcelain/ceramic - two surfaces	$230*

Code	Description	Copay/ Reimbursement
D2643	Onlay - porcelain/ceramic - three surfaces	$230*
D2644	Onlay - porcelain/ceramic - four or more surfaces	$230*
D2650	Inlay - resin-based composite - one surface	$230
D2651	Inlay - resin-based composite - two surfaces	$230
D2652	Inlay - resin-based composite - three or more surfaces	$230
D2662	Onlay - resin-based composite - two surfaces	$230
D2663	Onlay - resin-based composite - three surfaces	$230
D2664	Onlay - resin-based composite - four or more surfaces	$230
D2710	*Crown - resin-based composite (indirect)	$230
D2712	*Crown - ¾ resin-based composite (indirect)	$230
D2720	*Crown- resin with high noble metal	$230*
D2721	*Crown - resin with predominantly base metal	$230*
D2722	*Crown - resin with noble metal	$230*
D2740	*Crown - porcelain/ceramic substrate	$280*
D2750	*Crown - porcelain fused to high noble metal	$280*
D2751	*Crown - porcelain fused to predominantly base metal	$280*
D2752	*Crown - porcelain fused to noble metal	$280*
D2780	*Crown - 3/4 cast high noble metal	$230*
D2781	*Crown - 3/4 cast predominantly base metal	$230*
D2782	*Crown - 3/4 cast noble metal	$230*
D2783	*Crown - 3/4 porcelain/ceramic	$230*
D2790	*Crown - full cast high noble metal	$280*
D2791	*Crown - full cast predominantly base metal	$280*
D2792	*Crown - full cast noble metal	$280*
D2794	*Crown - titanium	$230*
D2799	Provisional Crown - further treatment or completion of diagnosis necessary prior to final impression	$0
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	$10
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$10
D2921	Reattachment of tooth fragment, incisal edge or cusp	$15
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$50*
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$35
D2933	Prefabricated stainless steel crown with resin window	$35
D2940	Protective restoration	$10

Code	Description	Copay/ Reimbursement
D2941	Interim therapeutic restoration - primary dentition	$15
D2949	Restorative foundation for an indirect restoration	$20
D2950	Core buildup, including any pins	$45
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$60
D2953	Each additional indirectly fabricated post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$60
D2955	Post removal	$10
D2957	Each additional prefabricated post - same tooth	$30
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300*
D2962	Labial veneer (porcelain laminate) - laboratory	$350*
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2975	Coping	$100
D2980	Crown repair necessitated by restorative material failure	$0
D2981	Inlay repair necessitated by restorative material failure	$100
D2982	Onlay repair necessitated by restorative material failure	$100
D2983	Veneer repair necessitated by restorative material failure	$100
D2990	Resin infiltration of incipient smooth surface lesions	$30
	Endodontic Services	
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3221	Pulpal debridement, primary and permanent teeth	$45
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$80
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$30
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$35
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$80
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$115
D3330	Endodontic therapy, molar (excluding final restoration)	$200
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3333	Internal root repair of perforation defects	$85

Code	Description	Copay/ Reimbursement
D3346	Retreatment of previous root canal therapy - anterior	$135
D3347	Retreatment of previous root canal therapy - bicuspid	$175
D3348	Retreatment of previous root canal therapy - molar	$275
D3351	Apexification/recalcification	$65
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy - anterior	$95
D3421	Apicoectomy - bicuspid (first root)	$95
D3425	Apicoectomy - molar (first root)	$95
D3426	Apicoectomy (each additional root)	$60
D3427	Periradicular surgery without apicoectomy	$100
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$50
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$45
D3430	Retrograde filling - per root	$40
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	$95
D3460	Endodontic endosseous implant	$550
D3470	Intentional reimplantation (including necessary splinting)	$175
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
	Periodontic Services	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$40
D4212	Gingivectormy or gingivoplasty to allow access for restorative procedure, per tooth	$50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$120
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$295

Code	Description	Copay/ Reimbursement
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$210
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$215
D4267	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$255
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$245
D4273	Subepithelial connective tissue graft procedures, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4275	Soft tissue allograft	$380
D4276	Combined connective tissue and double pedicle graft, per tooth	$70
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$220
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$80
D4320	Provisional splinting - intracoronal	$95
D4321	Provisional splinting - extracoronal	$85
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$40†
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30†
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40†
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$45†
D4910	*Periodontal maintenance	$30
D4910	Periodontal maintenance Additional	$55
D4920	Unscheduled dressing change (by someone other than treating dentist)	$20
D4921	Gingival irrigation - per quadrant	$15
D4999	Unspecified periodontal procedure, by report	$0
	Prosthodontics Removable	
D5110	*Complete denture - maxillary	$210*
D5120	*Complete denture - mandibular	$210*
D5130	*Immediate denture - maxillary	$225*
D5140	*Immediate denture - mandibular	$225*
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$240*
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$240*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases	$260*

