Dental Benefit Providers

UnitedHealthcare New York Select Managed Care Plan Dental Provider Manual

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Welcome

Welcome to the UnitedHealthcare New York Select Managed Care Plan Dental Provider Manual.

Our Managed Care UHIC Dental Select Plans were created to provide an array of Managed Care Dental plans for our members.

These plans were created to meet the needs of employers who wish to offer employees access to affordable, quality dental care. As a participating Dentist in the Dental Select Network, you may be selected by Members as their Primary Care Dentist or Specialist, and you will be responsible for providing and coordinating dental treatment for these members.

The Dental Select Members that have selected you as their Dentist, are our members, but your patients. All treatment plans, delivery of care and office administration are let to your professional discretion, but must be consistent with professionally recognized standards of dental practice, continued maintenance of sound dental health and the procedures, guidelines and policies of the Dental Select Plans.

The provider manual is designed to assist your dental office staff in the daily administration of the Dental Select Plans. This guide is intended to supplement the agreement executed with your participating dental office.

The provider manual is organized in sections which cover areas of interest to your participating dental office. As procedures and policies are revised or created, updates will be distributed to you. Please keep the provider manual readily available and insert the updated material promptly so that it remains current at all times.

This manual is being provided in accordance with your executed agreement. We encourage you to contact our Provider Services team at 1-800-232-0990 during regular business hours for assistance, or our Integrated Voice Response (IVR) is available at the same number 24 hours per day/7 days per week.

UnitedHealthcare Insurance Company (UHIC) of NY

UHIC of NY Dental Select Plan members must select a Primary Care Provider (PCP) and be assigned to that provider's practice before treatment is rendered. It is important that the provider verify a member's eligibility and assignment **prior** to providing dental services.

All in-network providers receive copayments from members at the time of service. Copayments are payments for covered procedures based on the member's contracted Schedule of Benefits.

In-network PCPs are also reimbursed at a predetermined fixed rate. The fixed rate, known as a prepayment fee, is paid on a per-member per-month (PMPM) basis, and is based on member eligibility and provider assignment. A monthly roster and corresponding prepayment fee check are usually mailed each month to participating providers with membership assigned to their office. Prepayment Fee is pre-paid for the month and represents UHIC of NY's payment in full. Additional compensation for supplemental payments, minimum procedural guarantees, etc., must be submitted for payment to the Plan as outlined within the following sections.

UHIC of NY Dental Select Plans has a Specialty Referral process in place for treatment beyond the scope of the PCP. It is mandatory that all Specialty Referral requests be initiated by the PCP and treatment is then authorized by UHIC of NY to a contracted MANAGED CARE Specialist for select procedures based upon Specialty Referral guidelines as provided in this manual. There are some exceptions to this requirement. Any unapproved referrals or unauthorized treatment will not be reimbursed by UHIC of NY and may become the Specialist's or PCP's financial responsibility. The member is not to be charged for the PCP or Specialist's failure to follow the Specialty Referral process.

Plan exclusions and limitations apply. For more information on the UHIC of NY Dental Select Plans, please contact Customer Service at 1-800-232-0990.

Frequently Asked Questions

Is there an annual maximum for members?

Please refer to the members' specific plan benefits.

Will I receive an eligibility list?

You will receive your list at the beginning of each month.

What is the phone number to check eligibility?

The toll-free number for **Dental Select Managed Care New York** products is 1-800-232-0990. Let the Customer Service Representative know that you are calling to check eligibility for a member.

Does the entire family need to receive care from my office?

No. Our plans allow members to choose different dental offices.

When do I collect copayments?

Copayments are due and payable directly from the Member at the time services are rendered.

Will I need to submit claim forms?

Yes, for **Dental Select Managed Care New York**, products, you need to submit Universal Claim Forms (ADA Claim Form). Mail completed form to:

Dental Select Managed Care New York
P.O. Box 30567, Salt Lake City, UT 84130

When do I send in our claim forms?

We request that you send your claims within 30 days and all Direct Compensation claims should be submitted by the 5th day of the month.

Is a referral to a specialist a covered benefit?

Please refer to the plan's exclusions and limitations. You will need to fill out a "Specialty Referral Request Form." Send the completed form to the following address:

Dental Select Managed Care New York
P.O. Box 30552, Salt Lake City, UT 84130

How do I refer for emergency care?

The general dentist is expected to provide relief of pain and palliative care and submit for a written referral.

How do I obtain additional forms or assistance?

For **Dental Select Managed Care New York,** please call 1-800-232-0990.

Quick Reference Guide

Especially for our providers — An easy reference guide that shows you how to reach us quickly. We're here to help!

Quick Reference Guide	Dental Benefit Providers, Inc. A UnitedHealth Group Company
Website The website offers many timesaving features including **eligibility verification, claims status** and **network specialist locations**.	www.dbp.com
Integrated Voice Response (IVR) System We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 7 days a week by responding to the system's voice prompts. Through this system, network dental offices can obtain immediate **eligibility information, assign a member to their office**, check the **status of claims** and receive an explanation of benefits. The system also has the ability to fax eligibility confirmation directly to the caller.	1-800-232-0990
Dedicated Toll-Free Customer Service Phone Number Call the toll-free number during normal business hours to speak with knowledgeable specialists. They are trained to handle specific dentist issues such as **eligibility, claims** and **dental plan information**.	1-800-232-0990
Provider Relations Contact the Provider Relations department when you have questions regarding **fee schedules, monthly rosters** and **contracts**.	1-800-232-0990
Addresses Submit paper claims	Dental Benefit Providers P.O. Box 30567 Salt Lake City, UT 84130
Written Inquiries and Appeals	Dental Benefit Providers P.O. Box 30569 Salt Lake City, UT 84130

Quick Reference Guide	Dental Benefit Providers, Inc. A UnitedHealth Group Company
Submit Referrals and Pre-treatment Estimates	Dental Benefit Providers P.O. Box 30552 Salt Lake City, UT 84130
Encounter data submission	Dental Benefit Providers P.O. Box 30567 Salt Lake City, UT 84130 Use ADA Claim Form.

Eligibility Verification

Prior to rendering services, your provider contract states that you must verify the *member's eligibility and assignment to your office*. This section contains helpful tips on how to establish eligibility quickly and easily, by utilizing our Interactive Voice Response system, our Internet website or your monthly roster.

Interactive Voice Response (IVR) Unit

Our Enhanced Technology Makes It Easier for Providers

The Interactive Voice Response (IVR) unit provides you with the ability to obtain up-to-the minute eligibility information with one quick telephone call. You may verify the eligibility and office assignment for one or more members using your touch-tone keypad. This 24-hours-a-day, 7-days-a-week, toll-free access delivers immediate eligibility information directly by fax to your office.

It's easy to get started.

All you need is the following:

- A touch-tone phone
- Your Provider ID number
- The member's name, subscriber ID number and date of birth
- Your dental office fax number

When you call our IVR system, here's what you'll receive:

- Confirmation of the member's name
- Dependent information
- Plan details

Upon your request, our IVR system will automatically fax your office all the information you need to effectively and efficiently service your patients.

It's as simple as that!

The IVR is never busy and there is never a wait.

The IVR is available 24 hours a day, 7 days a week.

IVR Telephone Numbers

DBP.com 1-800-232-0990

*A member's ID card is not proof of eligibility. Please refer to your roster.

You can also verify eligibility on our website at www.dbp.com 24 hours a day, 7 days a week. In addition to current eligibility verification, our website offers other functionality for your convenience such as claims status, procedure level pricing, fee schedules, benefit information and a provider search.

We Make It Easy to Get Started

Once you have registered on our provider website at www.dbp.com, you can verify your patients' eligibility online with just a few clicks.

To register at the site you will need the following information:

- Tax Identification Number
- Practitioner ID Number — if you do not know your new UnitedHealthcare Dental ID Number, please contact Customer Service
- Password (you will create your own)

Note: *Passwords are the responsibility of the dental office (see agreement during the registration process).*

Prepayment Fee Overview

A Prepayment Fee is an alternative to the traditional PPO insurance system. Under a prepayment fee arrangement, a comprehensive set of dental benefits is provided to the member at a predetermined fixed rate. The fixed rate, known as a prepayment fee or PMPM (per member per month), is paid for a specific period, usually monthly.

Here is how it works:

1. A new Dental Select plan roster is mailed each month. The roster details the prepayment fee being paid for each covered member assigned to your office.
2. The member's eligibility is typically effective the first day of the month.
3. It is important that your facility verify member eligibility and member assignment prior to treatment.
4. If a member does not show on the roster, we offer several ways to verify eligibility via IVR and the web portal.
5. Copayments are due and should be collected from the member at the time services are rendered. Refer to the member's specific dental plan/schedule.

General Exclusions

Except as may be specifically provided in the *Schedule of Covered Dental Services* or through a Rider to the Policy, the following are not Covered:

A. Dental Services that are not Necessary.

B. Hospitalization or other facility charges.

C. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the *Schedule of Covered Dental Services*.

D. Reconstructive surgery, except when the surgery is related to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any Dental Procedure not directly associated with dental disease.

F. Any Dental Procedure not performed in a participating dental setting.

G. Procedures that are considered to be 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 to be Experimental, Investigational or Unproven in the treatment of that particular condition.

H. Any implant procedures performed which are not listed as Covered implant procedures in the *Schedule of Covered Dental Services*.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

M. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. 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.

N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral, that are predominately medical in nature. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

O. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

P. Attachments to conventional removable prostheses 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.

Q. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

R. Replacement of crowns, bridges, and fixed or removable prosthetic appliances, inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.

S. Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.

T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

V. Services rendered by a provider who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

W. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

X. Services while the insured is outside the United States, its possessions or the countries of Canada or Mexico unless required as an emergency.

Y. Dental Services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

Z. Any Dental Services or Procedures not listed in the *Schedule of Covered Dental Services*.

Orthodontic = Coverage

If a member requires the services of an orthodontist, a referral must first be obtained. If a member requires the services of an orthodontist, a referral must first be obtained. You must provide the member a referral to a contracted Orthodontic provider; if not, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered only by a Network orthodontist.

If a member terminates coverage from the UHC Plan after the start of orthodontic treatment, the member will be responsible for any additional charges incurred for the remaining orthodontic treatment.

A. The following are not covered orthodontic benefits:
   - Lost, stolen, or broken appliances
   - Treatment in progress prior to the effective date of UHC Dental coverage
   - Extractions required for orthodontic purposes
   - Surgical orthodontics or jaw repositioning
   - Myofunctional therapy
   - Cleft palate
   - Micrognathia
   - Macroglossia
   - Hormonal imbalances
   - Orthodontic re-treatment when initial treatment was rendered under this plan
   - Palatal expansion appliances

B. If a treatment plan is for less than 24 months, then a prorated portion of the full Covered Person Copayment shall apply.

C. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.

D. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.

E. A Covered Person is eligible for only one 24-month orthodontic treatment period while covered under this Plan.

F. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24-month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24-month benefit period.

G. Extractions performed solely to facilitate orthodontic treatment, re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident or replacement or repair of orthodontic appliances damaged due to the neglect of the Covered Person are not covered.

Limitation of Benefits

The following are the limitations of benefits:

Diagnostic Services

1. **Periodic Oral Evaluation** — Limited to 2 times per consecutive 12 months.
2. **Limited or Detailed Oral Evaluation** — Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.
3. **Comprehensive Oral Evaluation** — Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.
4. **Intraoral – Complete Series (including bitewings)** — Limited to 1 time per consecutive 36 months. Vertical Bitewings can not be billed in conjunction with a complete series.
5. **Extraoral Radiographs** — Limited to 2 films per calendar year.
6. **Intraoral Bitewing Radiographs** — Limited to 1 series of films per calendar year.
7. **Panorex Radiographs** — Limited to 1 time per consecutive 36 months.
8. **Oral/Facial Photographic Images** — Limited to 1 time per consecutive 36 months.
9. **Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures** — Limited to Covered Persons over the age of 30 and limited to 1 per consecutive 12 months.
10. **Pulp Vitality Tests** — Limited to 1 charge per visit, regardless of how many teeth are tested.
11. **Diagnostic Casts** — Limited to 1 time per consecutive 24 months.
12. **Comprehensive Periodontal Evaluation – new or established patient** — Limited to 2 times per consecutive 12 months.

Preventive Services

1. **Dental Prophylaxis** — Limited to 2 times per consecutive 12 months.
2. **Fluoride Treatments – child** — Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
3. **Fluoride Treatments – adult** — Limited to Covered Persons over the age of 16 years, and limited to 2 times per consecutive 12 months.
4. **Sealants** — Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
5. **Space Maintainers** — Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
6. **Re-cement Space Maintainers** — Limited to 1 per consecutive 6 months after initial insertion.

Minor Restorative Services

1. **Amalgam Restorations** — Multiple restorations on one surface will be treated as a single filling.
2. **Composite Resin Restorations – Anterior** — Multiple restorations on one surface will be treated as a single filling.
3. **Composite Resin Restorations – Posterior** — Multiple restorations on one surface will be treated as a single filling.

Endodontics

1. **Pulp Caps – Direct/Indirect – excluding final restoration** — Not Covered if utilized solely as a liner or base underneath a restoration
2. **Therapeutic Pulpotomy** — Limited to 1 time per primary or secondary tooth per lifetime.
3. **Pulpal Debridement, Primary and Permanent Teeth** — Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.
4. **Pulpal Therapy (resorbable filling) – Anterior or Posterior, Primary Tooth (excluding final restoration)** — Limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.
5. **Root Canal Therapy** — Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the re-treatment for the first 12 months.
6. **Re-treatment of Previous Root Canal Therapy** — Dentist who performed the original root canal should not be reimbursed for the re-treatment for the first 12 months.
7. **Apexification** — Limited to 1 time per tooth per lifetime.
8. **Apicoectomy and Retrograde Filling** — Limited to 1 time per tooth per lifetime.
9. **Root Resection/Amputation** — Limited to 1 time per tooth per lifetime.
10. **Hemisection** — Limited to 1 time per tooth per lifetime.

Periodontics

1. **Gingivectomy/Gingivoplasty** — Limited to 1 per quadrant or site per consecutive 36 months.
2. **Gingival Flap Procedure** — Limited to 1 per quadrant or site per consecutive 36 months.
3. **Crown Lengthening** — Limited to 1 per quadrant or site per consecutive 36 months.
4. **Osseous Surgery** — Limited to 1 per quadrant or site per consecutive 36 months.
5. **Osseous Graft** — Limited to 1 per quadrant or site per consecutive 36 months.
6. **Soft Tissue Surgery** — Limited to 1 per quadrant or site per consecutive 36 months.
7. **Scaling and Root Planing** — Limited to 1 time per quadrant per consecutive 24 months. Limited to 2 quadrants per visit.
8. **Full Mouth Debridement** — Limited to once per consecutive 36 months.
9. **Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report** — Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.
10. **Periodontal Maintenance** — Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

Fixed and Removable Prosthetics

1. **Partial Dentures** — Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
2. **Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns** — Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

3. **Relining and Rebasing Dentures** — Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
4. **Tissue Conditioning – Maxillary or Mandibular** — Limited to 1 time per consecutive 12 months.

Major Restorative Services

1. **Pontics** — Limited to 1 time per tooth per consecutive 60 months.
2. **Pontics – Porcelain/Ceramic** — Limited to 1 time per tooth per consecutive 60 months
3. **Inlays/Onlays – Retainers/Abutments** — Limited to 1 time per tooth per consecutive 60 months.
4. **Inlays/Onlays – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
5. **Inlays/Onlays – Porcelain/Ceramic or Composite/Resin – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
6. **Crowns – Retainers/Abutments** — Limited to 1 time per tooth per consecutive 60 months.
7. **Crowns – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
8. **Crowns – Resin-Based Composite – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
9. **Crowns – ¾ Porcelain/Ceramic – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
10. **Crowns – ¾ Resin-Based Composite – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
11. **Temporary Crowns – Restorations** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. **Stainless Steel Crowns** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown — primary tooth, are limited to primary anterior teeth.
13. **Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core** — Limited to those performed more than 12 months after the initial insertion.
14. **Post and Cores** — Covered only for teeth that have had root canal therapy.
15. **Pin Retention** — Limited to 2 pins per tooth; not Covered in addition to cast restoration.
16. **Sedative Filling** — 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.
17. **Labial Veneers – Chairside or Laboratory** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

Major Services, Fixed Prosthetics and Removable Prosthetics

1. **Fixed Partial Dentures (Bridges)** — Limited to 1 time per tooth per consecutive 60 months.
2. **Full Dentures** — Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.

3. Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.
4. A Covered Person's recommended treatment plan may include six (6) or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the Covered Person must pay both: (a) the usual crown or bridge patient charge for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Schedule of Benefits. The maximum benefit within a 12-month period is for 6 crowns or pontics.

Implants

1. **Implant Placement** — Limited to 1 time per consecutive 60 months. Implant Supported Prosthetics — Limited to 1 time per consecutive 60 months.
2. **Implant Maintenance Procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis** — Limited to 1 time per consecutive 12 months.
3. **Repair Implant Supported Prosthesis, by report** — Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months
4. **Abutment Supported Crown (titanium) or Retainer Crown for FPD – titanium** — Limited to 1 time per consecutive 60 months.
5. **Repair Implant Abutment, by report** — Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.
6. **Implant Removal, by report** — Limited to 1 time per consecutive 60 months.
7. **Radiographic/Surgical Implant Index, by report** — Limited to 1 time per consecutive 60 months.
8. **Replacement of implants, implant crowns, implant prosthesis, and implant supporting structures** (such as connectors) previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.

Oral Surgery

1. **Simple Extractions** — Limited to 1 time per tooth per lifetime.
2. **Surgical Extraction of Erupted Teeth or Roots** — Limited to 1 time per tooth per lifetime.
3. **Surgical Extraction of Impacted Teeth** — Limited to 1 time per tooth per lifetime.
4. **Primary Closure of a Sinus Perforation** — Limited to 1 per tooth per lifetime.
5. **Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth** — Limited to 1 time per tooth per lifetime.
6. **Biopsy** — Limited to 1 biopsy per site per visit.
7. **Removal of a Benign Odontogenic Cyst/Lesions** — Limited to 1 per site per visit.
8. **Removal of Torus** — Limited to 1 per site per visit.
9. **Surgical Incision** — Limited to 1 per site per visit.
10. **Excision of Hyperplastic Tissue or Pericoronal Gingiva** — Limited to 1 per site per consecutive 36 months.
11. **Root Removal, Surgical** — Limited to 1 time per tooth per lifetime.
12. **Placement of Device to Facilitate Eruption of Impacted Tooth** — Limited to 1 time per tooth per lifetime.

