	PPO 1500 Dental	PPO 3000 Dental	EPO Dental	Vision
Member	**$62.00**	**$67.00**	**$37.00**	**$12.00**
M+Spouse	**$118.00**	**$128.00**	**$61.00**	**$20.00**
M+Child(ren)	**$133.00**	**$143.00**	**$73.00**	**$24.00**
M+Family	**$182.00**	**$197.00**	**$91.00**	**$30.00**

(Renewal 4/30/2022)

EPO Dental available in 39 states

PPO Dental and Vision available in most states

PPO 1500 Dental Plan

- Deductible: $50 Single/ $150 Family ($50 x Max 3)
- Co-Insurance: 100% Preventative, 80% Basic, 50% Major
- Orthodontic: None
- $1500 Yearly Max per Person
- 12 Month Wait on: Crowns-Inlays, Bridges & Dentures

PPO 3000 Dental Plan

- Deductible: $0 Single/ $0 Family
- Co-Insurance: 100% Preventative, 90% Basic, 60% Major
- Orthodontic: None
- $3000 In-Network Yearly Max per Person
- $2500 Out-of-Network Yearly Max per Person
- 12 Month Wait on: Crowns-Inlays, Bridges & Dentures

EPO Dental Plan

- Office Visit: $0 Co Pay
- Preventative Basic & Major have Co-pays
- No Waiting Periods or Pre-existing Exclusions
- Orthodontic: Yes
- No Yearly Maximums

Vision Plan

- Eye Exam: 12 months / Spectacle Lenses: 12 months
- Contact Lenses (in lieu of eyeglasses): 12 months
- Frame Allowance (Retail): Up to $130, plus 20% discount
- Eyeglass Benefit: Spectacle Lenses – Various Copays
- Contact Lenses Benefit (in lieu of eyeglasses): Up to $130, plus 15% discount
- Out-of-network Reimbursement Schedule (up to): Eye Exam $40, Single Vision Lenses $40, Trifocal Lenses $80, Elective Contact Lenses $80, Frame $50

Providers can be located @ www.solsticebenefits.com

***All Dental plans include $7,000 Basic Life at no extra cost.**
See Plan summaries included in this kit for Details.
Note: Vision does NOT include $7,000 Life

Solstice Benefits
Enrollment Worksheet

(Renewal Date 4/30/22)

Please make plan selection below by circling desired plan

PPO 1500 Dental	**Member**	**$ 62.00**	**PPO 3000 Dental**	**Member**	**$ 67.00**
	M+Spouse	**$ 118.00**		**M+Spouse**	**$ 128.00**
	M+Child(ren)	**$ 133.00**		**M+Child(ren)**	**$ 143.00**
	M+Family	**$ 182.00**		**M+Family**	**$ 197.00**
EPO Dental	**Member**	**$ 37.00**	**Vision Plan**	**Member**	**$ 12.00**
	M+Spouse	**$ 61.00**		**M+Spouse**	**$ 20.00**
	M+Child(ren)	**$ 73.00**		**M+Child(ren)**	**$ 24.00**
	M+Family	**$ 91.00**		**M+Family**	**$ 30.00**

***All Dental plans include $7,000 of Basic Life at no extra cost.**
See Plan summaries included in this kit for Details.

Note: Vision does NOT include $7,000 Basic Life

Find Providers at www.solsticebenefits.com

One Time Processing Fee: $ **30.00**

Total Contribution at Enrollment: $_____

- **Make One Check Payable to: Elevate Wellness**
- **Billing is through electronic funds transfer (EFT) only**
- **Applicant must complete all forms**
- **Applications must be received by 20th of the month prior to the start date**
- **Mail to: Elevate Wellness, 20 Madison Ave, Valhalla, NY 10595**

Member Name _____ Date _____

Member Signature _____

Note: ID Cards will take 15-20 days after effective to arrive by mail.

Plan offered through membership in Elevate to Wellness Association

Dental PPO Summary of Benefits Effective 5/1/2021

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$50	$50	$0	$0
Family Annual Calendar Year Deductible	$150	$150	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	$1500 per person per Calendar Year	$1500 per person per Calendar Year	N/A	N/A

Annual deductible applies to preventive and diagnostic services	No (In Network)	No (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	Yes	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	N/A	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	100%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	100%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	100%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	100%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	80%	80%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	80%	80%	Limited to one (1) time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics	80%	80%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area. Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	80%	80%	
Anesthetics	80%	80%	General Anesthesia: When clinically necessary.
Adjunctive Services	80%	80%	
MAJOR SERVICES			**12-Month Waiting Period**
Inlays/Onlays/Crowns	50%	50%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	50%	50%	Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	Not Covered	Not Covered	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

*The network percentage of benefits is based on the discounted fees negotiated with the provider.

