UHA

Better Health, Better Life…

Choose UHA for your employees!

We've Got You Covered

- **At home**—Virtually all Hawaii health care providers participate with UHA
- **On the mainland**—Through a special arrangement with a mainland network, members can obtain health care services in the event of a travel emergency and services for their covered dependents attending college
- **Around the world**—Members receive this unique global emergency service through Assist America while traveling 100 miles or more from home

Physician Guidance

Founded by physicians from the University Of Hawaii John A. Burns School Of Medicine, UHA continues to partner with medical scientists to improve the quality of our members' health care.

Hawaii's Premier Benefit Plans

- **UHA 3000**—Hawaii's first health insurance plan to offer full, complete, **100% coverage for wellness and preventive medicine**. There are no co-payments for services that keep members healthy, detect diseases early, and manage chronic disease. Furthermore, members enjoy **lower premiums** than with traditional health plans.
- **UHA 600**—A Preferred Provider Organization (PPO) plan that provides the state's top comprehensive medical benefits, paying at 90% of the eligible charge for most services rendered by a participating provider
- **Chiropractic** and **acupuncture** benefits included
- **Drug** and **vision** plans designed to fit your group's needs and budget
- **Dental**—Choice of various dental plans including **HDS**

Services and Programs To Improve Your Health

- **Weight Watchers**®—Rebate for entire cost of the program upon successful completion
- **Smoking/tobacco cessation**—Rebate of up to $100 for classes by the American Lung Association and other approved providers, and coverage for nicotine replacement products
- **Asthma Management**—10 sessions with a Certified Asthma Educator
- **Diabetes Management**—10 sessions with a Certified Diabetes Educator to help you learn to manage diabetes
- **Seasonal flu shots**— Fully covered at worksites for employers (subject to minimum participation), at select Longs Drug Stores, or through your physician's office
- **Longs Mail Order and Extend Fill services**—Significant savings on maintenance prescriptions

Leader in Quality and Service

UHA's mission is to provide our members with access to quality health care services and to be a force for continuously improving the quality of health care in Hawaii. By meeting strict quality standards to ensure clinically sound decision-making that respects the rights of both patients and medical providers, UHA received accreditation in Health Utilization Management through URAC, an independent non-profit organization that promotes health care quality through accreditation and certification programs.

The **quality of our customer service** is something of which we are especially proud. That is why **UHA retains over 90%** of our customers. You too will be delighted with the superior service you receive!

Visit **uhahealth.com** for more information

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Benefit Plan Comparison
UHA 3000 and UHA 600

QUESTIONS?
Call Member Services
(808) 532-4000
Toll-free: 1-800-458-4600

The following chart displays a summary of plan provisions and benefits[1]

Plan Provisions	UHA 3000	UHA 600
Annual deductible[2]	$200 per person; $600 per family	None
Annual co-pay maximum	$2,500 per person; $7,500 per family	$2,500 per person; $7,500 per family
Lifetime maximum[3]	Unlimited	Unlimited
Full-time student coverage	Up to age 25	Up to age 25

Medical Services	UHA 3000	UHA 600
PREVENTIVE CARE SERVICES		
Physical exam (office visit) once per calendar year	No co-payment	No co-payment
Preventive screening services: Mammography, Pap Smear, PSA Test	No co-payment	No co-payment
Well child care visit	No co-payment	10% of EC
Childhood Immunizations	No co-payment	No co-payment
Adult Immunizations	No co-payment	No co-payment
Laboratory	No co-payment	20% of EC
MATERNITY SERVICES		
Maternity care and delivery	No co-payment	10% of EC
Birthing room	No co-payment	No co-payment
Newborn nursery	No co-payment	10% of EC
DISEASE MANAGEMENT PROGRAMS		
Smoking cessation, Nutrition counseling Disease education, and Prenatal programs	No co-payment	No co-payment
PHYSICIAN SERVICES		
Physician office visit	$12	10% of EC
HOSPITAL SERVICES		
Room & Board (semi-private room)	20% of EC	10% of EC
Ancillary Inpatient Services	20% of EC	10% of EC
Laboratory & pathology (inpatient)	20% of EC	10% of EC
EMERGENCY SERVICES		
Emergency room services	20% of EC	10% of EC
Ambulance services - Ground/Air	20% of EC	20% of EC
Complimentary Alternative Medicine		
Chiropractic/Acupuncture Services Benefits limited to treatment of conditions of the neuromusculoskeletal system by licensed providers	$10 co-payment per visit First set of x-rays at 50% of EC; full charge for add'l sets; $500 combined maximum per calendar year	$10 co-payment per visit First set of x-rays at 50% of EC; full charge for add'l sets; $500 combined maximum per calendar year

1. Not all plans are listed. Check with Member Services for more benefit plan information.
2. Annual deductible does not apply to all services. Refer to your Medical Benefits Guide to verify which services apply.
3. Annual maximum of $2,000,000 per member per calendar year with no lifetime maximum.

EC = Eligible Charge. Refer to your Medical Benefits Guide for detailed definition.

The information above is intended to provide a condensed explanation of UHA medical plan benefits. Please refer to the appropriate Medical Benefits Guide (MBG) for complete information on benefits and provisions. In case of a discrepancy between this comparison and the language contained in the MBG, the MBG will take precedence.

MKT-0023-060608

UHA Drug Plan P

BETTER HEALTH • BETTER LIFE

UHA

UHA Drug Plan P features a tiered co-payment structure. Your co-payment is based on the type of drug that is used to fill your prescription.

- Refills will be covered for up to twelve (12) months from the date the original prescription was written
- Drugs must be federally approved and obtained with a prescription from a physician

Drug Type (Non-diabetic)	Days' Supply	Participating Pharmacy Your Co-payment	Non-Participating Pharmacy Your Co-payment
Generic	30	$7*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Preferred Brand	30	$20*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Non-Preferred Brand	30	$40*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Mail Order Generic	90	$7*	Not Covered
Mail Order Preferred Brand	60	$20*	Not Covered
Mail Order Non-Preferred Brand	60	$40*	Not Covered
Diabetic Benefits	**Days' Supply**	**Participating Pharmacy Your Co-payment**	**Non-Participating Pharmacy Your Co-payment**
Diabetic Supplies —Generic or Preferred Brand	30	$0	Any charges that exceed UHA's payment of 70% of Eligible Charge
Diabetic Drugs & Insulin —Generic or Preferred Brand	30	$7	Any charges that exceed UHA's payment of 70% of Eligible Charge
Diabetic Supplies, Drugs & Insulin — Non-Preferred Brand	30	$40*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Mail Order Diabetic Supplies —Generic or Preferred Brand	90	$0	Not Covered
Mail Order Diabetic Drugs & Insulin —Generic or Preferred Brand	90	$7	Not Covered
Mail Order Diabetic Supplies, Drugs & Insulin — Non-Preferred Brand	60	$40*	Not Covered

*Or 20% of Eligible Charge if the Eligible Charge for a 30-day supply is over $200.00 for each original prescription or each covered refill.

Mandatory Generic Substitution Policy

If a Preferred or Non-Preferred Brand Covered Drug or Diabetic Supply is obtained when a generic equivalent is available, the member is responsible for (i) the difference in Eligible Charge between the Preferred or Non-Preferred Brand Covered Drug or Diabetic Supply and the generic equivalent, and (ii) the generic co-payment. By requesting generic drugs you can reduce your costs. Speak with your physician about the drug that is appropriate for your medical condition.

See back page for more information, or
call UHA Member Services at 532-4000, or 1-800-458-4600 from the neighbor islands

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UHA Drug Plan Q

BETTER HEALTH • BETTER LIFE

UHA

UHA Drug Plan Q features a tiered co-payment structure. Your co-payment is based on the type of drug that is used to fill your prescription.

- Refills will be covered for up to twelve (12) months from the date the original prescription was written
- Drugs must be federally approved and obtained with a prescription from a physician

Drug Type (Non-diabetic)	Days' Supply	Participating Pharmacy Your Co-payment	Non-Participating Pharmacy Your Co-payment
Generic	30	$7*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Preferred Brand	30	$15*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Non-Preferred Brand	30	$30*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Mail Order Generic	90	$7*	Not Covered
Mail Order Preferred Brand	60	$15*	Not Covered
Mail Order Non-Preferred Brand	60	$30*	Not Covered
Diabetic Benefits	**Days' Supply**	**Participating Pharmacy Your Co-payment**	**Non-Participating Pharmacy Your Co-payment**
Diabetic Supplies —Generic or Preferred Brand	30	$0	Any charges that exceed UHA's payment of 70% of Eligible Charge
Diabetic Drugs & Insulin —Generic or Preferred Brand	30	$7	Any charges that exceed UHA's payment of 70% of Eligible Charge
Diabetic Supplies, Drugs & Insulin — Non-Preferred Brand	30	$30*	Any charges that exceed UHA's payment of 70% of Eligible Charge
Mail Order Diabetic Supplies —Generic or Preferred Brand	90	$0	Not Covered
Mail Order Diabetic Drugs & Insulin —Generic or Preferred Brand	90	$7	Not Covered
Mail Order Diabetic Supplies, Drugs & Insulin — Non-Preferred Brand	60	$30*	Not Covered

*Or 20% of Eligible Charge if the Eligible Charge for a 30-day supply is over $150.00 for each original prescription or each covered refill.

Mandatory Generic Substitution Policy

If a Preferred or Non-Preferred Brand Covered Drug or Diabetic Supply is obtained when a generic equivalent is available, the member is responsible for (i) the difference in Eligible Charge between the Preferred or Non-Preferred Brand Covered Drug or Diabetic Supply and the generic equivalent, and (ii) the generic co-payment. By requesting generic drugs you can reduce your costs. Speak with your physician about the drug that is appropriate for your medical condition.

