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CORRESPONDENCE MEMORANDUM

DATE: July 29, 2013

TO: Group Insurance Board

FROM: Mary Statz, Director, Health Benefits and Insurance Plans Bureau
Emily Loman, Manager, Alternate Health Plans

SUBJECT: Uniform Dental Benefit

This memo is for informational purposes only. No Board action is required.

At the May 21, 2013, Group Insurance Board (Board) meeting the Board approved a no deductible, cost-neutral uniform dental plan design for benefit year 2014. Subsequent technical changes made to the plan design presented at the May Board meeting include:

- Eliminating the limited stainless steel crown benefit
- Eliminating the limited endodontic benefit

As a result of removing these limited benefits, restorative services are now covered at 100%. With these final technical changes diagnostic, preventive and restorative services are all at 100% with in-network providers.

Clarifications also include the three types of dental providers and the roles of the dental plan and the dental provider.

Staff will be at the Board meeting to answer any questions.

Attachment: Uniform Dental Plan Certificate (Redline Strikeout)

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services
Lisa Ellinger
Electronically Signed 8/12/13

Board	Mtg Date	Item #
GIB	8.27.13	3F1

Uniform Dental Benefits Certificateof Coverage ~~Plan Design Attachment~~
~~April 25~~August 2, 2013

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

All dental benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. The Uniform Dental Benefits are wholly incorporated in the Master Contract.

This is a list of Uniform Dental Benefits and is based upon the Current Dental Terminology © American Dental Association. Codes are provided as a reference and may be subject to change; Plans may substitute alternative codes to provide essentially equivalent coverage.

No payment will be made for a benefit that is not listed.

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- ~~Benefit Period means the period from January 1 of any year through December 31 of the same year. But d~~During the first year a person is insured, ~~a benefit period means the period from his or her~~ benefits begin on the effective date and continue through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for Plan review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.
- Note that uniform medical benefit may provide coverage for oral surgery.

LIMITATIONS

The following services ***are limited*** under this **Plan**:

- Oral Exams limited to two per year.
- Full Mouth or Panoramic x-rays limited to once every 60~~36~~ months.
- Bite wing x-rays limited to two sets per year.
- Cleaning of teeth limited to two times per year.
- Fluoride treatment allowed only for a child under age 19, limited to two times per year.
- Sealants allowed only for a child under age 16, and must be applied to non-restored, non-decayed first and second permanent molars, limited to once per tooth per lifetime.

- Routine pediatric dental services as required under federal law.

Special note on fillings: On anterior (front) teeth you will have ~~90~~100% coverage subject to your benefit maximum for both amalgam (silver) and composite/resin (tooth colored) fillings. On posterior (back) teeth, you have ~~90~~100% coverage subject to your benefit maximum for amalgam (silver) fillings only. If you have a composite/resin (tooth colored) filling on a posterior tooth, you will be responsible for the difference between the amount your provider charges for an amalgam and a composite/resin filling.

EXCLUSIONS

The following are **not Covered Services** under this **Plan**:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer Liability laws.
2. Services or appliances, including prosthetics (crowns, bridges or dentures), started prior to the date the patient became eligible under this ~~d~~**Dental Plan**.
3. Prescription drugs, pre-medications or relative analgesia charges for anesthesia connection with covered oral surgery procedures.
4. Preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged~~s~~ by a dentist for treatment in any such facility.
6. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
7. Services that are determined to be partially or wholly cosmetic in nature.
8. ~~8.~~ Appliances, restorations or procedures for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques or for splints, unless necessary as a result of accidental injury.
~~8.~~9. Replacement of lost or broken retainer.
~~9.~~10. Treatment by other than a ~~**Plan**~~**Dental Provider**, his or her employees, or his or her agents. A Plan may designate and authorize out-of-network providers in the absence of an existing in-network provider or provider network.
~~10.~~11. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
~~11.~~12. Claims not submitted to ~~**Plan Provider**~~**Dental Plan** within 90 days from the date the procedure was provided.
~~12.~~13. Dental procedures in cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
14. Procedures and services not specifically provided under this **Certificate of Coverage** and procedures and services excluded by **Dental Plan** ~~**Provider**~~.

~~13.~~15. Any oral surgical procedures not specifically listed as a covered benefit or for which coverage exists under the medical policy.