**Out of-Network benefits are based on the participating provider contracted fees.

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits your Certificate of Coverage/benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Limitations, Non-Covered Services, and Exclusions

General Limitations

ALTERNATE BENEFIT – Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $300; please consult your dentist.

BASIC RESTORATIONS – Multiple restorations on one (1) surface will be treated as a single filling.

B**ITEWING RADIOGRAPHS** are limited to one (1) series of films per consecutive twelve (12) months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS are limited to one (1) time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANINGS) are limited to

(2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.

EXTRAORAL RADIOGRAPHS are limited to two (2) films per consecutive twelve (12) months.

FLUORIDE TREATMENTS are limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.

FULL OR PARTIAL DENTURES are limited to one (1) time every consecutive sixty (60) months. No additional allowances for precision or semi-precision attachments.

FULL-MOUTH DEBRIDEMENT is limited to one (1) time per consecutive thirty-six (36) months.

GENERAL ANESTHESIA, IV SEDATION are covered when necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.

MAJOR RESTORATIONS – Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one (1) time per consecutive sixty (60) months from initial or subsequent placement.

OCCLUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control habitual grinding.

ORAL EVALUATIONS - Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if not in conjunction with other exams.

ORTHODONTIC SERVICES – When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

PERIODONTAL MAINTENANCE is limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance procedures in any twelve (12) consecutive months.

PERIODONTAL SURGERY – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) pins per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have had root canal therapy.

RELINING, REBASING AND TISSUE CONDITIONING DENTURES are limited to relining/rebasing performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) time per consecutive thirty-six (36) months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) time per consecutive six (6) months.

REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for twelve (12) continuous months.

REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12), continuous months.

SEALANTS are limited to Covered Persons under the age of sixteen (16) years and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.

SCALING AND ROOT PLANING is limited to one (1) time per quadrant per consecutive twenty-four (24) months. Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report, is not covered when performed on the same day as root planing and scaling.

SEDATIVE FILLINGS are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

SPACE MAINTAINERS are limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.

Non-Covered Services

The following are NOT covered under the plan:

1. Dental Services that are not Reasonable and/or Necessary.
2. Hospital or other facility charges.
3. Reconstructive surgery to the mouth or jaw.
4. Any Procedures not directly associated with dental disease.
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are considered Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered Experimental, Investigational or Unproven in the treatment of that particular condition.
7. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
10. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
11. If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
12. If damage or breakage was directly related to provider error, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
14. Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hours notice.
15. Expenses for dental procedures begun before enrollment under the plan.
16. Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Attachments to conventional removable prosthesis or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
19. Occlusal guards used as safety items or for sports-related activities.
20. Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
21. Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
22. Acupuncture, acupressure, and other forms of alternative treatment, whether or
23. Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
24. Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.
25. Inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.
26. Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
27. Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
28. Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

1. Illness, accident, treatment or medical condition arising out of:
   - i. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
   - ii. service in the Armed Forces or units auxiliary thereto;
   - iii. suicide, attempted suicide or intentionally self-inflicted injury;
   - iv. aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and,
   - v. with respect to blanket insurance, interscholastic sports.
2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
3. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;
4. Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
5. ILLEGAL OCCUPATION: Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
6. INTOXICANTS AND NARCOTICS: Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Dental PPO Summary of Benefits Effective 5/1/2021

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$0	$0	$0	$0
Family Annual Calendar Year Deductible	$0	$0	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	$3000 per person per Calendar Year	$2500 per person per Calendar Year	N/A	N/A

Annual deductible applies to preventive and diagnostic services	No (In Network)	No (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	Yes	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	N/A	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	100%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	100%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	100%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	100%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	100%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	90%	90%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	90%	90%	Limited to one (1) time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	90%	90%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	90%	90%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	90%	90%	Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	90%	90%	
Anesthetics	90%	90%	General Anesthesia: When clinically necessary.
Adjunctive Services	90%	90%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	60%	60%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	60%	60%	Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	60%	60%	Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	Not Covered	Not Covered	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

*The network percentage of benefits is based on the discounted fees negotiated with the provider.

**Out of-Network benefits are based on the participating provider contracted fees.

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits your Certificate of Coverage/benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Limitations, Non-Covered Services, and Exclusions

General Limitations

ALTERNATE BENEFIT – Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $300; please consult your dentist.

BASIC RESTORATIONS – Multiple restorations on one (1) surface will be treated as a single filling.

B**ITEWING RADIOGRAPHS** are limited to one (1) series of films per consecutive twelve (12) months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS are limited to one (1) time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANINGS) are limited to

(2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.

EXTRAORAL RADIOGRAPHS are limited to two (2) films per consecutive twelve (12) months.

FLUORIDE TREATMENTS are limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.

FULL OR PARTIAL DENTURES are limited to one (1) time every consecutive sixty (60) months. No additional allowances for precision or semi-precision attachments.

FULL-MOUTH DEBRIDEMENT is limited to one (1) time per consecutive thirty-six (36) months.