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UHA Vision Plan 100

BETTER HEALTH • BETTER LIFE

UHA Vision 100

Eye Examination

- Plan pays 80% of the eligible charge for one eye examination per member, per calendar year
- The benefit reimbursement is the same for both participating and non-participating UHA vision providers

Appliances

- Up to $100 every calendar year towards the purchase of eyeglasses, contact lenses, frames, lenses, or any combination thereof

Vision Care Providers

Members have the choice of going to a participating or non-participating UHA vision provider who must be a licensed Opthalmologist (M.D.) or Optometrist (O.D.)

Limitations And Exclusions

The following services are not covered:

- Repair or replacements of frame parts and accessories
- Eye refractions
- Sunglasses
- Prescription inserts for diving masks
- Nonprescription industrial safety goggles
- Tinting of glasses

Please refer to your plan summary description for specific information on vision plan benefits

How To File A Vision Claim For Services From A Non-Participating Provider

- Present your UHA member identification card to the provider of services
- Ask the provider of services to file a claim on your behalf
- All claims must be filed within one year from the date of service; claims filed after one year will not be paid

If you have any questions about your vision plan benefits, please contact UHA Member Services at (808) 532-4000, or 1-800-458-4600 from the neighbor islands.

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SUMMARY OF DENTAL BENEFITS

Note: This brochure includes a brief description of your HDS dental benefits. All benefits are governed by the provisions of UHA's dental agreement with Hawaii Dental Service and HDS's procedure code guidelines.

Dependent age limit through age 18
Dependent full-time student age limit through age 24

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per calendar year	$1,000
DIAGNOSTIC	
• Examinations - once per calendar year	100%

• Bitewing X-rays
  • Twice per calendar year through age 14;
  • Once per calendar year thereafter
	100%

• Other X-rays (full mouth X-rays limited to once every 5 years)	70%
PREVENTIVE	

• Cleanings – twice per calendar year
  • Diabetic patients – four cleanings or *periodontal maintenance
  • Expectant mothers – three cleanings or *periodontal maintenance
  *Periodontal maintenance benefit level
	100%
	
	*70%

• Topical fluoride (once per calendar year through age 17) • Fluoride varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	70%
• Space maintainers (through age 17)	70%
• Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	70%
RESTORATIVE	
• Amalgam (silver-colored) fillings	70%
• Composite (white-colored) fillings – limited to the anterior (front) teeth	70%
• Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	50%
Note: Composite restorations or porcelain (white) crowns on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	

BENEFIT	PLAN COVERS
ENDODONTICS • Pulpal therapy • Root canal treatment, retreatment, apexification, apicoectomy	70%
PERIODONTICS • Periodontal scaling and root planing (once every two years) • Gingivectomy, flap curettage and osseous surgery (once every three years) • Periodontal maintenance – twice per calendar year	70%
PROSTHODONTICS • Fixed bridges (once every 5 years; ages 16 and older) • Removable dentures (complete and partial – once every 5 years; ages 16 and older) • Repairs and adjustments • Relines and rebase • Implants (covered as alternate benefit) when one tooth is missing between two natural teeth	50%
ORAL SURGERY • Extractions • Other oral surgery procedures to supplement medical care plan	70%
ADJUNCTIVE GENERAL SERVICES • Consultations • Office visits (injury related) • Sedation: General & IV • Palliative – treatment for dental pain	70%

Hawaii Family Dental Centers

UHA Standard Dental and Dental Plus Co-Payments

Description of Service	Standard Dental Copayment	Dental Plus Copayment
EXAMINATIONS (limited to TWO EXAMS, per PLAN year)		
PERIODIC ORAL EVALUATION	$ 15.00	No Charge
LIMITED ORAL EVALUATION	$ 15.00	No Charge
COMPREHENSIVE EVALUATION	$ 15.00	No Charge
DETAIL/EXTENSIVE EVALUATION	$ 25.00	No Charge
COMP PERIODIC EVALUATION	$ 55.00	No Charge
RADIOGRAPHS		
FULL MOUTH SERIES XRAY	$ 30.00	$ 25.00
PERIAPICAL FIRST FILM	$ 15.00	$ 15.00
PERIAPICAL ADD.FILM	$ 12.00	$ 10.00
INTRAORAL-OCCLUSAL FLM	$ 15.00	$ 12.00
BITEWING -1	$ 10.00	$ 10.00
BITEWINGS -2	$ 15.00	$ 12.00
BITEWINGS -4	$ 30.00	$ 25.00
PANORAMIC FILM	$ 40.00	$ 35.00
CEPHALOMETRIC FILM	$ 75.00	$ 65.00
PULP VITALITY TESTS	$ 35.00	$ 30.00
DIAGNOSTIC CASTS	$ 65.00	$ 55.00
PROPHYLAXIS (limited to TWO per PLAN year)		
PROPHYLAXIS -ADULT	$ 30.00	No Charge
PROPHYLAXIS -CHILD	$ 30.00	No Charge
FLOURIDE TREATMENTS		
FLUORIDE - CHILD	$ 15.00	$ 10.00
FLUORIDE -ADULT	$ 15.00	$ 10.00
SEALANTS		
SEALANT -PER TOOTH	$ 30.00	$ 25.00
SPACE MANAGEMENT THERAPY		
SPACE MAINT.FIXED UNILATERAL	$ 125.00	$ 100.00
SPACE MAINT.FIXED BILATERAL	$ 150.00	$ 125.00
SPACE MAINT - REM	$ 150.00	$ 125.00
SPACE MAINT - REM. BILATERAL	$ 150.00	$ 125.00
RECEMENT SPACE MAINTAINER	$ 60.00	$ 55.00
AMALGAM RESTORATIONS		
AMALGAM 1 SURFACE PRIMARY	$ 40.00	$ 40.00
ALAMGAM 2 SURFACES PRIMARY	$ 45.00	$ 45.00
AMALGAM 3 SURFACES PRIMARY	$ 55.00	$ 50.00
AMALGAM 4 SURFACES PRIMARY	$ 65.00	$ 60.00
AMALGAM 5 SURFACES PRIMARY	$ 60.00	$ 55.00
AMALGAM 1 SURFACE	$ 50.00	$ 45.00
AMALGAM 2 SURFACES	$ 65.00	$ 60.00
AMALGAM 3 SURFACES	$ 75.00	$ 70.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
AMALGAM 4 SURFACES	$ 90.00	$ 80.00
AMALGAM 5 SURFACES	$ 90.00	$ 80.00
SILICATE CEMENT	$ 30.00	$ 25.00
RESIN RESTORATIONS		
RESIN 1 SURFACE ANTERIOR	$ 60.00	$ 55.00
RESIN 2 SURFACES ANTERIOR	$ 75.00	$ 70.00
RESIN 3 SURFACES ANTERIOR	$ 90.00	$ 80.00
RESIN 4 SURFACES ANTERIOR	$ 125.00	$ 100.00
RESIN 5 SURFACES ANTERIOR	$ 125.00	$ 100.00
RESIN 4 SURFACES ANTERIOR PRIMARY	$ 115.00	$ 100.00
COMPOSITE CROWN	$ 130.00	$ 115.00
RESIN 1SURFACE POSTERIOR PRIMARY	$ 90.00	$ 80.00
RESIN 2 SURFACES POSTERIOR PRIMARY	$ 115.00	$ 100.00
RESIN 3 SURFACES POSTERIOR PRIMARY	$ 140.00	$ 125.00
RESIN 4 SURFACES POSTERIOR PRIMARY	$ 140.00	$ 125.00
RESIN 1 SURACE POSTERIOR	$ 100.00	$ 90.00
RESIN 2 SURACES POSTERIOR	$ 125.00	$ 100.00
RESIN 3 SURACES POSTERIOR	$ 150.00	$ 125.00
RESIN 4 SURACES POSTERIOR	$ 200.00	$ 180.00
INLAY RESTORATIONS		
INLAY 1 SURFACE METALLIC	$ 500.00	$ 400.00
INLAY 2 SURFACES METALLIC	$ 575.00	$ 500.00
INLAY 3 SURFACES METALLIC	$ 650.00	$ 600.00
INLAY 4 SURFACES METALLIC	$ 650.00	$ 650.00
INLAY 5 SURFACES METALLIC	$ 650.00	$ 650.00
INLAY 1 SURFACE PORCELAIN	$ 550.00	$ 500.00
INLAY 2 SURFACES PORCELAIN	$ 600.00	$ 550.00
INLAY 3 SURFACES PORCELAIN	$ 650.00	$ 600.00
INLAY 4 SURFACES PORCELAIN	$ 650.00	$ 600.00
INLAY 5 SURFACES PORCELAIN	$ 650.00	$ 600.00
INLAY 1 SURFACE COMPOSITE	$ 550.00	$ 500.00
INLAY 2 SURFACES COMPOSITE	$ 575.00	$ 525.00
INLAY 3 SURFACES COMPOSITE	$ 625.00	$ 575.00
ONLAY RESTORATIONS		
ONLAY 3 SURFACES METALLIC	$ 700.00	$ 650.00
ONLAY 4 SURFACES METALLIC	$ 750.00	$ 700.00
ONLAY 5 SURFACES METALLIC	$ 750.00	$ 700.00
ONLAY 2 SURFACES PORCELAIN	$ 725.00	$ 650.00
ONLAY 3 SURFACES PORCELAIN	$ 775.00	$ 700.00
ONLAY 4 SURFACES PORCELAIN	$ 775.00	$ 700.00
ONLAY 5 SURFACES PORCELAIN	$ 775.00	$ 700.00
ONLAY 2 SURFACES COMPOSITE	$ 650.00	$ 600.00
ONLAY 3 SURFACES COMPOSITE	$ 725.00	$ 650.00
ONLAY 4 SURFACES COMPOSITE	$ 750.00	$ 675.00
ONLAY 5 SURFACES COMPOSITE	$ 750.00	$ 675.00
SINGLE CROWN RESTORATIONS		
CROWN - RESIN (LABORATORY)	$ 400.00	$ 350.00
CROWN - RESIN WITH HIGH NOBLE METAL	$ 450.00	$ 400.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$ 400.00	$ 350.00
CROWN - RESIN WITH NOBLE METAL	$ 425.00	$ 375.00
CROWN - PORCELAIN, ANTERIOR	$ 650.00	$ 600.00
CROWN - PORCELAIN, POSTERIOR	$ 650.00	$ 600.00
CROWN - PORCELAIN FUSED TO GOLD-ANTERIOR	$ 550.00	$ 500.00
CROWN - PORCELAIN FUSED TO GOLD-POSTERIOR	$ 550.00	$ 500.00
CROWN - PORCELAIN FUSED TO NONPRECIOUS METAL-ANTERIOR	$ 525.00	$ 475.00
CROWN - PORCELAIN FUSED TO NONPRECIOUS METAL- POSTERIOR	$ 525.00	$ 475.00
CROWN - PORCELAIN FUSED TO SEMIPRECIOUS METAL - ANTERIOR	$ 550.00	$ 500.00
CROWN - PORCELAIN FUSED TO SEMIPRECIOUS METAL - MOLAR	$ 550.00	$ 500.00
CROWN - PORCELAIN FUSED TO SEMIPRECIOUS METAL - POSTERIOR	$ 550.00	$ 500.00
CROWN 3/4 HI NOBLE METAL	$ 525.00	$ 475.00
CROWN 3/4 CAST METAL	$ 500.00	$ 450.00
CROWN - FULL GOLD	$ 600.00	$ 550.00
CROWN - NONPRECIOUS METAL	$ 450.00	$ 400.00
CROWN - FULL CAST SEMIPRECIOUS METAL	$ 500.00	$ 450.00
CROWN - FULL CAST-MOLAR	$ 500.00	$ 450.00
CROWN - 3/4 CAST METAL	$ 500.00	$ 450.00
RECEMENT INLAY	$ 50.00	$ 40.00
RECEMENT CROWN	$ 75.00	$ 70.00
CROWN - STAINLESS STEEL PRIMARY TOOTH	$ 90.00	$ 80.00
CROWN - STAINLESS STEEL	$ 150.00	$ 125.00
PREFABRICATED RESIN CROWN	$ 150.00	$ 125.00
STAINLES STEEL CROWN WITH RESIN WINDOW	$ 200.00	$ 175.00
SEDATIVE FILLING	$ 60.00	$ 55.00
CORE BUILDUP	$ 125.00	$ 100.00
PIN RETENTION - PER TOOTH	$ 30.00	$ 25.00
CAST POST & CORE IN ADDITION TO CROWN	$ 180.00	$ 150.00
PREFAB POST & CORE IN ADDITION TO CROWN	$ 150.00	$ 125.00
POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY	$ 170.00	$ 150.00
VENEER - LAMINATE - CHAIRSIDE	$ 550.00	$ 500.00
VENEER - RESIN - LABORATORY	$ 400.00	$ 350.00
VENEER - PORCLAMINATE - LABORATORY	$ 600.00	$ 600.00
CROWN - TEMPORARY	$ 200.00	$ 175.00
CROWN REPAIR	$ 150.00	$ 125.00
NON-COVERED MATERIAL	$ 175.00	$ 150.00
PULPOTOMY		
PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	$ 40.00	$ 35.00
PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	$ 25.00	$ 25.00
PULPOTOMY	$ 75.00	$ 65.00
PULPAL THERAPY - ANTERIOR	$ 100.00	$ 90.00
PULPAL THERAPY - POSTERIOR	$ 125.00	$ 100.00
ROOT CANAL THERAPY		
ROOT CANAL - ANTERIOR	$ 325.00	$ 300.00
ROOT CANAL - BICUSPID	$ 375.00	$ 350.00
ROOT CANAL - MOLAR	$ 450.00	$ 400.00
RETREATMENT ROOT CANAL THERAPY - ANTERIOR	$ 350.00	$ 325.00
RETREATMENT ROOT CANAL THERAPY - BICUSPID	$ 400.00	$ 350.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
RETREATMENT ROOT CANAL THERAPY - MOLAR	$ 475.00	$ 425.00
