Dental Provider Manual

Nevada Pacific Dental
A UnitedHealthcare Company

Provider Services: 1-800-926-0925

2025

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United Healthcare® | Nevada Pacific Dental™

Contents

Section 1: Introduction — who we are

Welcome to Nevada Pacific Dental, Inc., a UnitedHealthcare Company

This Provider Manual (the "Manual") is designed as a comprehensive reference guide focusing on Direct Compensation (DC) plans. Here you will find the tools and information needed to successfully administer the Nevada Pacific Dental (NVPD) DC plans. As changes and new information arise, updates to the manual will be posted on the Provider Portal along with the latest version of the manual. Sign into **UHCdental.com** and select Manuals/Other Supporting Documents under Quick Links.

Our Commercial Preferred Provider Organization (PPO) and Medicare plans are summarized separately. If you support our Commercial PPO and/or Medicare plan and need that Manual, please log into the Provider Portal at **UHCdental.com**.

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the Nevada Pacific Dental Provider Services team at **1-800-926-0925**.

Note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to Nevada Pacific Dental, Inc on behalf of itself and its other affiliates for those products and services subject to this Manual.

Provider Online Academy

Provider Online Academy is a resource for 24/7, on-demand, interactive, and self-paced courses for providers that cover the following topics:

- Dental provider portal training guide and digital solutions
- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit **UHCdental.com** and go to Resources > Dental Provider Online Academy.

Section 2: Products

Product ID	Plan name	Exclusion / limitations version & plan benefits
D0012099	NV Individual 1000 (D001I)	Individual E&L
D0012751	Aon Exchange Platinum NV DHMO 500 Plan DD026	General E&L
D0012850	NV 10I Plan (D501N)	General E&L
D0012851	NV 10-I-5C Plan (D502C)	General E&L
D0012852	NV 10-I-5C Plan (D503C)	General E&L
D0012853	NV 10-I-10C Plan (D504C)	General E&L
D0012854	NV 10-I-10C Plan (D505C)	General E&L
D0012855	NV 20I Plan (D506N)	General E&L
D0012856	NV 20I Plan (D507N)	General E&L
D0012857	NV 20-I-5C Plan (D508C)	General E&L
D0012859	NV 20-I-10C Plan (D510C)	General E&L
D0012860	NV 20-I-10C Plan (D511C)	General E&L
D0012861	NV 30I Plan (D512N)	General E&L
D0012862	NV 30I Plan (D513N)	General E&L
D0012864	NV 30-I-5C Plan (D515C)	General E&L
D0012865	NV 30-I-10C Plan (D516C)	General E&L
D0012866	NV 30-I-10C Plan (D517C)	General E&L
D0012872	NV 40-I-10C Plan (D523C)	General E&L
D0012877	NV 50-I-10C Plan (D528C)	General E&L
D0012879	NV 10I Plan (D500N)	General E&L
D0014305	NV 20-I-5C Plan (D509C)	General E&L
D0018633	Aon Exchange Platinum NV DHMO 500 Plan D1088	General E&L
D1000189	NV DC - AFFINITY 110 50/150 $1000 - Sequoia-Child (D0225)	General E&L
D1000367	NV DC - MAXIMA 110 50/150 $1000 - Sequoia-Child (D0230)	General E&L
D1000417	NV DC - VENTURA 125 50/150 $1000 - Sequoia-Child (D0235)	General E&L

See Appendix C for Limitations and Exclusions

Section 3: Direct Compensation overview

Direct Compensation (DC) is a unique managed care product that is designed to compensate the dentist on a per procedure basis.

Reimbursement in the Direct Compensation program is funded by the Group premiums collected. Specialist claims and Quality Assurance expenses are deducted from this amount and the balance of the premium dollars are placed into a pool and distributed monthly to all treating dentists based on the reported Relative Value Unit (RVU) utilization activity reported each month.

3.1 Relative Value Unit (RVU)

The RVU schedule that is used to give value to procedures performed by dental providers is one of the key elements in this reimbursement tool.

All procedures performed by general dentists are valued and totaled using a relative value unit (RVU) schedule. An RVU schedule measures each procedure in relation to all other procedures as to the time, intensity, and possible risk associated with the procedure. This payment method encourages diagnostic, preventive, and basic restorative procedures and maintains incentives to deliver further restorative care where appropriate.

The total RVU generated by all providers during the month is divided by a fixed percentage of the total monthly premium income, less the cost of direct out-of-network services and specialty care. The result is a dollar value per RVU generated in that month.

The dollar value factor per RVU is then multiplied by the RVUs generated by each participating dentist to determine the amount each dentist receives that month.

Members select one General Dentist as their Primary Care Provider (PCP) but can use the services of any participating General Dentist. If a General Dentist requests a specialist referral, the member MUST be assigned to the General Dentist prior to making the referral.

3.2 IPA (Individual Practice Association)

All membership enrolled in the Direct Compensation product is separated into groupings called IPAs, which can be organized by geography or by employer group.

The IPA is a partnership between Nevada Pacific Dental and the IPA dentists that manages the patient population and the associated revenue and expenses. Each IPA is managed independently, and the participating dentist's compensation is determined by the overall performance of the IPA. Dentists generally participate in multiple IPAs. The dentist's total reimbursement from the Direct Compensation program is the sum of the payments from each of the participating IPAs. Reimbursement is issued separately for each IPA. See Appendix A: Attachment A.1.b for example.

NVPD funds the IPA from the insurance premiums and performs the necessary administrative, operational, and quality assurance functions. The IPA network dentist manages the patient's care by:

- Providing patient education with a strong preventive orientation
- Controlling the extent of specialist referrals
- Maintaining good patient satisfaction

3.3 Patient Detail Report

The Patient Detail Report is a detail of each patient and each procedure considered for payment during the statement period. See Appendix A: Attachment A.1.c for example. The Plan highly recommends that you keep these reports for future reference and reconciliation.

Production is listed by patient name.

MEMBER ID AND SUFFIX	To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number. The suffix number is the identifier that indicates each individual member assigned to a subscriber.
THE GROUP#	Prints out the entire group number
SERVICE DATE	Indicates the Date of Service reported
QTY	Will always be indicated as 1
TOOTH NO.	Reports the Tooth Number or the Quadrant pertaining to the service
PAID AMOUNT	Indicates that a dollar amount other than the RVU value is being paid
VALUE	Shows the RVU value for the procedure reported
COPAY	Shows the co payment that pertains to this procedure for this group. Sometimes adjustments may have been made to reflect copayment to align with lower RVU. Please remember to charge the member/patient the applicable copayment as defined on the benefit schedule.
PROC DT	Indicates the date the service was processed for payment
EOB CODE	Refers to any EOB reason codes that pertain to the reported procedure or coverage
THE EOB CODE LEGEND	Is printed at the bottom of the page for easy reference

3.4 General guidelines for all Direct Compensation plans

As dentistry is both an art and a science, there are often several clinically acceptable treatment options associated with the repair and restoration of the hard and soft tissues of the oral cavity. To ensure that the Plan delivers acceptable dental benefits in a consistent manner, the following guidelines have been developed. Please be aware that these guidelines are subject to change based upon emerging technologies, outcomes-based research and evolving clinical practices.