GENERAL ANESTHESIA, IV SEDATION are covered when necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.

MAJOR RESTORATIONS – Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one (1) time per consecutive sixty (60) months from initial or subsequent placement.

OCCLUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control habitual grinding.

ORAL EVALUATIONS - Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if not in conjunction with other exams.

ORTHODONTIC SERVICES – When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

PERIODONTAL MAINTENANCE is limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance procedures in any twelve (12) consecutive months.

PERIODONTAL SURGERY – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) pins per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have had root canal therapy.

RELINING, REBASING AND TISSUE CONDITIONING DENTURES are limited to relining/rebasing performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) time per consecutive thirty-six (36) months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) time per consecutive six (6) months.

REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for twelve (12) continuous months.

REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12), continuous months.

SEALANTS are limited to Covered Persons under the age of sixteen (16) years and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.

SCALING AND ROOT PLANING is limited to one (1) time per quadrant per consecutive twenty-four (24) months. Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report, is not covered when performed on the same day as root planing and scaling.

SEDATIVE FILLINGS are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

SPACE MAINTAINERS are limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.

Non-Covered Services

The following are NOT covered under the plan:

1. Dental Services that are not Reasonable and/or Necessary.
2. Hospital or other facility charges.
3. Reconstructive surgery to the mouth or jaw.
4. Any Procedures not directly associated with dental disease.
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are considered Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered Experimental, Investigational or Unproven in the treatment of that particular condition.
7. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
10. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
11. If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
12. If damage or breakage was directly related to provider error, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
14. Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hours notice.
15. Expenses for dental procedures begun before enrollment under the plan.
16. Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Attachments to conventional removable prosthesis or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
19. Occlusal guards used as safety items or for sports-related activities.
20. Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
21. Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
22. Acupuncture, acupressure, and other forms of alternative treatment, whether or
23. Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
24. Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.
25. Inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.
26. Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
27. Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
28. Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

1. Illness, accident, treatment or medical condition arising out of:
   - i. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
   - ii. service in the Armed Forces or units auxiliary thereto;
   - iii. suicide, attempted suicide or intentionally self-inflicted injury;
   - iv. aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and,
   - v. with respect to blanket insurance, interscholastic sports.
2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
3. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;
4. Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
5. ILLEGAL OCCUPATION: Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
6. INTOXICANTS AND NARCOTICS: Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

P.O. Box 19199
Plantation, FL 33318
Telephone: 877-760-2247
Fax: 954-370-1701
www.SolsticeInsurance.com

SOLSTICE
S500A
Summary of Benefits

Members of the Solstice S500A dental plan are eligible to receive Benefits immediately upon the effective date of coverage with:

- No Benefit Waiting Periods
- No Deductibles
- No Claim Forms to Submit

The Member Copayments listed are offered by a Participating Provider. The Member receives:

- Most diagnostic and preventive care at no charge
- Cosmetic and orthodontia treatment Covered

Members can choose a Participating Provider at
www.SolsticeInsurance.com

Member Services Department: 1.877.760.2247

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

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

CODE	DESCRIPTION	MEMBER COPAY
	appointments	
D0120	Periodic oral evaluation, established patient	No charge
D0140	Limited oral evaluation - problem focused	No charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge
D0150	Comprehensive oral evaluation - new or established patient	No charge
D0160	Detailed and extensive oral evaluation - problem focused	No charge
D0170	Re-evaluation - limited, problem focused	No charge
D0180	Comprehensive periodontal evaluation - new or established patient	No charge
D9110	Palliative (emergency) treatment of dental pain	No charge
D9430	Office visit for observation/OSHA	No charge
D9440	Office visit - after regularly scheduled hours	30.00
	RaDioGRapHY / DiaGnostiC DentistRY	
D0210	*X-Ray - intraoral - complete series (including bitewings)	No charge
D0220	X-Ray - intraoral - periapical first film	4.00
D0230	X-Ray - intraoral - periapical each additional film	2.00
D0240	X-Ray - intraoral - occlusal film	No charge
D0250	X-Ray - extraoral - first film	No charge
D0260	X-Ray - extraoral - each additional film	No charge
D0270	*X-Ray - bitewing - single film	No charge
D0272	*X-Ray - bitewing - two films	No charge
D0273	*X-Ray - bitewing - three films	No charge
D0274	*X-Ray - bitewing - four films	No charge
D0277	*Vertical bitewings - 7 to 8 films	27.00
	Not to be taken if D0274 was done within prior six months. Copies of X-rays can be obtained for $2.00 per periapical film up to a maximum of $30.00. Panoramic X-rays can be obtained for a $15.00 fee.	
D0290	Posterior-anterior or lateral skull and facial bone survey	150.00
D0310	Sialography	150.00
D0320	TMJ, including injection	250.00
D0321	Other TMJ films, by report	150.00
D0322	Tomographic survey	150.00
D0330	Panoramic film (not to replace FMX)	45.00
D0340	Cephalometric film, non-orthodontic	100.00
D0350	Oral/facial photographic images (includes intra & extraoral)	20.00
D0415	Collection of microorganisms for culture and sensitivity	No charge
D0425	Caries susceptibility tests	No charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	65.00
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts	No charge
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Charge
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	No Charge
	pReVentiVe DentistRY	
D1110	Routine prophylaxis-adult (once every 6 months)	No charge
D1110	Additional routine prophylaxis - adult	15.00
D1120	Routine prophylaxis - children under the age of 16 (once every 6 months)	No charge
D1120	Additional routine prophylaxis - children under the age of 16)	15.00
D1203	Topical application of fluoride (excluding prophylaxis) children under the age of 16	No charge
D1204	Topical application of fluoride (excluding prophylaxis) adult	10.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	10.00
D1310	Nutritional counseling for control of dental disease	No charge
D1320	Tobacco counseling for the control & prevention of oral disease	No charge