Adjunctive Services

1. **Palliative Treatment** — Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.
2. **General Anesthesia** — Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.
3. **Intravenous Sedation and Analgesia** — Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.
4. **Occlusal Guards** — Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
5. **Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment)** — Not Covered if done with exams or professional visit performed on the same day by the same provider performing services related to diagnosis.

Miscellaneous Services

1. **External Bleaching – Per Arch** — Coverage for external bleaching is limited to the fabrication of bleaching trays for home application of a bleaching product. In-office techniques, such as those using light activated material, are excluded from coverage. Limited to 1 time per consecutive 12 months.
2. The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person may pay: (a) the usual patient charge for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal not to exceed $150.
3. **Labial Veneers – Chairside or Laboratory** — Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

Specialty Referral-General Dentist

The general dentist is responsible for performing services specifically listed on the Schedule of Benefits. However, during the course of patient treatment, the general dentist may determine that the services of a specialist are necessary to address the Patient's dental needs. Specialty referral requests are coordinated through the general dentist.

Not all referrals for specialty care are processed in the same manner; therefore, it is essential that you check the member's specific Schedule of Benefits to ensure that you are following appropriate guidelines for their specialty referral.

The referring general dentist is not financially responsible for charges for specialty care services when the patient has been appropriately referred to a contracted specialty provider for covered dental services. The referring general dentist may be financially responsible for a portion of the specialty dental care when an inappropriate referral is made. An inappropriate referral is a referral that does not meet Specialty Referral Criteria and guidelines described in this section.

To facilitate referrals for specialty dental care, DBP utilizes two methods for referral:

- **Direct Referral:** The general dentist directly refers the enrollees to any contracted specialists (limited to certain procedures, as described below).
- **Pre-Authorization Referral:** The general dentist must submit a pre-authorization request to have an enrollee treated by a specialist.

Following the completion of specialty services, the referring general dentist is responsible for maintaining the continuity of care, including the coordination of and follow-up of care for the patient. In almost every situation, it is advisable for the contracting general dentist and the contracting specialist to consult in order to clarify treatment objectives. The dental plan encourages a close working relationship with communication between referring dentist and specialists to improve treatment outcomes.

Referral requests initiated by contracting specialist providing services to an enrollee; e.g., a Periodontist recommending endodontic procedures, must be coordinated and requested through the contracting general dentist.

Pre-Authorization Steps for the General Dentist

For plans that require pre-authorization of benefits prior to referring the patient to a specialty practice, the contracting general dentist will complete the following steps to obtain the pre-authorization of benefits.

1. Verify patient eligibility and plan coverage for dental services. A specialist referral will not be authorized for procedures that are not covered on the enrollee's specific plan.
2. Complete the Specialty Referral Form.
3. Attach supporting documentation (diagnostic radiograph, pocket charting, if indicated, and any other documentation that supports the clinical indication/rationale for the referral). Please label all radiographs with patient name, date taken and your facility's name and address.
4. Send the form with all documentation attached to the DBP.com plan address as indicated on the Specialty Referral Form.

Upon receipt of the pre-determination of benefits, the enrollee will contact the specialty office to schedule an appointment for completion of treatment.

Should a situation arise where additional information is required to determine the coverage of benefits, the following should occur:

1. A Pre-Determination of Benefits Form will be generated and mailed to the enrollee indicating that additional information has been requested from the referring dentist.

2. A Pre-Determination of Benefits Form will be sent to the referring general dentist with the original referral request, records, and documentation indicating what additional information is required to determine coverage of benefits.

When coverage of benefits is denied, a copy of the original referral request with all documentation is returned to the referring dentist. A reconsideration of denied benefits will be re-evaluated by resubmitting the original Specialty Referral Form with all appropriate documentation and any additional information pertinent to the appeal.

Emergency Service Language

An emergency is defined as conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection.

The general dentist is responsible for providing 24-hour emergency care to eligible members assigned to your office. Emergency patients must be seen within 24 hours of their initial request for treatment. Message retrieval systems or alternate coverage is required to ensure the patient timely access to your office or a participating designee.

If a referral to a specialist is anticipated, the general dentist should provide palliative care to alleviate symptoms and stabilize the member's condition and then follow the normal referral process, including obtaining applicable prior authorization.

Direct Referral (Pediatrics, Orthodontics, Molar Endodontics, Implant Placement, and Extraction of Partial or Full Bony Impacted Teeth)

These treatment categories have a direct referral feature. DBP.com established the direct referral process to facilitate delivery of dental care, to reduce paperwork for the dental office, and to improve customer satisfaction. As a general dentist, you may locate a contracting specialist by visiting DBP.com or by contacting our Customer Service department. You may directly refer your DBP.com patients for routine or emergency specialty care to any of the specialists listed in the directory on our website, or names you received from customer service, without requesting pre-authorization.

To find a contracted specialist participating with the member's plan, please contact Customer Service, or log onto DBP.com, and choose the following plan: Dental Select Prepaid — New York.

When a routine or emergency specialty care referral is indicated for enrollees whose plan allows for direct referral, the contracting general dentist will:

1. Verify the enrollee's eligibility and coverage of benefits for the proposed dental care services.
2. Select a contracting specialty care dentist from DBP.com or by contacting our Customer Service department at 1-800-232-0990.
3. Complete the Specialty Referral Form. All sections of the form must be completed.
4. Give the Specialty Referral Form and all clinical documentation to the patient for transmittal to the specialty care dentist. If time permits, the referring dentist may mail all documentation to the specialty care dentist.
5. The contracting general dentist is responsible to follow up with the patient to ensure completion of referred specialty care.

If there is no specialist in your area, contact DBP.com at 1-800-232-0990 for assistance in locating a specialist and to acquire pre-authorization of this type of referral. If allowed, the non-participating specialist will generally have authorization only for the initial consultation and necessary radiographs. For definitive treatment, additional pre-authorization must be obtained through the same process. If your office refers to a non-participating specialist, without prior approval from DBP.com, your office may be financially liable for the difference in fees between a participating and a non-participating specialist.

Complete the Specialty Referral Form in duplicate, retain a copy for your records, and give the member a copy to accompany them to the specialty appointment.

Pre-authorization of specialty treatment services by a participating specialist is required with the exception of:

- Services by a pediatric dentist under $300.00. Complete treatment plans and definitive treatment must be pre-authorized with DBP.com
- Orthodontic treatment
- Molar endodontics
- Surgical placement of an implant body
- Extraction of partial or full bony impacted teeth

The specialty care dentist should:

1. Verify the enrollee's eligibility and coverage of the benefits for the proposed dental care services by calling DBP.com Customer Service at our toll-free telephone number, 1-800-232-0990.
2. Determine if proposed treatment listed is an appropriate referral. Please refer to the Specialty Referral Criteria.
3. It is advisable that the contracting specialty care dentist and contracting general dentist consult to clarify treatment objectives. DBP.com encourages a close working relationship and communication between referring dentist and specialty care dentist to improve treatment outcomes.
4. Provide treatment and submit a dental claim form for payment within ninety (90) days from the date of service, along with the Specialty Referral Form and appropriate clinical documentation; i.e., radiographs, periodontal charting, etc.
5. DBP.com recommends that the specialty office provide a report to the referring dentist upon completion of the treatment.

Retrospective Review for Direct Referrals

Direct referrals are subject to retrospective review by the DBP.com Dental Director or a Dental Consultant to confirm that the referral guidelines and criteria were met. In cases where the referral was deemed inappropriate, DBP.com will notify the referring general dentist of such determination within thirty (30) days of the completed review. In such cases, the member will be financially responsible only for the applicable copayment and the treating specialist shall receive payment of benefits for covered services. The referring dentist may be subject to a back charge to cover the costs DBP.com incurred for the inappropriate referral. The referring dentist may appeal the determination in writing via letter, e-mail, or facsimile. DBP.com will process the appeal request in accordance with any regulatory requirements and existing policies and procedures.

Specialty Referral Criteria

Please refer to the following criteria to determine the appropriateness of specialty referral for your patient. In order for benefits to apply, the member must be eligible at the time services are rendered.

DBP.com's Specialty Referral Guidelines are based upon professionally recognized standards of care, are referenced as standards and parameters of care as described by the American Dental Association, and are reviewed by DBP.com's clinical committees on an annual basis.

Endodontic

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

- Teeth with extreme curvature of roots
- Teeth with incomplete apex formation
- Teeth with completely calcified canals (totally obliterated); teeth with partially calcified canals (after a documented unsuccessful attempt to fully negotiate the canals and treat the tooth has been made)
- Re-treatments of teeth that have had previous root canal therapy and are exhibiting one or more of the following conditions:
  a. Unresolved periradicular pathology with radiographic evidence of a deficiency in the quality of root canal filling;
  b. Teeth with questionable quality root canal therapy treatment planned for restorative or prosthetic procedures; or
  c. Persistent symptoms associated with previously treated tooth when there is reason to question the adequacy of previous endodontic therapy.
- Apicoectomies/retrofills of teeth that meet one or more of the following conditions:
  a. A marked apical or lateral overextension of root canal filling material
  b. A periradicular lesion that is enlarging as noted on follow-up radiographs
  c. A persistent periradicular lesion that has not decreased in size one to two years after the completion of root canal therapy
  d. A persistent sinus tract
  e. An unfilled apical portion in the root canal system or previously treated canal is not accessible because of unusual anatomy or obstruction
- Root amputations
- An unsuccessful attempt to retrieve an instrument broken in the canal
- Apexification/recalcification procedures

Non-covered Endodontic Services May Include, But Are Not Limited To (Per Individual Plan):

- Teeth with a poor, guarded, or hopeless periodontal or endodontic prognosis
- Teeth that cannot be adequately restored
- Teeth that are non-functional and for which no future function is treatment planned (i.e., unopposed third molars)
- Endodontic consultations for treatments that are not covered benefits

Endodontic Referrals That Will Not Be Approved:

- Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under the Plan.
- Any procedure referred because the general dentist does not have the proper size endodontic instruments.
- Root canal treatment which was initiated prior to the member's eligibility to receive benefits under the Plan.
- Procedures performed to facilitate non-covered services.

General Dentist Must Submit the Following Documentation for an Endodontic Referral:

1. Procedure code and description of recommended treatment
2. Tooth number
3. Reason that a referral to a specialist is required
4. Pre-operative periapical radiographs
5. Working periapical radiographs, if appropriate
6. For endodontic re-treatment or apicoectomy, indicate the name of the treating dentist and the date of the previous treatment if within 12 months

Oral Surgery

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

- Partial or full bony impacted third molars and other teeth that have caused or become associated with one or more of the following pathologic conditions:
  a. Follicular cysts or tumors
  b. Persistent infection
  c. Periodontitis caused by or exacerbated by third molars
  d. Resorption of an adjacent tooth due to pressure from the third molar
- Greater than six simple extractions; more than one soft tissue impaction; or multiple surgical extractions
- Biopsy of cysts, neoplasms, soft- and hard-tissue lesions
- Soft-tissue surgeries including frenulectomy, frenectomy or surgical exposures
- Exostosis/torus removal

Non-covered Oral Surgery Services May Include, But Are Not Limited To (Per Individual Plan):

- The prophylactic removal (elective removal) of third molars, impacted teeth and residual roots impacted in bone
- Extractions for orthodontic purposes only (based on the patient's benefit plan)
- Orthognathic surgery

- Treatment of fractures
- Placement/removal of implants or any other services related to implants
- Ridge augmentations
- Treatment of malignancies, cysts, or neoplasms
- Treatment of TMJ disorders
- General anesthesia or IV sedation unless otherwise listed as a covered benefit
- Oral surgery consultations for procedures that are not covered benefits

Oral Surgery Referrals That Will Not Be Approved:

- Any procedure listed as exclusion, in excess of Plan limitations, or as not covered under the Plan
- Routine simple extractions
- Surgical extractions of erupted teeth
- Histopathological examinations or removal of tumors, cysts, neoplasms, or foreign bodies that are not tooth-related
- Oral surgery requiring the setting of a fracture or dislocation
- Extractions performed solely to facilitate orthodontic treatment
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges
- Extraction of teeth when there is no radiographic evidence of pathological condition or for the following conditions:
  - Prophylactic/elective removal of non-pathologic teeth or tooth buds
  - Lack of erupted space
  - Non-specific pain
  - Pain due to eruption
  - Headaches
  - Solely for orthodontic reasons

General Dentist Must Submit the Following Documentation for an Oral Surgery Referral:

1. Procedure code and description of recommended treatment
2. Tooth number
3. Reason that a referral to a specialist is required
4. Pre-operative periapical radiograph
5. Pre-operative panoramic radiograph, if available
6. Documentation of a specific pathological condition which supports the need for removal of requested tooth

Periodontics

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

- Gingivectomy
- Soft tissue flap surgery
- Crown lengthening
- Mucogingival surgery
- Osseous surgery
- Soft tissue grafts
- Distal wedge procedure
- Root amputation/hemisection
- Consultations for aid in diagnosis: The general dentist may recommend referral to the periodontist when a member presents a periodontal condition in which the general dentist requires assistance to determine the restorability of teeth and/or periodontal diagnosis/treatment plan prior to initial periodontal treatment (i.e., scaling and root planing, etc.). It is important that this be clearly documented on the referral form.

Non-covered periodontal services may include, but are not limited to (per individual plan):

- Consultations for non-covered services
- Splinting
- Occlusal guards
- Implant services
- Periodontal surgery for teeth with a guarded, poor, or hopeless endodontic, restorative or periodontal prognosis

Periodontal Referrals That Will Not Be Approved:

- Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under the Plan
- Procedures performed to facilitate non-covered services
- Following an appropriate informed consent, if the member elects to proceed with treatment that is not covered, the member is responsible for the specialist's usual and customary charge. The specialist should have the member sign a written financial agreement
- Cases for which appropriate initial periodontal therapy (such as scaling and root planing) has not been completed by the general dentist

General Dentist Must Submit the Following Documentation for a Periodontic Referral:

1. Procedure code and description of recommended treatment
2. Tooth number
3. Reason that a referral to a specialist is required

4. Complete series of radiographs (panoramic radiograph is not acceptable)
5. Initial periodontal pocket charting and evaluation
6. Dates of scaling and root planing
7. Periodontal pocket charting, taken at least thirty (30) days after scaling and root planing is performed
8. Diagnosis, surgical and non-surgical

Restorative and Prosthetics

The general dentist is required to perform all appropriate operative, crown, bridge and removable-prosthetic treatment. The general dentist should be proficient in procedures that are considered covered and non-covered benefits. Non-covered procedures should be available to the patient on a fee-for-services basis. Services provided by a prosthodontist are not covered.

Direct Referral

Orthodontics

Not all members have orthodontic coverage. Patients with orthodontic coverage must be referred to a contracted orthodontic office.

Pediatric Dentistry

When a child under 6 years old is determined to be unmanageable by the general dentist, and specialty referral is listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist. In order for benefits to apply, the member must be eligible at the time services are rendered.

Following completion of the pediatric treatment plan by the specialist, the member must return to the general dentist for subsequent services. Pediatric referrals are required for each treatment series up to the member's sixth (6th) birthday. Any services performed by the pediatric dentist after the member's sixth (6th) birthday will not be covered, and the member will be responsible for the pediatric dentist's usual and customary charges.

General dentists are expected to provide routine dental care for children 6 years and older. In some cases, a referral to a pediatric dentist may be appropriate when, in the opinion of the general dentist, such referral is warranted. The previous treatment attempt should be documented on the referral form and include the specific date and circumstances. Coverage benefits to a contracting specialist may be indicated when one or more of the following medical conditions, such as, but not limited to, exists:

- Down syndrome
- Deafness
- Autism
- Multiple sclerosis
- Mentally/physically disadvantaged
- Severe medical problems as documented in writing by a licensed treating physician

- Baby Bottle syndrome (rampant early childhood caries)
- Root canal therapy on permanent teeth with incomplete root formation
- Other conditions/syndromes where formation of the teeth is incomplete or inadequate and restoration or removal of most of the teeth will be necessary

Endodontics

The general dentist may directly refer a member to a contracted specialist for molar endodontic therapy. In order for benefits to apply, the member must be eligible at the time services are rendered.

Implants

When appropriate and listed as a covered service on the eligible member's plan, the general dentist may refer a member to a contracted specialist for the surgical placement of an implant body. In order for benefits to apply, the member must be eligible at the time services are rendered.

The general dentist is expected to coordinate all implant-related restorative procedures, including abutment placement and crown or prosthesis fabrication.

Oral Surgery

The general dentist may refer a member to a contracted specialist for the extraction of impacted teeth. In order for benefits to apply, the member must be eligible at the time services are rendered. Prophylactic or elective extractions are not eligible for coverage.

Specialty Referral Quick Reference Guide for the General Dentist

See the following section for detailed referral guidelines. Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under the Plan are considered inappropriate referrals. Procedures performed to facilitate non-covered services are considered inappropriate referrals.
Referral must be made to an in-network, contracted specialist.

Procedure Category	Appropriate Referrals	Inappropriate Referrals	Criteria for Non-Coverage	Documentation Required
Endodontics (Pre-Authorization Referral)	• Extreme root curvature • Calcified canals • Endodontic re-treatment • Incomplete apex formation • Apicoectomy/retrofill • Root amputation • Broken instrument in canal • Apexification/ recalcification	General dentist does not have the proper size instruments.	• Teeth with poor restorative, periodontal or endodontic prognosis • Teeth that are non-functional • Consultations for treatments that are not covered benefits	• Rationale for referral • Pre-operative X-ray • For re-treatment or apicoectomy: name of treating dentist and date of previous treatment
Endodontics (Direct Referral)	Molar endodontics may be referred directly.			
Oral Surgery (Pre-Authorization Referral)	• Impactions associated with pathology or significant symptoms • Biopsies • Excision of benign odontogenic tumors and cysts • Soft tissue surgery including frenulectomy • Exostosis/torus removal • More than six simple extractions • Greater than one soft tissue impaction • Multiple surgical extractions	• Routine simple extractions • Surgical extractions of erupted teeth	• Prophylactic or elective extractions • Extractions for orthodontic purposes (based on the patient's benefit plan) • Orthognathic surgery, fracture care, ridge augmentation, TMJ disorders • Treatment of malignancies • Consultations for procedures that are not covered benefits	• Rationale for referral • Pre-operative X-ray • Documentation of pathology

Procedure Category	Appropriate Referrals	Inappropriate Referrals	Criteria for Non-Coverage	Documentation Required
Oral Surgery (Direct Referral)	Surgical extractions of partial or full bony impacted teeth.	• Routine simple extractions • Surgical extractions of erupted teeth		
Implants (Direct Referral)	The surgical placement of an implant body may be referred directly.	The general dentist is responsible for coordination of the restoration of the implant.		• Treatment plan • Full mouth X-ray series
Periodontics (Pre-Authorization Referral)	• Hard and soft tissue surgery • Crown lengthening • Root amputation/ hemisection • Consultation for aid in diagnosis or treatment plan	Initial therapy has not been performed by the general dentist.	• Splinting • Occlusal guards • Teeth with a poor endodontic, restorative or periodontal prognosis	• Referral rationale • Complete X-ray series • Periodontal charting (initial and post-scaling/root planing • Date of scaling/ root planing
Orthodontics (Direct Referral)	Patients with orthodontic coverage must be referred to a contracted orthodontic office.			
Pediatric Dentistry under age 6 (Direct Referral) Pediatric Dentistry age 6 and over (Pre-Authorization Referral)	• Children under the age of 6 who are unmanageable • Children 6 years and older when there is a severe medical/ developmental problem as documented in writing by a licensed treating physician	General dentists are expected to provide routine dental care for children age 6 years and older.		