Optional treatment

To ensure that the Plan is able to provide both comprehensive and cost-effective dental benefits, the least expensive generally accepted dental service or plan of treatment shall be considered the "covered benefit". All other alternative treatments shall be considered "optional treatment(s)." If the Member selects a treatment plan that includes one or more optional treatments, the Member is responsible for any difference in cost(s) between the participating dentist's Usual, Customary and Reasonable fees ("UCR") associated with the optional treatment, and the UCR fees associated with the covered benefit, plus any applicable copayment associated with the covered benefit.

In addition to those items identified in the limitations and exclusions, optional treatments shall specifically include any restoration or device placed where the principal benefit is cosmetic enhancement; or the procedure is performed prophylactically to prevent the potential loss of tooth structure.

Treatment planning

The Plan desires to bring and maintain each Member to an optimal level or oral health. To achieve this objective, the Plan recognizes the importance of the dentist-patient relationship in diagnosis, treatment planning and delivery of necessary services. To assist in this effort, the Plan has established the following treatment priorities:

- First priority is to be given to those procedures, which, if not performed in a timely manner, will have an immediate, adverse impact upon a Member's overall oral health. (Examples include treatment of avulsed teeth, gross caries, acute periodontal disease or endodontic infection, and related diagnostic entities.)
- Second priority is to be given to the removal and restoration of active pathology. (Examples include the treatment of periodontal disease – gingivitis and periodontitis – and the removal and restoration of dental caries.)
- Third priority is given to replacement of missing teeth not causing gross impairment of function. (Examples include bridges, partial dentures, and related appliances.)

Exceptions to these planning guidelines may occasionally occur based upon individual circumstances consistent with good dental practices.

Restorative dentistry

General policies

The replacement of any prosthetic device (removable partial denture, full denture, crown or fixed bridge) is only considered to be a covered benefit if the original device is no longer functional and cannot be adequately repaired or relined, if the replacement occurs 5 or more years after the date that the device was originally placed, regardless of payor, and all abutment teeth are periodontally sound and do not require any surgical procedure. Optional treatment includes the use or incorporation of noble metal in the construction of any prosthesis; any device used to secure or temporarily retain a fixed or removable appliance.

Fillings

The Plan provides amalgam (silver) and resin restorations (composites) as covered benefits when the procedure is required to restore tooth structure lost as a result of dental caries or normal masticatory function. Amalgam and resin fillings are the covered restoration when there is enough retentive quality left to retain the filling, i.e., buccal and/or lingual walls are intact. If an adequate restoration can be achieved with either an amalgam or a resin material, all other services (cast restorations, inlays and onlays) are considered optional forms of treatment. Resin restorations (composites) placed on anterior teeth, or the facial surfaces of bicuspids are considered covered benefits. Resins are considered optional treatment if they are placed on the occlusal or interproximal surfaces of bicuspids or molars (unless the contracted provider considers this the necessary and appropriate treatment of choice).

Crowns

Crowns (or other cast restorations) are covered benefits only if all of the following criteria are met:

- There is radiographic evidence of enough restorable tooth structure to retain a crown without surgical procedure,
- The remaining alveolar bone and periodontal tissues are adequate to support the crown, and

- The need for the restoration is related to caries or a result of normal masticatory function.
- The expected longevity of the restored tooth is at least 5 years.

Optional treatments for crowns

A crown shall be considered optional treatment if:

- The crown is required as a result of a Member-influenced habit or behavior such as abrasion, erosion, atypical attrition, or bruxism, or if the primary diagnostic justification for a fixed, cast restoration is based upon visible enamel cracks, fracture or crazing lines; the presence of existing large restorations without other symptoms or pathology that do not clinically justify the placement of a cast restoration; prevention of a possible cusp or tooth fracture; prevention of possible recurrent caries which are not identifiable by radiograph or clinical exam, or if
- The sole reason for placing a crown is to provide abutment for a posterior bridge or partial denture
- Optional treatment also includes the use of porcelain or porcelain fused to metal crowns on molars
- Procedures performed where the primary benefit is cosmetic enhancement, including, but not limited to, remaking crowns where the metal margin is visible due to gingival recession or other reasons, when there is no recurrent decay present
- Cast restorations solely placed to accommodate removable partial dentures
- Cast metal, porcelain or porcelain fused to metal crowns if the beneficiary is 16 or under

Partial dentures

A removable partial denture (with cast metal framework) is considered the covered benefit rather than a fixed bridge for the replacement of missing teeth if:

- The probability exists that the beneficiary will experience a clear clinical benefit and significantly improve function
- The prosthesis replaces missing teeth in 2 quadrants of the same arch
- Any of the proposed abutments are third molars
- Three or more adjacent teeth are missing
- There is insufficient and/or compromised (periodontally involved) abutment teeth and/or soft tissue necessary to support the placement of a fixed prosthesis

Optional treatments for partial dentures

Optional treatment includes:

- Crown restoration on abutment teeth, when the crown is needed solely to provide retention for the removable partial denture
- Specialized acrylic bases such as “Valplast” or others designed for special needs or for a more cosmetic result
- Replacement of long-standing missing teeth in an otherwise stable dentition

Related services for partial dentures

- An acrylic partial denture (with clasps) may be considered a covered benefit for Members presenting with clinically compromised abutment teeth and/or active periodontal disease. In this situation the Member is responsible for paying the applicable copayment associated with a cast metal partial denture.

- Interim Partial Dentures constructed in conjunction with fixed or removable appliances are considered Covered Benefits if employed as a replacement for a tooth extracted under coverage during the healing period or as a space maintainer for beneficiaries under the age of 16, or if it is intended to be used for a minimum of 3 months or longer.

Complete dentures

Complete dentures should be fabricated only after proper case evaluation of the Member and their tissues occur. Age, denture history, adequate ridge, habits, length of time of edentulism, and provider skill and comfort with denture techniques should all be considered prior to consenting to fabricate complete dentures. The provider determines the treatment plan and determines that dentures are a viable treatment with a good chance for success and longevity of at least 5 years. A Member's desire or request for treatment is only honored insofar as it agrees with generally accepted professional practices.

Optional treatments for complete dentures

Optional treatment includes:

- The use of non-standard techniques including, but not limited to, overdentures with or without attachments, copings, and implants
- The use of non-standard materials including, but not limited to, characterized resin bases, specialized base materials, or the use of porcelain or special application teeth
- The fabrication of a complete denture, when, in the opinion of the treating dentist, that an adequate result cannot be obtained or predicted. This includes cases such as inadequate ridge for retention, repeat denture fabrication over recent years, longstanding full or partial edentulism, and/or tongue-thrust or other habits which could contribute to denture failure.

Fixed bridge

Fixed Bridge is considered a covered benefit if the bridge is employed to replace a missing permanent anterior tooth or to replace a single missing permanent molar, in an otherwise intact arch, and is not excluded for other reasons stated herein.

Optional treatments for a fixed bridge

Optional treatment includes:

- Posterior bridges supported by crowns placed on otherwise sound abutment teeth where the sole reason for placing a crown is to support a pontic
- A fixed bridge placed in the same arch as a partial denture
- Fixed bridges placed to replace bilaterally missing teeth (e.g., 2 or more bridges in the same arch)
- A fixed bridge when any of the proposed abutments are third molars
- Gnathological recordings, diagnostic study models, and/or equilibrating the dentition
- Replacement of long-standing missing teeth in an otherwise stable dentition
- Fixed bridges for patients under age 16 (an allowance will be made for a space maintainer)
- A fixed bridge placed in conjunction with full-mouth reconstruction. Full mouth reconstruction is defined as any procedure or combination of procedures which results in the placement of 5 more units of fixed bridgework being placed in a single arch OR more than ten units are being placed in aggregate.
- An increase or decrease in the beneficiary's vertical dimension

In full-mouth reconstruction cases, an allowance will be made for complete or partial dentures. The Member will be responsible for all additional charges, plus the copayment for the complete or partial dentures allowed.

