



**BEST HEALTH PLANS**



## Advantage Prepaid Dental Plans

For Florida | Group Sizes 2 or more

This plan is underwritten by: Solstice Benefits, Inc., a licensed prepaid Limited Health Services Organization; Chapter 636 F.S.  
Marketed and Distributed by BEST Health Plans, LLC.

## Bringing Value with Affordable Dental Care

Dental plans are the second benefit most asked for by employees. With BEST Health Plans Advantage Prepaid Dental plans, employer groups as small as 2 employees enrolling can now offer these valuable benefits to their organization.

## Voluntary Dental Plans

All of the Advantage Prepaid Dental plans are offered on a voluntary basis and provide a low-cost option for employers. A minimum of 2 employees enrolling is required, depending on the plan selected.

## Dual Option

BEST Health Plans sell a variety of dental plans that can be offered alongside these Prepaid Dental plans. Please contact your BEST Health Plans Sales Representative for plan information.



## Advantage Prepaid Dental Plans



# Beyond Basic Care



Individuals and families enrolled on the Advantage plans receive most diagnostic and preventive care at no charge. Additionally, Advantage Prepaid Dental provides coverage for cosmetic procedures, new technology and treatment clinically proven to be the best methods for improving oral health:

- ✓ Additional cleanings
- ✓ New x-ray technology like oral/facial imaging
- ✓ Posterior composites
- ✓ Oral cancer screening
- ✓ Cosmetic bleaching
- ✓ Veneers
- ✓ Adult and child orthodontia

## Specialty Care

Based on a group's needs, employers may select a prepaid plan that covers Orthodontic services at a copayment or at 25% off the provider's usual and customary fee.

Members who require the services of a specialist (Oral Surgeon, Endodontist, Orthodontist, Periodontist, Prosthodontist or Pedodontist) may go directly to any participating specialist and receive care at 25% off the provider's usual and customary fee; or members on "S" plans may get prior written approval from Solstice and receive specialty care at the plan's listed copayments. Orthodontic services may be covered at copayment, depending on the plan selected.

## The Solstice Network

Members on the Advantage Prepaid Dental Plans can select any primary care dentist from the Solstice network, and each family member may choose a different primary care dentist. Because no pre-selection is required at enrollment, members can change dentists without having to call Member Services.

## My Dental Health Web Portal

The Advantage Prepaid Dental Plans provides members an online portal where they can logon for:

- **Dentist Locator** enables members to find general dentists and specialists close to their home or office, including maps and printable driving directions to the dentist's office.
- **Plan Information** for verifying eligibility for family members, request ID cards and review benefit plan summaries which detail the amount the plan pays for procedures. The treatment cost calculator allows for members to determine their out of pocket costs prior to seeing a dentist. A Frequently Asked Questions provides answers to commonly asked questions about the dental plan, including Member Service and Claims information.
- **The Dental Education** section offers little-known facts about the dental industry, dental articles, brushing and flossing techniques, an A-Z guide of frequently used dental words, and more.



# Advantage Prepaid Dental Plans Overview

Code	Benefit	Premium 300
D9430	Office visit	\$5
<b>Diagnostic Services</b>		
D0120	Periodic oral evaluation (every 6 months)	No Charge
D0150	Comprehensive oral evaluation	No Charge
D0210	Complete series x-rays	No Charge*
D0270	Bitewings – single film	No Charge*
D0330	Panoramic film	\$50
D0350	Oral/facial images (intra & extraoral)	\$20
<b>Preventive Services</b>		
D1110	Prophylaxis – adult (every 6 months)	No Charge
D1110	Additional prophylaxis – adult	\$40
D1120	Prophylaxis – child (every 6 months)	No Charge
D1120	Additional prophylaxis – child	\$25
D1203	Topical application of fluoride (including prophylaxis) < age 14 (every 6 months)	No Charge
D1351	Sealant – per tooth	No Charge
D1510	Space maintainer – fixed - unilateral	No Charge
<b>Restorative &amp; Prosthodontic Services</b>		
D2140	Amalgam – one surface	No Charge
D2391	Resin-based composite – one surface, posterior	\$70
D2630	Inlay – porcelain/ceramic, three surfaces	\$375
D2752	Crown – porcelain fused to noble metal	\$475
D2960	Labial veneer (resin laminate) – chair side	\$200
D5110	Complete upper denture	\$625
D6240	Pontic – porcelain fused to noble metal	\$495
<b>Endodontic Services</b>		
D3320	Root canal therapy – bicuspid	\$375
D3330	Root canal therapy – molar	\$485
<b>Periodontic Services</b>		
D4260	Osseous surgery	\$450
D4341	Periodontal scaling & root planing – per quadrant	\$80
D4910	Periodontal maintenance after active therapy	\$55
<b>Oral Surgery</b>		
D7230	Removal of impacted tooth – partially bony	\$140
D7286	Biopsy of oral tissue – soft (for cancer screening)	\$95
<b>Orthodontic Services</b>		
D8080	Comprehensive orthodontic treatment of adolescent dentition (24 month case)	25% of usual & customary
D8090	Comprehensive orthodontic treatment of adult dentition (24 month case)	25% of usual & customary
D8660	Pre-orthodontic treatment visit (Orthodontic consult)	25% of usual & customary
<b>Cosmetic Services</b>		
D9972	Cosmetic bleaching – per arch	\$150