Solstice Health Insurance Company is a licensed Accident and Health Insurance Company under New York Insurance Law Section 1113(a)(3)

CODE	DESCRIPTION	MEMBER COPAY
D1330	Oral hygiene instructions	No charge
D1351	Application of sealant per tooth - children under the age of 16	No charge
D1510	Space maintainer - fixed - unilateral - children under the age of 16	No charge
D1515	Space maintainer - fixed - bilateral - children under the age of 16	No charge
D1520	Space maintainer - removable - unilateral - children under the age of 16	No charge
D1525	Space maintainer - removable - bilateral - children under the age of 16	No charge
D1550	Recementation of space maintainer	10.00
D1555	Removal of fixed space maintainer	10.00
D8210	Removable appliance therapy	103.00
D8220	Fixed appliance therapy	103.00
	RestoRatiVe DentistRY	
D2140	Amalgam - 1 surface, primary or permanent	No charge
D2150	Amalgam - 2 surfaces, primary or permanent	No charge
D2160	Amalgam - 3 surfaces, primary or permanent	No charge
D2161	Amalgam - 4 surfaces, primary or permanent	No charge
D2330	Resin-based composite - 1 surface, anterior	25.00
D2331	Resin-based composite - 2 surfaces, anterior	35.00
D2332	Resin-based composite - 3 surfaces, anterior	45.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, anterior	75.00
D2390	Resin-based composite crown, anterior	105.00
D2391	Resin-based composite - 1 surface, posterior	55.00
D2392	Resin-based composite - 2 surfaces, posterior	70.00
D2393	Resin-based composite - 3 surfaces, posterior	85.00
D2394	Resin-based composite - 4 or more surfaces, posterior	105.00
D2410	Gold foil - 1 surface	70.00
D2420	Gold foil - 2 surfaces	92.00
D2430	Gold foil - 3 surfaces	120.00
D2510	Inlay - metallic - 1 surface	85.00
D2520	Inlay - metallic - 2 surfaces	96.00
D2530	Inlay - metallic - 3 or more surfaces	120.00
D2542	Onlay - metallic - 2 surfaces	290.00
D2543	Onlay - metallic - 3 surfaces	300.00
D2544	Onlay - metallic - 4 or more surfaces	330.00
D2610	Inlay - porcelain/ceramic - 1 surface	250.00*
D2620	Inlay - porcelain/ceramic - 2 surfaces	275.00*
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	300.00*
D2642	Onlay - porcelain/ceramic - 2 surfaces	335.00*
D2643	Onlay - porcelain/ceramic - 3 surfaces	365.00*
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	375.00*
D2650	Inlay - resin-based composite - 1 surface	195.00
D2651	Inlay - resin-based composite - 2 surfaces	220.00
D2652	Inlay - resin-based composite - 3 or more surfaces	255.00
D2662	Onlay - resin-based composite - 2 surfaces	230.00
D2663	Onlay - resin-based composite - 3 surfaces	250.00
D2664	Onlay - resin-based composite - 4 or more surfaces	280.00
D2710	Crown – resin-based composite (indirect)	195.00
D2712	Crown – ¾ resin-based composite (indirect)	195.00
D2720	Crown - resin with high noble metal	240.00*
D2721	Crown - resin with predominantly base metal	240.00*
D2722	Crown - resin with noble metal	240.00*
D2740	Crown - porcelain/ceramic substrate	240.00*
D2750	Crown - porcelain fused to high noble metal	240.00*
D2751	Crown - porcelain fused to predominantly base	
D2752	Crown - porcelain fused to noble metal	240.00*
D2780	Crown - 3/4 cast high noble metal	240.00*
D2781	Crown - 3/4 cast predominantly base metal	240.00*
D2782	Crown - 3/4 cast noble metal	240.00*
D2783	Crown - 3/4 porcelain/ceramic	240.00*
D2790	Crown - full cast high noble metal	240.00*
D2791	Crown - full cast predominantly base metal	220.00*
D2792	Crown - full cast noble metal	220.00*
D2799	Provisional crown	125.00
D2910	Recement inlay, onlay, or partial coverage restoration	10.00
D2915	Recement cast or prefabricated post and core	10.00
D2920	Recement crown	10.00
D2930	Prefabricated stainless steel crown - primary tooth	40.00