Oral surgery

Extraction is a covered benefit only when accompanied by associated pathology. The extraction of asymptomatic teeth is not a covered benefit.

Optional treatments for oral surgery

Optional treatment includes:

- The extraction of asymptomatic teeth for preventive purposes
- Hard and soft tissue grafts in association with extractions.

Periodontics

Prophylaxis ("cleaning"), periodontal pocket charting, periodontal scaling and root planing ("SRP"), oral hygiene instruction ("OHI") are covered benefits considered to be within the scope of the general dentist.

Optional treatments for periodontics

Optional treatment includes:

- Soft tissue management programs (except as identified above)
- Hard and soft tissue grafts including pedicle flaps
- All types of temporary or permanent implants
- Guided tissue regeneration
- Crown lengthening procedures
- Prescription and non-prescription medications including mouth rinses, chips, gels, infusions, irrigation, and irrigation devices, etc.

Endodontics

Routine endodontic treatment of anterior, bicuspid, and uncomplicated first molar teeth are considered within the scope of general dentist. Surgical and retreatment procedures are considered appropriate for referral to an endodontic specialist practice.

Endodontic treatment is a covered benefit if:

- The tooth has a fair or better clinical prognosis
- The tooth has a reasonable clinical significance
- There is adequate supporting bone
- Is restorable with routine restorative procedures and does not need surgical intervention

Optional treatments for Endodontics

Endodontic treatment of third molars is considered optional treatment unless the tooth will function as a distal abutment for a qualifying prosthetic device.

Related services (post and cores)

- Post and core procedures are to be performed by the general dentist, unless unusual circumstances can be documented and pre-authorized
- Buildups are considered part of the post and core procedure

Section 4: Resources and services

Web Site Offers many time-saving features including eligibility verification, claims status and network specialist locations.	**UHCdental.com**
Using our website to locate Dentists including Specialists Visit **UHCdental.com** and click "Find a Dentist"	**NV Direct Compensation – General Dentist** **NV Direct Compensation - Specialists**
Specialty Referral Process **Pre-Authorization:** General Dentist must obtain pre-authorization for all specialty services. Services without prior authorization will not be covered.	**PRE-AUTHORIZATION**
Member ID Cards The following brand names are found on the member ID cards for your reference.	UnitedHealthcare®
Integrated Voice Response (IVR) System • Enables you to access information 24 hours a day by responding to the system's voice prompts. • Obtain immediate eligibility information • Assign a member to your office (Voluntary basis) • Obtain claims status and copies of EOB's • Fax eligibility confirmation directly to the caller	**1-866-345-1090**
Provider Services Knowledgeable trained specialists who can handle specific dentist issue such as eligibility, claims, dental plan information, fee schedules, monthly rosters and contracts.	**1-800-926-0925**
Emergency Specialty Referral Phone Number	**1-800-926-0925**
Address	
Claims	**P.O. Box 30567** **Salt Lake City, UT 84130**
Specialty Referral and Pre-Treatment Estimates	**P.O. Box 30552** **Salt Lake City, UT 84130**
Written Inquiries and Appeals	**P.O. Box 30569** **Salt Lake City, UT 84130**
Electronic Claims Submission – Payor ID	**52133**

Section 5: Patient eligibility verification process

5.1 Eligibility verification

Prior to rendering services, you must verify the member's eligibility. Eligibility may be verified 1 of 3 ways:

1. Through our Interactive Voice Response (IVR)
2. At our website **UHCdental.com**
3. By speaking with a provider services representative

Important note: A member's ID card is not proof of eligibility. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity, and other limitations and/or exclusions. Additional rules may apply to some benefit plans.

5.2 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, 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.

5.3 Website UHCdental.com

The Nevada Pacific Dental website, **UHCdental.com**, offers helpful tools to assist with verifying eligibility, pre-authorization, claim submission and status, remittance, procedure level pricing, fee schedules, benefit information, provider search and much more 24 hours a day, 7 days a week.

We also have a self-service feature that allows your office to validate, change and attest to your office information online. We recommend that you validate your demographic information every 90 days. To access this feature, click on Provider Self Service after you register and log in to **UHCdental.com**.

Please contact our Provider Services at **1-800-926-0925** if you have additional questions or need help registering on our website.

Section 6: Patient access

As a participating dentist in the Nevada Pacific Dental network, you have agreed to offer appointments to members using standards applicable to non-network patients. You will not unlawfully discriminate against any member based on race, ethnicity, religion, national origin, ancestry, disability, medical condition, source of payment, marital status, age, sexual orientation, or gender.

You have agreed to offer appointments to members without unreasonable waiting periods for appointments, or waiting periods for services for members once an appointment is made.

6.1 Appointment scheduling

Nevada Pacific Dental standards

Listed below are guidelines for appointment scheduling:

- **Initial appointments** should be offered within 14 business days
- **Existing patient visits** should be offered for basic services within 14 business days.
- **Routine hygiene visits** should be available within 14 business days. Each facility is required to have a recall system in place.
- **Emergency appointments** should be offered within 24-hours.
- **Wait time in reception area** should be 30 minutes or less

6.2 Emergency coverage

Your office is required to provide 24-hour emergency coverage to eligible members assigned to your office. All contracted providers must employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

Section 7: Specialty care referral guidelines

7.1 Specialty referral (Non-emergency)

The general dentist is responsible for performing services specifically listed on the Schedule of Benefits. However, after a thorough examination has been performed, or during member treatment, the general dentist may determine that the service of a specialist is required to address the member's dental needs. Specialty care referral requests are coordinated through the general dentist.

Nevada Pacific Dental (NVPD) plans require pre-authorization of benefits prior to referring the member to a contracted Specialist.

The general dentist must complete the following steps to obtain the pre-authorization of benefits for non-emergent services:

1. Validate member is assigned to the referring general dentist prior to submitting a specialist referral request. If member is not assigned to the referring dentist, provider assignment must be requested while member is still present in the office. If member is not present in the office, member must call NVPD directly to request provider assignment to the referring dentist.
2. Verify the procedure(s) is a covered benefit according to the patient's benefit schedule. Non-covered procedures may be referred to a Specialist, however, the patient is responsible for all fees related to non-covered services and the patient must be informed, in advance of this financial responsibility. It is not necessary to complete an NVPD Specialty Care Referral Form for non-covered procedures.
3. Complete the NVPD Specialty Request Referral Form. Refer to Appendix A.3 for sample.
4. Attach all related radiographs and/or other clinical documentation (diagnostic radiographs, pocket charting, if indicated, any other documentation that supports clinical indication/rationale for the referral) and list the procedure code you are requesting authorization for. Label all radiographs with patient name, date taken and your practice name and address.
5. Sign the form
6. Send the form with all documentation attached to the NVPD plan address as indicated on the Specialty Request Referral form.

