



GUARANTY ASSURANCE COMPANY

People's Health Network

Secure Health (Dual SNP) and Secure Choice (Dual SNP)

No Annual Deductible
\$2000 Maximum Annual Benefit per Calendar Year

Procedure

| Code | Procedure Description | Frequency | Co-Pay |
|--|--|-------------|---------|
| Diagnostic | | | |
| Clinical Oral Evaluations | | | |
| D0120 | Periodic Oral Evaluation | 1/6 months | \$0.00 |
| D0140 | Limited Oral Evaluation | 1/12 months | \$0.00 |
| D0150 | Comprehensive Oral Evaluation - new or established | 1/12 months | \$0.00 |
| Radiographs/Diagnostic Imaging | | | |
| *D0210 | Intraoral - Complete Series (including bitewings) | 1/12 months | \$0.00 |
| D0220 | Intraoral - Periapical first film | 1/12 months | \$0.00 |
| D0230 | Intraoral - Periapical each additional film | 1/12 months | \$0.00 |
| D0240 | X-rays Intraoral-Occlusal Film | 1/12 months | \$0.00 |
| D0270 | Bitewings, single film | 1/12 months | \$0.00 |
| D0272 | Bitewings, two films | 1/12 months | \$0.00 |
| D0274 | Bitewings, four films | 1/12 months | \$0.00 |
| *D0330 | Panoramic film | 1/12 months | \$0.00 |
| Preventative | | | |
| Dental Prophylaxis | | | |
| D1110 | Prophylaxis - Adult | 1/6 months | \$0.00 |
| Restorative | | | |
| Amalgam Restorations (Including Polishing) | | | |
| D2140 | Amalgam, one surface, primary or permanent | | \$11.00 |
| D2150 | Amalgam, two surfaces, primary or permanent | | \$14.00 |
| D2160 | Amalgam, three surfaces, primary or permanent | | \$17.00 |
| D2161 | Amalgam, four surfaces or more | | \$20.00 |
| Resin-Based Composite Restorations - Direct | | | |
| D2330 | Resin - one surface, anterior | | \$14.00 |
| D2331 | Resin - two surfaces, anterior | | \$19.00 |
| D2332 | Resin - three surfaces, anterior | | \$24.00 |
| D2335 | Resin - four or more surfaces, anterior | | \$27.00 |
| D2391 | Resin - one surface, posterior | | \$15.00 |
| D2392 | Resin - two surfaces, posterior | | \$23.00 |
| D2393 | Resin - three surfaces, posterior | | \$28.00 |
| D2394 | Resin - four or more surfaces, posterior | | \$35.00 |



| Procedure Code | Procedure Description | Frequency | Co-Pay | |
|---|--|------------------|---------------|--|
| Periodontics | | | | |
| Non-Surgical Periodontal Service | | | | |
| D4341 | Periodontal Scaling and Root Planing, per quadrant | 1/12 months | \$53.00 | |
| D4342 | Periodontal Scaling and Root Planing, 1-3 teeth | 1/12 months | \$30.00 | |
| D4355 | Full Mouth Debridement | 1/12 months | \$32.00 | |
| Other Periodontal Service | | | | |
| D4910 | Periodontal Maintenance | 1/60 months | \$32.00 | |
| Prostodontics (removable) | | | | |
| Complete Dentures (Including Routine Post-Delivery Care) | | | | |
| D5110 | Complete Denture - Maxillary | 1/60 months | \$517.00 | |
| D5120 | Complete Denture - Mandibular | 1/60 months | \$517.00 | |
| D5130 | Immediate Denture - Maxillary (in lieu of D5110) | 1/60 months | \$555.00 | |
| D5140 | Immediate Denture - Mandibular (in lieu of D5120) | 1/60 months | \$555.00 | |
| Partial Dentures (Including Routine Post-Delivery Care) | | | | |
| D5213 | Maxillary Partial Denture - Cast Metal Framework | 1/60 months | \$547.50 | |
| D5214 | Mandibular Partial Denture - Cast Metal Framework | 1/60 months | \$547.50 | |
| Adjustments to Dentures | | | | |
| D5410 | Adjust Complete Denture - Maxillary | | \$30.00 | |
| D5411 | Adjust Complete Denture - Mandibular | | \$30.00 | |
| D5421 | Adjust Partial Denture - Maxillary | | \$30.00 | |
| D5422 | Adjust Partial Denture - Mandibular | | \$30.00 | |
| Repairs to Complete Dentures | | | | |
| D5510 | Repair Broken Complete Denture Base | | \$58.00 | |
| D5520 | Replace missing or broken teeth - Complete Denture | | \$46.00 | |
| Repairs to Partial Dentures | | | | |
| D5610 | Repair Resin Denture Base | | \$67.00 | |
| D5640 | Replace Broken Teeth - Per Tooth | | \$45.00 | |



DINA Dental Plan™

Procedure

| Code | Procedure Description | Frequency | Co-Pay |
|--|---|------------------|---------------|
| Oral and Maxillofacial Surgery | | | |
| <i>Extractions (Includes local anesthesia, suturing, if needed and routine postoperative care)</i> | | | |
| D7140 | Extraction - Erupted tooth or exposed root (elevation and/or forceps removal) | | \$15.00 |
| Adjunctive General Services | | | |
| <i>Unclassified Treatment</i> | | | |
| D9110 | Palliative (emergency) Treatment of Dental Pain | 1/12 months | \$0.00 |

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

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

Service Area: Ascension, [Assumption](#), East Baton Rouge, [East Feliciana](#), [Iberville](#), Jefferson, [Lafourche](#), Livingston, Orleans, Plaquemines, [Pointe Coupee](#), St. Bernard, St. Charles, [St. Helena](#), St. James, St. John the Baptist, [St. Mary](#), St. Tammany, Tangipahoa, [Terrebonne](#), Washington, West Baton Rouge and [West Feliciana](#).

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)