



GUARANTY ASSURANCE COMPANY

People's Health Network

PH Group Medicare (HMO-POS), PH Group Medicare (HMO-POS) for Office of Group Benefits

\$50 Annual Deductible

**Deductible does not apply to services listed in the
Diagnostic or Preventive categories (exams, x-rays or cleanings)**

\$2000 Maximum Annual Benefit per Calendar Year
Out of Network Benefits

Procedure Code	Procedure Description	Frequency	Member Co-Pay	Total Provider Reimbursement
Diagnostic				
Clinical Oral Evaluations				
D0120	Periodic Oral Evaluation	1/6 months	\$0.00	\$21.00
D0140	Limited Oral Evaluation	1/12 months	\$0.00	\$30.00
D0150	Comprehensive Oral Evaluation - new or established	1/12 months	\$0.00	\$35.00
Radiographs/Diagnostic Imaging				
*D0210	Intraoral - Complete Series (including bitewings)	1/12 months	\$0.00	\$57.00
D0220	Intraoral - Periapical first film	1/12 months	\$0.00	\$10.00
D0230	Intraoral - Periapical each additional film	1/12 months	\$0.00	\$6.00
D0240	X-rays Intraoral-Occlusal Film	1/12 months	\$0.00	\$14.00
D0270	Bitewings, single film	1/12 months	\$0.00	\$12.00
D0272	Bitewings, two films	1/12 months	\$0.00	\$17.00
D0274	Bitewings, four films	1/12 months	\$0.00	\$25.00
*D0330	Panoramic film	1/12 months	\$0.00	\$55.00
Preventative				
Dental Prophylaxis				
D1110	Prophylaxis - Adult	1/6 months	\$0.00	\$44.00
Restorative				
Amalgam Restorations (Including Polishing)				
D2140	Amalgam, one surface, primary or permanent		\$11.00	\$52.00
D2150	Amalgam, two surfaces, primary or permanent		\$14.00	\$68.00
D2160	Amalgam, three surfaces, primary or permanent		\$17.00	\$84.00
D2161	Amalgam, four surfaces or more		\$20.00	\$98.00
Resin-Based Composite Restorations - Direct				
D2330	Resin - one surface, anterior		\$14.00	\$70.00
D2331	Resin - two surfaces, anterior		\$19.00	\$94.00
D2332	Resin - three surfaces, anterior		\$24.00	\$118.00
D2335	Resin - four or more surfaces, anterior		\$27.00	\$132.00
D2391	Resin - one surface, posterior		\$15.00	\$79.00
D2392	Resin - two surfaces, posterior		\$23.00	\$115.00
D2393	Resin - three surfaces, posterior		\$28.00	\$140.00
D2394	Resin - four or more surfaces, posterior		\$35.00	\$175.00
Only one (1) crown procedure code is covered every twelve (12) months per member				
Crowns - Single Restorations Only				
D2740	Crown - Porcelain/Ceramic Substrate		\$295.00	\$590.00
D2750	Crown - Porcelain fused to high noble metal		\$275.00	\$550.00
D2751	Crown - Porcelain fused predominantly base metal		\$255.00	\$500.00
D2752	Crown - Porcelain fused to noble metal		\$260.00	\$520.00
D2783	Crown - 3/4 Porcelain/Ceramic Substrate		\$295.00	\$565.00
D2790	Crown - full cast high noble metal		\$265.00	\$530.00
D2791	Crown - full cast predominantly base metal		\$210.00	\$420.00
D2792	Crown - full cast noble metal		\$230.00	\$460.00
Other Restorative Services				
D2930	Prefabricated stainless steel crown - primary tooth		\$55.00	\$110.00
D2931	Prefabricated stainless steel crown - permanent tooth		\$57.00	\$114.00