The Specialist request will be reviewed to ensure it meets all Specialist Referral criteria, it will be processed, and an authorized Specialist will be selected to perform the treatment. An Explanation of Benefits (EOB) will be created and sent to the member, the assigned general dentist (PCP) on file, and the authorized Specialist. Upon receipt of the EOB, the member will contact the authorized Specialist office to schedule an appointment for treatment.

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

1. An EOB will be generated and mailed to the member indicating the at additional information has been requested from the referring general dentist.
2. An EOB will be sent to the member's assigned PCP on file.

When coverage of benefits is denied, the following will occur:

1. An EOB will be generated and mailed to the member indicated the request has been denied.

2. An EOB will be sent to member's assigned PCP on file explaining the denial.
3. A reconsideration of denied benefits will be re-evaluated by resubmitting the original EOB with the denial along with the additional information pertinent to the appeal.

Additional Information

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

Specialty care referral form

It is critical that the general dentist complete the entire NVPD Specialty Request Referral Form and to provide any supportive documentation needed to coordinate the referral. See Appendix A.3 for a sample of the referral form. The NVPD Specialty Request Referral Form can also be obtained by signing into **UHCdental.com** and selecting Manuals/Other Supporting Documents under Quick Links.

7.2 Emergency referrals

There may be situations where referring a patient to a specialist for emergency treatment is necessary. However, the Plan expects the general dentist to stabilize any condition adequately to allow us to review requests for specialist care. Often, it may be appropriate for the general dentist to handle the emergency themselves. Treatment provided by a specialist is subject to retrospective review to determine if it could have been managed by the general dentist. As stated in the Provider Agreement, the provider is obligated to offer 24-hour emergency service. There are several ways to ensure patients have 24-hour access to emergency care, including through answering machines, answering services, and cell phones.

A dental emergency is considered to be:

- acute pain
- fever
- swelling
- infection
- any condition, which a reasonable person under the circumstances believes, if left untreated may result in disability, death, or the delay of treatment would be medically inadvisable

For such situations, treatment should be limited to services necessary for:

- relief of pain
- control of bleeding
- treatment of swelling
- treatment of infection
- stabilization of trauma and related emergency conditions

In emergency situations requiring pre-authorization of benefits, the general dentist must complete the following actions to obtain a pre-authorization referral number for all emergency appointments (including a consultation with radiographs and/or any treatment rendered), prior to scheduling:

1. Verify member eligibility
2. Examine the member
3. Take appropriate radiographs
4. Render an accurate diagnosis
5. Develop an emergency treatment plan that is appropriate for the diagnosis and consistent with the overall treatment plan for the member.
6. Perform any appropriate palliative treatment to alleviate pain and or improve/stabilize the condition of the member.
7. Contact NVPD at **1-800-926-0925** for emergency referral authorization while the member is still present in the office.
8. Validate the member is assigned to your office. If member is not assigned to the referring dentist, provider assignment must be requested while member is still present in the office. If member is not present in the office, member must call NVPD directly to request provider assignment to the referring general dentist. NVPD will process provider assignment effective on the day the request was made.
9. Give the appropriate records to the member to hand carry to the specialist appointment:
   - Completed Specialty Request Referral Form – the form must be completely filled out.
   - Supporting documentation (diagnostic radiographs- with patient's name date taken and your facilities name/address, pocket charting, if indicated)
   - Any other documentation that supports clinical indication/rationale for the referral

For pre-authorization of benefits, NVPD will:

1. Verify member eligibility
2. Verify member benefits.
3. Assist the referring dentist in identifying a contracted specialist in proximity to the member's home or place of business.
4. Provide the referring dentist with an authorization number, eligibility, and member copayment.
5. Mail an Explanation of Benefits Form to the authorized specialist.

The specialty care dentist may contact NVPD directly for pre-authorization of benefits for services other than those listed on the referral form. Please contact our Provider Services Department at **1-800-926-0925** to obtain pre-authorization of benefits.

Authorization of benefits for emergency referral is valid for 7 business days.

All documentation for emergency referrals is subject to retrospective review. The referring dentist may be financially responsible when the referral for emergency dental services does not fall within plan guidelines. If the Emergency Referral expires, the Referring PCP will have to call customer service and initiate the Emergency Referral process again.

If you have any questions concerning our emergency care guidelines and requirements, please call Provider Services at **1-800-926-0925**.

Section 8: Claim submission procedures

8.1 Claim/Encounter submission options

Nevada Pacific Dental requires its offices to submit utilization information for every patient seen no later than thirty (30) calendar days from the date of service being rendered. ADA Claim Forms or Encounter Reports should be submitted by mail or electronically, and sent to the Claims Department address listed below:

Nevada Pacific Dental
C/O United Healthcare Dental
P.O. Box 30567
Salt Lake City, UT 84130-0567

8.1.a Paper claims

To receive payment for services, practices must submit claims via paper or electronically. When submitting a paper claim, dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later).

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached, when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Refer to Appendix C: Limitations and exclusions to find the recommendations for dental services.

8.1.b Electronic claims

Electronic Claims Submission refers to the ability to submit claims electronically versus paper. This expedites the claim adjudication process and can improve overall claim payment turnaround time (especially when combined with Electronic Payments, which is the ability to be paid electronically directly into your bank account).

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may sign up with one to initiate this process. The Nevada Pacific Dental website (**UHCdental.com**) also offers the feature to directly submit your claims online through the provider portal. Refer to Section 3.3 for more information on how to register as a participating user.

8.1.c Encounter reporting

Encounter reporting or utilization data is an integral part of our Quality Management Program. The data collected validates the volume and frequency of dental care delivered.

To make utilization reporting easier and consistent, all Encounter Reports must include the following:

- Subscriber Name
- Subscriber ID
- Subscriber Date of Birth
- Group Name or Number

- Patient's Full Name
- Relationship to Subscriber
- ADA Code Performed
- Tooth # / Quadrant
- Surface
- Treating Dentist Name
- Dentist Tax I.D. for Billing
- Treating Location Address

8.2 Using current ADA codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling ADA or visiting the ADA store at **engage.ada.org**.

8.3 Coordination of benefits (COB)

The Nevada Pacific Dental Direct Compensation product always considers the patient to be prime and does not coordinate benefits. The provider is paid only once for each service and should not expect dual payment if both patient and spouse are covered by this product.

8.4 Provider appeals

If you believe that your claim has not been paid correctly, you may send a written appeal to Nevada Pacific Dental. Any written appeal should include the member's name and subscriber ID, the reason for your appeal and any other information you feel might help us in reviewing your claim. The appeal should be mailed directly to:

Nevada Pacific Dental, c/o United Healthcare
Dental Attention: Claim Appeals/Complaints
P.O. Box 30569
Salt Lake City, UT 84130

Section 9: Office administration

9.1 New associates

A credentialing application must be submitted for each new dentist to initiate the credentialing process for new associates prior to any treatment being rendered to eligible NVPD members. In addition, your office is required to notify NVPD in writing in the event that any dentist terminates his or her employment and will no longer be treating NVPD members.

9.2 Change of address, phone number, email address, fax or Tax Identification Number

As a Participating provider, when there are demographic changes within your office, it is important to notify us so we may update our records. This supports accurate claims processing as well as helps to ensure member directories are accurate.