D2931	Prefabricated stainless steel crown - permanent tooth	40.00
D2932	Prefabricated resin crown	92.00
D2933	Prefabricated stainless steel crown with resin window	140.00
D2940	Sedative filling	10.00
D2950	Core build up, including any pins	40.00
D2951	Pin retention - per tooth, in addition to restoration	12.00
D2952	Cast post and core in addition to crown	85.00
D2953	Each additional cast post - same tooth	95.00
D2954	Prefabricated post and core in addition to crown	75.00
D2955	Post removal (not in conjunction with endodontic therapy)	25.00
D2957	Each additional prefabricated post - same tooth	30.00
D2960	Labial veneer (resin laminate) - chair side	200.00
D2961	Labial veneer (resin laminate) - laboratory	225.00*
D2962	Labial veneer (porcelain laminate) - laboratory	350.00*
D2970	Temporary crown (fractured tooth)	75.00
D2980	Crown repair, by report	95.00
	When crown and/or bridgework exceeds six (6) consecutive units, an additional charge of $30.00 per unit applies.	
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D3110	Pulp cap - direct (excluding final restoration)	20.00
D3120	Pulp cap - indirect (excluding final restoration)	20.00
D3220	Therapeutic pulpotomy (excluding final restoration)	25.00
D3221	Pulpal debridement, primary and permanent teeth	95.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary	45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary	40.00
D3310	Endodontic therapy - anterior (excluding final restoration)	100.00
D3320	Endodontic therapy - bicuspid (excluding final restoration)	185.00
D3330	Endodontic therapy - molar (excluding final restoration)	225.00
D3331	Treatment of root canal obstruction; non-surgical access	85.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75.00
D3333	Internal root repair of perforation defects	125.00
D3346	Retreatment of previous root canal therapy - anterior	280.00
D3347	Retreatment of previous root canal therapy - bicuspid	305.00
D3348	Retreatment of previous root canal therapy - molar	380.00
D3351	Apexification/recalcification - initial visit	90.00
D3352	Apexification/recalcification - interim medication replacement	90.00
D3353	Apexification/recalcification - final visit	90.00
D3410	Apicoectomy/periradicular surgery - anterior	96.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	305.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	320.00
D3426	Apicoectomy/periradicular surgery - each additional root	80.00
D3430	Retrograde filling - per root	60.00
D3450	Root amputation - per root	100.00
D3470	Intentional reimplantation (including splinting)	175.00
D3910	Surgical procedure for isolation of tooth with rubber dam	95.00
D3920	Hemisection (including root removal)	85.00
D3950	Canal preparation and fitting of preformed dowel or post	75.00
	peRioDontiC seRViCes	
D4210	Gingivectomy/gingivoplasty - 4 or more	
D4211	Gingivectomy/gingivoplasty - 1 to 3 teeth per quad	72.00
D4240	Gingival flap procedure, including root planing - 4 or more teeth per quad	187.00
D4241	Gingival flap procedure, including root planing - 1 to 3 teeth per quad	175.00
D4245	Apically positioned flap	150.00
D4249	Clinical crown lengthening - hard tissue	175.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth per quad	375.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quad	325.00
D4263	Bone replacement graft - first site in quad	450.00
D4264	Bone replacement graft - each additional site in quad	325.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	325.00
D4266	Guided tissue regeneration - resorbable barrier, per site	325.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site	325.00
D4270	Pedicle soft tissue graft procedure	240.00
D4271	Free soft tissue graft procedure (including donor site surgery)	215.00