Code	Description	Copay/ Reimbursement
	(including any conventional clasps, rests and teeth)	
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365*
D5281	*Removable unilateral partial denture - one piece cast metal (including clasps and teeth	$250*
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5510	*Repair broken complete denture base	$15*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	$15*
D5610	*Repair resin denture base	$15*
D5620	*Repair cast framework	$30*
D5630	*Repair or replace broken clasp	$15*
D5640	*Replace broken teeth - per tooth	$15*
D5650	*Add tooth to existing partial denture	$30*
D5660	*Add clasp to existing partial denture	$35*
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	$165*
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	$165*
D5710	*Rebase complete maxillary denture	$60*
D5711	*Rebase complete mandibular denture	$60*
D5720	*Rebase maxillary partial denture	$60*
D5721	*Rebase mandibular partial denture	$60*
D5730	*Reline complete maxillary denture (chairside)	$35*
D5731	*Reline complete mandibular denture (chairside)	$35*
D5740	*Reline maxillary partial denture (chairside)	$35*
D5741	*Reline mandibular partial denture (chairside)	$35*
D5750	*Reline complete maxillary denture (laboratory)	$35*
D5751	*Reline complete mandibular denture (laboratory)	$35*
D5760	*Reline maxillary partial denture (laboratory)	$35*
D5761	*Reline mandibular partial denture (laboratory)	$35*
D5810	*Interim Complete denture (maxillary)	$230*
D5811	*Interim complete denture (mandibular)	$230*
D5820	*Interim partial denture (maxillary)	$60*
D5821	*Interim partial denture (mandibular)	$60*

Code	Description	Copay/ Reimbursement
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$160
D5899	Unspecified removable prosthodontic procedure, by report	$0
D5982	Surgical stent	$150*
D5987	Commissure splint	$150*
D5988	Surgical splint	$150*
	***Implant Supported Prosthetics**	
D6190	Radiographic/surgical implant index, by report	$235
D6010	*Surgical placement of implant body; endosteal implant	$950
D6012	*Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$950
D6100	Implant removal, by report	$700
D6056	*Prefabricated abutment – includes placement	$400
D6057	*Customer abutment – includes placement	$600
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$950
D6055	Dental implant supported connecting bar	$1,800
D6110	*implant /abutment supported removable denture for edentulous arch – maxillary	$1,200
D6111	*implant /abutment supported removable denture for edentulous arch – mandibular	$1,200
D6112	*implant /abutment supported removable denture for partially edentulous arch – maxillary	$940
D6113	*implant /abutment supported removable denture for partially edentulous arch – mandibular	$940
D6114	*implant /abutment supported fixed denture for edentulous arch – maxillary	$3,800
D6115	*implant /abutment supported fixed denture for edentulous arch – mandibular	$3,800
D6116	*implant /abutment supported fixed denture for partially edentulous arch – maxillary	$2,200
D6117	*implant /abutment supported fixed denture for partially edentulous arch – mandibular	$2,200
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis, and abutments and reinsertion 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	$750

Code	Description	Copay/ Reimbursement
D6210	*Pontic - cast high noble metal	$280*
D6211	*Pontic - cast predominantly base metal	$280*
D6212	*Pontic - cast noble metal	$280*
D6214	*Pontic - titanium	$280*
D6240	*Pontic - porcelain fused to high noble metal	$280*
D6241	*Pontic - porcelain fused to predominantly base metal	$280*
D6242	*Pontic - porcelain fused to noble metal	$280*
D6245	*Pontic - porcelain/ceramic	$280*
D6250	*Pontic - resin with high noble metal	$250*
D6251	*Pontic - resin with predominantly base metal	$230*
D6252	*Pontic - resin with noble metal	$230*
D6253	Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No charge
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$200*
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$375*
D6600	Inlay - porcelain/ceramic, two surfaces	$230*
D6601	Inlay - porcelain/ceramic, three or more surfaces	$230*
D6602	Inlay - cast high noble metal, two surfaces	$230*
D6603	Inlay - cast high noble metal, three or more surfaces	$230*
D6604	Inlay - cast predominantly base metal, two surfaces	$230*
D6605	Inlay - cast predominantly base metal, three or more surfaces	$230*
D6606	Inlay - cast noble metal, two surfaces	$230*
D6607	Inlay - cast noble metal, three or more surfaces	$230*
D6608	Onlay -porcelain/ceramic, two surfaces	$230*
D6609	Onlay - porcelain/ceramic, three or more surfaces	$230*
D6610	Onlay - cast high noble metal, two surfaces	$230*
D6611	Onlay - cast high noble metal, three or more surfaces	$230*
D6612	Onlay - cast predominantly base metal, two surfaces	$230*
D6613	Onlay - cast predominantly base metal, three or more surfaces	$230*
D6614	Onlay - cast noble metal, two surfaces	$230*
D6615	Onlay - cast noble metal, three or more surfaces	$230*
D6624	*Inlay - titanium	$250*
D6634	*Onlay - titanium	$250*
D6710	*Crown - indirect resin based composite	$230*
D6720	*Crown - resin with high noble metal	$230*
D6721	*Crown - resin with predominantly base metal	$230*
D6722	*Crown - resin with noble metal	$230*