Requests for change will need to include an outline of the old information as well as the changes that are being requested. This should include the TIN(s) and/or Provider names for all associates to whom the changes apply to. Providers may utilize the Demographic Change Form found in Appendix A.5.

Changes may be submitted through the provider self-service portal at **UHCdental.com**. Some requests may need to be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W-9 and a new Provider Agreement, versus an office closing notice where we would need the notice submitted in writing on office letterhead.

Examples of changes requiring notification within 30 days of the change to Nevada Pacific Dental:

- The status as to whether the participating provider is accepting new patients or not
- The address(es) of the office location where the participating provider currently practices
- The phone number(s) of the office location where the participating provider currently practices
- The email address of the participating provider
- If the participating provider is still affiliated with the listed provider groups
- The specialty of the participating provider
- The license(s) of the participating provider
- The tax identification number used by the participating provider. Tax identification number updates require a new provider agreement to be completed
- The NPI(s) of the participating provider
- The language spoken/written by the participating provider or the staff
- The ages services by the participating provider
- Office hours (7 days a week)

Changes should be submitted to:

Nevada Pacific Dental – RMO
ATTN: 400-Provider Services
P.O. Box 30567
Salt Lake City, UT 84130

Fax: 1-855-363-9691
Email: **dbpprvfx@uhc.com**

Credentialing updates should be sent to:

Email: **dbpcredsupport@uhc.com**
Nevada Pacific Dental Credentialing
2300 Clayton Road, Suite 1000
Concord, CA 94520

A Participating Provider is expected to review, update provider records and attest to the information available to Nevada Pacific Dental members, including the information listed below, on no less than a quarterly basis. You are responsible for notifying NVPD of these changes for all participating providers within your office.

Nevada Pacific Dental reserves the right to conduct an onsite inspection of any new facilities and will do so based on state and plan requirements.

If you have any questions, contact Provider services at **1-800-926-0925** for guidance.

9.3 Office conditions

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 and ambu bag should be readily available for emergency use.

9.4 Sterilization and asepsis control

Dental office sterilization protocols must 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.

Sterilization and asepsis control fees are to be included within office procedure charges and should not be billed to members or the plan as a separate fee.

9.5 Recall system

It is expected that offices will have an active and definable recall system to make sure that the practice maintains preventive services, including patient education and appropriate access. Examples of an active recall system include, but are not limited to: postcards, letters, phone calls, emails, and advance appointment scheduling. The recall system should be individualized to the patient's need and should not be a fixed interval for all patients.

9.6 Transfer of dental records

Your office shall copy all requested member dental files to another participating dentist as designated by NVPD. The member is responsible for the cost of copying the patient dental files if the member is transferring to another provider. Please refer to the member's fee schedule to determine if there is a plan copayment. If your office terminates from NVPD, dismisses the member from your practice, or is terminated by NVPD, the cost of copying files shall be borne by your office. Your office shall cooperate

with NVPD in always maintaining the confidentiality of such member dental records, in accordance with state and federal law.

9.7 Cultural Competency

Cultural competence is of great importance in the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent health care providers. Cultural competence includes awareness and understanding of the many factors that influence culture and how that awareness translates into providing dental services within clients' cultural parameters.

Nevada Pacific Dental recognizes that the diversity of American society has long been reflected in our member population. Nevada Pacific Dental acknowledges the impact of race and ethnicity and the need to address varying risk conditions and dental care disparities.

Understanding diverse cultures, their values, traditions, history and institutions is integral to eliminating dental care disparities and providing high-quality care. A culturally proficient health care system can help improve dental outcomes, quality of care and contribute to the elimination of racial and ethnic disparities.

Nevada Pacific Dental is committed to providing a diverse provider network that supports the achievement of the best possible clinical outcomes through culturally proficient care for our members.

Section 10: Quality management

10.1 Quality Improvement Program (QIP) description

Nevada Pacific Dental has established and maintains 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.

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 QIP Description is reviewed annually and updated as needed.

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

- To measure, monitor, trend and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
- To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
- When indicated, implement improvement plans and document actions taken to increase performance.
- To evaluate the effectiveness of implemented changes to the QIP.
- To reduce or minimize opportunity for adverse impact to members.
- To improve efficiency, value, and productivity in the delivery of oral health services.
- To promote effective communications, awareness and cooperation between members, participating providers and the plan.
- To ensure quality of care, dentists are vetted through a credentialing and recredentialing process.
- To comply with pertinent legal, professional and regulatory standards.
- To foster the provision of appropriate dental care according to professionally recognized standards.
- 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.
- To communicate results of performance measurement to the committees and Board of Directors.

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line at **1-800-926-0925.**

10.2 Credentialing

To become a participating provider in Nevada Pacific Dental's network, all applicants must be fully credentialed and approved by our Credentialing Committee. In addition, to remain a participating provider, all practitioners must go through periodic recredentialing approval (typically every 3 years unless otherwise mandated by the state in which you practice).

Nevada Pacific Dental will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. NVPD will request a written explanation regarding any adverse incident and its resolution and will request corrective action be 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 each location. Offices must pass the facility review prior to activation.

Nevada Pacific Dental Credentialing Committee reviews the information submitted in detail based on approved credentialing criteria. NVPD will request a resolution of any discrepancy in credentialing forms submitted. Providers have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria is reviewed/ approved by the Credentialing Committee, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines.

Nevada Pacific Dental contracts with an external 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 make sure that the credentialing and/or recredentialing process is completed as quickly as possible.

You have the right to appeal any credentialing decision if your practice is in a state that allows for credentialing Appeals which is based on information received during the credentialing process. If you practice in a state that allows for Appeals, to initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Committee Coordinator.

It is important to note that the recredentialing process is a requirement of both the provider agreement and continued participation with NVPD. Any failure to comply with the recredentialing process constitutes termination for cause under your 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, NVPD 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 6 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, NVPD will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

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

Initial credentialing

- Completed Nevada State Application
- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate

- Current copy of Controlled Dangerous Substance (CDS) certificate
- Current copy of Sedation and/or General Anesthesia certificates, if applicable
- Copy of Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows name on the certificate, expiration dates and limits – limits $1/3m
- Explanation of any adverse information, if applicable
- Five years' work history in month/date format with no gaps; if there is a gap of 6 months or more, an explanation of the gap should be submitted

Recredentialing

- Completed Nevada State Application
- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Malpractice face sheet which shows name on the certificate, expiration dates and limits– limits $1/3m
- Explanation of any adverse information, if applicable

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

We also accept the Council for Affordable Quality Healthcare (CAQH) process for credentialing/recredentialing application submissions.

Nevada Pacific Dental is committed to supporting the American Dental Association (ADA) and CAQH in streamlining the credentialing process, making it easier for you to complete one application for multiple insurance companies and maintain your credentials in a secure and central location at no cost to you.

If you are new to CAQH, visit ADA.org/godigital to get started.

If you are already using CAQH, we can accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

10.3 Site visits

With appropriate notice, provider locations may receive facility and chart review as part of our quality management oversight process. All surveyed offices are expected to perform quality dental work, maintain appropriate dental records and a clean and safe facility.

The site visit focuses primarily on documentation, quality of care, outcomes of care, accessibility and sterilization and infection control. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Peer Review Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

Section 11: Member appeals

11.1 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 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 time frames upon receipt of all necessary information. Providers and/ or members will be notified of an appeal determination within the state law statute requirements.