CODE	DESCRIPTION	MEMBER COPAY
D4273	Subepithelial connective tissue graft procedures	300.00
D4274	Distal or proximal wedge procedure	120.00
D4275	Soft tissue allograft	502.00
D4320	Provisional splinting - intracoronal	115.00
D4321	Provisional splinting - extracoronal	105.00
D4341	Periodontal scaling and root planing - 4 or more contiguous teeth per quad	45.00†
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quad	35.00†
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	35.00†
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth	45.00†
D4910	Periodontal maintenance	45.00
D4910	Additional periodontal maintenance procedures	100.00
D4920	Unscheduled dressing change (by someone other than the treating dental office)	25.00
D4999	Periodontal charting for planning treatment of periodontal disease	No Charge
D4999	Periodontal hygiene instruction	No Charge
	PROSTHODONTICS - REMOVABLE	
D5110	Complete denture - maxillary	260.00*
D5120	Complete denture - mandibular	260.00*
D5130	Immediate denture - maxillary (including two relines)	280.00*
D5140	Immediate denture - mandibular (including two relines)	280.00*
D5211	Maxillary partial denture - resin base (including clasps)	260.00*
D5212	Mandibular partial denture - resin base (including clasps)	260.00*
D5213	Partial denture - maxillary cast metal - acrylic	280.00*
D5214	Partial denture - mandibular cast metal - acrylic	280.00*
D5225	Maxillary partial denture – flexible base	280.00*
D5226	Mandibular partial denture – flexible base	280.00*
D5281	Removable unilateral partial denture - one piece cast metal	240.00*
D5410	Adjustment - complete denture - maxillary	10.00
D5411	Adjustment - complete denture - mandibular	10.00
D5421	Adjustment - partial denture - maxillary	15.00
D5422	Adjustment - partial denture - mandibular All denture adjustment charges are for dentures which were not fabricated in the present office; all denture adjustments for new dentures or dentures made within twelve (12) months are at no charge.	15.00
D5510	Repair broken complete denture base	15.00
D5520	Replace missing or broken tooth - complete denture (each tooth)	10.00
D5610	Repair denture resin base	15.00
D5620	Repair cast framework	30.00
D5630	Repair or replace broken clasp	15.00
D5640	Repair broken teeth - per tooth	10.00
D5650	Add tooth to existing partial denture	30.00
D5660	Add clasp to existing partial denture	30.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	100.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	100.00
D5710	Rebase complete maxillary denture	75.00
D5711	Rebase complete mandibular denture	75.00
D5720	Rebase maxillary partial denture	75.00
D5721	Rebase mandibular partial denture	75.00
D5730	Reline complete maxillary denture - chair side	45.00
D5731	Reline complete mandibular denture - chair side	45.00
D5740	Reline partial maxillary denture - chair side	45.00
D5741	Reline partial mandibular denture - chair side	45.00
D5750	Reline complete maxillary denture - laboratory	35.00*
D5751	Reline complete mandibular denture - laboratory	35.00*
D5760	Reline partial maxillary denture - laboratory	35.00*
D5761	Reline partial mandibular denture - laboratory	35.00*
D5810	Interim complete denture - maxillary	250.00*
D5811	Interim complete denture - mandibular	250.00*
D5820	Interim partial denture - maxillary	250.00*
D5821	Interim partial denture - mandibular	250.00*
D5850	Tissue conditioning - maxillary	25.00
D5851	Tissue conditioning - mandibular	25.00
D5862	Precision attachment	150.00
D5899	Denture cleaning	No charge

CODE	DESCRIPTION	MEMBER COPAY
	PROSTHODONTICS - FIXED	
D6210	Pontic - cast high noble metal	220.00*
D6211	Pontic - cast predominantly base metal	220.00*
D6212	Pontic - cast noble metal	220.00*
D6240	Pontic - porcelain fused to high noble metal	240.00*
D6241	Pontic - porcelain fused to predominantly base metal	240.00*
D6242	Pontic - porcelain fused to noble metal	240.00*
D6245	Pontic - porcelain/ceramic	300.00*
D6250	Pontic - resin with high noble metal	240.00*
D6251	Pontic - resin with predominantly base metal	240.00*
D6252	Pontic - resin with noble metal	240.00*
D6253	Provisional pontic	No Charge
D6545	Retainer - cast metal for resin bonded fixed prosthesis	180.00*
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00*
D6600	Inlay – porcelain/ceramic, two surfaces	240.00*
D6601	Inlay – porcelain/ceramic, three or more surfaces	240.00*
D6602	Inlay – cast high noble metal, two surfaces	240.00*
D6603	Inlay – cast high noble, three or more surfaces	240.00*
D6604	Inlay – cast predominantly base metal, two surfaces	240.00*
D6605	Inlay – cast predominantly base metal, three or more surfaces	240.00*
D6606	Inlay – cast noble metal, two surfaces	240.00*
D6607	Inlay – cast noble metal, three or more surfaces	240.00*
D6608	Onlay – porcelain/ceramic, two surfaces	240.00*
D6609	Onlay – porcelain/ceramic, three or more surfaces	240.00*
D6610	Onlay – cast high noble metal, two surfaces	240.00*
D6611	Onlay – cast high noble metal, three or more surfaces	240.00*
D6612	Onlay – cast predominantly base metal, two surfaces	240.00*
D6613	Onlay – cast predominantly base metal, three or more surfaces	240.00*
D6614	Onlay – cast noble metal, two surfaces	240.00*
D6615	Onlay – cast noble metal, three or more surfaces	240.00*
D6710	Crown – indirect resin based composite	240.00
D6720	Crown - resin with high noble metal	240.00*
D6721	Crown - resin with predominantly base metal	240.00*
D6722	Crown - resin with noble metal	240.00*
D6740	Crown - porcelain/ceramic	240.00*
D6750	Crown - porcelain fused to high noble metal	240.00*
D6751	Crown - porcelain fused to predominantly base metal	240.00*
D6752	Crown - porcelain fused to noble metal	240.00*
D6780	Crown - 3/4 cast high noble metal	240.00*
D6781	Crown - 3/4 cast predominantly base metal	240.00*
D6782	Crown - 3/4 cast noble metal	240.00*
D6783	Crown - 3/4 porcelain/ceramic	240.00*
D6790	Crown - full cast high noble metal	220.00*
D6791	Crown - full cast predominantly base metal	220.00*
D6792	Crown - full cast noble metal	220.00*
D6930	Recement fixed partial denture	10.00
D6940	Stress breaker	125.00
D6950	Precision attachment	195.00
D6970	Cast post and core in addition to fixed partial denture retainer	65.00
D6971	Cast post as part of fixed partial denture retainer	60.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	50.00
D6973	Core build up for retainer, including pins	50.00
D6975	Coping - metal	95.00
D6976	Each additional cast post - same tooth	75.00
D6977	Each additional prefabricated post - same tooth	75.00
D6980	Fixed partial denture repair	80.00
	ORAL SURGERY	
D7111	Coronal remnants - deciduous tooth	45.00
D7140	Extraction of erupted tooth or exposed root	10.00
D7210	Surgical removal of erupted tooth	25.00
D7220	Removal of impacted tooth - soft tissue	40.00
D7230	Removal of impacted tooth - partially bony	60.00
D7240	Removal of impacted tooth - completely bony	75.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	128.00
D7250	Surgical removal of residual tooth roots	25.00
D7260	Oroantral fistula closure	160.00
D7270	Tooth reimplantation	50.00
D7280	Surgical access of an unerupted tooth	125.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	115.00
D7286	Biopsy of oral tissue - soft (all others)	75.00

