

# Dental care clear and simple

Imagine paying less for all these benefits. That's the Solstice S700 Plan from UnitedHealthcare Dental\*.

## People First Plan Code 4014

Tier	Monthly Premiums
Employee Only	\$10.91
Employee & Spouse	\$23.95
Employee & Child(ren)	\$29.90
Employee & Family	\$41.98



### Our plan offers you:

- Low premiums
- No primary dentist selection required, EVER
- Preventive services including sealants for children at no charge
- No waiting periods OR claim forms to submit
- Children can see their network Pediatric Dentist up to the age of 16
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included at a copayment level
- 3,700-plus provider network
- No referrals are necessary
- You can make appointments at your convenience

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UnitedHealthcare Dental®

## Plan Benefits – People First Plan Code 4014

No Benefit Maximum — In-Network Open Access

Solstice S700 Plan From UnitedHealthcare Dental		
Typical Annual Cost	What You Pay	
	With Our S700 Dental Coverage	Without Dental Coverage
<b>Adult</b>		
Two Periodic Exams	\$0	\$102
Bitewing X-Rays (Four Films)	\$0	\$62
Two Routine Cleanings	\$0	\$172
One Resin/Composite 1-Surface Filling (Anterior)	\$30	\$161
Anterior Root Canal	\$110	\$844
Porcelain Crown*	\$245	\$1,163
<b>TOTAL</b>	<b>\$385</b>	<b>\$2,504</b>

Solstice S700 Plan From UnitedHealthcare Dental		
Typical Annual Cost	What You Pay	
	With Our S700 Dental Coverage	Without Dental Coverage
<b>Child</b>		
Two Periodic Exams	\$0	\$102
Bitewing X-Rays (Two Films)	\$0	\$43
Two Routine Cleanings	\$0	\$130
One Fluoride Treatment	\$0	\$37
Single Extraction	\$20	\$168
<b>TOTAL</b>	<b>\$20</b>	<b>\$480</b>

\* Please see exclusions and limitations for details. This comparison is based on national averages.

## Prenatal Dental Care Program

Taking care of your teeth and gums during your pregnancy is an important part of your and your unborn child's overall good health and well-being. Experts say that disease related to the gums and tooth-support structures (periodontal disease) during pregnancy could lead to an increased risk of pre-term delivery.

That's why we've created a UnitedHealthcare Dental program which provides additional network preventive dental care coverage for expectant mothers. If you are in your second or third trimester of pregnancy, you are eligible for this program's benefits as part of your benefit plan.

On your next visit, tell your dentist that you are pregnant. Provide the stage of your pregnancy and due date, and also make sure the dentist notes your attending physician's or obstetrician's name (this must be included on the claim form). All fees and expenses for cleanings, deep scaling (cleaning the teeth deeper down the tooth), debridement (removing dead or infected tissue) and periodontal maintenance will be waived, if your dentist determines you require these procedures.



## Informative Web site and Toll-Free Number for Our Customer Service

For more information, call UnitedHealthcare Dental Customer Service at (800) 980-0292, or visit [myuhcdental.com/statefl](http://myuhcdental.com/statefl)

## Dental Benefits at [myuhcdental.com/statefl](http://myuhcdental.com/statefl)

Get the most out of your dental benefits! [myuhcdental.com/statefl](http://myuhcdental.com/statefl) has practical tools and personalized information for your dental care. Register at [myuhcdental.com/statefl](http://myuhcdental.com/statefl) and connect to view, learn about and manage your dental benefits.



### Great reasons to use [myuhcdental.com/statefl](http://myuhcdental.com/statefl)

1. Locate and get information about dentists and specialists.
2. Compare costs for treatments.
3. Learn about dental health conditions, treatments and procedures.
4. Learn more about your coverage.
5. Request a dental ID card.