APEXIFICATION - FIRST VISIT	$ 200.00	$ 175.00
APEXIFICATION - INTERIM MEDICATION REPLACEMENT	$ 200.00	$ 175.00
APEXIFICATION - FINAL VISIT	$ 275.00	$ 250.00
PERIAPICAL SERVICES		
APICOECTOMY - ANTERIOR	$ 225.00	$ 200.00
APICOECTOMY - BICUSPID	$ 250.00	$ 225.00
APICOECTOMY - MOLAR	$ 300.00	$ 275.00
APICOECTOMY- EACH ADDITIONAL ROOT	$ 125.00	$ 100.00
RETROGRADE FILLING	$ 125.00	$ 100.00
APICAL CURRETAGE	$ 225.00	$ 200.00
ROOT AMPUTATION - PER ROOT-	$ 250.00	$ 225.00
HEMISECTION - NOT INCLUDING ROOT CANAL THERAPY	$ 200.00	$ 175.00
BLEACHING - ONE ARCH	$ 150.00	$ 125.00
BLEACHING BOTH ARCHES	$ 275.00	$ 250.00
PERIODONTICS		
GINGIVECTOMY - PER QUADRANT	$ 350.00	$ 300.00
GINGIVECTOMY - PER TOOTH	$ 100.00	$ 75.00
GINGIVAL CURETTAGE - PER QUADRANT	$ 175.00	$ 150.00
GINGIVAL CURETTAGE - PER TOOTH	$ 40.00	$ 30.00
GINGIVAL FLAP PROCEDURE	$ 350.00	$ 300.00
CROWN LENGTHENING	$ 400.00	$ 350.00
MUCOGINGIVAL SURGERY - PER QUADRANT	$ 450.00	$ 400.00
OSSEOUS SURGERY - PER QUADRANT	$ 650.00	$ 600.00
BONE REPLACEMENT - FIRST SITE	$ 350.00	$ 300.00
BONE REPLACEMENT - EACH ADDITIONAL SITE	$ 300.00	$ 250.00
GUIDED TISSUE REGENERATION	$ 450.00	$ 400.00
GUIDED TISSUE REGENERATION - NONRESTORABLE BARRIER	$ 400.00	$ 350.00
SOFT TISSUE GRAFT	$ 450.00	$ 400.00
FREE SOFT TISSUE GRAFT	$ 450.00	$ 400.00
PERIO SPLINT - INTRACORONAL	$ 200.00	$ 175.00
PERIO SPLINT - EXTRACORONAL	$ 200.00	$ 175.00
PERIODONTAL SCALING & ROOT PLANING, 4+TEETH PER QUADRANT	$ 175.00	$ 150.00
PERIODONTAL SCALING & ROOT PLANING, 1-3 TEETH	$ 50.00	$ 40.00
FULL MOUTH DEBRIDEMENT	$ 100.00	$ 75.00
LOCAL ANTI-BACT TX	$ 100.00	$ 75.00
PERIODONTAL MAINTENANCE THERAPY	$ 100.00	$ 75.00
GINGIVAL FLAP PROCEDURE PER TOOTH	$ 40.00	$ 35.00
OSSEOUS SURGERY - PER TOOTH	$ 100.00	$ 75.00
PROSTHODONTICS		
COMPLETE UPPER DENTURE	$ 775.00	$ 700.00
COMPLETE LOWER DENTURE	$ 775.00	$ 700.00
IMMEDIATE UPPER DENTURE	$ 800.00	$ 750.00
IMMEDIATE LOWER DENTURE	$ 800.00	$ 750.00
PARTIAL DENTURE - UPPER, RESIN BASE	$ 750.00	$ 700.00
PARTIAL DENTURE - LOWER, RESIN BASE	$ 750.00	$ 700.00
PARTIAL DENTURE - UPPER, METAL	$ 850.00	$ 800.00
PARTIAL DENTURE - LOWER, METAL	$ 850.00	$ 800.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
PARTIAL DENTURE - REMOVABLE UNILATERAL	$ 600.00	$ 550.00
ADJUST DENTURE - UPPER	$ 60.00	$ 50.00
ADJUST DENTURE - LOWER	$ 60.00	$ 50.00
ADJUST PARTIAL - UPPER	$ 60.00	$ 50.00
ADJUST PARTIAL - LOWER	$ 60.00	$ 50.00
REPAIR DENTURE BASE	$ 125.00	$ 125.00
REPAIR MISSING TOOTH	$ 125.00	$ 125.00
REPAIR PARTIAL BASE	$ 125.00	$ 125.00
REPAIR PARTIAL FRAME	$ 150.00	$ 125.00
REPAIR PARTIAL CLASP	$ 150.00	$ 125.00
REPLACE PARTIAL TOOTH	$ 125.00	$ 125.00
ADD TOOTH TO PARTIAL	$ 125.00	$ 125.00
ADD CLASP TO PARTIAL	$ 150.00	$ 125.00
REBASE FULL UPPER DENT	$ 400.00	$ 350.00
REBASE FULL LOWER DENT	$ 400.00	$ 350.00
REBASE PARTIAL UPPER	$ 400.00	$ 350.00
REBASE PARTIAL LOWER	$ 400.00	$ 350.00
RELINE FULL UPPER DENT	$ 200.00	$ 175.00
RELINE FULL LOWER DENT	$ 200.00	$ 175.00
RELINE UPPER PARTIAL	$ 200.00	$ 175.00
RELINE LOWER PARTIAL	$ 200.00	$ 175.00