CODE	DESCRIPTION	MEMBER COPAY
D7287	Exfoliative cytological sample collection	65.00
D7288	Brush biopsy – transepithelial sample collection	25.00
D7310	Alveoloplasty with extractions - per quad	20.00
D7311	Alveoloplasty with extractions - one to three teeth, per quad	20.00
D7320	Alveoloplasty without extractions - per quad	50.00
D7321	Alveoloplasty without extractions – one to three teeth, per quad	50.00
D7450	Removal of odontogenic cyst or tumor up to 1.25 cm	65.00
D7451	Removal of odontogenic cyst or tumor greater than 1.25 cm	95.00
D7471	Removal of lateral exostosis	95.00
D7472	Removal of torus palatinus	95.00
D7473	Removal of torus mandibularis	95.00
D7485	Surgical reduction of osseous tuberosity	95.00
D7510	Incision and drainage of abscess - intraoral soft tissue	20.00
D7511	Incision and drainage of abscess – intraoral soft tissue - complicated	20.00
D7520	Incision and drainage of abscess – extraoral soft tissue	20.00
D7521	Incision and drainage of abscess – extraoral soft tissue - complicated	20.00
D7910	Suture of recent small wounds up to 5 cm	35.00
D7960	Frenulectomy - separate procedure	90.00
D7963	Frenuloplasty	90.00
D7970	Excision of hyperplastic tissue - per arch	140.00
D7971	Excision of pericoronal gingiva	102.00
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D9120	Fixed partial denture sectioning	No charge
D9210	Local anesthesia not in conjunction with operative or surgical procedures	No charge
D9215	Local anesthesia	No charge
D9220	Deep sedation, general anesthesia - first 30 minutes	125.00
D9221	Deep sedation, general anesthesia - each additional 15 minutes	15.00
D9230	Analgesia nitrous oxide - per 1/2 hour	20.00
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	125.00
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	55.00
D9610	Therapeutic drug injection, by report	15.00
D9630	Oral irrigation/other drugs/medicament - per quad	15.00
D9910	Application of desensitizing medicament	20.00
D9940	Occlusal guard	250.00
D9942	Repair and/or reline of occlusal guard	40.00
D9950	Occlusal analysis - mounted case	75.00
D9951	Occlusal adjustment - limited	25.00
D9952	Occlusal adjustment - complete	95.00
D9972	External bleaching - per arch	150.00
D9972	External bleaching - both arches (excluding bleaching material for home use)	275.00
	Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence outside the service area (Florida).	
	oRtHoDontia	
D8660	Pre-orthodontic treatment visit	35.00
D8999	Orthodontic treatment plan & records	250.00
D8010	Limited orthodontic treatment of the primary dentition (up to 24 months)	1,000.00
D8020	Limited orthodontic treatment of the transitional dentition (up to 24 months)	1,000.00
D8030	Limited orthodontic treatment of the adolescent dentition (up to 24 months)	1,000.00
D8040	Limited orthodontic treatment of the adult dentition (up to 24 months)	1,350.00
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case up to 24 months - including fixed/removable appliances)	2,000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	2,050.00
D8090	Comprehensive orthodontic treatment of the adult dentition (full treatment case up to 24 months - including fixed/removable appliances)	2,150.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) - includes fee for fixed/removable retainers and monthly visits)	300.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	20.00

Orthodontic treatment is prorated over 24 months and is only payable under a current status. Solstice bears no liability towards treatment unable to be completed due to a terminated status.