# People First Plan Code 4014

## Commonly Covered Procedures

	What You Pay	
	With Our \$700 Dental Coverage	Without Dental Coverage
<b>Diagnostic/Preventive</b>		
Oral Evaluation	\$0	\$51
Consultation	\$25	\$117
Office Visit for Observation	\$0	\$52
Prophylaxis - Adult	\$0	\$86
Prophylaxis - Adult <sup>1</sup>	\$20	\$86
Prophylaxis - Child	\$0	\$65
Prophylaxis - Child <sup>1</sup>	\$20	\$65
Fluoride App (Adlt) (Inc Prophylaxis)	\$15	\$95
Fluoride App (Adlt) (Exc Prophylaxis)	\$15	\$36
Fluoride App (Chd) (Inc Prophylaxis)	\$0	\$40
Fluoride App (Chd) (Exc Prophylaxis)	\$0	\$37
X-Rays Intraoral - Complete Series	\$0	\$126
X-Rays Intraoral - Periapical First Film	\$4	\$28
X-Rays Intraoral - Periapical Add'l Film	\$2	\$25
X-Rays Intraoral - Occlusal Film	\$0	\$36
X-Rays Extraoral - First Film	\$0	\$48
X-Rays Extraoral - Add'l Film	\$0	\$45
X-Rays (Bitewing) - Single Film	\$0	\$29
X-Rays (Bitewing) - Two Films	\$0	\$43
X-Rays (Bitewing) - Four Films*	\$0	\$62
Vertical Bitewings (7-8 Films)*	\$29	\$89
X-Rays-Panoramic (not to replace FMX)	\$50	\$109
Diagnostic Casts	\$0	\$116
Sealant (Per Tooth)	\$0	\$49
Removable Appliance Therapy	\$103	\$432
Fixed Appliance Therapy	\$103	\$535
Re-Cementation of Space Maintainer	\$15	\$71
Oral Hygiene Instructions	\$0	\$45
<b>Restorative (Fillings)</b>		
Amalgam - 1 Surface, Primary/Perm	\$0	\$162
Amalgam - 2 Surface, Primary/Perm	\$0	\$200
Amalgam - 3 Surface, Primary/Perm	\$0	\$259
Amalgam - 4+ Surface, Primary/Perm	\$0	\$310
Resin-Based Comp - 1 Sfce, Anterior	\$30	\$161
Resin-Based Comp - 2 Sfce, Anterior	\$37	\$190
Resin-Based Comp - 3 Sfce, Anterior	\$50	\$242
Resin-Based Comp - 4+ Sfce, Anterior	\$80	\$291
Resin-Based Comp - Crown, Anterior	\$115	\$381
Resin-Based Comp - 1 Sfce, Posterior	\$65	\$171
Resin-Based Comp - 2 Sfce, Posterior	\$75	\$217
Resin-Based Comp - 3 Sfce, Posterior	\$90	\$277
Resin-Based Comp - 4+ Sfce, Posterior	\$115	\$329
Inlay-Metallic - 1 Surface	\$225	\$759
Inlay-Metallic - 2 Surfaces	\$235	\$867
Inlay-Metallic - 3+ Surfaces	\$245	\$1,034
<b>Crown &amp; Bridges</b>		
Crown - Porcelain/Ceramic Substrate*	\$245	\$1,163
Crown - Porcelain Fused to High Noble Metal*	\$245	\$1,066
Crown - Porcelain Fused to Base Metal*	\$245	\$1,007
Crown - Porcelain Fused to Noble Metal*	\$245	\$1,031
Crown - Resin (indirect)	\$195	\$445
Crown - Full-Cast Noble Metal*	\$245	\$1,061
Recement Crown	\$15	\$102
Sedative Filling	\$15	\$116
Core Buildup, Including Any Pins	\$70	\$261
Prefab Post & Core in addition to Crown	\$75	\$316
Post Removal	\$30	\$278
Temporary Crown (Fractured Tooth)	\$75	\$334
Crown Repair	\$95	\$263
<b>Endodontics (Root Canal Treatment, Excluding Final Restorations)</b>		
Pulp Cap - Direct (Excluding Final Restoration)	\$25	\$116
Pulp Cap - Indirect (Excluding Final Restoration)	\$25	\$82
Pulpal Debridement	\$95	\$243
Therapeutic Pulpotomy <sup>2</sup>	\$30	\$213
Anterior Root Canal (Permanent Tooth) <sup>2</sup>	\$110	\$844
Bicuspid Root Canal (Permanent Tooth) <sup>2</sup>	\$195	\$946

	What You Pay	
	With Our \$700 Dental Coverage	Without Dental Coverage
Molar Root Canal (Permanent Tooth) <sup>2</sup>	\$245	\$1,135
Retrograde Filling - Per Root	\$75	\$258
Root Amputation - Per Root	\$110	\$653
Hemisection	\$90	\$428
Canal Preparation/Fitting	\$75	\$201
Intentional Reimplantation (Including Splinting)	\$175	\$1,056
<b>Periodontics (Treatment of Supporting Tissues [Gum/Bone] of the Teeth)</b>		
Comprehensive Periodontal Evaluation	\$0	\$110
Periodontal Scaling & Root Planing (1-3 Teeth) <sup>3*</sup>	\$43	\$173
Periodontal Scaling & Root Planing(4+ Teeth) <sup>3*</sup>	\$50	\$259
Full-Mouth Debridement	\$50	\$161
Periodontal Maintenance	\$50	\$128
Unscheduled Dressing Change	\$25	\$105
Gingival Flap Procedure (Inc Root Planing) 1-3 teeth	\$185	\$591
Gingival Flap Procedure (Inc Root Planing) 4 or more teeth, per quad	\$195	\$1,014
Apically Positioned Flap	\$150	\$481
<b>Prosthetics</b>		
Complete Denture - Maxillary*	\$325	\$1,459
Complete Denture - Mandibular*	\$325	\$1,453
Maxillary Part Dent - Resin Base (Inc Clasp)*	\$400	\$1,067
Mandibular Part Dent - Resin Base (Inc Clasp)*	\$400	\$1,078
Adjustment-Maxillary - Complete	\$15	\$83
Adjustment-Mandibular - Complete	\$15	\$81
Precision Attachment	\$150	\$560
Denture Cleaning	\$0	\$395
Add Tooth to Existing Partial Denture*	\$35	\$193
Add Clasp to Existing Partial Denture*	\$35	\$254
<b>Oral Surgery (Includes Routine Post-Operative Treatment)</b>		
Extraction (Single Tooth)	\$20	\$168
Surgical Extraction Erupted Tooth	\$30	\$278
Coronal Remnants	\$50	\$126
Removal of Impacted Tooth (Sft Tissue)	\$50	\$338
Removal of Impacted Tooth (Prt Bony)	\$65	\$397
Removal of Impacted Tooth (Bony)	\$80	\$465
Removal of Impacted Tooth (Bony with Surgical Complications)	\$135	\$596
Surgical Removal of Resid Tooth Roots	\$40	\$292
Oroantral Fistula Closure	\$160	\$1,113
Tooth Reimplantation	\$50	\$512
Surgical Access of an Unerupted Tooth	\$125	\$544
Surgical Exposure of Impacted/Unerupted	\$125	\$327
Biopsy of Oral Tissue - Hard	\$125	\$838
Biopsy of Oral Tissue - Soft	\$85	\$382
Alveoplasty w/Extractions (p/quad)	\$40	\$317
Alveoplasty w/out Extractions (p/quad)	\$60	\$430
Incision/Drainage of Abscess Intraoral	\$20	\$244
Frenulectomy	\$105	\$466
Excision of Hyperplastic Tissue (p/arch)	\$140	\$420
<b>Orthodontics (Tooth Movement)</b>		
Pre-Orthodontic Treatment Visit	\$35	\$88
Orthodontic Treatment Plan and Records	\$250	\$593
Limited Orthodontic Tx (Up to 24 Mos)		
Transitional Dentition	\$1,000	\$2,000
Adolescent Dentition	\$1,000	\$2,500
Adult Dentition	\$1,350	\$2,880
Class I, II, III Malocclusion - Comprehensive	\$2,200	\$4,064
Treatment - Combination of Primary and Permanent Teeth		
Class I, II, III Malocclusion -		
Comprehensive Treatment - Permanent Teeth		
Children (Up to 19th Birthday)	\$2,250	\$2,756
Adults	\$2,350	\$3,798
Retention - Post Treatment Stabilization (Includes Appliance(s) & Treatment)	\$300	\$450
<b>Miscellaneous</b>		
Cosmetic Bleaching (Per Arch)	\$150	\$317
Occlusal Guard	\$250	\$572
Occlusal Analysis - Mounted Case	\$75	\$269
Occlusal Adjustment - Limited	\$30	\$139

\* Not to be taken if X-ray bitewing (four films) was done within prior six (6) months. Copies of X-rays can be obtained for \$2 per periapical film up to a maximum of \$30. Panoramic X-rays can be obtained for a \$15 fee.