RELINE FULL UPPER DENTURE (LABORATORY)	$ 275.00	$ 250.00
RELINE LOWER DENTURE (LABORATORY)	$ 275.00	$ 250.00
RELINE UPPER PARTIAL DENTURE (LABORATORY)	$ 250.00	$ 250.00
RELINE LOWER PARTIAL DENTURE (LABORATORY)	$ 250.00	$ 250.00
FULL INTERIM DENTURE - UPPER	$ 400.00	$ 350.00
FULL INTERIM DENTURE - LOWER	$ 400.00	$ 350.00
PARTIAL INTERIM DENTURE - UPPER	$ 375.00	$ 325.00
PARTIAL INTERIM DENTURE - LOWER	$ 375.00	$ 325.00
TISSUE CONDITIONING - UPPER	$ 100.00	$ 75.00
TISSUE CONDITIONING - LOWER	$ 100.00	$ 75.00
FULL OVERDENTURE	$ 1,200.00	$ 1,000.00
PARTIAL OVERDENTURE	$ 1,200.00	$ 1,000.00
PRECISION ATTACHMENT	$ 300.00	$ 250.00
FLUORIDE GEL CARRIER	$ 175.00	$ 150.00
SURGICAL - INITIAL IMPLANT	$ 1,300.00	$ 1,200.00
SURGICAL - EACH ADDITIONAL IMPLANT	$ 1,300.00	$ 1,200.00
IMPLANT ABUTMENT PLACE	$ 500.00	$ 450.00
IMPLANT - PREFABRICATED ABUTMENT	$ 500.00	$ 450.00
IMPLANT - CUSTOM ABUTMENT	$ 804.00	$ 804.00
IMPLANT - PORCELAIN FUSED TO HIGH NOBLE METAL ABUTMENT	$ 1,108.00	$ 1,108.00
IMPLANT - HIGH NOBLE METAL RETAINER ABUTMENT	$ 1,017.00	$ 1,017.00
REPAIR IMPLANT ABUTMENT	$ 450.00	$ 400.00
PONTIC - CAST GOLD	$ 500.00	$ 450.00
PONTIC - CAST NONPRECIOUS METAL	$ 450.00	$ 400.00
PONTIC - CAST SEMIPRECIOUS METAL	$ 475.00	$ 400.00
PONTIC - PORCELAIN FUSED TO GOLD	$ 525.00	$ 475.00
PONTIC - PORCELAIN FUSTED TO GOLD - POSTERIOR	$ 525.00	$ 475.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
PONTIC - PORCELAIN FUSED TO GOLD	$ 525.00	$ 475.00
PONTIC - PORCELAIN FUSED TO NONPRECIOUS METAL	$ 475.00	$ 425.00
PONTIC - PORCELAIN FUSED TO NONPRECIOUS METAL, POSTERIOR	$ 475.00	$ 425.00
PONTIC - PORCELAIN FUSED TO NONPRECIOUS METAL	$ 475.00	$ 425.00
PONTIC - PORCELAIN FUSED TO SEMIPRECIOUS METAL	$ 500.00	$ 450.00
PONTIC - PORCELAIN FUSED TO SEMIPRECIOUS METAL, POSTERIOR	$ 500.00	$ 450.00
PONTIC - RESIN WITH GOLD	$ 500.00	$ 450.00
PONTIC - RESIN WITH NONPRECIOUS METAL	$ 425.00	$ 350.00
PONTIC - RESIN WITH SEMIPRECIOUS METAL	$ 450.00	$ 350.00
INLAY - METALLIC, 2 SURFACES	$ 425.00	$ 400.00
INLAY - METALLIC, 3 SURFACES	$ 450.00	$ 400.00
INLAY - METALLIC, 4 SURFACES	$ 450.00	$ 400.00
RETAINER - METAL	$ 300.00	$ 270.00
BR ABUTMENT - RESIN WITH GOLD	$ 525.00	$ 473.00
BR ABUTMENT - RESIN WITH NONPRECIOUS METAL	$ 475.00	$ 350.00
BR ABUTMENT - RESIN WITH SEMIPRECIOUS METAL	$ 475.00	$ 375.00
ABUTMENT - PORCELAIN WITH GOLD	$ 550.00	$ 500.00
ABUTMENT - PORCELAIN WITH GOLD, POSTERIOR	$ 550.00	$ 500.00
BR ABUTMENT - PORCELAIN WITH GOLD	$ 550.00	$ 500.00
BR ABUTMENT - PORCELAIN WITH NONPRECIOUS METAL	$ 500.00	$ 450.00
BR ABUTMENT - PORCELAIN WITH SEMIPRECIOUS METAL	$ 525.00	$ 475.00
BR ABUTMENT - 3/4 GOLD	$ 525.00	$ 423.00
BR ABUTMENT - FULL GOLD	$ 525.00	$ 475.00
BR ABUTMENT - CAST NONPRECIOUS METAL	$ 475.00	$ 400.00
BR ABUTMENT - CAST SEMIPRECIOUS METAL	$ 500.00	$ 450.00
BR ABUTMENT - SEMIPRECIOUS METAL	$ 500.00	$ 450.00
RECEMENT BRIDGE	$ 100.00	$ 100.00
STRESS BREAKER	$ 200.00	$ 175.00
PRECISION ATTACHMENT	$ 325.00	$ 300.00
COPING - METAL	$ 325.00	$ 300.00
REPLACE BROKEN PIN FACNG	$ 225.00	$ 200.00
REPLACE BROKEN FACNG NO PST	$ 225.00	$ 200.00
REPLACE FACING WITH ACRYLIC	$ 225.00	$ 200.00