- Copayments marked by “\*” do not include the cost of metal and laboratory fees. Additional cost is as follows: High noble metal (precious), all ceramic and/or porcelain crown material fees up to \$130, Noble metal (semi-precious) up to \$110, Predominantly base metal (non-precious) up to \$55, Crown laboratory fees up to \$125, Laboratory fees on dentures up to \$200, Porcelain laboratory fees for D2610 to D2644, and D2962 up to \$50; Denture repair laboratory fees up to \$40.

500	800	S200	S500	S700
\$5	\$5	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge
No Charge*	No Charge*	No Charge*	No Charge*	No Charge*
No Charge*	No Charge*	No Charge*	No Charge*	No Charge*
\$45	\$50	\$35	\$45	\$50
\$20	\$20	\$20	\$20	\$20
No Charge	No Charge	No Charge	No Charge	No Charge
\$15	\$35	\$15	\$15	\$20
No Charge	No Charge	No Charge	No Charge	No Charge
\$15	\$22	\$15	\$15	\$20
No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	\$12	No Charge	No Charge	No Charge
\$55	\$70	\$45	\$55	\$65
\$300*	\$325*	\$275*	\$325*	\$325*
\$240*	\$290*	\$195*	\$240*	\$245*
\$200	\$200	\$200	\$200	\$200
\$260*	\$440*	\$210*	\$260*	\$325*
\$240*	\$290*	\$195*	\$240*	\$245*
\$185	\$210	\$175	\$185	\$195
\$225	\$310	\$210	\$225	\$245
\$375	\$375	\$375	\$300	\$375
\$45	\$70	\$36**	\$45**	\$50**
\$45	\$65	\$40**	\$45**	\$50**
\$60	\$90	\$55	\$60	\$65
\$75	\$95	\$60	\$75	\$85
\$2,050	25% of usual & customary	\$1,850	\$2,050	\$2,250
\$2,150	25% of usual & customary	\$1,950	\$2,150	\$2,350
\$35	25% of usual & customary	\$35	\$35	\$35
\$150	\$150	\$150	\$150	\$150

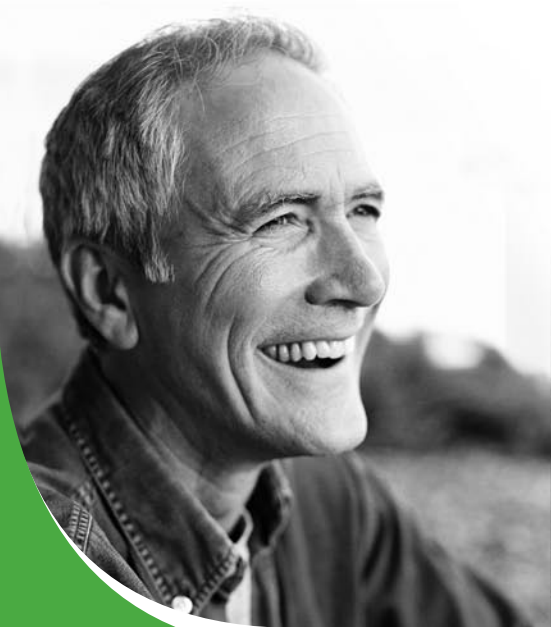
- Copayments marked by ‘\*\*\*’ are not eligible for reimbursement under specialty plans.
- Specialty care is covered at 25% off the provider’s usual and customary fee; on the “S” plans, if prior approval is obtained, specialty care is covered at copayment.
- The S200 and S500 plans require a minimum of 15 employees enrolled; all other plans require a minimum of 2 employees enrolled.

The following is a summarized list of exclusions and limitations. For a complete list, please refer to the plan's Schedule of Benefits.

## Exclusions and Limitations

1. Any oral evaluation is limited to one (1) time in any six (6) consecutive month period at no charge. All subsequent oral evaluations will be at a 25% discount off the dentist's usual and customary fee without a frequency limitation.
2. Bitewing X-rays (2-4 films) are limited to one set in any twelve (12) consecutive 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 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. 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 is covered when medically necessary and previously approved.
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 within 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. On the S plans: Surgical removal of impacted tooth is available at listed co-pay when pathology (disease) exists. Surgical removal of wisdom tooth/3rd molar when pathology does not exist is available at a 25% reduction off of the dentist's (specialist's) usual and customary fees.

# notes



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