<sup>1</sup> In addition to the 1 Prophylaxis allowed every six (6) months.

<sup>2</sup> Excluding Final Restoration

<sup>3</sup> Limit four Quadrants per consecutive 12 months

## Discount Prescription Drug Benefit Program\*

As part of the S700 Solstice plan from UnitedHealthcare Dental, you can access substantial savings on brand prescriptions and generic drugs through a network of more than 65,000 retail pharmacies nationwide, including all major retail chains. Your physician's choice of prescribed medications and your preference for brand or generic prescriptions will always be honored.

Your Discount Prescription benefit includes:

- Name brand and generic drugs with up to 20% savings
- Up to 40% savings on home delivery pharmacy service

There are no limits: You and your family may use the drug discount program any time your prescription is not covered by insurance.

There are no restrictions and no limits on how many times you or any member of your household may use your prescription card. And your pets are included!

Save an average of 20% on brand and generic drugs when visiting a participating pharmacy.

- Savings on more than 99% of all commonly prescribed medications
- Save an average of 40% on generic medications when you order by mail

Go to [myuhcdental.com/statefl](http://myuhcdental.com/statefl) and click on the Pharmacy Discount link where you can:

- Check drug costs
- Locate a pharmacy
- Refill mail order prescriptions, and much more

\*This program is not associated with your medical plan and is not insurance. There is no coordination of benefits, and prescriptions may only be filled through participating pharmacies.

## Exclusions and Limitations

1. Any oral evaluation is limited to one (1) time in any consecutive six-month (6) period at no charge. All subsequent oral evaluations will be at 25% discount off the doctor's usual and customary fee without a frequency limitation.
2. Bitewing X-rays (2-4 films) are limited to one set in any consecutive 12-month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one 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 consecutive 12-month period for children under the age of 16.
5. Sealants are limited to one (1) time per tooth in any consecutive three-year (3) 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. Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
9. 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.
10. 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.
11. General anesthesia or IV sedation unless otherwise listed as covered benefit on Schedule of Benefits.
12. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
13. Treatment of malignancies, cysts or neoplasms.
14. Dental implants and related services.
15. Dental procedures initiated prior to the member's eligibility under this benefit plan or started after the member's termination from the plan.
16. 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.
17. New dentures include one (1) relines with the first six (6) months.
18. Replacement of crowns, fixed bridges or dentures is limited to once every five (5) years.
19. When crown and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.
20. Copayments for endodontic procedures do not include the cost of the final restoration.
21. Either D0210 or D0330 are payable once every five (5) years.
22. Copayments marked by an asterisk (\*) do not include the cost of metal and laboratory fees. Additional cost to patient is as follows:

- High Noble Metal (precious)	up to \$130.00
- Noble Metal (semi-precious)	up to \$110.00
- Predominantly base metal (non-precious)	up to \$55.00
- Crown Laboratory Fees	up to \$125.00
- Laboratory fees on dentures	up to \$200.00
- Porcelain laboratory fees for D2610-D2644 and D2962	up to \$50.00
- Denture repair laboratory fees	up to \$40.00
23. Copayments marked by "+" are not eligible for reimbursement under specialty plans.

This is only an overview of the most common exclusions and limitations. Please see your Schedule of Benefits for more detailed information.

## Specialty Services

1. The fees within this overview of services apply when such services are performed by a participating general dentist, unless otherwise authorized by UnitedHealthcare Dental'.
2. If services are not listed within the Schedule of Benefits and are performed by a participating general dentist, fees will be charged at dentist's usual and customary fee less 25%.
3. The participating general dentist you select may not perform all outlined procedures. The copayments shown apply to general dentists who perform these procedures. 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, Orthodontist, Periodontist, Prosthodontist or Pedodontist) be necessary, you may receive this care in one 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 by UnitedHealthcare Dental' and receive specialty treatment by an approved participating specialist at the listed copayments. Please refer to the Specialty Care Referral Policy in your member ID packet.

This is only an overview, please see your Schedule of Benefits for more detailed information.

\* UnitedHealthcare Dental plans are administered by Dental Benefit Providers, Inc.