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 services. Therefore, you are encouraged to secure availability of the scheduled 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 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 Copayment.

NON-COVERED SERVICES

1. Services performed by a General Dentist or 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 and/or experimental in nature, as determined by the Participating 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. Bleaching materials for home use related to D9972.

LIMITATIONS

1. Any oral evaluation (excluding problem-focused) is limited to one (1) time in any six (6) consecutive month period at no charge. All subsequent oral evaluations (excluding problem-focused) will be at a 25% reduction off the Provider's usual and customary fee without a frequency limitation.
2. All bitewing X-rays are limited to one (1) set in any twelve (12) consecutive month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one (1) in any six (6) consecutive 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 for children under the age of 16.
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, fixed bridges or dentures is limited to one (1) time per five (5) year period.
11. When crown and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
12. Copayments for endodontic procedures do not include the cost of the final restoration.
13. Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to the Member is as follows:
    - High noble metal (precious) up to $145.00
    - 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, 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 or D0330 are reimbursable one (1) time per five (5) year period.
16. Copies of X-rays can be obtained for $2.00 per periapical film up to a maximum of $30.00. Panoramic X-ray can be obtained for a $15.00 fee.
17. D0274, D0277 or D0210 are payable only when other inclusive films 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 adjustments for new dentures made within twelve (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 teeth 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 Orthodontic Copayment plus the difference in cost for the enhanced treatment.

IMPORTANT DISCLAIMER

The above Summary of Benefits is for informational purposes only and is not an offer of coverage. For a complete listing of your coverage, including specialty services, non covered services, exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the Certificate of Coverage/benefits administrator will govern. All terms and conditions and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Solstice

Solstice Vision Plan IC 4

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

Out-of-Network Reimbursement Schedule: up to

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

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

One-year eyeglass breakage warranty included

Solstice Enrollment/Change Form

Solstice
P.O. Box 19199
Plantation, FL 33318
Office 1.877.760.2247
Fax 954.370.1701

Effective Date (MM/DD/YYYY)

	/		/	
	/		/	

PLEASE MARK APPROPRIATE BOX

☐ New enrollment ☐ Change of plan ☐ Change of name ☐ Waive
☐ Change of address ☐ Change of dependents ☐ Reinstate Terminated employment

Group, Association, or Employer Name

Group Number

NOTE : PLEASE COMPLETE ALL INFORMATION

SOCIAL SECURITY # - -	**NAME** (Last, First, Middle Initial)	**DATE OF BIRTH** *(MM/DD/YYYY)* / /

ADDRESS / CITY / STATE /ZIP

DATE EMPLOYED *(MM/DD/YYYY)* / /	**TELEPHONE NUMBER** ( ) -	**GENDER** ☐ Male ☐ Female	**EMAIL ADDRESS**

SELECT YOUR PLAN (Refer to your Schedule of Benefits for plan details)
☐ Dental ☐ Vision ☐ Other (If multiple plan options have been offered, please write in plan selection below)

FAMILY INFORMATION

RELATIONSHIP	NAME (Include last name if different)	SOCIAL SECURITY #	SEX	DATE OF BIRTH *(MM/DD/YYYY)*	(CHECK ONE)
SPOUSE		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel

Please submit proof of handicapped status for over age dependents. I hereby apply for benefits for which I am eligible as either an employee or association member. If contributions or fees are required, I authorize my employer to deduct such fees from my salary.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have read and accept the provisions printed above	**SIGNATURE**	**DATE** / /

Solstice Health Insurance Company is a licensed Accident and Health Insurance Company under New York Insurance Law Section 1113(a)(3)
SHI-ENR-01-01-NY0914

Billing Application

Requested effective date (mm/dd/year) ____/____/____

Billing Information – Invoices should be sent to:

Contact Person **Title**

Company Name

Address

City **State** **Zip Code**

Telephone **Fax**

Rep: _____

Payment Options:

☐ EFT-Direct Withdrawal (No Charge, please complete authorization form below)

☐ Monthly Invoice ($20 Billing Fee)

EFT AUTHORIZATION

Please Note there is a $30 Insufficient Funds Fee

Bank Route Code#_____ Bank Account#_____

Please deduct payment of $_____ between the 21st & 26th of the month Prior to the next months coverage.

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by sending written notification by fax to (914) 428-8080 three (3) business days or more before this payment is scheduled to be made. **Please be aware that your bank statement will reflect the debit as Nu Era Benefits.**

Signature of Depositor: _____

Date: ____/____/_____

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY