HealthPass℠ / ANCILLARY EXCHANGE

Solstice Dental PPO

Dental PPO Rates

	Four Tier
Employee	**$58.90**
Employee/Spouse	**$105.14**
Employee/Child(ren)	**$125.82**
Family	**$163.04**

About Solstice Dental PPO

From a cleaning, to dental implants Solstice dental offers members more than just basic care. With Solstice Dental PPO, all covered services In-Network are based on a percentage of the fixed charges and varies whether the procedure is preventive, basic or a major service. Specialist referrals are not necessary In and Out-of-Network. If you choose to go Out-of-Network, most dentists will submit your claims directly to Solstice.

Plan Highlights

- Includes 4 cleanings in any 12 consecutive months
- In and Out-of-Network benefits
- $50 deductible/$150 deductible family
- $2,000 In-Network and $1,000 Out-of-Network calendar year maximum
- Implant benefit is covered
- Dependent coverage until the end of the year in which the child turns 30 years of age

The following billing and administrative fees apply to the Solstice PPO plan: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $18.25, Family $26.50
Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers.
Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.

Dental PPO Summary of Benefits Effective

	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)*	$2000 per person per Calendar Year	$1000 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)*	No	
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 (4) prophylaxis in any twelve (12) consecutive months, to a maximum of (4) 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)	100%	80%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	100%	80%	Limited to one (1) time per tooth per lifetime.
Anesthetics	100%	80%	General Anesthesia: When clinically necessary.
Adjunctive Services	100%	80%	
MAJOR SERVICES			
Oral Surgery (includes surgical extractions)	60%	50%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics	60%	50%	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	60%	50%	
Inlays/Onlays/Crowns/Implants	60%	50%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	60%	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)	60%	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 80th Percentile of Usual and Customary Charge.

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.

BITEWING 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
(4) prophylaxis in any twelve (12) consecutive months, to a maximum of (4) 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.