Specialty Referral Processes - Specialty Dentist

The general dentist is responsible for performing services specifically listed on the Schedule of Benefits. However, during the course of patient treatment, the general dentist may determine that the services of a specialist are necessary to address the patient's dental needs. Specialty referral requests are coordinated through the general dentist.

Not all referrals for specialty care are processed in the same manner; therefore, it is essential that you understand the guidelines to facilitate the ease of treating and obtaining payment for treating the member.

To facilitate referrals for specialty dental care, DBP.com utilizes two methods for referral:

- **Direct referral from general dentist:** The general dentist directly refers the enrollees to any contracted specialists. Limited to certain procedures, as described below.
- **Pre-authorization referral from general dentist:** The general dentist must submit a pre-authorization request to have an enrollee treated by a specialist.

Following the completion of specialty services, the referring general dentist is responsible for maintaining the continuity of care, including the coordination of and follow-up of care for the patient. In almost every situation, it is advisable for the contracting general dentist and the contracting specialist to consult in order to clarify treatment objectives. The dental plan encourages a close working relationship with communication between referring dentist and specialists to improve treatment outcomes.

Referral requests initiated by the contracting specialist providing services to an enrollee; e.g., a periodontist recommending endodontic procedures, must be coordinated and requested through the contracting general dentist.

Pre-Authorization by the General Dentist

For DBP.com plans that require the general dentist to pre-authorize benefits prior to referring the patient to a specialty practice, the contracting general dentist will complete the followings steps to obtain the preauthorization of benefits for non-emergency services.

1. Verify patient eligibility and plan coverage for dental services. A specialist referral will not be authorized for procedures that are not covered on the enrollee's specific plan.
2. Complete the DBP.com Specialty Referral Form.
3. Attach supporting documentation (diagnostic radiograph, pocket charting, if indicated, and any other documentation that supports clinical indication/rationale for the referral). The facility will label all radiographs with patient name, date taken, and the name and address of the facility.
4. Send the form with all documentation attached to the DBP.com plan address as indicated on the Specialty Referral Form.

Upon receipt of the pre-determination of benefits, the enrollee will contact the specialty office to schedule an appointment for completion of treatment.

The specialty care dentist should:

1. Verify the enrollee's eligibility and coverage of the benefits for the proposed dental care services by calling DBP.com Customer Service at our toll-free telephone number, 1-800-232-0990.
2. Determine if proposed treatment listed is an appropriate referral. Please refer to the Specialty Referral Criteria.
3. If the treatment requested and approved does not appear to be appropriate or additional treatment is determined to be needed, the specialty dentist will need to submit a pre-determination request to DBP.com, with the appropriate clinical documentation; i.e., radiographs, periodontal charting, etc.

4. It is advisable that the contracting specialty care dentist and contracting general dentist consult to clarify treatment objectives. DBP.com encourages a close working relationship and communication between the referring dentist and specialty care dentist to improve treatment outcomes.
5. Provide treatment and submit a dental claim form for payment within ninety (90) days from the date of service, along with the Specialty Referral Form.

Direct Referral from General Dentist (Pediatrics, Orthodontics, Molar Endodontics, Implant Placement, and Extraction of Partial or Full Bony Impacted Teeth)

These treatment categories have a direct referral feature. As a specialty dentist, you are listed as a contracting specialist and can be located on DBP.com or by contacting our Customer Service department. The general dentist may directly refer DBP.com patients to the appropriate specialists for routine or emergency care, to any of the specialists listed in the directory on our website, or names they received from Customer Service, without requesting pre-authorization.

When a routine or emergency specialty care referral is indicated for enrollees whose plan allows for direct referral, the contracting general dentist will:

1. Verify the enrollee's eligibility and coverage of benefits for the proposed dental care services.
2. Select a contracting specialty care dentist from DBP.com or by contacting our Customer Service department at 1-800-232-0990.
3. Complete the Specialty Referral Form. All sections of the form must be completed.
4. Give the Specialty Referral Form and all clinical documentation including X-rays to the patient for transmittal to the specialty care dentist. If time permits, the referring dentist may mail all documentation to the specialty care dentist.
5. The contracting general dentist is responsible to follow up with the patient to ensure completion of referred specialty care.

The patient will contact the specialty office to schedule an appointment for completion of treatment.

The specialty care dentist should:

- Verify the enrollee's eligibility and coverage of the benefits for the proposed dental care services by calling DBP.com Customer Service at our toll-free telephone number, 1-800-232-0990.
- Determine if proposed treatment listed is an appropriate referral. Please refer to the Specialty Referral Criteria.
- If the referral does not appear to be appropriate or additional treatment is determined to be needed, the specialty dentist will need to submit a pre-determination request to DBP.com, with the appropriate clinical documentation; i.e., radiographs, periodontal charting, etc.
- It is advisable that the contracting specialty care dentist and contracting general dentist consult to clarify treatment objectives. DBP.com encourages a close working relationship and communication between referring dentist and specialty care dentist to improve treatment outcomes.
- For Pediatric, Endodontic, Implant, and Oral Surgery Specialty services, submit a Dental Claim Form for payment within ninety (90) days from the date of service.

Pediatric Dental Care

Pediatric Specialty treatment plans more than $300.00 require the specialty dentist to submit pre-determinations.

Specialty Referral Quick Reference Guide for the Specialist

See the following section for detailed referral guidelines. Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under the Plan are excluded. Procedures performed to facilitate non-covered services are excluded.

Procedure Category	Process	Criteria for Non-Coverage
Endodontics (Pre-Authorization Referral)	The general dentist obtains pre-authorization. If additional treatment is needed, the specialty dentist must submit a pre-determination request to DBP, with the appropriate clinical documentation.	• Teeth with poor restorative, periodontal or endodontic prognosis • Teeth that are non-functional • Consultations for treatments that are not covered benefits
Endodontics (Direct Referral)	Molar endodontics may be directly referred to the specialist, who may render treatment without additional pre-authorization. The general dentist will provide applicable diagnostic radiographs.	Additional diagnostic X-rays unless non-diagnostic X-rays are received from the general dentist. Panoramic X-rays are subject to the frequency limitations of the Plan.
Oral Surgery (Pre-Authorization Referral)	The general dentist obtains pre-authorization. If additional treatment is needed, the specialty dentist must submit a pre-determination request to DBP, with the appropriate clinical documentation.	• Prophylactic or elective extractions • Extractions for orthodontic purposes (based on the patient's benefit plan) • Orthognathic surgery, fracture care, ridge augmentation, TMJ disorders • Treatment of malignancies • Consultations for procedures that are not covered benefits
Oral Surgery (Direct Referral)	Surgical extractions of full or partial bony impacted teeth may be directly referred to the specialist, who may render treatment without additional pre-authorization.	Additional diagnostic X-rays unless non-diagnostic X-rays are received from the general dentist. Panoramic X-rays are subject to the frequency limitations of the Plan.

Procedure Category	Process	Criteria for Non-Coverage
Implants (Direct Referral)	The surgical placement of the implant body may be directly referred to the specialist, who will then submit a treatment plan for pre-authorization, along with appropriate clinical documentation. The general dentist is responsible for coordination of the restoration of the implant.	Additional diagnostic X-rays unless non-diagnostic X-rays are received from the general dentist. Panoramic X-rays are subject to the frequency limitations of the Plan.
Periodontics (Pre-Authorization Referral)	The general dentist obtains pre-authorization. If additional treatment is needed, the specialty dentist must submit a pre-determination request to DBP, with the appropriate clinical documentation.	• Splinting • Occlusal guards • Teeth with a poor endodontic, restorative or periodontal prognosis • Consultations for procedures that are not covered benefits
Orthodontics (Direct Referral)	Members with orthodontic coverage may be directly referred to the specialist, who may render treatment without additional pre-authorization.	
Pediatric Dentistry under age 6 (Direct Referral)	For children under the age of 6 who are unmanageable. Pediatric treatment plans, other than exams, diagnostic and preventative services, require the specialty dentist to submit pre-determinations. The specialist may provide services on the first visit up to a limit of $300.00 without pre-authorization.	
Pediatric Dentistry age 6 and over (Pre-Authorization Referral)	The general dentist obtains pre-authorization. If additional treatment is needed, the specialty dentist must submit a pre-determination request to DBP, with the appropriate clinical documentation.	

Claim Guidelines

How to Read Your Roster

Please refer to the chart below for information on how to verify member eligibility prior to treatment.

Status	Description	Instructions
"A" – Active	Patient Eligible	Locate AGREEMENT ID on eligibility list and refer to fee schedule for copayments (Ex: SCFG00000019)
"N" – Not Eligible	Patient Not Eligible	Contact UHIC OF NEW YORK with patient information to verify status
"T" – Transferred	Patient Eligible in Another DBP Office	Contact UHIC OF NEW YORK with patient information to verify or change office assignment

You can verify eligibility with up-to-the-minute information, 7 days a week, 24 hours a day, by simply calling the Integrated Voice Response (IVR) system at 1-800-232-0990. Please have the following information available:

- Subscriber name, or,
- Subscriber identification number, medical record number or Social Security number.
- The system will prompt you for information. If you get lost, or do not respond, a Customer Service Representative will come on the line during normal business hours.

Note: In the event that a member presents himself/herself for treatment and does not appear on your current eligibility list, your office should immediately call DBP at 1-800-232-0990 to obtain eligibility verification, determine the appropriate patient and plan copayments and, if deemed eligible for care, treat the member accordingly.

Sample Roster

NYCAP -200611012020021100

UnitedHealthcare Dental®
PO Box 30567
Salt Lake City, UT 84130-0567

Phone: 800-821-5813

1826473G2C000110002

CHEN, JOYCE P.
6710-A RITCHIE HWY
GLEN BURNIE MD 21061

SAMPLE NOT NEGOTIABLE

PATIENT ROSTER

Sheet: 2 of 2
Cap Period: 11/01/2006-11/30/2006
Run Date: 07/01/2010
Check No: 00001001
Tax Id Number: 999963554
Payee Id Number: 000000006606

Member Name	Subscriber Id	Mbr #	Client Name	Elig Stat	Effective Date	Prior Balance	Current Capitation Amount	Retro Capitation Amount	Capitation Adjustment Amount	Total Capitation	Adj Reason Code	Agreement Id
TESTOO ARTHUR	T22337788	00	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
TESTOO GWEN	T22337788	01	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
TESTMEMBER ISOLDE	T11223366	00	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
TESTMEMBER TRISTAN	T11223366	01	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
			Total Active Members		4	.00	21.48	.00	.00	21.48		
			Total Non Eligible and Transferred Members									

MC0012.GRN(11805)

This is confidential material and is protected by HIPAA. Please keep this list in a secure place.
Patient Rosters are only printed for members belonging to capitated plans.
Eligibility Status: A - Active, N - Non Eligible, T - Transfer

Sample Roster

NYCAP -20061101202002l100

UnitedHealthcare Dental®
PO Box 30567
Salt Lake City, UT 84130-0567

Phone: 800-822-6613

1826473G2C0000Ca002

CHEN, JOYCE P.
6710-A RIFLE HWY
GLEN BURNIE MD 21061

PATIENT ROSTER

Sheet: 2 of 2
Cap Period: 11/01/2006-11/30/2006
Run Date: 07/01/2010
Check No: 00001001
Tax Id Number: 999963554
Payee Id Number: 000000006606

Member Name	Subscriber Id	Mbr #	Client Name	Elig Stat	Effective Date	Prior Balance	Current Capitation Amount	Retro Capitation Amount	Capitation Adjustment Amount	Total Capitation	Adj Reason Code	Agreement Id
TESTOO ARTHUR	T22337788	00	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
TESTOO GWEN	T22337788	01	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
TESTMEMBER ISOLDE	T11223366	00	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
TESTMEMBER TRISTAN	T11223366	01	United Healthcare	A	11/01/06	.00	5.37	.00	.00	5.37		SCFG00000055
MC0012.GRN(11805)			Total Active Members		4	.00	21.48	.00	.00	21.48		
			Total Non Eligible and Transferred Members									

SAMPLE NOT NEGOTIABLE

This is confidential material and is protected by HIPAA. Please keep this list in a secure place.
Patient Rosters are only printed for members belonging to capitated plans.
Eligibility Status: A - Active, N - Non Eligible, T - Transfer

New York Select Member Copayment Schedules

	Plan Name		Plan 150		Plan 250		Plan 350		Plan 450
	Contributory Plan Code - Office Visit $0		DNY01		DNY07		DNY13		DNY19
	Contributory Product ID - Office Visit $0		D0012400		D0012475		D0012479		D0012485
	Voluntary Plan Code - Office Visit $0		DNY02		DNY08		DNY14		DNY20
	Voluntary Product ID - Office Visit $0		D0012470		D0012476		D0012480		D0012486
	Plan Name		150-5c		250-5c		350-5c		450-5c
	Contributory Plan Code - Office Visit $5		DNY03		DNY09		DNY15		DNY21
	Contributory Product ID - Office Visit $5		D0012471		D0012477		D0012481		D0012487
	Voluntary Plan Code - Office Visit $5		DNY04		DNY10		DNY16		DNY22
	Voluntary Product ID - Office Visit $5		D0012472		D0012478		D0012482		D0012488
	Plan Name		150-10c		250-10c		350-10c		450-10c
	Contributory Plan Code - Office Visit $10		DNY05		DNY11		DNY17		DNY23
	Contributory Product ID - Office Visit $10		D0012473		D0012401		D0012483		D0012489
	Voluntary Plan Code - Office Visit $10		DNY06		DNY12		DNY18		DNY24
	Voluntary Product ID - Office Visit $10		D0012474		D0012402		D0012484		D0012490

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
D0999	Office Visit Charge, per visit	$0, $5, $10	$0, $5, $10	$0, $5, $10	$0, $5, $10	$0, $5, $10	$0, $5, $10	$0, $5, $10	$0, $5, $10
D0120	Periodic Oral Evaluation - Established Patient	$0	$0	$0	$0	$0	$0	$0	$0
D0140	Limited Oral Evaluation - Problem Focused (Emergency)	$0	$0	$0	$0	$0	$0	$0	$0
D0145	Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver	$0	$0	$0	$0	$0	$0	$0	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient	$0	$0	$0	$0	$0	$0	$0	$0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	$0	$0	$0	$0	$0	$0	$0	$0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	$0	$0	$0	$0	$0	$0	$0	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	$0	$0	$0	$0	$0	$0	$0	$0
D0210	Intraoral - Complete Series (Including Bitewings) (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0220	Intraoral - Periapical First Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0230	Intraoral - Periapical Each Additional Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0240	Intraoral - Occlusal Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0250	Extraoral - First Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0260	Extraoral - Each Additional Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0270	Bitewings - Single Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0272	Bitewings - Two Films (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0273	Bitewings - Three Films (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0274	Bitewings - Four Films (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0277	Vertical Bitewings - Seven to Eight Films (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0330	Panoramic Film (X-ray)	$0	$0	$0	$0	$0	$0	$0	$0
D0415	Collection of Microorganisms for Culture and Sensitivity	$0	$0	$0	$0	$0	$0	$0	$0
D0425	Caries Susceptibility Tests	$0	$0	$0	$0	$0	$0	$0	$0
D0431	Oral Cancer Screening Using a Light Source	$45	$45	$45	$45	$48	$45	$48	$45
D0460	Pulp Vitality Tests	$0	$0	$0	$0	$0	$0	$0	$0
D0470	Diagnostic Casts	$0	$0	$0	$0	$0	$0	$0	$0
D0472	Diagnostic Casts	$0	$0	$0	$0	$0	$0	$0	$0
D0473	Pathology Report - Gross Examination of Lesion	$0	$0	$0	$0	$0	$0	$0	$0
D0474	Pathology Report - Microscopic Examination of Lesion and Area	$0	$0	$0	$0	$0	$0	$0	$0
Preventive									
D1110	Prophylaxis - Adult for first two services in any 6-month period	$0	$0	$0	$0	$0	$0	$0	$0
	Prophylaxis - Adult, each additional service in any 6-month period	$65	$65	$65	$60	$65	$60	$65	$60
D1120	Prophylaxis - Child for first two services in any 6-month period	$0	$0	$0	$0	$0	$0	$0	$0
	Prophylaxis - Child, each additional services in any 6-month period	$55	$60	$50	$60	$50	$60	$50	$60

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
D1203	Topical Application of Fluoride (Prophylaxis Not Included) - Child for first two services in any 12-month period	$0	$0	$0	$0	$0	$0	$0	$0
	Topical Application of Fluoride (Prophylaxis Not Included) - Child for each additional services in any 12-month period	$25	$20	$20	$20	$20	$20	$20	$20
D1204	Topical Application of Fluoride (Prophylaxis Not Included) - Adult for first two services in any 12-month period	$0	$0	$0	$0	$0	$0	$0	$0
	Topical Application of Fluoride (Prophylaxis Not Included) - Adult for each additional services in any 12-month period	$28	$25	$24	$20	$24	$24	$24	$25
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients	$15	$12	$13	$12	$10	$10	$10	$0
D1310	Nutritional Counseling	$0	$0	$0	$0	$0	$0	$0	$0
D1320	Tobacco Cnsl Cntrl and Prevention	$0	$0	$0	$0	$0	$0	$0	$0
D1330	Oral Hygiene Instructions	$0	$0	$0	$0	$0	$0	$0	$0
D1351	Sealant - Per Tooth	$15	$12	$12	$10	$8	$8	$0	$0
D1510	Space Maintainer - Fixed - Unilateral	$85	$80	$76	$72	$45	$45	$65	$55
D1515	Space Maintainer - Fixed - Bilateral	$125	$118	$112	$106	$50	$50	$80	$70
D1520	Space Maintainer - Removable - Unilateral	$85	$80	$76	$72	$45	$45	$65	$55
D1525	Space Maintainer - Removable - Bilateral	$125	$118	$112	$106	$50	$50	$80	$70
D1550	Re-cementation of Space Maintainer	$20	$18	$18	$16	$8	$8	$0	$0
D1555	Removal of Fixed Space Maintainer	$20	$18	$18	$16	$0	$0	$15	$10

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Restorative temporization and cementation of cast restorations; and cast crowns.									
D2140	Amalgam - One Surface, Primary or Permanent	$35	$32	$30	$28	$10	$10	$0	$0
D2150	Amalgam - Two Surfaces, Primary or Permanent	$45	$42	$38	$35	$14	$14	$0	$0
D2160	Amalgam - Three Surfaces, Primary or Permanent	$52	$48	$44	$40	$16	$16	$0	$0
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$60	$55	$52	$48	$18	$18	$0	$0
D2330	Resin-Based Composite - One Surface, Anterior	$40	$38	$34	$32	$18	$18	$0	$0
D2331	Resin-Based Composite - Two Surfaces, Anterior	$48	$45	$40	$37	$22	$22	$0	$0
D2332	Resin-Based Composite - Three Surfaces, Anterior	$62	$58	$52	$48	$26	$26	$0	$0
D2335	Resin-Based Composite - Four or More Surfaces, or Involving Incisal Angle (Anterior)	$68	$64	$58	$54	$30	$30	$0	$0
D2390	Resin-Based Composite Crown, Anterior	$105	$100	$90	$85	$50	$50	$80	$70
D2391	Resin-Based Composite - One Surface, Posterior	$60	$56	$50	$46	$20	$20	$0	$0
D2392	Resin-Based Composite - Two Surfaces, Posterior	$80	$75	$68	$64	$30	$30	$0	$0
D2393	Resin-Based Composite - Three Surfaces, Posterior	$95	$90	$80	$75	$40	$40	$0	$0
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$108	$102	$92	$86	$55	$55	$0	$0
D2510	Inlay - Metallic - One Surface	$355	$335	$315	$290	$205	$195	$315	$275
D2520	Inlay - Metallic - Two Surfaces	$385	$365	$345	$320	$235	$222	$355	$325
D2530	Inlay - Metallic - Three Or More Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D2542	Onlay - Metallic - Two Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D2543	Onlay - Metallic - Three Surfaces	$425	$405	$390	$365	$255	$242	$395	$365
D2544	Onlay - Metallic - Four Or More Surfaces	$450	$430	$405	$385	$265	$255	$415	$375
D2610	Inlay - Porcelain/Ceramic - One Surface	$345	$330	$315	$295	$205	$195	$315	$275
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	$385	$365	$345	$325	$235	$222	$355	$325
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	$425	$405	$390	$365	$255	$242	$395	$365
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	$450	$430	$405	$385	$265	$255	$415	$375
D2650	Inlay - Resin-Based Composite - One Surface	$210	$200	$190	$180	$125	$120	$192	$175
D2651	Inlay - Resin-Based Composite - Two Surfaces	$238	$228	$215	$205	$142	$138	$218	$202
D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	$250	$240	$225	$215	$148	$145	$228	$212
D2662	Onlay - Resin-Based Composite - Two Surfaces	$275	$262	$250	$240	$164	$162	$252	$236
D2663	Onlay - Resin-Based Composite - Three Surfaces	$360	$345	$325	$310	$215	$210	$330	$308
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	$405	$388	$365	$348	$240	$236	$375	$348
D2710	Crown - Resin-Based Composite (Indirect)	$150	$142	$138	$132	$92	$88	$142	$128
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	$170	$162	$155	$148	$104	$100	$160	$145
D2720	Crown - Resin With High Noble Metal	$405	$388	$362	$348	$242	$230	$380	$340
D2721	Crown - With Predominantly Base Metal	$405	$388	$362	$348	$242	$232	$380	$340
D2722	Crown - Resin With Noble Metal	$405	$388	$362	$348	$242	$234	$380	$340
D2740	Crown - Porcelain/ceramic substrate	$495	$475	$450	$425	$295	$280	$450	$425
D2750	Crown - Porcelain Fused to High Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$395
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$470	$445	$420	$395	$295	$280	$420	$395
D2752	Crown - Porcelain Fused to Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$395
D2780	Crown - 3/4 Cast High Noble Metal[3]	$450	$430	$405	$385	$295	$280	$420	$385
D2781	Crown - 3/4 Cast Predominantly Base Metal	$450	$430	$405	$385	$295	$280	$420	$385
D2782	Crown - 3/4 Cast Noble Metal[3]	$450	$430	$405	$385	$295	$280	$420	$385
D2783	Crown - 3/4 Porcelain/ceramic	$450	$430	$405	$385	$295	$280	$420	$385
D2790	Crown - Full Cast High Noble Metal[3]	$450	$430	$405	$385	$295	$280	$420	$385
D2791	Crown - Full Cast Predominantly Base Metal	$450	$430	$405	$385	$295	$280	$420	$385

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
D2792	Crown - Full Cast Noble Metal[3]	$450	$430	$405	$385	$295	$280	$420	$385
D2794	Crown - Titanium[3]	$470	$445	$420	$395	$295	$280	$420	$395
D2910	Re-Cement Inlay, Onlay, or Partial Coverage Restoration	$20	$20	$18	$16	$10	$10	$0	$0
D2915	Re-Cement Cast or Prefabricated Post and Core	$20	$20	$18	$16	$10	$10	$0	$0
D2920	Re-Cement Crown	$20	$20	$18	$16	$10	$10	$0	$0
D2930	Prefabricated Stainless Steel Crown - Primary Tooth[1]	$115	$110	$104	$95	$75	$70	$95	$90
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth[1]	$125	$120	$110	$104	$75	$70	$95	$90
D2932	Prefabricated Resin Crown	$145	$138	$130	$122	$85	$80	$108	$100
D2933	Prefabricated Stainless Steel Crown with Resin Window	$145	$138	$128	$120	$100	$95	$108	$100
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth[1]	$155	$148	$138	$130	$110	$102	$115	$105
D2940	Sedative Filling	$35	$32	$30	$26	$8	$8	$0	$0
D2950	Core Build-Up, Including Any Pins	$115	$110	$102	$95	$55	$50	$90	$95
D2951	Pin Retention - Per Tooth, in Addition to Restoration	$30	$28	$26	$24	$10	$10	$24	$20
D2952	Cast Post and Core In Addition to Crown - Indirectly Fabricated	$165	$155	$142	$132	$100	$95	$125	$140
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	$75	$70	$66	$62	$40	$36	$65	$60
D2954	Prefabricated Post and Core in Addition to Crown	$140	$132	$122	$115	$85	$80	$115	$105
D2955	Post Removal (Not in Conjunction with Endodontic Therapy)	$130	$122	$112	$105	$80	$75	$105	$95
D2957	Each Additional Prefabricated Post - Same Tooth	$35	$33	$30	$26	$15	$15	$25	$20
D2960	Labial veneer (resin laminate) - chairside	$275	$262	$265	$250	$245	$225	$260	$250
D2962	Labial veneer (porcelain laminate)	$445	$425	$430	$405	$398	$365	$422	$405
D2970	Temporary Crown (Fractured Tooth)	$95	$95	$85	$78	$65	$60	$75	$85
D2971	Additional procedure to construct new crown under existing denture	$125	$125	$125	$115	$125	$118	$125	$120
Endodontics									
D3110	Pulp Cap - Direct (Excluding Final Restoration)	$15	$14	$13	$10	$10	$10	$0	$0
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	$15	$14	$13	$10	$10	$10	$0	$0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	$55	$52	$48	$45	$25	$18	$0	$0
D3221	Pulpal Debridement, Primary and Permanent Tooth	$55	$52	$48	$45	$25	$18	$0	$0
D3222	Partial Pulpotomy (w/ inc. root development)	$55	$52	$48	$45	$25	$18	$0	$0
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	$85	$80	$75	$70	$30	$26	$0	$0
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	$88	$84	$78	$72	$35	$32	$0	$0
D3310	Root Canal Therapy - Anterior (Excluding Final Restoration)	$325	$265	$275	$235	$125	$118	$150	$125
D3320	Root Canal Therapy - Bicuspid (Excluding Final Restoration)	$375	$315	$315	$275	$150	$145	$175	$150
D3330	Root Canal Therapy - Molar (Excluding Final Restoration)	$475	$415	$405	$360	$175	$165	$315	$275
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	$0	$0	$0	$0	$0	$0	$0	$0
D3332	Incomplete Endodontic Therapy; Inoperable or Fractured Tooth	$155	$148	$135	$128	$105	$100	$115	$105
D3333	Internal Root Repair of Perforation Defects	$125	$120	$112	$106	$75	$70	$85	$100
D3346	Re-treatment of root canal - Anterior, per tooth	$380	$325	$330	$285	$180	$170	$425	$225
D3347	Re-treatment of root canal - Bicuspid, per tooth	$430	$370	$370	$335	$205	$195	$475	$275
D3348	Re-treatment of root canal - Molar, per tooth	$545	$470	$465	$415	$375	$355	$575	$355
D3351	Apexification/recalcification - initial visit	$165	$145	$142	$126	$115	$110	$176	$110
D3352	Apexification/recalcification - interim visit	$112	$98	$96	$85	$78	$74	$120	$74
D3353	Apexification/recalcification - final visit	$192	$168	$164	$146	$135	$130	$208	$130
D3410	Apicoectomy/Periradicular Surgery - Anterior	$275	$220	$250	$215	$125	$120	$250	$135
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$315	$225	$275	$250	$150	$145	$280	$195
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$375	$275	$325	$295	$175	$165	$250	$225
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$115	$95	$100	$95	$65	$60	$110	$105

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
D3430	Retrograde Filling - Per Root	$95	$85	$84	$80	$35	$32	$70	$70
D3450	Root Amputation - Per Root	$192	$168	$164	$146	$135	$130	$208	$130
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$45	$40	$38	$35	$32	$30	$50	$30
D3920	Hemisection - including root removal	$160	$140	$138	$122	$114	$108	$175	$115
D3950	Canal preparation and fitting of preformed dowel or post	$28	$26	$28	$26	$20	$20	$20	$20

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Periodontics									
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	$275	$245	$245	$230	$105	$100	$225	$175
D4211	Gingivectomy or Gingivolplasty - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	$90	$80	$80	$74	$55	$50	$75	$55
D4240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	$325	$255	$290	$260	$175	$165	$275	$215
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	$175	$160	$155	$140	$95	$90	$125	$95
D4245	Apically Positioned Flap	$275	$245	$245	$230	$105	$100	$225	$175
D4249	Clinical Crown Lengthening - hard tissue	$325	$295	$285	$265	$115	$105	$275	$245
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	$525	$475	$455	$410	$275	$265	$405	$375
D4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	$445	$385	$395	$355	$225	$215	$345	$320
D4263	Bone Replacement Graft - First Site in Quadrant	$312	$285	$278	$250	$158	$152	$245	$228
D4264	Bone Replacement Graft - Each additional Site in Quadrant	$234	$214	$210	$190	$120	$115	$185	$175
D4268	Surgical revision procedure, per tooth	$0	$0	$0	$0	$0	$0	$0	$0
D4270	Pedicle soft tissue graft	$375	$335	$340	$322	$175	$165	$360	$300
D4271	Soft tissue graft procedure (including donor site surgery)	$395	$355	$355	$335	$195	$185	$375	$325
D4273	Subepithelial tissue graft procedure	$435	$385	$390	$368	$215	$205	$415	$350
D4341	Periodontal Scaling and Root Planing - Four or More Teeth, Per Quadrant	$65	$60	$58	$55	$35	$32	$0	$0
D4342	Periodontal Scaling and Root Planing, One to Three Teeth, Per Quadrant	$40	$36	$36	$34	$20	$20	$0	$0
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	$55	$55	$50	$47	$30	$30	$0	$0
D4381	Localized site - specific therapy	$60	$60	$55	$50	$50	$45	$50	$45
D4910	Periodontal Maintenance - First two services in any 12-month period	$35	$35	$25	$25	$20	$20	$0	$0
	Periodontal Maintenance - Each additional (to 2 services covered) in any 12-month period	$65	$65	$65	$65	$65	$65	$65	$65

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Prosthodontics, Removable									
D5110	Complete Denture - Maxillary	$615	$585	$510	$480	$360	$340	$450	$425
D5120	Complete Denture - Mandibular	$615	$585	$510	$480	$360	$340	$450	$425
D5130	Immediate Denture - Maxillary	$655	$625	$555	$525	$385	$365	$495	$475
D5140	Immediate Denture - Mandibular	$655	$625	$555	$525	$385	$365	$495	$475
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	$615	$590	$510	$480	$345	$330	$450	$425
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	$615	$590	$510	$480	$345	$330	$450	$425
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	$655	$630	$555	$525	$395	$375	$495	$475
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	$655	$630	$555	$525	$395	$375	$495	$475
D5225	Maxillary Partial Denture - Flexible base (incl clasps, rests and teeth)	$695	$665	$575	$545	$450	$430	$535	$525
D5226	Mandibular Partial Denture - Flexible base (incl clasps, rests and teeth)	$695	$665	$575	$545	$450	$430	$535	$525
D5281	Removable Unilateral Partial Denture- 1 Piece Cast Metal	$610	$580	$505	$475	$395	$375	$468	$460
D5410	Adjust Complete Denture - Maxillary	$35	$33	$30	$27	$15	$15	$0	$0
D5411	Adjust Complete Denture - Mandibular	$35	$33	$30	$27	$15	$15	$0	$0
D5421	Adjust Partial Denture - Maxillary	$35	$33	$30	$27	$15	$15	$0	$0
D5422	Adjust Partial Denture - Mandibular	$35	$33	$30	$27	$15	$15	$0	$0
D5510	Repair Broken Complete Denture Base	$65	$62	$55	$50	$38	$35	$48	$40
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	$65	$62	$55	$50	$35	$32	$42	$40
D5610	Repair Resin (Partial) Denture Base	$65	$62	$55	$50	$45	$40	$48	$40
D5620	Repair Cast (Partial Denture) Framework	$85	$80	$72	$65	$75	$70	$75	$55
D5630	Repair or Replace Broken Clasp (Partial Denture)	$90	$84	$80	$76	$65	$60	$80	$60
D5640	Replace Broken Teeth (Partial Denture) - Per Tooth	$65	$62	$55	$50	$35	$32	$42	$40
D5650	Add Tooth to Existing Partial Denture	$85	$81	$75	$70	$50	$45	$75	$55
D5660	Add Clasp to Existing Partial Denture	$105	$100	$92	$86	$55	$50	$68	$65
D5670	Replace All Teeth and Acrylic on Cast Metal (Partial) Framework (Maxillary)	$215	$205	$190	$180	$155	$148	$195	$185
D5671	Replace All Teeth and Acrylic on Cast Metal (Partial) Framework (Mandibular)	$215	$205	$190	$180	$155	$148	$195	$185
D5710	Rebase Complete Maxillary Denture	$225	$215	$200	$190	$165	$160	$205	$195
D5711	Rebase Complete Mandibular Denture	$225	$215	$200	$190	$165	$160	$205	$195
D5720	Rebase Maxillary Partial Denture	$225	$215	$200	$190	$165	$160	$205	$195
D5721	Rebase Mandibular Partial Denture	$225	$215	$200	$190	$165	$160	$205	$195
D5730	Reline Complete Maxillary Denture (Chairside)	$125	$118	$110	$102	$75	$70	$115	$90
D5731	Reline Complete Mandibular Denture (Chairside)	$125	$118	$110	$102	$75	$70	$115	$90
D5740	Reline Maxillary Partial Denture (Chairside)	$125	$118	$110	$102	$75	$70	$115	$90
D5741	Reline Mandibular Partial Denture (Chairside)	$125	$118	$110	$102	$75	$70	$115	$90
D5750	Reline Complete Maxillary Denture (Laboratory)	$175	$168	$155	$146	$115	$110	$165	$120
D5751	Reline Complete Mandibular Denture (Laboratory)	$175	$168	$155	$146	$115	$110	$165	$120
D5760	Reline Maxillary Partial Denture (Laboratory)	$175	$168	$155	$146	$115	$110	$165	$120
D5761	Reline Mandibular Partial Denture (Laboratory)	$175	$168	$155	$146	$115	$110	$165	$120
D5820	Interim Partial Denture (Maxillary)	$180	$172	$160	$154	$125	$115	$170	$155
D5821	Interim Partial Denture (Mandibular)	$180	$172	$160	$154	$125	$115	$170	$155
D5850	Tissue Conditioning (Maxillary)	$65	$62	$58	$54	$30	$26	$50	$45
D5851	Tissue Conditioning (Mandibular)	$65	$62	$58	$54	$30	$26	$50	$45

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Implant Service									
D6010	Surgical Placement of Implant Body	$2,289	$2,289	$2,289	$2,289	$2,289	$2,289	$2,289	$2,289
D6053	Implant/abutment supported fixed dentures for completely edentulous arch	$2,674	$2,674	$2,674	$2,674	$2,674	$2,674	$2,674	$2,674
D6054	Implant/abutment supported fixed dentures for partially edentulous arch	$2,674	$2,674	$2,674	$2,674	$2,674	$2,674	$2,674	$2,674
D6055	Connecting bar - implant supported or abutment supported	$1,488	$1,488	$1,488	$1,488	$1,488	$1,488	$1,488	$1,488
D6056	Prefabricated abutment - includes placement	$676	$676	$676	$676	$676	$676	$676	$676
D6057	Custom abutment - includes placement	$923	$923	$923	$923	$923	$923	$923	$923
D6058	Abutment supported porcelain/ceramic crown	$1,614	$1,614	$1,614	$1,614	$1,614	$1,614	$1,614	$1,614
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$1,775	$1,775	$1,775	$1,775	$1,775	$1,775	$1,775	$1,775
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$1,410	$1,410	$1,410	$1,410	$1,410	$1,410	$1,410	$1,410
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$1,835	$1,835	$1,835	$1,835	$1,835	$1,835	$1,835	$1,835
D6062	Abutment supported cast metal crown (high noble metal)	$1,613	$1,613	$1,613	$1,613	$1,613	$1,613	$1,613	$1,613
D6063	Abutment supported cast metal crown (predominantly base metal)	$1,520	$1,520	$1,520	$1,520	$1,520	$1,520	$1,520	$1,520
D6064	Abutment supported cast metal crown (noble metal)	$1,873	$1,873	$1,873	$1,873	$1,873	$1,873	$1,873	$1,873
D6065	Implant supported porcelain/ceramic crown	$1,834	$1,834	$1,834	$1,834	$1,834	$1,834	$1,834	$1,834
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$1,944	$1,944	$1,944	$1,944	$1,944	$1,944	$1,944	$1,944
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$1,903	$1,903	$1,903	$1,903	$1,903	$1,903	$1,903	$1,903
D6068	Abutment supported retainer for porcelain/ceramic FPD	$1,868	$1,868	$1,868	$1,868	$1,868	$1,868	$1,868	$1,868
D6069	Abutment supported retainer for porcelain/ceramic FPD (high noble metal)	$1,847	$1,847	$1,847	$1,847	$1,847	$1,847	$1,847	$1,847
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$1,742	$1,742	$1,742	$1,742	$1,742	$1,742	$1,742	$1,742
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$1,518	$1,518	$1,518	$1,518	$1,518	$1,518	$1,518	$1,518
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$1,814	$1,814	$1,814	$1,814	$1,814	$1,814	$1,814	$1,814
D6073	Abutment supported retainer for cast metal FPD (predominanty base metal)	$1,642	$1,642	$1,642	$1,642	$1,642	$1,642	$1,642	$1,642
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$1,521	$1,521	$1,521	$1,521	$1,521	$1,521	$1,521	$1,521
D6075	Implant supported retainer for ceramic FPD	$1,837	$1,837	$1,837	$1,837	$1,837	$1,837	$1,837	$1,837
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal	$1,781	$1,781	$1,781	$1,781	$1,781	$1,781	$1,781	$1,781
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$1,737	$1,737	$1,737	$1,737	$1,737	$1,737	$1,737	$1,737
D6080	Implant maintenance procedures, including removal of prosthesis, cleaning, and re-insertion	$194	$194	$194	$194	$194	$194	$194	$194
D6090	Repair implant supported by prosthesis, by report	$453	$453	$453	$453	$453	$453	$453	$453
D6091	Replacement of semi-precision or precision attachment of implant/abutment per attachment	$736	$736	$736	$736	$736	$736	$736	$736
D6092	Re-cement implant/abutment supported crown	$143	$143	$143	$143	$143	$143	$143	$143
D6093	Re-cement implant/abutment supported fixed partial denture	$225	$225	$225	$225	$225	$225	$225	$225
D6094	Abutment supported crown (titanium)	$1,462	$1,462	$1,462	$1,462	$1,462	$1,462	$1,462	$1,462
D6095	Repair implant abutment, by report	$621	$621	$621	$621	$621	$621	$621	$621
D6100	Implant removal, by report	$702	$702	$702	$702	$702	$702	$702	$702
D6190	Radiographic/surgical implant index, by report	$328	$328	$328	$328	$328	$328	$328	$328
D6194	Abutment supported retainer for cast metal FPD (noble metal)	$1,506	$1,506	$1,506	$1,506	$1,506	$1,506	$1,506	$1,506

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Prosthodontics, Fixe									
D6210	Pontic - Cast High Noble Metal[3]	$425	$405	$390	$365	$255	$242	$395	$365
D6211	Pontic - Cast Predominantly Base Metal	$450	$430	$405	$385	$265	$255	$415	$375
D6212	Pontic - Cast Noble Metal[3]	$450	$430	$405	$385	$265	$255	$415	$375
D6214	Pontic - Titanium[3]	$450	$430	$405	$385	$265	$255	$415	$375
D6240	Pontic - Porcelain Fused to High Noble Metal[3]	$450	$430	$405	$385	$265	$255	$415	$375
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$450	$430	$405	$385	$265	$255	$415	$375
D6242	Pontic - Porcelain Fused to Noble Metal[3]	$450	$430	$405	$385	$265	$255	$415	$375
D6245	Pontic - Porcelain/Ceramic	$495	$475	$450	$425	$295	$280	$430	$400
D6250	Pontic - Resin with High Noble Metal[3]	$405	$388	$362	$348	$242	$230	$380	$340
D6251	Pontic - Resin with Predominantly Base Metal	$405	$388	$362	$348	$242	$232	$380	$340
D6252	Pontic - Resin with Noble Metal[3]	$405	$388	$362	$348	$242	$234	$380	$340
D6600	Inlay - porcelain/ceramic - two surfaces	$385	$365	$345	$320	$235	$222	$355	$325
D6601	Inlay - porcelain/ceramic - three or more surfaces	$395	$380	$360	$360	$270	$255	$370	$350
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$385	$365	$345	$320	$235	$222	$355	$325
D6603	Inlay - Cast High Noble Metal, Three or more Surfaces	$395	$380	$360	$360	$270	$255	$370	$350
D6604	Inlay - Cast Predominantly base Metal, Two Surfaces	$385	$365	$345	$320	$235	$222	$355	$325
D6605	Inlay - Cast Predominantly base Metal, Three or more Surfaces	$395	$380	$360	$360	$270	$255	$370	$350
D6606	Inlay - cast Noble Metal, Two Surfaces	$385	$365	$345	$320	$235	$222	$355	$325
D6607	Inlay - cast Noble Metal, Three or more Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D6608	Onlay - porcelain/ceramic, Two surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D6609	Onlay - porcelain/ceramic, Three or more surfaces	$450	$430	$405	$385	$265	$255	$415	$375
D6610	Onlay - Cast High Noble Metal, Two Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D6611	Onlay - Cast High Noble Metal, Three or more Surfaces	$450	$430	$405	$385	$265	$255	$415	$375
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D6613	Onlay - Cast Predominantly Base Metal, Three or more Surfaces	$450	$430	$405	$385	$265	$255	$415	$375
D6614	Onlay - Cast Noble Metal, Two Surfaces	$395	$380	$360	$340	$270	$255	$370	$350
D6615	Onlay - Cast Noble Metal, Three or more Surfaces	$450	$430	$405	$385	$265	$255	$415	$375
D6624	Inlay Titanium	$385	$365	$345	$320	$235	$222	$355	$325
D6634	Onlay Titanium	$395	$380	$360	$340	$270	$255	$370	$350
D6720	Crown - Resin with High Noble Metal[3]	$405	$388	$362	$348	$242	$230	$380	$340
D6721	Crown - Resin with Predominantly Base Metal	$405	$388	$362	$348	$242	$232	$380	$340
D6722	Crown - Resin with Noble Metal[3]	$405	$388	$362	$348	$242	$234	$380	$340
D6740	Crown - Porcelain/ceramic substrate	$495	$475	$450	$425	$295	$280	$450	$400
D6750	Crown - Porcelain Fused to High Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$470	$445	$420	$395	$295	$280	$420	$375
D6752	Crown - Porcelain Fused to Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6780	Crown - 3/4 Cast High Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6781	Crown - 3/4 Cast Predominantly Base Metal	$470	$445	$420	$395	$295	$280	$420	$375
D6782	Crown - 3/4 Cast Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6790	Crown - Full Cast High Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6791	Crown - Full Cast Predominantly Base Metal	$470	$445	$420	$395	$295	$280	$420	$375
D6792	Crown - Full Cast Noble Metal[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6794	Crown - Titanium[3]	$470	$445	$420	$395	$295	$280	$420	$375
D6930	Re-Cement Fixed Partial Denture	$48	$45	$42	$39	$10	$10	$35	$30
D6940	Stress Breaker	$230	$215	$205	$195	$145	$138	$206	$185
D6970	Post and Core in Addition to Fixed Partial Denture Retainer - Indirectly Fabricated	$165	$155	$145	$136	$100	$95	$125	$125

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	$145	$138	$128	$118	$85	$80	$115	$100
D6973	Core Build-Up for Retainer, Including any Pins	$115	$110	$102	$94	$55	$50	$90	$80
D6976	Each additional cast post - same tooth	$55	$52	$48	$45	$35	$32	$75	$50
D6977	Each additional prefabricated post - same tooth	$30	$28	$26	$24	$20	$20	$50	$25

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Oral Surgery - including sutures, if necessary, related procedures; includes pre-op and post-op evaluations and treatment under local anesthetic.									
D7111	Extraction, Coronal Remnants, Deciduous Tooth	$25	$25	$22	$20	$10	$10	$0	$0
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$45	$42	$40	$36	$10	$10	$0	$0
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	$115	$110	$102	$95	$35	$32	$35	$35
D7220	Removal of Impacted Tooth - Soft Tissue	$150	$125	$135	$128	$50	$45	$110	$90
D7230	Removal of Impacted Tooth - Partially Bony	$185	$160	$165	$155	$75	$70	$145	$115
D7240	Removal of Impacted Tooth - Completely Bony	$275	$235	$240	$220	$100	$95	$225	$160
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	$295	$265	$260	$235	$115	$105	$255	$195
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$105	$95	$92	$85	$35	$32	$45	$65
D7261	Primary closure of sinus perforation	$350	$315	$315	$295	$250	$240	$275	$250
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	$250	$250	$250	$250	$250	$250	$250	$250
D7280	Surgical Access of an Unerupted Tooth	$225	$205	$200	$188	$95	$90	$275	$195
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$315	$315	$315	$315	$315	$315	$315	$315
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$45	$42	$40	$36	$30	$26	$35	$35
D7285	Biopsy of oral tissue - hard	$150	$140	$134	$125	$75	$70	$75	$95
D7286	Biopsy of oral tissue - soft	$125	$118	$110	$100	$70	$65	$85	$75
D7288	Brush Biopsy - Transepithelial Sample Collection	$75	$70	$66	$60	$65	$60	$65	$65
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	$110	$102	$98	$90	$50	$45	$150	$90
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	$60	$55	$52	$48	$25	$26	$60	$45
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	$115	$108	$100	$94	$75	$70	$175	$135
D7321	Alveoloplasty Not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	$175	$160	$152	$144	$85	$80	$115	$90
D7450	Removal of Benign Odontogenic Cyst or Tumor up to 1.25 cm	$195	$155	$168	$158	$115	$105	$215	$165
D7451	Removal of Benign Odontogenic Cyst or Tumor greater than 1.25 cm	$285	$225	$252	$240	$215	$205	$275	$255
D7471	Reoval of Lateral Exostosis (Maxilla or Mandible)	$250	$215	$218	$205	$125	$115	$195	$185
D7472	Removal of Torus Palatinus	$250	$215	$218	$205	$125	$115	$195	$185
D7473	Removal of Torus Mandibularis	$250	$215	$218	$205	$125	$115	$195	$185
D7485	Surgical Reduction of Osseous Tuberosity	$250	$215	$218	$205	$125	$115	$195	$185
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$50	$45	$44	$40	$30	$30	$30	$28
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue Complicated	$55	$50	$48	$44	$35	$35	$35	$32
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	$125	$115	$110	$102	$75	$70	$125	$125
D7963	Frenuloplasty	$185	$175	$165	$155	$115	$115	$175	$170
D7970	Excision of hyperplastic tissue - per arch	$215	$210	$210	$205	$195	$190	$210	$205
D7971	Excision of pericoronal gingiva	$110	$108	$105	$100	$95	$90	$105	$100
D7972	Surgical Reduction of Fibrous Tuberosity	$250	$215	$218	$205	$125	$115	$195	$185

CDT-11 Codes	Procedure Description	Plan 100	Plan 150	Plan 200	Plan 250	Plan 300	Plan 350	Plan 400	Plan 450
Diagnostic									
Orthodontics									
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (24-Month Case)	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (24-Month Case)	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (24-Month Case)	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615	$2,615
D8660	Pre-Orthodontic Treatment Visit (Orthodontic Consultation)	$250	$250	$250	$250	$250	$250	$250	$250
D8670	Periodic Orthodontic Treatment (In Conjunction With Comprehensive Orthodontic Treatment)	$0	$0	$0	$0	$0	$0	$0	$0
D8680	Orthodontic Retention - Per Arch (Removal of Appliances, Construction and Placement of Retainer(s)	$425	$425	$425	$425	$425	$425	$425	$425
D8999	Start-up Fee (including exam, beginning records, X-rays, tracing, photos and models)								
D8999	Post-treatment records								
Adjunctive General Services									
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	$25	$25	$20	$20	$15	$15	$10	$10
D9120	Fixed Partial Denture Sectioning	$25	$25	$20	$20	$20	$20	$20	$20
D9211	Regional Block Anesthesia	$0	$0	$0	$0	$0	$0	$0	$0
D9212	Trigeminal Division Block Anesthesia	$0	$0	$0	$0	$0	$0	$0	$0
D9215	Local Anesthesia	$0	$0	$0	$0	$0	$0	$0	$0
D9220	General Anesthesia - First 30 Minutes	$200	$195	$200	$200	$200	$200	$200	$200
D9221	General Anesthesia - Additional 15 Minutes	$80	$75	$80	$80	$80	$80	$80	$80
D9241	IV Conscious Sedation - First 30 Minutes	$200	$195	$200	$200	$200	$200	$200	$200
D9242	IV Conscious Sedation - Additional 15 Minutes	$80	$75	$80	$80	$80	$80	$80	$80
D9430	Office Visit-Observation (During office hours)	$0	$0	$0	$0	$0	$0	$0	$0
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	$30	$30	$15	$15	$0	$0	$0	$0
D9440	Office Visit - After Regularly Scheduled Hours	$50	$50	$50	$50	$50	$50	$50	$50
	Broken Appointment	$25	$25	$25	$25	$25	$25	$25	$25
D9450	Case Presentation, Detailed and Extensive Treatment Planning	$0	$0	$0	$0	$0	$0	$0	$0
D9930	Treatment of Complications - Post Surgical - Unusual Circumstances	$0	$0	$0	$0	$0	$0	$0	$0
D9940	Occlusal Guard - By Report	$350	$350	$350	$350	$350	$350	$350	$350
D9951	Occlusal adjustment - limited	$25	$25	$15	$15	$15	$15	$15	$15
D9971	Odontoplasty - one to three teeth	$25	$25	$15	$15	$15	$15	$15	$15
D9972	External bleaching - per arch	$165	$155	$165	$165	$165	$165	$165	$165

Crowns (3) - Lab upgrades including specialized services for dentures, and charges for the cost of precious metals (noble, high noble, titanium) are the Member's responsibility. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory, not to exceed $150.

External Bleaching - Per Arch - Coverage for external bleaching is limited to the fabrication of bleaching trays for home application of a bleaching product. In-office techniques, such as those using light activated material, are excluded from coverage. Limited to 1 time per consecutive 12 months.

Submission for Minimum Guarantee Payment

All Minimum Guarantee submissions should be made within 30 days of the date of service. All requests must list the name of the treating dentist. To ensure that the request is paid correctly, make certain that the Tax ID Number (TIN) matches the number that DBP.com has on file for your office.

Submit a current ADA form to the appropriate address for reimbursement, along with any additional information required, as shown in the following table.

- Accuracy in reporting procedure code, procedure description, and area of oral cavity, etc. will expedite processing.
- If the clinical nature of your care is not readily apparent, make sure to include a narrative detailing all pertinent rationale for treatment.
- Use the ID number of the Subscriber rather than the spouse or dependent's ID number.
- USE ONLY VALID CDT CODES. (Please refer to the most current CDT book.) Failure to use a valid code may result in an unreported service.

The mailing address is listed below:

Dental Select Managed Care NY
UHIC of New York
Attn: Payment Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Required Documentation for MANAGED CARE Minimum Guarantee Payment

Procedure	Description	Supplemental Information Required for Payment
Single Unit Fixed Restorations	Crown(s), Core Buildup(s), and/or Post and Core(s)	Labeled and dated pre-operative X-ray(s) Lab invoice: Lab surcharges are paid by the member. If materials exceed base metal, the dentist can bill the difference in actual lab cost, not to exceed $150. Prior placement date(s) if replacing existing crown(s)
Multiple Unit Fixed Restorations	Multiple Crown(s), Fixed Partial Denture Crown(s) and Pontic(s), Core Buildup(s), and/or Post and Core(s)	Mounted, labeled and dated full-arch pre-operative X-rays Lab invoice: Lab surcharges are paid by the member. If materials exceed noble metal, the dentist can bill the difference in actual lab cost, not to exceed $150. Prior placement date(s) if replacing existing crown(s) or fixed prosthodontic(s)
Removable Restorations	Full and Partial Dentures	Mounted, labeled and dated full-arch pre-operative X-rays Lab invoice: Lab surcharges are paid by the member. If materials exceed base metal, the dentist can bill the difference in actual lab cost, not to exceed $150. Prior placement date(s) if replacing existing prosthesis
Endodontics	Root Canal Therapy (RCT) and Re-treatment of RCT for Permanent Teeth and Endodontic Surgery	Labeled and dated pre- and post-operative X-rays Date of original RCT if performing re-treatment
Oral Surgery	Surgical and Impacted Extractions, Alveoplasty, and Pathology	Labeled and dated pre-operative X-rays and narrative where appropriate Pathology reports where appropriate
Pedodontics	All Pedodontic Services	Labeled and dated pre-operative X-rays, when possible Narrative of any existing medical condition/physical limitation and/or inability of patient cooperation Any services more than $300.00 need to be prior authorized.
Periodontics	Root Planing and Scaling, Gingivectomy, Crown Lengthening, and Periodontal Surgery	Mounted, labeled and dated pre-operative X-rays Perio case type Dated periodontal charting (pre- and post-scaling) Date(s) of prior root planing and scaling by quadrant(s) and re-evaluation date(s)
Anesthesia	General Anesthesia and/or I.V. Sedation	Type and duration of agent and narrative of necessity where appropriate

New York Select Plans Minimum Guarantee Schedule

Procedural Minimum Guarantees	Description	Total Comp = Copay+Plan Pays
D1351	Sealant - Per Tooth	20
D2330	Resin-Based Composite - One Surface, Anterior	18
D2331	Resin-Based Composite - Two Surfaces, Anterior	22
D2332	Resin-Based Composite - Three Surfaces, Anterior	26
D2335	Resin-Based Composite - Four or More Surfaces, or Involving Incisal Angle (Anterior)	30
D2391	Resin-Based Composite - One Surface, Posterior	20
D2392	Resin-Based Composite - Two Surfaces, Posterior	30
D2393	Resin-Based Composite - Three Surfaces, Posterior	40
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	55
D2750	Crown - Porcelain Fused to High Noble Metal 3	350
D2751	Crown - Porcelain Fused to Predominantly Base Metal	350
D2752	Crown - Porcelain Fused to Noble Metal 3	350
D2780	Crown - 3/4 Cast High Noble Metal 3	350
D2781	Crown - 3/4 Cast Predominantly Base Metal	350
D2782	Crown - 3/4 Cast Noble Metal 3	350
D2783	Crown - 3/4 Porcelain/Ceramic	350
D2790	Crown - Full Cast High Noble Metal 3	350
D2791	Crown - Full Cast Predominantly Base Metal	350
D2792	Crown - Full Cast Noble Metal 3	350
D2794	Crown - Titanium 3	350
D3310	Root Canal Therapy - Anterior (Excluding Final Restoration)	250
D3320	Root Canal Therapy - Bicuspid (Excluding Final Restoration)	350
D3330	Root Canal Therapy - Molar (Excluding Final Restoration)	450
D4249	Clinical Crown Lengthening - hard tissue	300
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	450
D4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	250
D4341	Periodontal Scaling and Root Planing - Four or More Teeth, Per Quadrant	40
D5110	Complete Denture - Maxillary	400
D5120	Complete Denture - Mandibular	400
05213	Maxillary Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	500
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	500
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	40

Procedural Minimum Guarantees	Description	Total Comp = Copay+Plan Pays
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	100
D7220	Removal of Impacted Tooth - Soft Tissue	150
D7230	Removal of Impacted Tooth - Partially Bony	200
D7240	Removal of Impacted Tooth - Completely Bony	250
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	275
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	100

NY Select Min Guarantee 2012

Encounter Form Submissions

Accurate and timely submission of encounter data is critical to analyzing dentist compensation, negotiating group contract renewals, and determining appropriate premium rates, prepayment fee rates and fee schedules. Encounter reporting is vital. The data collected validates the volume and frequency of dental care delivered. We use the data to justify premium and provider compensation levels as well as to perform quality reviews.

For Dental Select plans, services that do not require a payment from the plan should be reported on a current ADA Claim Form. This data should be submitted to DBP.com on no less than a monthly basis.

For UHIC of New York

In order to submit encounter information, your office will need to utilize a current ADA Claim Form for all encounter data. The ADA claim needs to be completed like any other claim which would include items such as:

- Subscriber Name
- Subscriber ID
- Subscriber Date of Birth
- Group Name or Number
- Patient's Full Name
- Relationship to Subscriber
- Patient's Date of Birth
- Date of Service
- ADA Code Performed
- Tooth # / Quadrant
- Surface
- Treating Dentist Name
- Dentist Tax ID for Billing
- Physical Address
- Billing Address

Encounter data can be submitted via electronic claims as you would do with your fee-for-service claims. Your encounter information submitted via claim form is to be mailed to the appropriate Plan addresses listed below:

UHIC of New York
P.O. Box 30567
Salt Lake City, UT 84130

Claim Submission for Specialists

All claims should be submitted within 30 days of the date of service. All claims must list the name of the treating dentist. To ensure that the claim is paid correctly, please make certain that the Tax ID Number (TIN) matches the number that DBP has on file for your office.

Please submit a current ADA Claim Form to the appropriate address for reimbursement, along with any additional information required, as shown in the table.

- Accuracy in reporting procedure code, procedure description, and area of oral cavity will expedite processing.
- If the clinical nature is not readily apparent, make sure to include a narrative detailing all pertinent rationale for treatment.
- Use the ID number of the Subscriber rather than the spouse or dependent's ID number.
- USE ONLY VALID CDT CODES. (Please refer to the most current CDT book.) Failure to use a valid code may result in an unreported service.

The mailing address is listed below:

Dental Select Managed Care NY
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Required Documentation for Specialist Claims Payment

Procedure	Description	Supplemental Information Required for Payment
Single Unit Fixed Restorations	Crown(s), Core Buildup(s), and/or Post and Core(s)	Labeled and dated pre-operative X-ray(s) Lab invoice: Lab surcharges are paid by the member. If materials exceed base metal, the dentist can bill the difference in actual lab cost, not to exceed $150. Prior placement date(s) if replacing existing crown(s)
Multiple Unit Fixed Restorations	Multiple Crown(s), Fixed Partial Denture Crown(s) and Pontic(s), Core Buildup(s), and/or Post and Core(s)	Mounted, labeled and dated full-arch pre-operative X-rays Lab invoice: Lab surcharges are paid by the member. If materials exceed noble metal, the dentist can bill the difference in actual lab cost, not to exceed $150. Prior placement date(s) if replacing existing crown(s) or fixed prosthodontic(s)
Removable Restorations	Full and Partial Dentures	Mounted, labeled and dated full-arch pre-operative X-rays Lab invoice: Lab surcharges are paid by the member. If materials exceed base metal, the dentist can bill the difference in actual lab cost, not to exceed $150. Prior placement date(s) if replacing existing prosthesis
Endodontics	Root Canal Therapy (RCT) and Re-treatment of RCT for Permanent Teeth and Endodontic Surgery	Labeled and dated pre- and post-operative X-rays Date of original RCT if performing re-treatment
Oral Surgery	Surgical and Impacted Extractions, Alveoplasty, and Pathology	Labeled and dated pre-operative X-rays and narrative where appropriate Pathology reports where appropriate
Pedodontics	All Pedodontic Services	Labeled and dated pre-operative X-rays, when possible Narrative of any existing medical condition/physical limitation and/or inability of patient cooperation Any services more than $300.00 need to be prior authorized
Periodontics	Root Planing and Scaling, Gingivectomy, Crown Lengthening, and Periodontal Surgery	Mounted, labeled and dated pre-operative X-rays Perio case type Dated periodontal charting Date(s) of prior root planing and scaling by quadrant(s) and re-evaluation date(s)
Anesthesia	General Anesthesia and/or I.V. Sedation	Type and duration of agent and narrative of necessity where appropriate

Tips on Claim Submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Attending dentist information should include dentist's name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.
- Patient information should include patient's full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT Codes of services performed — Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, are required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges — As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA Claim Form are used.
- Narratives are an essential ingredient to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn't part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits — If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved — this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

Notes: The notes section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing. A common note added to claims is "Please pay promptly." Adding this note actually has the opposite effect — delaying the claim.

Governing Administrative Policies

Practice Capacity and Appointment Scheduling

DBP.com requires your office to appoint eligible members, for both new and interval appointments, within 14 business days of the member's request for appointment. Thirty minutes or less wait time in the office for a scheduled appointment is also required by DBP.com. This will allow eligible members reasonable access to care and will allow your office to complete treatment plans in a timely manner.

If your office or DBP.com determines your practice has reached capacity and can no longer schedule appointments for members in a manner that allows reasonable access and promotes the completion of treatment plans within an appropriate and efficient timeframe, your office will be temporarily placed in an "unpublished status" (i.e., will be closed to new members), within 60 days of this determination. Your office is required to provide covered services to all members who have chosen or will choose your office during the 60-day notice period. When both your office and DBP.com agree that the practice can again become "published" on our dentist directory, DBP.com will do so immediately.

Emergency Coverage

An emergency is defined as conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection.

The general dentist is responsible for providing 24-hour emergency care to eligible members assigned to your office. Emergency patients must be seen within 24 hours of their initial request for treatment. Message retrieval systems or alternate coverage is required to ensure the patient timely access to your office or a participating designee.

If a referral to a specialist is anticipated, the general dentist should provide palliative care to alleviate symptoms and stabilize the member's condition and then follow the normal referral process, including obtaining applicable prior authorization.

New Associates

Your office is required to inform DBP.com in writing within 30 days if the practice employs, or in some other manner associates with, other dentists who will treat eligible DBP.com members. Such notification shall occur prior to any treatment being rendered by such dentist. An Associate Credentialing Application must be submitted for each new dentist and completed prior to initiating care. In addition, your office is required to notify DBP.com in writing in the event that any dentist terminates his or her employment and will no longer be treating DBP.com members.

Change of Address, Phone Number, E-Mail Address, Fax or Tax Identification Number

Your office is required to provide DBP.com with at least 30 days' written notice prior to relocation of the practice or change in practice tax identification number. DBP.com reserves the right to conduct an on-site inspection of the new location.

Office

Dental plan office equipment should be in good working condition. The office should be kept neat and clean. Dental plan providers' offices and treatment accessibility should comply with the Americans with Disabilities Act. A portable oxygen unit or ambu bag should be readily available for emergency use.

Sterilization and Asepsis Control

Dental office sterilization protocol should meet OSHA requirements. All instruments should be heat sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure.

The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA guidelines.

Recall System

There should be an active and definable recall system to ensure that the practice maintains preventive services, including patient education and appropriate access. The recall system should be individualized to the patient's need and should not be a fixed interval for all patients.

Transfer of Dental Records

Your office shall copy all requested member dental files to another participating dentist as designated by DBP.com.

The member is responsible for the cost of copying the patient dental files if the member is transferring to another provider. Fee for copies of dental records, would align to member's fee schedule or state guidelines. If your office terminates from DBP.com, dismisses the member from your practice, or is terminated by DBP.com, the cost of copying files shall be borne by your office. Your office shall cooperate in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

Quality Improvement Program Description

Purpose:

The Quality Improvement Program Description provides an overview of the Quality Improvement Program (the "QIP"), which focuses on assessing important aspects of Member care and the systems that support its delivery.

Scope:

The Quality Improvement Program (QIP) Description applies to Dental Benefit Providers, Inc. (DBP or the Plan) and all their legal entities. The Program is comprehensive and includes all activities that have a direct or indirect influence on the quality and outcome of dental services delivered to all Members.

Policy:

DBP will establish and maintain an ongoing program of quality management and quality improvement to facilitate, enhance, and improve Member care and services while meeting or exceeding customer needs, expectations, accreditation, and regulatory standards.

Procedure:

I. Goals and Objectives:

The objective of the QIP is to ensure that quality of care is being reviewed; that problems are being identified; and that follow-up is planned where indicated. The Program is directed by all state, federal and client requirements. The Program addresses various service elements including accessibility, availability, and continuity of care. It also monitors the provisions and utilization of services to ensure they meet professionally recognized standards of care. The Program is reviewed and updated annually.

The QIP includes, but is not limited to, the following goals:

A. To measure, monitor, trend, and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks;

B. To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement;

C. To evaluate the effectiveness of implemented changes to the QIP;

D. To reduce or minimize opportunity for adverse impact to Members;

E. To improve efficiency, cost-effectiveness, value, and productivity in the delivery of oral health services;

F. To promote effective communications, awareness, and cooperation between Members, participating Providers, and the Plan;

G. To comply with all pertinent legal, professional, and regulatory standards;

H. To foster the provision of appropriate dental care according to professionally recognized standards; and

I. To ensure that written policies and procedures are established and maintained by the Plan to ensure that quality dental care is provided to the Members.

II. Organizational Structure and Responsibility:

The Board of Directors has overall responsibility for the environment of care and services provided to Members. The Board delegates responsibility for oversight of the effectiveness of operational components of the QIP to the Quality Improvement Committee. Reports are received and acted upon by the Board at its regularly scheduled meetings. The minutes from the Quality Improvement Committee are forwarded to the Board of Directors for review.

A. Job Descriptions

The DBP National Dental Director is a licensed dentist responsible for the oversight and evaluation of the clinical quality of health care services provided to Members and supervises and provides clinical direction to the QIP.

The Director of Quality Management oversees quality improvement activities and provides direction to the QIP. The Director of Quality Management has the responsibility for implementation, direction, and evaluation of related Program objectives, which are to:

- Objectively and systematically monitor and evaluate aspects of Member care;
- Provide a system for the identification of opportunities for improvement and implement strategies to achieve improvement in care and services to Members;
- Promote the coordination, documentation, and communication of plan-wide quality management and quality improvement activities;
- Monitor the effectiveness of network quality management/peer review activities, including the selection and performance of dentists who review issues, the outcomes and effectiveness of those reviews, and their remedial actions;
- Promote inter-departmental collaboration in network-wide quality improvement activities;
- Promote compliance by network Providers with defined credentialing requirements, standards of care, access, availability of services, dental record documentation, and guidelines for the use of preventive health services and clinical guidelines;
- Provide a mechanism for the credentialing and recredentialing of network and oversight of delegated credentialing that complies with nationally recognized credentialing standards; and
- Implement and oversee preventive dental health systems to improve the oral and overall health status of Members.

It is the policy of the Plan to have sufficient support staff to ensure that all aspects of the QIP are properly implemented and evaluated, including tracking, monitoring, reporting, and the performance of regulatory compliance activities.

B. Confidentiality

Federal and state laws govern responsibility and liability for quality improvement activities. All quality assessment, peer review, and clinical review activities, including claims review, are confidential and privileged. Information obtained will be disclosed only to the extent necessary to carry out objectives of the QIP and applicable contractual or regulatory guidelines, including the Health Insurance Portability and Accountability Act of 1996. All proceedings of formal QIP activities shall be documented and maintained in a confidential manner. Reviewers do not receive incentives to perform reviews. The Plan does not maintain original dental charts at its administrative offices. Plan auditors and Committee Members sign annual confidentiality statements ensuring the confidential treatment of all Member information.

III. Committee Structure

The Board of Directors structures the Quality Improvement Committee (QIC) to coordinate and oversee all metrics of the organization, including clinical measures such as: quality management, quality improvement, utilization management, credentialing, Members' rights, dental records, and preventive health services in addition to operational metrics.

A. National Quality Improvement Committee

The QIC oversees the effectiveness of DBP quality improvement activities. The committee acts to plan and coordinate network-wide improvements in environment of care and service. Responsibilities of this committee are to:

- Determine what Quality Improvement projects or activities to undertake;
- Design, oversee, and evaluate the Quality Improvement activities including dental health management programs;
- Endorse performance benchmarks and goals;
- Receive reports from Quality Improvement project teams;
- Approve action plans and follow-up to ensure actions are effective;
- Review results of network-wide quality measurements, including annual Satisfaction Survey Reports, and identify opportunities for improvement;
- Receive reports from the Clinical Affairs Committee on patient care indicators;
- Conduct annual review of quality improvement effectiveness; and
- Oversee all survey data and action plans that result from those surveys.

B. National Clinical Affairs Committee

The Clinical Affairs Committee (CAC) reviews all aspects of clinical quality and provides representative operational and network input on clinical issues to the National Dental Director. Participating network Providers are voting Members of this committee who ensure that clinical aspects include the perspective of network Providers. Responsibilities of this committee are to:

- Provide input to the QIC on all aspects of clinical quality such as, but not limited to, access, dental record documentation, preventive service, credentialing and recredentialing processes, Member complaints, and utilization;
- Review all clinical aspects of Quality Management Program including credentialing and recredentialing, Provider sanctions and terminations, complaints and grievances, quality-of-care matters, peer review activities as reported by the Peer Review Committee (PRC), site visits, dental record audits, utilization, and access;
- Review and make recommendations on clinical policies and clinical studies;
- Review and approve activities performed by Clinical Policy and Technology, Peer Review, and Credentialing committees; and
- Effectively communicate quality management reports and metrics, best practices and opportunities for improvement to participating Providers.

C. National Clinical Policy and Technology Committee

The National Clinical Policy and Technology Committee (CPT) researches, adopts, and disseminates clinical guidelines based on the principles of Evidence-Based Dentistry. The Committee also:

- Provides a comprehensive evaluation of current as well as emerging technologies and products used in the practice of dentistry;
- Provides a systemic mechanism for continuing Clinical policy evaluation and Dentist input. This information is disseminated to network dentists and other external and internal stakeholders; and
- Provides recommendations for the incorporation of guidelines and/or new technologies in areas such as plan benefit design and adjudication criteria, utilization review criteria, marketing and underwriting collaterals, and new product development.

D. National Credentialing Committee

The Credentialing Committee performs all first-level reviews for credentialing and recredentialing. The committee includes participating network dentists as voting members. Responsibilities of this committee are to:

- Identify trends related to credentialing and recredentialing; and
- Review and make determinations on credentialing and recredentialing applications with or without adverse issues.

E. National Peer Review Committee

The Peer Review Committee reviews and makes determinations for all clinical quality issues related to individual dentists including but not limited to:

- Individual quality of care complaints from Members or any other source;
- Appeals for the Credentialing Committee;
- Report any action to the CAC on peer review recommendations;
- Site visit results and chart audit results, as appropriate; and
- Review and make recommendations for cases of fraud and abuse.

IV. Processes and Procedures

A. Access and Availability

Participating Providers are required by contract to comply with the Plan's access standards to ensure that care is available and is properly coordinated. Standards are published as mandated by state and/or client requirement. The Plan ensures that all requirements are met relating to the access and availability of our Providers, and has filed the current access and availability standards with the state regulatory agencies as required. The Plan monitors the following appointment availability:

- Initial visits;
- Routine visits;
- Hygiene visits;
- Emergency care; and
- In-office wait time.

The Plan uses several means to measure and monitor access to care within the network such as, but not limited to:

- Access surveys;
- Grievance data;
- Member satisfaction surveys;
- Onsite audits; and
- Provider after-hours accessibility.

The Plan also uses Geo-Access reports to ensure that the locations of its contracted Providers are within reasonable proximity to the Members.

As part of the QIP, Access and Availability reports are provided to the various advisory committees on a regular basis. This allows for the identification of improvement opportunities.

If required, the Plan may also monitor after-hours availability, provide emergency out-of-area benefits, and may offer payment to non-participating Providers when compliance with access or availability standards is not possible.

The Plan evaluates the access and availability of Providers, and monitors continuity and coordination of care as part of the QIP and Quality Improvement Annual Work Plan activities, which may include but are not limited to, Member surveys, Provider surveys, and Member and Provider complaints. The Plan addresses any identified deficiencies through corrective action as part of the Quality Improvement activities.

B. Member Satisfaction Survey

The Plan has policies and procedures to track and trend Member satisfaction using various data fields, such as, but not limited to: employer groups, specific dental plans, and specific lines of business. The Plan shall report the results, findings, and corrective actions, if any, to the appropriate committees. The committees or appropriate personnel shall have the ability to request Member Satisfaction Surveys with parameters. Survey questions are designed to assess Member satisfaction with access to care, quality of care, staff and Provider attitudes, satisfaction with the dental office, communication, and overall satisfaction with the Plan.

C. Member Complaint/Grievance Resolution Process

The Plan has a grievance system and mechanism in place to allow for its Members and/or their representatives to file grievances against both the Providers and the Plan.

The Plan has a Member appeal and grievance process that encompasses investigation, review and resolution of Member issues related to the Plan and/or contracted Providers. Issues are accepted via telephone, fax, email, letter, or grievance form. Grievance forms may be requested from our Customer Service department, the Plan's website or from a dental Provider office in accordance with state regulations. The Plan does not delegate grievance processing and resolution to any Provider group. All Member benefit complaints and quality of care grievances are received and processed by the Plan.

The Plan ensures that all state and federal regulatory, and client-specific requirements are met relating to the specific timeframe and notices required. The Plan also recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on Member complaint and grievance activities are made to all appropriate committees and the Board of Directors.

The Plan's Complaint, Grievance and Appeals policies are filed with the necessary regulatory agencies when required.

D. Provider Disputes, Grievances and Appeals

Participating Providers or formerly contracted Providers, who believe they have been adversely impacted by the policies, procedures, decisions, or actions of the Plan may have a right to file a dispute with the Plan as provided by state regulation or provider contract. Any such dispute or Provider grievance shall be submitted in writing to the Plan, as provided in the Plan's Provider Dispute Resolution Policy. In the process, Provider disputes will be logged and routed to the appropriate department for resolution. The Plan accepts Provider disputes relating to, but not limited to, the following:

- Capitation or other reimbursement reductions (or withholds);
- Claim modifications/denials for all types of coverage plans;
- Contract issues;
- Plan policies and procedures; and
- Quality of care issues.

The Plan will acknowledge receipt of the dispute within fifteen (15) business days and resolve the dispute within forty-five (45) business days of receipt of all information necessary to make a resolution unless otherwise required by individual state requirements. Following notification of the Plan resolution, if unsatisfactory, the Provider may appeal this decision as provided in their Provider Contract. In some cases, parties may seek further action through independent arbitration services.

The Provider Dispute Resolution policy completely outlines the process in which the Provider's dispute or grievance is handled, including the timeframes and sample letters. Provider Dispute policies are filed with the state regulatory agency when required.

E. Guidelines for Quality of Care and Quality of Services

The Plan has developed and maintains criteria and guidelines for care and service to ensure that Plan Members receive all necessary, adequate and appropriate preventive, and restorative dental services which are consistent with generally accepted professionally recognized standards. The Plan continues to research and develop evidence-based clinical guidelines.

F. Quality of Care Oversight and Monitoring

The Plan has various methods for monitoring quality of care to ensure Members receive the necessary, adequate and appropriate preventive and restorative dental services which are consistent with generally accepted professionally recognized standards and within expected guidelines. These methods include, but are not limited to, On-Site Audits, Potential Quality Issue investigation, analysis of Grievances and Appeals, review of Credentialing issues, Utilization statistics, and Member Satisfaction surveys.

G. Potential Quality Issues (PQI)

The Plan tracks Quality of Care, Quality of Service and/or Access issues to identify systemic issues that may relate to specific Providers or the Plan. Information that is tracked comes from various sources, such as, but not limited to: Member grievances, on-site Provider reviews, outside sources, and access surveys. Information is collated from these various sources to identify any systemic quality issues. PQIs are reported to the various advisory committees to foster change and improvement in plan design and operations, and to improve quality of care and/or service wherever possible. The PQI program is aimed at continuously reviewing Providers for quality of care and quality of service issues, and to coordinate corrective actions to improve care and service where appropriate.

H. Identification of Clinical and/or High-Risk Issues

To identify and prioritize quality issues, membership data is reviewed periodically to identify and prioritize quality issues using basic demographics, such as age and geographic location (including suburban, urban and rural), and comparing this data to available local and/or national benchmark data. Among the

items reviewed periodically are audits of Members' most frequent dental treatment procedures. The data is reviewed to establish benchmarks for future health care study and quality improvement. The quality improvement focus includes, but is not limited to, populations in urban or suburban environments and rural communities. These are compared to local or national data when available.

I. Credentialing

The Plan maintains a comprehensive credentialing process to verify the professional credentials of all contracted dentist Providers. The Plan contracts with an NCQA Certified Credentialing Verification Organization (CVO) to assist in the required data collection to complete the credentialing process. The Plan may also perform "in-house" credentialing following all NCQA guidelines.

Before an applicant dentist is accepted as a participating Provider, the dentist's credentials are evaluated. The Plan will request a written explanation from the applicant of any adverse incident and its resolution, as well as corrective action taken to prevent future occurrences. The Plan will request a resolution of any discrepancies in credentialing forms submitted by the applicant.

The National Dental Director and the Credentialing Committee review the information in detail based on approved credentialing criteria. Credentialing criteria is reviewed by committees, which include input from practicing network Providers to ensure that criteria are within generally accepted guidelines.

J. Recredentialing

The Plan maintains a comprehensive recredentialing process. The Plan contracts with a CVO to assist in the required data collection to complete the recredentialing process of all contracted Providers. Dentists are recredentialed on a three (3) year cycle unless otherwise required by state regulation.

In order for a thorough review to be completed at the time of recredentialing, in addition to the items verified in the initial credentialing process, the Plan may review Provider performance measures such as, but not limited to:

- Utilization Reports;
- Current Facility Review Scores;
- Current Member Chart Review Score; and
- Grievance and Appeals Data.

The Plan will request a written explanation of any adverse incident, its resolution and corrective action taken to prevent future occurrences.

K. Provider On-Site Reviews

The QIP includes mechanisms for evaluation of the facilities at participating dental offices, as well as mechanisms for evaluation regarding the clinical process of care rendered by participating dentists at dental plan offices, including audits of clinical records.

The Plan uses valid and reliable data collection and analysis methodologies to evaluate the clinical process of care at dental plan offices, and evaluates participating dentists against current professionally recognized standards of practice as promulgated by national dental professional associations. The clinical evaluations are conducted by qualified licensed dentists and overseen by the National Dental Director where such oversight includes regular training, calibration, and validation of results.

The Plan's evaluations are of sufficient scope to address all aspects of clinical care rendered at participating dental offices, taking into account Member/patient mix and covered services. The Plan may select to conduct a clinical site review of a participating dentist to ensure that dental quality problems that arise at participating offices are identified and corrected in a timely manner. The selection of an office may be triggered by multiple factors, including but not limited to, Member grievances or a severe quality of care issue. The evaluation processes provide for progressive corrective action and follow-up with participating Providers, where required, and the results are reported to the committees and the Board of Directors. Such reports may include peer review, and will be considered in the recredentialing process.

On-Site Reviews are conducted to determine if a new dental office is qualified to participate with the Plan's program, to determine whether existing dental offices have met the contractual performance standards, and to respond to specific complaints from dental plan Members or if the Provider has been identified as having a potential quality issue.

Facility reviews may be conducted by a licensed dentist or by appropriate personnel. Chart reviews are conducted by licensed dentists. The interval between reviews is determined by the score of the previous review and/or quality indicators used throughout the QIP. More frequent audits may be needed based on Provider profile indices or triggers, such as, but not limited to, grievance history, utilization history, or other quality improvement data.

A post-audit summary letter detailing deficiencies to be corrected is sent to the contracted Provider and any corrective action plans are monitored for closure. Non-compliance with any requests for corrective actions may result in additional action or sanction up to and including termination.

Corrective actions may include:

- Telephonic counseling;
- Written corrective action plan to be submitted to the Plan by the Provider;
- Recall patient(s) for re-evaluation;
- Submission of patient records;
- Obtain missing items noted on the facility review and submit evidence of remediation; and
- Obtain new chart forms.

A focused office review may be required because of a grievance, utilization review, or other trigger. A Provider or Provider group exhibiting these issues will be referred to the Peer Review Committee for oversight and corrective action as deemed necessary.

The Plan selects Providers/Provider offices for such On-Site review based on triggering activities such as, but not limited to, previous audit score, outstanding credentialing issues, identified utilization Issues, complaints/grievances and/or inquiry reports, and Provider transfer reports.

L. Dental Records

The Plan maintains policies regarding Dental Record requirements, such as required and recommended information to be contained in proper dental records. The Plan may perform dental record audits if concerns exist about quality or when the Plan has concerns about dental recordkeeping. In addition, chart review may be involved in anti-fraud investigation.

The Plan requires contracted Providers to make the contents of the dental records available upon request as part of Quality Improvement activities or Utilization Management.

The Plan requires Providers to cooperate with Member requests for copies of their dental records. Providers may charge a nominal fee for this service in accordance with state laws.

Providers must comply with all state laws requiring the storage of dental records for the requisite time periods.

M. Provider Satisfaction Survey

The Plan periodically conducts Provider Satisfaction Surveys to assess the Provider perception of Plan performance and to identify opportunities for improvement. Areas surveyed include, but are not limited to, the following: Provider Relations (internal and field representatives), Customer Service, specialty referrals, quality management activities, and Provider involvement in grievances and appeals.

Survey results are presented to the appropriate committees for the identification of opportunities for improvement.

N. Provider Sanctions and Disciplinary Actions

The Plan maintains policies and procedures for corrective action of Providers when deficiencies are noted or when non-compliance with Plan-required activities is identified. The Plan may employ a variety of disciplinary actions up to and including Provider probation and Provider termination. In some cases, the Plan must comply with fair hearing requirements in accordance with federal or state regulations. If a Provider is terminated for quality reasons, the Plan must inform the Provider databases as required by state and federal regulation.

O. Preventive Care Guidelines and Dental Health Education

The Plan's preventive dental health services activities are designed to measure indicators of preventive health and to share feedback to clients, individual Providers, and internally at DBP. The goal is to increase the utilization of preventive health services, in an effort to promote healthy behaviors and wellness of the Member. Additional efforts are offered to educate Members on the importance of preventive health and the services available in their plan, through communication and outreach, coordinated with the health plan. Primary responsibility is coordinated between Quality Management and the National Dental Director, with input from Client Operations, Network Development and Marketing. Employer and Member input is obtained through direct contact, survey results and in specific promotional activities with employer groups. Results of individual studies are reported to the CAC, who makes recommendations to be shared with the QIC.

P. Linguistic Access

The Plan complies with all federal, state, and client mandated linguistic access requirements. The Plan may make materials available in various languages, large print, and also offers hearing-impaired services when required, in accordance with all contractual, state, and federal requirements.

Q. Health Insurance Portability and Accountability Act (HIPAA) Compliance

The Plan adheres to all required HIPAA requirements in the processing of Member's protected health information (PHI). The Plan maintains HIPAA Policies and Procedures and performs the required training for all employees. The Plan also requires all contracted Providers to handle Member health care information with the same sensitivity. Chart audits are reviewed for confidentiality issues. Providers are subject to their own federal HIPAA requirements. The Plan requires signed business agreements ensuring that HIPAA requirements are met for all required activities.

R. Non-Discrimination

The Plan does not discriminate or tolerate discrimination against a Member who has filed a complaint of any kind with the Plan (i.e., against a Provider or the plan itself, or any other complaint). No plan contract shall be cancelled because a Member or their representative has filed a complaint with the Plan. In addition, the Plan complies with all state, federal, and local anti-discrimination laws.

S. Emergency Care/Emergency Dental Services

Within the scope of dental care benefits under the Member's benefit plan, emergency dental services are services required in the event of unforeseen medical conditions such as pain, hemorrhage, infection, or trauma, where immediate attention is necessary. In general, emergency services include relief of pain, swelling, infection, and/or bleeding by procedures to stabilize the emergency condition, and may include issuing prescription medications. Definitive procedures may need to be deferred to a more appropriate time.

Emergency services do not require pre-authorization when performed by the Member's general dentist. Emergency treatment from other than the Member's general dentist (i.e., contracted specialist, non-contracted general dentist or specialist) also requires no pre-authorization, but should be limited to the services necessary for the relief of pain, or to stabilize any emergency situation. Specific requirements may vary by plan.

T. Member and Provider Notification of Substantive Changes

The Plan provides timely and full disclosure of all substantive changes to Member contracts, Certificates of Coverage, Evidence of Coverage or to Provider Contracts and Provider materials such as Provider Reference Manuals, by providing written notification as prescribed by law or in the contract. Sufficient notice is given of the change as required by law.

U. Government Programs

Government programs may have unique quality management requirements as required by the government proposal, statute, or regulation. The Plan monitors such unique requirements and incorporates them into its QM program as appropriate.

V. Fraud and Abuse Program

A key component of the Plan's management of benefit costs is the identification and investigation of potential fraudulent, abusive, unusual services, or aberrant patterns of care. Should it be seen that a Provider's utilization falls outside of the expected norms; if a Provider submits an improper claim or makes an improper referral; if a Member's activity is inconsistent with claims or enrollment documents submitted; or if a third party vendor submits invoices that are inconsistent with its contract terms, this will initiate a process for further review and analysis. The goal of the analysis and investigation is to determine if the activities in question are supported, the result of honest errors, or indicative of fraudulent or abusive behavior.

The Fraud and Abuse Program is reviewed periodically as required by specific contract, state, and/or federal requirements. The Fraud and Abuse Program is concerned with all sources of potential fraud, including Provider, Member, and operational. For those cases that are verified as being "fraudulent," they are summarized at the appropriate committees, and referred to the appropriate authorities for further action. Annual reports of anti-fraud or abuse activity are filed with the state regulatory agencies when required.

W. Delegation Arrangements

When delegating QIP activities, the Plan shall ensure there is a process in place for appropriate regular and periodic oversight of the delegated activity. The Plan shall ensure that there is a written and executed agreement delegating specific activities to the delegated entity. Results of the oversight activities are periodically reported to the appropriate committees and the Board of Directors.

X. Annual Quality Improvement Activities and Work Plan

The Plan is committed to quality improvement activities to identify systemic quality of care and quality of service issues, and to create initiatives to improve identified quality parameters and hence to improve care and service.

The QIP includes mechanisms to evaluate and report trends and patterns with complaints, appeals, and other data sources used to measure quality performance. Such reports are reviewed and acted upon by the QIC. The QIP uses established quality of care indicators relevant to its membership and based on current and sound clinical knowledge and practice, such as national evidence-based guidelines or national consensus guidelines to evaluate the quality of care provided.

The Plan uses valid and reliable data collection and analysis methodologies to identify, track, and trend quality of care and quality of service issues. The Plan establishes performance goals for the quality of care and quality of service indicators to assess performance, identify and set priority areas for improvement, and determine desired level of improvement, as applicable. The Plan tracks and trends performance on quality of care indicators on a Provider-specific basis, as appropriate.

A written evaluation of the QIP is prepared annually and submitted to the QIC and the Board of Directors for review and approval. This evaluation focuses on strengths and weaknesses, trends and patterns, barriers to improvement, and demonstrated accomplishments in improving dental care and services to Members. Input is obtained from the QIC, CAC, staff, data sources, satisfaction indicators, and the Plan management.

A Quality Improvement Work Plan is prepared for the upcoming year for submission to the Board of Directors for approval. The Work Plan incorporates aspects of the QIP annual evaluation, and revisions, if applicable, indicator requirements, and employer requests for monitoring and reporting. The Quality Improvement Work Plan is prepared and based primarily on the annual QIP evaluation but may also include client and regulatory requirements or other quality improvement initiatives.

If the Plan does not achieve its quality of care or quality of service performance goals, the Plan performs quantitative and qualitative data analysis to identify barriers to the improvement of both clinical and non-clinical aspects of its health service delivery system. The Plan designs and implements interventions to address the identified barriers in order to improve performance. Also, the Plan re-measures its performance to determine if it has improved its performance and met its goals.

Y. Utilization Management

The Plan maintains a comprehensive Utilization Management (UM) Program with supporting policies and procedures. Utilization data may be analyzed to ensure that Members receive quality oral health services. UM activities identify aberrant utilization patterns, and provide source data for outcomes studies, allowing analysis of client performance which can suggest targeted QI interventions aimed at improving Member oral health outcomes.

UM is an additional source of quality indicators, which can be used to evaluate quality in the following four areas: clinical results or treatment choices, over- and under-utilization compared to network baselines, accuracy of coding procedures, and cost of care. Utilization and dental management information may be incorporated in the processes for evaluating new technologies and determining dental appropriateness for use and coverage, and detailing access standards and plan/benefit design. The Annual Work Plan may contain initiatives aimed at improving identified utilization parameters.

Z. Members' Rights and Responsibilities

Members may have rights according to their plan or state requirements including, but not limited to: access, second opinions, linguistic and cultural sensitivity, external clinical review (Independent Review), and the complaint/grievance process.

Members have the responsibility to treat contracting dentists, office staff, and Plan employees with respect and courtesy; to keep scheduled appointments or contact dental offices in advance to cancel appointments; to make applicable copayments at the time of treatment or cost-sharing following treatment depending on their benefit plan; and to notify their employer of any changes in family status, address, or other life-changing event.

Further rights and responsibilities may be enumerated in each benefit plan's collateral materials.

AA. Cultural Competency Program

Cultural Competency has emerged as an important issue in health and dental care. The Plan understands the population is becoming increasingly diverse; therefore, the Plan and our contracted Providers will need to treat patients appropriately regarding their dental needs, as it may be influenced by their social or cultural background. The Plan has developed a Cultural Competency Program to ensure that the needs of our multicultural membership are met.

The purpose of the Cultural Competency Program is to make certain that the Plan meets the individual, cultural and linguistically diverse needs of all Members; meets the needs of the Members that are in need of linguistic services; and enables Members to obtain adequate communication support.

BB. Mechanisms for Overseeing Program Effectiveness

The QIC oversees the effectiveness of the Plan quality management, quality improvement, and preventive health education activities. Quarterly status reports are provided by the Clinical Affairs Committee and made available to the Plan's management, clients (as required) and to the Board of Directors for review and evaluation of effectiveness.

The Chief Dental Officer has overall responsibility for the quality management program. The National Dental Director and the Director of Quality Management are responsible for monitoring follow-through when clinical and service opportunities for improvement are identified. Documentation regarding the implementation of recommendations for system changes, corrective actions, educational endeavors, and overall effectiveness is maintained.

Annual critical evaluation of the QIP is completed to ascertain that the goals are met and improvement initiatives are effective. Such review focuses on evaluation of defined goals and objectives, review of completed QI activities, program scope and organization. Highlights include trending of key clinical and service indicators, documentation of quantitative improvements in care and service attributable to QI initiatives, evaluation of QI resources, and recommendations for the coming year in the work plan. Any barriers to the QI process are analyzed and identified to create actions to overcome any and all barriers to the improvement process. It is the desire of the Quality Management staff for the QIP and any and all QI activities to be successful and effective.