REPLACE PONTIC WITH ACRYLIC	$ 225.00	$ 200.00
BRIDGE REPAIR	$ 225.00	$ 200.00
REPLACE FACING WITH RESIN	$ 225.00	$ 200.00
REPLACE PONTIC WITH RESIN	$ 225.00	$ 200.00
BRIDGE REPAIR	$ 225.00	$ 200.00
ORAL SURGERY		
EXTRACTION-SINGLE	$ 65.00	$ 55.00
EXTRACT DECIDUOUS	$ 65.00	$ 55.00
EXTRACTION - EACH ADDITIONAL TOOTH	$ 65.00	$ 55.00
ROOT REMOVAL	$ 75.00	$ 65.00
EXTRACTION - SURGICAL	$ 150.00	$ 125.00
EXTRACT - SURGICAL, EACH ADDITIONAL TOOTH	$ 150.00	$ 125.00
EXTRACTION - SOFT TISSUE	$ 200.00	$ 175.00
EXTRACTION - PARTIAL BONY IMPACTION	$ 275.00	$ 250.00
EXTRACTION - FULL BONY IMPACTION	$ 325.00	$ 300.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
EXTRACTION - FULL BONY WITH COMPLICATION	$ 375.00	$ 325.00
EXTRACT - RESIDUAL ROOT	$ 200.00	$ 175.00
OROANTRAL FISTULA CLOSURE	$ 325.00	$ 300.00
REIMPLANT TOOTH	$ 300.00	$ 250.00
SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH FOR ORTHOD	$ 400.00	$ 350.00
SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH TO AID ERUP	$ 200.00	$ 175.00
BIOPSY ORAL TISSUE - HARD	$ 250.00	$ 200.00
BIOPSY ORAL TISSUE - SOFT	$ 200.00	$ 175.00
ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS PER QUADRANT	$ 175.00	$ 150.00
ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS PER QUADRA	$ 250.00	$ 225.00
RADICAL EXCISION<1.25C	$ 200.00	$ 175.00
RADICAL EXCISION>1.25C	$ 200.00	$ 175.00
EXCISE BENIGN < 1.25CM	$ 200.00	$ 175.00
EXCISE BENIGN > 1.25CM	$ 250.00	$ 225.00
EXCISE MALIGNANT<1.25C	$ 200.00	$ 175.00
EXCISE MALIGNANT>1.25C	$ 400.00	$ 350.00
CYSTECTOMY < 1.25 CM	$ 250.00	$ 225.00
CYSTECTOMY > 1.25 CM	$ 350.00	$ 300.00
EXOSTOSIS	$ 250.00	$ 225.00
INCISION & DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	$ 150.00	$ 125.00
INCISION & DRAINAGE OF ABSCESS -EXTRAORAL SOFT TISSUE	$ 200.00	$ 180.00
SEQUESTRECTOMY	$ 250.00	$ 225.00
FRENULECTOMY	$ 150.00	$ 125.00
EXCISION OF HYPERPLASTIC TISSUE PER ARCH	$ 225.00	$ 200.00
EXCISION OF PERIOCORONAL GINGIVA	$ 150.00	$ 125.00
ALVEOLECTOMY PER TOOTH	$ 50.00	$ 45.00
ORTHODONTICS		
ORTHODONTIC TREATMENT - TRANSITIONAL DENTITION	20% discount	25% discount
ORTHODONTIC TREATMENT - ADOLESCENT DENTITION	20% discount	25% discount
ORTHODONTIC TREATMENT - ADULT DENTITION	20% discount	25% discount
REMOVABLE APPLIANCE THERAPY	$ 400.00	$ 360.00
FIXED APPLIANCE THERAPY	$ 400.00	$ 360.00
PRE-ORTHODONTIC TREATMENT	$ 150.00	$ 125.00
PERIODIC ORTHODONTIC VISIT	$ 100.00	$ 90.00
ADJUNCTIVE SERVICES		
EMERGENCY PALLIATIVE	$ 60.00	$ 55.00
LOCAL ANESTHESIA	$ 40.00	$ 35.00
NITROUS OXIDE	$ 50.00	$ 45.00
IV SEDATION	$ 250.00	$ 225.00
CONSULTATION	$ 100.00	$ 90.00
OFFICE VISIT-AFTER HRS	$ 200.00	$ 180.00
OTHER DRUGS/MEDICAMENT	$ 75.00	$ 65.00
DESENSITIZE MEDICATION	$ 40.00	$ 35.00
OCCLUSAL SPLINT	$ 300.00	$ 270.00
ANESTHESIA BY SURGEON	$ 200.00	$ 180.00
OCCLUSION ANALYSIS	$ 175.00	$ 150.00
OCCLUSAL ADJUSTMENT - LIMITED	$ 75.00	$ 65.00
OCCLUSAL ADJUSTMENT - COMPLETE	$ 350.00	$ 300.00

Description of Service	Standard Dental Copayment	Dental Plus Copayment
WHITENING SERVICES		
BRITESMILE	10% discount	10% discount
NITEWHITE	10% discount	10% discount