~~No Deductible~~
~~$1,000 Annual Benefit Max per calendar year~~

~~IN = In network provider~~
~~OON = Out of network provider (Designated and authorized by Plan)~~

~~Key Plan Provisions~~		~~Covered Services (Examples)~~
~~Deductible:~~	~~$0 / $0~~	
~~Annual Benefit Max:~~	~~$1,000~~	
~~Diagnostic / Preventive:~~	~~100% IN / 75% OON~~	~~Evaluations, X-Rays, Fluoride~~
~~Restorative:~~	~~90% IN / 50% OON~~	~~Fillings, Inlays, Onlays~~
~~Endodontic:~~	~~80% IN / 50% OON~~	~~Limited to Pulpal Therapy~~
~~Periodontic:~~	~~80% IN / 50% OON~~	~~Limited to Periodontal Maintenance~~
~~Oral Surgery:~~	~~80% IN / 50% OON~~	~~Extractions~~
~~Adjunctive Services:~~	~~80% IN / 50% OON~~	~~Local Anesthesia, Occlusal Guard~~
~~Ortho:~~	~~50% (Children Only)~~	
~~Ortho Lifetime Max:~~	~~$1,500~~	

Types of Dental Providers:

- **In-Network Dental Provider** – Services as provided in the grid below.
- ***Designated Out-of-Network Dental Provider** – A health plan may designate and authorize out-of-network providers so that at least one dentist is available in each county or major city, if applicable. Services as provided in the grid below.
- **Other Out-of-Network Dental Provider** – When a health plan has an existing network of providers in a particular county or major city, if applicable, and the dental provider that you want to see is neither an In-Network Dental Provider nor a Designated Out-of-Network Dental Provider as described above, services for other Out-of-Network Dental Providers will be paid at 0%. If you are uncertain about whether your preferred dental provider is an in-network provider,

designated out-of-network provider, or other out-of-network provider, contact your health plan.

Key Plan Provisions			Covered Services (Examples)
	In-Network Provider	**Designated Out-of-Network Provider***	
Deductible:	$0	$0	
Annual Benefit Max:	$1,000	$1,000	
Diagnostic / Preventive:	100%	75%	• Routine Evaluations • X-Rays • Fluoride
Restorative:	100%	50%	• Fillings
Periodontal:	80%	50%	• Limited to Periodontal Maintenance
Adjunctive Services:	80%	50%	• Local Anesthesia
Orthodontia:	50% (Children Only)	50% (Children Only)	
Ortho Lifetime Max:	$1,500	$1,500	

DIAGNOSTIC/PREVENTATIVE:

ROUTINE ORAL EVALUATION - exams are limited to two per year. Note that comprehensive exams are not done multiple times in a year.

D0120 Periodic oral evaluation.
D0145 Oral evaluation for patients under three years of age.
D0150 Comprehensive oral evaluation – new/established patient or a patient who has been absent from dental care for more than three years; included as one of the two exams per year.
D0160 Detailed & extensive oral evaluation.

D0180 Comprehensive perio evaluation – new/established patient; included as one of the two exams per year.

LIMITED ORAL EVALUATION

- D0140 Limited oral evaluation - problem focused.

COMPLETE SERIES OR PANORAMIC FILM: limited to one (either D0210 or D0330) once every 60 months.

- D0210 Intraoral - Complete including bitewings.~~; limited to once every 36 months.~~
- D0330 Panoramic radiographic image.~~; limited to once every 36 months.~~

OTHER XRAYS

- D0220 Intraoral periapical first radiographic image.
- D0230 Intraoral periapical additional radiographic image.
- D0240 Intraoral occlusal radiographic image.
- D0250 Extraoral first radiographic image.
- D0260 Extraoral each additional radiographic image.

DIAGNOSTIC/PREVENTATIVE continued:

BITEWING FILMS - limited to two sets per year.

- D0270 Bitewing single radiographic image.
- D0272 Bitewings two radiographic images.
- D0273 Bitewings three radiographic images.
- D0274 Bitewings four radiographic images.
- D0277 Vertical bitewings 7 to 8 radiographic images.

PROPHYLAXIS (CLEANING) AND FLUORIDE

PROPHYLAXIS: D1110, D1120

- D1110 Prophylaxis (cleaning) – Adult; limited to twice per year.
- D1120 Prophylaxis (cleaning) – Child; limited to twice per year.

FLOURIDE - limited to twice per year up to age 19

- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride.

SEALANT

- D1351 Sealant - per tooth; limited to once per lifetime up to age 16, first and second molars only.

SPACE MAINTAINERS - limited to primary teeth lost prematurely.

- D1510 Space maintainer fixed unilateral.
- D1515 Space maintainer fixed bilateral.
- D1520 Space maintainer removable unilateral.

- D1525 Space maintainer removable bilateral.
- D1550 Recementation space maintainer.
- D1555 Removal of fixed space maintainer.

RESTORATIVE:

AMALGAM RESTORATIONS

- D2140 Amalgam filling - one surface.
- D2150 Amalgam filling - two surfaces.
- D2160 Amalgam filling - three surfaces.
- D2161 Amalgam filling – four/more surfaces.