Formulation of the annual Quality Management Program incorporates findings from the program evaluation (i.e., needed improvements, changes in process or structure, follow-up studies) in addition to activities mandated state and federal programs, and client contractual agreements. The Quality Improvement Program Evaluation and Annual Work Plan are reviewed and approved by the QIC and the Plan's Board of Directors.

Credentialing

To become a participating provider in DBP's network, all applicants must be fully credentialed and approved by our Credentialing panel. In addition, to remain a participating provider, all providers must go through periodic recredentialing approval (typically every three years unless otherwise mandated by the state in which you practice).

Depending on the state in which you practice, DBP will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. If you have Council for Affordable Quality Healthcare (CAQH) ID, please submit and DBP will pull your application and accompanying documentation from the site for processing. DBP will request a written explanation regarding any adverse incident and its resolution, and corrective action taken to prevent future occurrences.

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for some plans and/or markets. This typically applies to DHMO plans based on the West Coast as well as some Medicaid plans. Your Professional Networks Representative will you inform you of any facility visits needed during the recruiting process. Where required, the office must pass the facility review prior to activation. DBP will request a resolution of any discrepancy in credentialing forms submitted.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to ensure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by DBP based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or recredentialing decision, please follow the instructions provided in the determination letter received from the Credentialing department.

DBP may contract with an affiliated Credentialing Verification Organization (CVO) to assist with collecting the data required for the credentialing and recredentialing process. Please respond to calls or inquiries from this organization or our offices to ensure that the credentialing and/or recredentialing process is completed as quickly as possible.

It is important to note that the recredentialing process is a requirement of both the provider agreement and continued participation with DBP. Any failure to comply with the recredentialing process constitutes termination for cause under the provider agreement.

So that a thorough review can be completed at the time of recredentialing, in addition to the items verified in the initial credentialing process, DBP may review provider performance measures such as, but not limited to:

- Utilization Reports
- Current Facility Review Scores
- Current Member Chart Review Score
- Grievance and Appeals Data

Recredentialing requests are sent six months prior to the recredentialing due date. The CVO will make three attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, DBP will also make an additional three attempts. If there is still no response, a termination letter will be sent to the provider in accordance with the provider agreement.

A list of the documents required for Initial Credentialing and Recredentialing is as follows:

Initial Credentialing

- Completed application
- Signed and dated Attestation
- Professional questions answered and if any are in the affirmation, then an explanation must be submitted
- Current copy of Professional license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Professional Liability Insurance (PLI) which shows the provider name on the certificate, expiration dates and limits — limits $1/3m
- Five years of work history in month/date format with no gaps of six months or more; if there are gaps, an explanation must be submitted
- Education (which is incorporated in the application)

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of professional license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Professional Liability Insurance (PLI) which shows the provider name on the certificate, expiration dates and limits — limits $1/3m
- Professional questions answered and if any are adverse, then an explanation must be submitted

Any questions regarding your initial or recredentialing status can be directed to our Provider Services line.

Grievances

The member grievance process encompasses investigation, review and resolution of member issues related to the plan and/or contracted and non-contracted providers.

Issues are accepted via telephone, fax, e-mail, letter, written grievance form, or through our web portal. Grievance forms may be requested from our Member Service department, website or from a contracted dental provider office. DBP does not delegate grievance processing and resolution to any provider group.

All member benefit and quality of care grievances are received and reviewed in accordance with state and federal regulatory and client specific requirements both in terms of the notifications sent and the timeframes allowed.

Your office is required to cooperate with DBP's Policies and Procedures; Member Rights and Responsibilities; (including grievances) and Dental Records.

DBP shall have access to office records for that purpose and such information obtained from the records shall be kept confidential. Your office is required to comply with DBP's request for patient records and films, etc., within five business days of receiving the request.

Failure to comply will result in the grievance resolution in favor of the member. Additionally, your right to appeal the decision will be considered waived.

DBP recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on member grievance activities are made to all appropriate committees and the Board of Directors.

DBP's Grievance policies are filed with the necessary regulatory agencies when required.

Member Appeals and Inquiries

Members and providers acting on a member's behalf have the right to appeal how a claim was paid or how a utilization management decision was made.

Appeals regarding a denial of coverage based on dental necessity must be submitted within 60 days of the date of notification of an adverse decision unless otherwise prescribed by state regulations.

Appeals may be filed in writing, by telephone, or by fax and must include:

- Member name
- Claim ID
- Nature of the appeal including identification of the service
- Appropriate supporting documentation (such as X-rays or periodontal charting) and a narrative stating why the service should be covered.

Appeal reviews will be completed within state mandated timeframes upon receipt of all necessary information. Providers and/or members will be notified of an appeal determination within two days unless otherwise prescribed by state law, statute, or act.

Expedited Appeals:

In time-sensitive circumstances in which the timeframe for issuing determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited appeal may be requested.

Expedited Appeals may be submitted by the member, the member's representative, or by the practitioner acting on behalf of the member in writing, telephonically, or by fax.

Determinations will be completed within 48 hours of receipt of all required documentation or within the time frame required by state law, statute, or act.

Please refer to the Resources and Services section of this manual for appeal address and fax number information. Our Provider Services line is also available for any questions.

Provider Claim Appeal and Inquiry Process

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the EOB for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:

Utilization Management (UM) Appeal: Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

Administrative Appeal: Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative and copy of the Provider Remittance Advice.

Refer to the Quick Reference Guide section for appeal submission addresses.

Optional, Upgraded or Alternative Treatment Guideline

IMPORTANT NOTE: The Exclusions and Limitations under each Plan will vary. Please refer to the member's specific fee schedules.

Overview:

The Plan recognizes that there may be treatment situations where the contracted provider feels that there may be more than one approach to solving a dental situation, and both are listed as covered benefits.

Usually, the least expensive, necessary, adequate and appropriate procedure considered to be within professionally recognized standards would be considered to be the covered benefit, unless the Plan's Exclusions and Limitations apply.

"Professionally recognized standards of care" means that the treatment and/or treatment plan could reasonably be expected to be performed by similar dentists in the same area under the similar treatment circumstances.

*The Plan notes that some procedures are expressly **excluded** from coverage as stated in each plan's Exclusions and Limitations. Excluded procedures may be charged at a dentist's usual fee, as though the service was rendered to a private, fee-for-service patient. The Plan recommends a signed financial disclosure and consent in these cases.*

When a dentist wishes to present care that is considered to be **optional, upgraded,** or **"alternate,"** the dentist must perform the following:

1. Explain to the member the service that is considered a benefit of the Plan. This service must be offered as a treatment option and be available becomes the basis for the fee for the upgraded or optional treatment.
2. Explain why the proposed treatment is not a covered service. It is also recommended to quote or refer to the Exclusions and Limitations of the plan for further explanation.
3. Provide the financial benefit (the usual fee "UCR") of the covered service toward the UCR charges for the upgraded or optional service. The member is responsible for this difference in the UCR charges of the optional service and the covered service.
4. Present the copayment of the covered service, if any. This fee would be added to the upgrade fee in #3 above. **NOTE:** For plans that do not have a copayment for the covered service, there would be no copayment to add to the upgrade fee.
5. Obtain a signed agreement for the charges proposed outlining why the procedure is optional and not considered a covered benefit.
6. Document in the member's chart any conversations regarding the proposed treatment, the choices, and the member's decision. Verbal agreements are less binding and may be subject to interpretation. Written documentation provides the best defense for the dentist.

Upgrade or Optional Care Fee Calculation
Member can be charged:

	UCR of upgraded procedure
–	UCR of covered benefit procedure
+	Copayment for covered benefit procedure (if any)
=	Patient portion

7. Present all options in a fair and even-handed manner, with all the proper necessary information that a person would need to reasonably make the decision. The member cannot be "coerced" into making the decision for the upgraded or optional service. The decision cannot be based on unfair or inaccurate portrayal of the procedures in question.
8. Perform the basic benefit if the member so chooses. A dentist must routinely offer the basic service in order to have a service from which to upgrade. See examples below.

Common examples of PROPER application of this policy:

1. UPGRADE A FILLING TO A CROWN: "You have decay in this tooth. The tooth will hold a filling adequately, and that would be your benefit on your plan in this case. We could do a crown which could provide a more lasting result, and/or a more cosmetic result. We can apply the benefit of a filling toward the charge for the crown, and you would only be responsible for the difference in charges, if you so choose."
2. UPGRADE METAL CROWN TO A DIFFERENT METAL: "Your tooth needs a crown due to the fracture of a section of the tooth. There are several materials that could be used in making this crown. In this case a metal crown will function adequately for you. We can provide the metal used if you so choose. You would only be responsible for the difference in cost for the different metal."
3. UPGRADE A PARTIAL DENTURE TO A FIXED BRIDGE: "Several teeth are missing in several areas of your upper arch. A removable partial denture will function adequately to replace them and stabilize your bite. If you'd like a fixed (non-removable) bridge as an alternative procedure, we can apply your benefit for the partial denture toward the bridge and make arrangements for you to pay the difference."
4. UPGRADE SILVER AMALGAM FILLINGS TO POSTERIOR COMPOSITE (TOOTH-COLORED) FILLINGS: "You have several areas of decay which need fillings. There are several materials that can be considered for your fillings. Silver amalgam is a perfectly adequate material and has certain advantages. Your plan covers silver amalgam fillings. If you'd like to have a more cosmetic material, tooth-colored fillings can be placed as an alternative treatment. We will apply your benefit for silver amalgam fillings toward the tooth-colored "resin composite" fillings, and you would be responsible only for the difference. Which material would you like?"

Sample upgrade calculations:

When a Removable Partial Denture is the covered benefit, and a provider offers the option of a fixed bridge, the following calculation would be indicated:

Example of an Upgrade from a Partial Denture (covered) to a Fixed Bridge (optional):

NOTE: Each provider to insert the UCR from his or her office in the following calculation.

Doctor's UCR for a fixed bridge	$ 1950
Less his or her UCR for a Partial Denture	1200
Difference charged to member	$ 750
Plus Copayment for Partial Denture	340
Total member payment	**$ 1090**

OPTIONAL, UPGRADED OR ALTERNATIVE TREATMENT DISCLOSURE FORM

Treatment Plan #:	
Patient's Name:	Chart ID#:

I. FORMULA for DETERMINING CHARGES for OPTIONAL, UPGRADED or ALTERNATIVE TREATMENT:

When a Member elects a more extensive service that is an alternative to an adequate, but more conservative covered service, please use the following formula to determine the charge:

UCR Fee of Proposed Upgrade [1] – UCR Fee of the Benefit [2] + Copayment for the Benefit [3] = Accepted Charge for the Proposed Upgrade [4]

			1	2	3	4
ADA Code of Proposed Treatment	Proposed Procedure Description (Indicate reason this is not covered in explanation area below*)	Tooth # or Area	UCR Fee of Upgrade	UCR Fee of Benefit	Copayment of Benefit	[1] – [2] + [3] = Accepted Charge

II. METAL UPGRADES (for crowns, bridge abutments and pontics)

Some plans only allow a metal laboratory upgrade charge. Metal Upgrades are based on the additional cost of the metal. In these instances, please use the following formula to determine the charge:

Copayment [1] + Metal Upgrade [2] = Accepted fee [3]

				1	2	3
ADA Code of Proposed Treatment	Proposed Procedure Description	Tooth # or Area	UCR Fee of Proposed Treatment	Copayment of Benefit	Additional Charge for Metal Upgrade	Accepted Charge

*Reason for Upgrade/Reason proposed service is not covered:

I agree to the above charges which represent additional financial obligations for treatment or features that I desire that are not part of my dental benefit plan.

Patient's (Parent or Guardian) Signature:	Date:
Treatment Plan Presented by (Office Staff or Doctor):	Date:

Specialty Referral Process

Evaluation of the recommended specialty care treatment will be made and if found to meet the criteria for referral, the treatment will be approved and notification will be made to the general dentist, the authorized Specialty Care Provider and member/patient. To achieve authorization, it is imperative that the general dentist provide all recommended treatment information. Please mail specialty referral request forms to:

Specialty Referral Request
P.O. Box 30552
Salt Lake City, UT 84130

Payment for unauthorized referral claims will be denied, except in the case of emergencies. Emergency treatment should be limited to the services necessary for the relief of pain, swelling, infection and/or stabilization of the emergency conditions. Definitive care should be deferred until a proper pre-authorization can be performed with X-rays, narrative and other documentation.

The general dentist is expected to provide emergency treatment for patients assigned to your practice. If a referral to a specialist is anticipated, the general dentist should provide palliative care to alleviate symptoms and stabilize the member's condition and then follow the normal referral process, including obtaining applicable prior authorization.

For any questions, please contact Customer Service at 1-800-232-0990.

To prevent any delay in processing, the Specialty Referral Request Forms must be completed in full, including the procedure code(s) for the service(s) you are requesting. To aid in this process, the following list was compiled of the most commonly referred specialty procedure codes.

UnitedHealthcare®

Specialty Care Referral Form

Date of Referral: _____/___/_____

Subscriber and Patient Data:

Subscriber (policy holder) Identification #: _____

Subscriber Name: _____ Group Name: _____

Last First Middle

Patient's Name: _____

Last First Middle

Patient's Date of Birth: _____/___/_____ Relationship to Subscriber: _____

Referring Dentist Information:

Name: _____ Practitioner ID #: _____

Street Address: _____ Phone Number: _____

City, State and Zip Code: _____

Specialist Information:

Name: _____ Phone Number: _____

Street Address: _____

City, State and ZIP Code: _____

Reason for Referral:

_____

_____

_____

Services Requested for Referral:

Procedure Code	Tooth/Quad/Arch	Description of Procedure

Note: For additional services, a standard ADA Claim Form may be appended to this form.

As the referring dentist, I affirm that all information above is true and accurate.

Referring Dentist's Signature: _____

Signature Date: _____/___/_____

Customer Service:
For any questions, please contact Customer Service at 1-800-232-0990.

Mail Completed Form with Appropriate Clinical Documentation To:
Specialty Referral Request, PO Box 30552, Salt Lake City, UT 84130

Referring Dentist: Please refer to your Provider Manual to verify that the referral is appropriate and that you have included the required documentation.

Quick Reference Guide: Most Commonly Referred Specialty Procedure Codes

Endodontics

- 9310 Consultation
- 3310 Anterior root canal: if complicated due to factors such as extreme root curvature
- 3320 Bicuspid root canal: if complicated due to factors such as extreme root curvature
- 3330 Molar root canal: may be direct referred without prior authorization
- 3346 Re-treatment of previous root canal therapy – anterior
- 3347 Re-treatment of previous root canal therapy – bicuspid
- 3348 Re-treatment of previous root canal therapy – molar
- 3410-3430 Surgical endodontics

Periodontics

- 9310 Consultation
- 4260, 4261 Osseous surgery
- 4270, 4271, 4273 Soft tissue grafts

Oral Surgery (teeth to be extracted must be associated with pathology or significant symptoms)

- 9310 Consultation
- 7220 Removal of impacted tooth – soft tissue
- 7230 Removal of impacted tooth – partially bony: may be direct referred without prior authorization
- 7240 Removal of impacted tooth – completely bony: may be direct referred without prior authorization

Orthodontics (for D8070-D8090 and D8660)

- Direct referral without prior authorization may be provided to a contracted orthodontist.

Pediatric Dentistry

- Direct referral without prior authorization may be provided for children under the age of 6, who are unmanageable.

Implants

- Direct referral without prior authorization may be provided for the surgical placement of an implant.

TEST COMPANY
TEST CONTACT
123 TEST CIRCLE
TEST CITY, TS 12345

UnitedHealthcare Dental®

Your new UnitedHealthcare Dental ID Card is here.

SUBSCRIBER BROWN
123 ANYWHERE STREET
ANYWHERE, US 99999

Attached is your new UnitedHealthcare Dental ID Card. We believe you will find this Dental ID card to be durable and convenient, and it should also help simplify your check-in process at the dental office.

You may notice an alternate number, rather than your Social Security Number, being used as the "Member ID" on your new card. This Member ID will minimize the need for you to reference your Social Security Number when visiting a provider, and thus aid in protecting your personal information. A Member ID is assigned to the primary insured only.

Should you have any questions, want to locate participating network dentists, get driving directions to dentists' offices or retrieve claim information, simply visit our Web site at www.myuhcdental.com, or contact customer service by calling the toll-free number on your Dental ID Card.

UnitedHealthcare Dental®

Plan ID (80840) 999-99999-99

Member ID: 999999999 Group Number: 678574

Member:
SUBSCRIBER BROWN

DENTAL IDENTIFICATION CARD

Dentist:
DR. PROVIDER BROWN

Payer ID: 521337971

Dentist ID:
9999999999999

UnitedHealthcare Dental Select Managed Care - NY Product ID D000xxxx
0502 Underwritten by UnitedHealthcare Insurance Company of New York

For additional plan information, consult your Certificate of Coverage. Printed: 06/01/12

Provider should verify eligibility before providing treatment. To verify benefits, view claims or find a provider, visit the website. Call for notification or preauthorization.

For Members: www.myuhcdental.com 800-232-0990

Benefits of the Dental Plan, other than emergency care, are available only when you receive covered services from your general dentist. Benefits for covered specialty services are provided only on referral from your general dentist or dental plan. There may be waiting periods for some procedures. A broken appointment fee will be charged without 24 hours notice. Please call the toll-free number listed on this card with any plan questions.

For Providers: www.dbp.com 800-822-5353
Dental Claims: P.O. Box 30567; Salt Lake City, UT 84130-05672

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UnitedHealthcare Dental®

Plan ID (80840) 999-99999-99

Member ID: 999999999 Group Number: 678574

Member:
SUBSCRIBER BROWN

DENTAL IDENTIFICATION CARD

Dentist:
DR. PROVIDER BROWN

Payer ID: 521337971

Dentist ID:
9999999999999

UnitedHealthcare Dental Select Managed Care - NY Product ID D000xxxx
0502 Underwritten by UnitedHealthcare Insurance Company of New York

For additional plan information, consult your Certificate of Coverage. Printed: 06/01/12

Provider should verify eligibility before providing treatment. To verify benefits, view claims or find a provider, visit the website. Call for notification or preauthorization.

For Members: www.myuhcdental.com 800-232-0990

Benefits of the Dental Plan, other than emergency care, are available only when you receive covered services from your general dentist. Benefits for covered specialty services are provided only on referral from your general dentist or dental plan. There may be waiting periods for some procedures. A broken appointment fee will be charged without 24 hours notice. Please call the toll-free number listed on this card with any plan questions.

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