Code	Description	Copay/ Reimbursement
D6740	*Crown - porcelain/ceramic	$230*
D6750	*Crown - porcelain fused to high noble metal	$230*
D6751	*Crown - porcelain fused to predominantly base metal	$230*
D6752	*Crown - porcelain fused to noble metal	$230*
D6780	*Crown - 3/4 cast high noble metal	$230*
D6781	*Crown - 3/4 cast predominantly base metal	$230*
D6782	*Crown - 3/4 cast noble metal	$230*
D6783	*Crown - 3/4 porcelain/ceramic	$230*
D6790	*Crown - full cast high noble metal	$230*
D6791	*Crown - full cast predominantly base metal	$230*
D6792	*Crown - full cast noble metal	$230*
D6793	Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$130
D6794	*Crown - titanium	$230*
D6930	Re-cement or re-bond fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6980	Fixed partial denture repair necessitated by restorative material failure	$45
	Oral Surgery	
D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30
D7220	Removal of impacted tooth - soft tissue	$45
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$80
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35
D7251	Cronectomy - intentional partial tooth removal	$270
D7260	Oroantral fistula closure	$140
D7261	Primary closure of a sinus perforation	$280
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	$100
D7280	Surgical access of an unerupted tooth	$85
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90

Code	Description	Copay/ Reimbursement
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$0
D7286	Incisional biopsy of oral tissue-soft	$0
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant	$70
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
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	$30
D7411	Excision of benign lesion greater than 1.25 cm	$50
D7412	Excision of benign lesion, complicated	$60
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)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$25
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7520	Incision and drainage of abscess - extraoral soft tissue	$30
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7910	Suture of recent small wounds up to 5 cm	$25
D7921	Collection and application of autologous blood concentrate product	$130
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogeneous or nonautogeneous, 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	$40

Code	Description	Copay/ Reimbursement
D7963	Frenuloplasty	$40
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of Pericoronal Gingiva	$35
D7972	Surgical reduction of fibrous tuberosity	$130
	Orthodontic	
D8010	Limited orthodontic treatment of the primary dentition	$1000
D8020	Limited orthodontic treatment of the transitional dentition	$1000
D8030	Limited orthodontic treatment of the adolescent dentition	$1000
D8040	Limited orthodontic treatment of the adult dentition	$1000
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1800
D8090	Comprehensive orthodontic treatment of the adult dentition	$1800
D8210	Removable appliance therapy	$103
D8220	Fixed appliance therapy	$103
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
D8999	Unspecified orthodontic procedure, by report	$250
	Miscillaneous	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10
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
D9220	Deep sedation/general anesthesia - first 30 minutes	$150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous moderate (conscious) sedation/analgesia – first 30 minutes	$150
D9242	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	$45
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	$15
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$0

Code	Description	Copay/ Reimbursement
D9940	*Occlusal guard, by report	$85
D9942	Repair and/or reline of Occlusal guard	$40
D9950	Occlusion analysis - mounted case	$75
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching - per arch - performed in office	$125
D9973	External bleaching - per tooth	$30
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$240

SPECIALTY SERVICES

1 This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice.

2 Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.

3 The participating General Dentist you select may not perform all procedures listed. The copayments shown apply to participating General Dentists.

4 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 specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating specialist at the listed copayments. Please refer to the Specialty Care Referral Policy in your Member handbook.

5 Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist 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-pay.

6 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. Please refer to the provider listing at www.myuhc.com under "find a physician."

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.

8 D9972 Excludes bleaching material for home use.

LIMITATIONS

1 Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.

2 All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.

3 The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.

4 Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period.

5 Sealants are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.

6 Space maintainers and all adjustments are limited to children under the age of 16.

7 Harmful habit appliances are limited to one (1) time per person under the age of 16.

8 General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.

9 New dentures include one (1) reline within the first six (6) months

10 Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.

11 When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.

12 Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows:
- High noble metal (precious) up to $145.00
- Titanium metal up to $120 (covered with proof of allergy to other metals)
- Noble metal (semi-precious) up to $120.00
- Predominantly base metal (non-precious) up to $55.00
- Crown laboratory fees up to $155.00
- Laboratory fees on dentures up to $225.00
- Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00
- Denture repair laboratory fees up to $50.00
- All ceramic and/or porcelain crown material fees up to $155.00

13 Copayments marked by "†" are not eligible at a specialist.

14 Either D0210 or D0330 are reimbursable one (1) time every five (5) consecutive years.

15 Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.

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

17 All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.

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

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

20 Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.

21 Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.

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

grinding/Bruxism.

23 D0364-D0395 is limited to one (1) time per sixty(60) months, covered only in a dental setting and not in a radiographic imaging center