11.2 Expedited appeals

In time-sensitive circumstances in which the time frame 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.

Appendix A : Attachments

A.1.a Direct Compensation Provider Statement

NPD Nevada Pacific Dental A UnitedHealthcare Dental Company
2720 N. Tenaya Way
Las Vegas, NV 89128

Underwritten by:
Nevada Pacific Dental, Inc.

Forwarding Service Requested

**********ALL FOR AADC 890
24

DENTAL OFFICE NAME
STREET ADDRESS
CITY, STATE ZIP

PROVIDER STATEMENT

Check Date:	03/15/2024
Payee Number:	000087654321
Check Amount:	$913.75
Quality Total:	17
RVU Total:	763
Co Pay Total:	$40.00

IPA Number	Total Paid
107	$913.75

NPD Nevada Pacific Dental, A UnitedHealthcare Dental Company
2720 N. Tenaya Way
Las Vegas, NV 89128

Underwritten by:
Nevada Pacific Dental, Inc.

Page: Page 3 of 6
Date: 03/20/2024

IPA SUMMARY

Net Premium for IPA:	$11,405.17

% Premium to Healthcare:	75.00%
Health Care Premium:	$8,553.88
Less Specialty Care:	($6,352.88)
Less Ortho Care:	$0.00
Less Quality Assurance:	($22.26)
Plus Total Copayments:	$175.00
Total Compensation:	$2,353.74
Total RVU Production Units:	1,883
% RVU Comp to Prod:	125.00%

Net Production Units:	763
% Compensation to Prod:	125.00%
Total Compensation:	$953.75
Copays Collected in Office:	$40.00
Total Direct Compensation:	$913.75
Net Direct Compensation:	$913.75

NPD Nevada Pacific Dental A UnitedHealthcare Dental Company
2720 N. Tenaya Way
Las Vegas, NV 89128

Underwritten by:
Nevada Pacific Dental, Inc.

Date: 03/20/2024

Patient Detail Report – By Provider

IPA Number 107

Provider Name: DENTIST NAME

Provider Number: 000012345678

Member ID and Suffix Group Number	Claim ID	Member Name	Service Date	QTY	ADA Code	Description	Tooth No	Surface	Paid Amount	Value	Copay	Proc Date	EOB CODE
123456789, 00 555555	123456780500	LAST, FIRST	02/05/2024	1	D0120	periodic oral evaluation			$0.00	25	$0.00	03/15/2024	
123456789, 00 555555	123456780500	LAST, FIRST	02/05/2024	1	D0220	intraoral - periapical first r			$0.00	10	$0.00	03/15/2024	
123456789, 00 555555	123456780500	LAST, FIRST	02/05/2024	1	D0274	bitewings - four radiographic			$0.00	18	$0.00	03/15/2024	
123456789, 00 555555	123456780500	LAST, FIRST	02/05/2024	1	D0230	intraoral - periapical each ad	11		$0.00	5	$0.00	03/15/2024	
123456789, 00 555555	123456780500	LAST, FIRST	02/05/2024	1	D0230	intraoral - periapical each ad	22		$0.00	5	$0.00	03/15/2024	
123456789, 00 555555	123456780800	LAST, FIRST	02/05/2024	1	D1110	prophylaxis - adult	01		$0.00	45	$0.00	03/15/2024	
123456789, 00 555555	123456780800	LAST, FIRST	02/05/2024	1	D0120	periodic oral evaluation			$0.00	25	$0.00	03/15/2024	
123456789, 00 555555	123456789000	LAST, FIRST	01/22/2024	1	D4341	periodontal scaling and root p	01		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789000	LAST, FIRST	01/22/2024	1	D4341	periodontal scaling and root p	25		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789100	LAST, FIRST	02/15/2024	1	D4341	periodontal scaling and root p	09		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789100	LAST, FIRST	02/15/2024	1	D4341	periodontal scaling and root p	17		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789200	LAST, FIRST	02/19/2024	1	D4341	periodontal scaling and root p	09		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789200	LAST, FIRST	02/19/2024	1	D4341	periodontal scaling and root p	17		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789900	LAST, FIRST	02/22/2024	1	D0120	periodic oral evaluation			$0.00	25	$0.00	03/15/2024	
123456789, 00 555555	123456789900	LAST, FIRST	02/22/2024	1	D1110	prophylaxis - adult	01		$0.00	45	$0.00	03/15/2024	
123456789, 00 555555	123456789000	LAST, FIRST	02/26/2024	1	D4341	periodontal scaling and root p	01		$0.00	70	$5.00	03/15/2024	
123456789, 00 555555	123456789000	LAST, FIRST	02/26/2024	1	D4341	periodontal scaling and root p	25		$0.00	70	$5.00	03/15/2024	
Provider Totals				17					$0.00	763	$40.00		
Totals for Payee and IPA				17					$0.00	763	$40.00		

Adjustments may have been made to reflect copayment to align with lower RVU. Please charge member applicable copayment as defined on benefit schedule

A.2 Provider Remittance Advice (PRA) sample

20230915B03
JA56
5044 28964

JA56 [418,906] 3 of 4

[EP-EP]

NPD Nevada Pacific Dental
A UnitedHealthcare Dental Company
2720 N. Tenaya Way
Las Vegas, NV 89128

Underwritten by:
Nevada Pacific Dental, Inc.

EXPLANATION OF DENTAL PLAN REIMBURSEMENT
THIS IS NOT A BILL

Page 3 of 3
Date: 09/15/2023

DENTAL OFFICE NAME
STREET ADDRESS
CITY, STATE ZIP

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
DENTIST NAME NPI Submitted: 1234567890 MEMBER NAME 55555555555; In Network; 55555555; 123456789012									
ADA CODE D3911 intraorifice barrier	06/13/23	14	$275.00	$0.00	$0.00	$0.00	$0.00	$0.00	K82
ADA CODE D3330 endodontic therapy, molar tooth (excluding final restoration)	06/13/23	14	$1,610.00	$0.00	$0.00	$0.00	$0.00	$0.00	B04
ADA CODE D9310 consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	06/13/23	01 32	$220.00	$0.00	$0.00	$0.00	$0.00	$0.00	K82
ADA CODE D0230 intraoral - periapical each additional radiographic image	06/13/23	01 32	$48.00	$0.00	$0.00	$0.00	$0.00	$0.00	B05
ADA CODE D0220 intraoral - periapical first radiographic image	06/13/23	01 32	$53.00	$0.00	$0.00	$0.00	$0.00	$0.00	BK2
SUB-TOTAL			$2,206.00	$0.00	$0.00	$0.00	$0.00	$0.00	

Notes:

BK2 Submitted procedure is disallowed when submitted more than once for the same date of service.

B05 Payment is included in the allowance for another service/procedure.

K82 Duplicate claim/service.

B04 Based on review of the patient's dental history this procedure code isnot eligible.