RESTORATIVE continued:

RESIN RESTORATIONS

- D2330 Resin filling - one surface anterior.
- D2331 Resin filling - two surfaces anterior.
- D2332 Resin filling - three surfaces anterior.
- D2335 Resin filling – four/more surfaces anterior.
- D2390 Resin Crown anterior.
- D2391 Resin filling - one surface posterior; benefits limited.
- D2392 Resin filling - two surfaces posterior; benefits limited.
- D2393 Resin filling - three surfaces posterior; benefits limited.
- D2394 Resin filling – four/more surfaces posterior; benefits limited.

~~PREFABRICATED STAINLESS STEEL CROWN~~

- ~~D2930 Prefabricated stainless steel crown primary tooth; limited to once every 3 years per tooth.~~
- ~~D2931 Prefabricated stainless steel crown permanent tooth; limited to once every 3 years per tooth.~~
- ~~D2932 Prefabricated resin crown; limited to once every 3 years per tooth.~~
- ~~D2933 Prefabricated stainless steel crown resin window; limited to once every 3 years per tooth.~~
- ~~D2934 Prefabricated stainless crown - esthetic coat (primary); limited to once every 3 years per tooth.~~

MISCELLANEOUS RESTORATIVE

- D2940 Sedative filling; limited to once per lifetime per tooth.

- D2951 Pin retention per tooth; limited to once per tooth.
- D2999 Unspecified restorative procedure by report.

~~**ENDODONTIC:**~~

- ~~D0460 Pulp vitality tests.~~
- ~~D3110 Pulp cap direct.~~
- ~~D3120 Pulp cap indirect.~~
- ~~D3220 Therapeutic pulpotomy.~~
- ~~D3221 Pulpal debridement primary and permanent teeth.~~
- ~~D3222 Partial pulpotomy for apexogenesis.~~
- ~~D3230 Pulpal therapy anterior primary tooth.~~
- ~~D3240 Pulpal therapy posterior primary tooth.~~

PERIODONTIC:

- D4910 Periodontal maintenance. Coverage is limited to two procedures per one benefit period.

ORAL SURGERY:

Please note that eligible oral surgical procedures are covered under the medical plan when furnished by a ~~p~~Plan P~~p~~rovider.

- ~~D7111 Coronal remnants – deciduous tooth; if done for orthodontic purposes, covered at 50% to age 19.~~
- ~~D7140 Extract Erupted tooth/exposed root; if done for orthodontic purposes, covered at 50% to age 19.~~
- ~~D7210 Surgical removal erupted tooth; if done for orthodontic purposes, covered at 50% to age 19.~~
- ~~D7220 Removal impacted tooth soft tissue; if done for orthodontic purposes, covered at 50% to age 19.~~
- ~~D7230 Removal impacted tooth partial bony; if done for orthodontic purposes, covered at 50% to age 19.~~

ADJUNCTIVE SERVICES:

- D9110 Emergency treatment/palliative.
- D9210 Local anesthesia not in conjunction with operative or surgical procedures.
- D9215 Local anesthesia used in conjunction with operative or surgical procedures.
- D9610 Therapeutic parenteral drugs, single administration.
- D9612 Therapeutic parenteral drugs.
- D9910 Application of Desensitizing.

- D9911 Apply desensitizing resin.
- D9930 Treatment of complications.
- D9999 Unspecified adjunctive procedure.
- ~~D9220 General anesthesia – 30 minutes.; if related to orthodontic services, limited to age 19, 50% coverage.~~
- D9221 General anesthesia – 15 minutes.; if related to orthodontic services, limited to age 19, 50% coverage.
- ~~D9230 Nitrous oxide sedation.; if related to orthodontic services, limited to age 19, 50% coverage.~~
- ~~D9241 Intravenous sedation analgesia – 30 minutes.; if related to orthodontic services, limited to age 19, 50% coverage.~~
- ~~D9242 Intravenous sedation analgesia – 15 minutes.; if related to orthodontic services, limited to age 19, 50% coverage.~~

ORTHODONTIC SERVICES - limited to age 19, 50% coverage.

- D8010 Limited orthodontic treatment of primary dentition.
- D8020 Limited orthodontic treatment of transitional dentition.
- D8030 Limited orthodontic treatment of adolescent dentition.
- D8040 Limited orthodontic treatment of adult dentition.
- D8050 Interceptive orthodontic treatment of primary dentition.
- D8060 Interceptive orthodontic treatment of transitional dentition.
- D8070 Comprehensive orthodontic treatment of transitional dentition.
- D8080 Comprehensive orthodontic treatment of adolescent dentition.
- D8090 Comprehensive orthodontic treatment of adult dentition.

~~**ORTHODONTIC SERVICES** continued - limited to age 19, 50% coverage.~~

- D8660 Pre-orthodontic treatment visit; may also be billed out as any combination of D0330, D0340, D0350, and D0470.
- D8680 Orthodontic retention (removal of appliances, construction/placement).
- D8690 Orthodontic treatment (alternative billing to a contract fee).
- D8999 Unspecified orthodontic procedure, by report.
- D9310 Consultation – diagnostic services other than requesting provider.