Procedure Code	Procedure Description	Frequency	Member Co-Pay	Total Provider Reimbursement
Periodontics				
Non-Surgical Periodontal Service				
D4341	Periodontal Scaling and Root Planing, per quadrant	1/12 months	\$53.00	\$120.00
D4342	Periodontal Scaling and Root Planing, 1-3 teeth	1/12 months	\$30.00	\$100.00
D4355	Full Mouth Debridement	1/12 months	\$32.00	\$80.00
Other Periodontal Service				
D4910	Periodontal Maintenance	1/60 months	\$32.00	\$70.00
Prosthodontics (removable)				
Complete Dentures (Including Routine Post-Delivery Care)				
D5110	Complete Denture - Maxillary	1/60 months	\$206.00	\$824.00
D5120	Complete Denture - Mandibular	1/60 months	\$206.00	\$824.00
D5130	Immediate Denture - Maxillary (in lieu of D5110)	1/60 months	\$213.75	\$855.00
D5140	Immediate Denture - Mandibular (in lieu of D5120)	1/60 months	\$213.75	\$855.00
Partial Dentures (Including Routine Post-Delivery Care)				
D5213	Maxillary Partial Denture - Cast Metal Framework	1/60 months	\$217.75	\$871.00
D5214	Mandibular Partial Denture - Cast Metal Framework	1/60 months	\$217.75	\$871.00
Adjustments to Dentures				
D5410	Adjust Complete Denture - Maxillary		\$20.00	\$40.00
D5411	Adjust Complete Denture - Mandibular		\$20.00	\$40.00
D5421	Adjust Partial Denture - Maxillary		\$20.00	\$40.00
D5422	Adjust Partial Denture - Mandibular		\$20.00	\$40.00
Repairs to Complete Dentures				
D5510	Repair Broken Complete Denture Base		\$39.00	\$78.00
D5520	Replace missing or broken teeth - Complete Denture		\$31.00	\$62.00
Repairs to Partial Dentures				
D5610	Repair Resin Denture Base		\$45.00	\$90.00
D5640	Replace Broken Teeth - Per Tooth		\$30.00	\$60.00
Oral and Maxillofacial Surgery				
Extractions (Includes local anesthesia, suturing, if needed and routine postoperative care)				
D7140	Extraction - Erupted tooth or exposed root (elevation and/or forceps removal)		\$15.00	\$75.00
Adjunctive General Services				
Unclassified Treatment				
D9110	Palliative (emergency) Treatment of Dental Pain	1/12 months	\$0.00	\$35.00

Total Reimbursement DOES NOT include lab costs. Lab fees are the member's responsibility.

Members with Peoples Health Group Medicare plans can utilize Out of Network dental providers.

***Panoramic Film (D0330) may be taken in place of Intraoral-Complete Series (D0210)**

Claims Submission:

1. **Mail:** DINA Dental Plan (Attention: Claims Department)
101 Parklane Boulevard, Suite 301
Sugar Land, Texas 77478
2. **Fax:** (281) 313-7154
3. **Electronic:** www.fcl dental.com
Third Party Clearinghouse: Emdeon (Payor ID # - CX090)

DINA Dental Plan/Peoples Health Network

DINA Limitations, Authorization and Claim Attachment Guidelines

Below is a list of procedure codes that have additional limitations or require specific information in order to process the claim. These procedure codes are marked with an asterisk (*) on the main benefit outline(s). Under certain circumstances additional information may be requested in order to process claims for procedures listed below.

Current CPT Code Documentation Guidelines

Radiographs/Diagnostic Imaging

D0210/D0330	Panoramic Film may be taken in place of D0210 (Intraoral-Complete Series) once every twelve (12) months
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Restorative

D2740	Pre-operative x-rays must be submitted with claim
D2750	Pre-operative x-rays must be submitted with claim
D2751	Pre-operative x-rays must be submitted with claim
D2752	Pre-operative x-rays must be submitted with claim
D2783	Pre-operative x-rays must be submitted with claim
D2790	Pre-operative x-rays must be submitted with claim
D2791	Pre-operative x-rays must be submitted with claim
D2792	Pre-operative x-rays must be submitted with claim

Periodontics

4341	Periodontal charting must be submitted with claim
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Oral and Maxillofacial Surgery

D7140	Pre-operative x-rays must be submitted with claim
D7210	Pre-operative x-rays must be submitted with claim
D7220	Pre-operative x-rays must be submitted with claim
D7230	Pre-operative x-rays must be submitted with claim
D7240	Pre-operative x-rays must be submitted with claim
D7241	Pre-operative x-rays must be submitted with claim
D7250	Pre-operative x-rays must be submitted with claim

Prosthodontics

All prosthodontic procedures will require pre-authorization and proof of completion of treatment.

General Information

Written Narratives	Must be clear, legible, and provide rationale for the proposed treatment.
Periodontal Charting	Must be comprehensive full mouth, legible, dated, and documented with probing depths (up to six per tooth), recorded in mm. per tooth, labeled right and left, mandibular and maxillary, with classified furcation defects and tooth mobility recorded as 1st, 2nd, 3rd degree.
Quality Radiographs	Radiographs should be dated, mounted, properly labeled left and right, and of diagnostic quality according to accepted standards of care. Radiographs should also be duplicates and less than 36 months old and labeled with the patient's name and the provider's name and address.

Submit Claims to:

1. Mail: First Continental Life (Attn: Claims Department)
101 Parklane Boulevard, Suite 301
Sugar Land, Texas 77478
2. Fax: (281) 313-7154
3. Electronically: Web - www.fcdental.com
Third Party Clearinghouse: Emdeon (Payor ID # – CX090)