Plan underwritten by Nevada Pacific Dental

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
TOTAL	$2,206.00	$0.00	$0.00	$0.00	$0.00	$0.00

DEN-PEOB1

A.3 Specialty Request Referral Form – page 1

Specialty Request Referral Form
Nevada Pacific Dental

United Healthcare | Nevada Pacific Dental™

Referring provider name	Phone number	Employee name	ID Number
Street address		Street address	
City, State and ZIP Code		City, State and ZIP Code	Home phone
Employer name	Group Number	Patient's name	Birth date / Relationship

Specialist (check one)	Attestation	(Must be completed for the specialty type, or request will be returned)			Other reasons
☐ Endodontist	☐ Yes ☐ No	All teeth to be treated by endodontist are restorable?	☐ Emergency palliative date		
	☐ Yes ☐ No	Teeth to be treated have a good periodontal prognosis?	Tooth/teeth #s		
	☐ Yes ☐ No	Hemisection or root amputation planned?			
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		☐ Canal(s) cannot be located	☐ Severely curved canal(s)/root	☐ Surgical procedure	
		☐ Canal(s) calcified/blocked	☐ Retreatment	☐ Other–Provide narrative in area at right	
☐ Oral surgeon	☐ Yes ☐ No	Referral is due to medical condition or physical limitation?			
	☐ Yes ☐ No	Service(s) for orthodontic purposes(s)?			
	☐ Yes ☐ No	Removal of supernumerary tooth/teeth?			
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		☐ Treatment of tumor and/or neoplasm	☐ Treatment of nondentigerous cyst		
		☐ Treatment fractured jaw	☐ Treatment of dislocation or subluxation		
		☐ Treatment TMJ/myofascial pain	☐ Specialized test or equipment needed		
		☐ Patient wants general anesthesia when local would normally suffice			
		☐ Consultation needed to aid in treatment planning or to evaluate a lesion			
		☐ Surgery too complex for general dentist	☐ Other–Provide narrative in area at right		
☐ Orthodontist	☐ Yes ☐ No	Patient's oral hygiene/home care is adequate?			
	☐ Yes ☐ No	All diagnosed preventive and resotrative treatment completed?			
		Orthodontic treatment is needed because of:	☐ Retreatment		
		☐ Treatment TMJ/myofascial pain	☐ Jaw repositioning		
		☐ Relapse after orthodontics	☐ Malocclusion or crowding		
		☐ Myofunctional therapy	☐ Orthodontic treatment is in progress		
		☐ Micrognathia, macroglossia or other congenital/developmental condition?			
☐ Pedodontist	☐ Yes ☐ No	If patient is over 3 years, treatment was attempted?			
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		☐ Complexity of case, not related to medical condition or limitations			
		☐ Inability to cooperate, not related to medical condition or limitations			
		☐ Medical condition/physical limitations	☐ Other–Provide narrative in area at right		
☐ Periodontist	☐ Yes ☐ No	Patient's oral hygiene/home care is adequate?	☐ Dates of SRP's		
	☐ Yes ☐ No	Prophylaxis and scaling/root planing completed?	UR	☐ Re-eval date	
	☐ Yes ☐ No	Pocket charting done before & after scaling/ root planing?	LR	☐ Case type IV	
	☐ Yes ☐ No	Bone graft/bone replacement?	UL	☐ Perioprognosis#	
	☐ Yes ☐ No	Crown lengthening?	LL		
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		☐ Osseous mucogingival surgery is needed to reduce pockets			
		☐ Gingival grafting is needed to treat recession in absence of pockets			
		☐ Patient has not responded to treatment by general practice provider			
		☐ To aid in treatment planning	☐ Other–Provide narrative in area at right		

A.3 Specialty Request Referral Form – page 2

Services requested for referral and specialist claim for services rendered		
Procedure code	Tooth/Quad/Arch	Description of procedure

Note: For additional services, a standard 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	As the specialist, I affirm services were needed and done on the date(s) above. Specialist's signature
Signature date:	Signature date: TAX ID #:

Emergency referrals
For emergency services, please contact our provider services at 800-926-0925 for authorization.

Mail completed form to:
Nevada Pacific Dental c/o UnitedHealthcare Dental, P.O. Box 30552, Salt Lake City, UT 84130

Specialist information		
Specialist name	Street address	City, State, and ZIP Code
		Phone number:

For emergency referrals - Member delivers a copy to the specialist. General dentist retains a copy for their records.

A.3 Specialty Request Referral Form – page 3

Request for specialty referral

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, non-emergency, specialty referral request forms to:

Nevada Pacific Dental
c/o UnitedHealthcare Dental
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.

In cases where **Emergency Services** are referred to a specialist, a **specialty referral request** form must be completed and accompany the patient to the specialist. For emergency referrals, please contact our Provider Services at 800-926-0925.

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 aide in this process, the following list was complied of the most commonly referred specialty procedure codes.

Quick reference guide

Most commonly referred specialty procedure codes

Endodontics

- 9310 Consultation
- 3310 Anterior root canal (excluding final restoration)
- 3320 Bicuspid root canal (excluding final restoration)
- 3330 Molar root canal (excluding final restoration)
- 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

Oral surgery

- 9310 Consultation
- 7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap removal of bone and/or section of tooth
- 7220 Removal of impacted tooth - soft tissue
- 7230 Removal of impacted tooth - partially bony
- 7240 Removal of impacted tooth - completely bony

Orthodontics

- 9310 Consultation

Pedodontics

- 9310 Consultation

Periodontics

- 9310 Consultation
- 4260 Osseous surgery 4+ contiguous teeth or bounded teeth spaces per quadrant
- 4361 Osseous surgery 1-3 teeth or hounded teeth spaces per quadrant

A.4 Demographic Change Form

Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

Description of when to use form: To be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). *Form must be signed at bottom to be processed. Please list all providers associated with this change.* ***Failure to sign, list all associated providers requesting the update or attach required documentation will delay your request.***

Providers: To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes **PRIOR** to submitting your claim(s) and within 30 days of the change taking place. For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on **uhcdental.com**

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right on this box:

Mailing Address: Dental Benefit Providers, Inc. (DBP-CA Inc)
ATTN: Dental Provider Services
PO Box 30567, Salt Lake City UT 84130
Fax: 248-733-6372
Email: dbpprvfx@uhc.com

☐ Please check box if making a TIN (Tax ID Number) change. (***Copy of updated W-9 form is required)*** ***May be subject to new contracting.***

Current Tax ID:	**New Tax ID:**	**Effective date of change :**	**Reprocess Claims? :** ☐ ***Yes***

☐ Please check box if making a dentist name change. (***Copy of updated dental license is required***)

Current Name:	(Last)	(First)
New Name:	(Last)	(First)

☐ Please check box if changing specialty. (***Copy of specialty certification is required)*** ☐ Please check box if board certified.

Effective date of the following information change: ☐ Please check if office is handicap accessible.

PRACTICE LOCATION:

(Only complete applicable fields)

☐ Please check box if ***updating practice name or address***

Previous Practice Name:		**New Practice Name:**	
Previous Physical Address:	(Suite #)	**New Physical Address:**	(Suite #)
(City)	(State) (Zip)	(City)	(State) (Zip)

REMITTANCE ADDRESS:

(Only complete applicable fields)

☐ Please check box if ***updating mailing address*** ☐ Please check box if ***remit is same as office location***

Previous Remit Address:	(Suite #)	**New Remit Address**	(Suite #)
(City)	(State) (Zip)	(City)	(State) (Zip)

ADDITIONAL DEMOGRAPHIC INFORMATION

(Only complete applicable fields)

Languages Spoken Other Than English:		**Directory Office website:**		**Directory Email Address:**			
Phone Number:		**Fax Number:**		**Internal Email Address:**			
New Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

☐ ***Please check box if Associate Provider(s) need to be termed.*** **Term Reason:** ☐ **Provider Left Practice** ☐ **Other**

Provider(s) associated with the requested change: _____

Notice*** ***Effective Date*** *may be different than the date of signature on this form. Please be sure your effective date reflects the actual date the change took place.*

AUTHORIZED SIGNATURE: **DATE:**

WPN: Prov W9 Rev Oct 2024

A.5 Site Audit Structural Review and Chart Form

Office/Provider Name:		Prac #:	United Healthcare / Nevada Pacific Dental
Address:		Plan:	
City:	State:	Auditor:	
Zip Code:		Date:	
***1=Acceptable *0=Unacceptable */ =Non Applicable**	**NOTES:**		

STRUCTURAL REVIEW

**** = Must have items for all offices. Automatic FAIL without these items.**

Languages:

☐ Other(non English) ☐ Armenian ☐ Korean ☐ Farsi/Persian ☐ Tagalog/Filipino
☐ French ☐ Hindi ☐ Cantonese ☐ Spanish ☐ Vietnamese
☐ Arabic ☐ Bengali ☐ Russian ☐ German ☐ Chinese

I. ACCESSIBILITY	*Earned	*Possible	Comments
A. 24-hour emergency contact system.			
B. Reasonable appointment scheduling for plan members.			
C. Language Assistance Program and Documents (California Only)			
II. FACILITY AND EQUIPMENT			
A. Clean, safe, neat and well maintained.			
B. Compliance with mercury hygiene, safety regulations.			
C. Nitrous oxide recovery system.			
D. Lead apron (with thyroid collar) for patient.			
III. EMERGENCY PROCEDURES AND EQUIPMENT			
A. Written emergency protocols.			
B. Medical emergency kit on-site.			
C. Portable emergency oxygen available.			
IV. STERILIZATION AND INFECTION CONTROL			
A. Sterilization and infection control protocols followed.			
B. Protocol posted for sterilization procedures.			
C. Weekly biological (spore) monitoring of sterilizer.			
D. All instruments and hand-pieces properly cleaned, sterilized, and stored.			
E. Log kept monitoring changing of sterilization solutions.			
F. Staff wears appropriate personal protective equipment.			
G. Proper and adequate use of barrier techniques.			
H. Hand-pieces & waterlines flushed appropriately.			
I. Infection control and cross-contamination prevention procedures followed in the office and laboratory.			
TOTAL			**Ratio out of 50** (Earned points / Possible points x 0.5 x 100 = Ratio)

Signature of Provider/Office Manager/Designee	Date	Reviewer's Signature	Date

Rev 04/2013

A.6 Optional, Upgraded or Alternative Treatment Disclosure Form

OPTIONAL, UPGRADED OR ALTERNATIVE TREATMENT DISCLOSURE FORM

Patient's Name:	ID:	UnitedHealthcare
Treatment Plan No.:		Chart ID No.:

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
CDT Code of Proposed Treatment	Proposed Procedure Description (Indicate reason this is not covered in explanation area below*)	Tooth No. 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 & pontics)

When a Member elects a laboratory upgrade of a standard covered service, please use the following formula to determine the charge:

Some plans only allow a metal laboratory upgrade charge (e.g. Blue Shield 65 Plus, plans with version 5 Limitations). 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
CDT Code of Proposed Treatment	Proposed Procedure Description	Tooth No. 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 DDS:	Date:

Appendix B: Member copayment schedule

B.1 NVPD Member Copayment Schedule

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
[1] Please collect applicable copay for this procedure as listed on the copay schedule. The member's copayment is the total compensation for this procedure. If the procedure is not covered (NTCV) under the plan, the member is responsible for the provider's UCR fee									
I. DIAGNOSTIC									
D0120	periodic oral evaluation - established patient	25	0	0	0	0	0	0	0
D0140	limited oral evaluation - problem focused	30	0	0	0	0	0	0	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	30	0	0	0	0	0	0	NTCV
D0150	comprehensive oral evaluation - new or established patient	30	0	0	0	0	0	0	0
D0160	detailed and extensive oral evaluation - problem focused, by report	45	0	0	0	0	0	NTCV	0
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	25	0	0	0	0	0	0	0
D0171	re-evaluation - post-operative office visit	19	5	5	5	5	NTCV	10	NTCV
D0180	comprehensive periodontal evaluation - new or established patient	30	0	0	0	0	0	NTCV	0
D0190	screening of a patient	19	5	5	5	5	5	70	NTCV
D0191	assessment of a patient	19	5	5	5	5	5	70	NTCV
D0210	intraoral - complete series of radiographic images	60	0	0	0	0	0	0	0
D0220	intraoral - periapical first radiographic image	10	0	0	0	0	0	0	0
D0230	intraoral - periapical each additional radiographic image	5	0	0	0	0	0	0	0
D0240	intraoral - occlusal radiographic image	12	0	0	0	0	0	0	0
D0250	extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	20	0	0	0	0	0	0	0

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D0251	extra-oral posterior dental radiographic image	20	0	0	0	0	0	0	0
D0270	bitewing - single radiographic image	8	0	0	0	0	0	0	0
D0272	bitewings - two radiographic images	10	0	0	0	0	0	0	0
D0273	bitewings - three radiographic images	14	0	0	0	0	0	0	0
D0274	bitewings - four radiographic images	18	0	0	0	0	0	0	0
D0277	vertical bitewings - 7 to 8 radiographic images	18	0	0	0	0	0	0	0
D0330	panoramic radiographic image	25	5	0	0	0	0	0	0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	40	0	0	0	0	0	NTCV	NTCV
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	48	25	0	0	0	0	10	NTCV
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	24	0	0	0	0	0	NTCV	0
D0415	collection of microorganisms for culture and sensitivity	24	0	0	0	0	0	NTCV	0
D0416	viral culture	24	0	0	0	0	0	NTCV	NTCV
D0422	collection and preparation of genetic sample material for laboratory analysis and report	24	0	0	0	0	0	NTCV	0
D0423	genetic test for susceptibility to diseases - specimen analysis	24	0	0	0	0	0	NTCV	0
D0425	caries susceptibility tests	24	0	0	0	0	0	0	0
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	45	20	20	20	20	20	NTCV	20
D0460	pulp vitality tests	24	0	0	0	0	0	NTCV	0
D0470	diagnostic casts	25	12	0	0	0	0	0	0

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D0472	accession of tissue, gross examination, preparation and transmission of written report	25	0	0	0	0	0	0	0
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report	65	0	0	0	0	0	NTCV	0
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	65	0	0	0	0	0	NTCV	0
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	24	0	0	0	0	0	NTCV	0
D0601	caries risk assessment and documentation, with a finding of low risk	30	0	0	0	0	NTCV	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk	30	0	0	0	0	NTCV	0	0
D0603	caries risk assessment and documentation, with a finding of high risk	30	0	0	0	0	NTCV	0	0
D0999	Office visit Fee- Per visit	0[1]	$0/ $5/ $10	$0/ $5/ $10	$0/ $5/ $10	$0/ $5/ $10	$0/ $5/ $10	0	0
II. PREVENTIVE									
[2] Additional Prophy within 6 months will be based upon the necessity recommended by the provider									
D1110	prophylaxis - adult	45	5	0	0	0	0	0	0
--------	Prophylaxis - Adult[2] **Additional Prophy within 6 months**	0[1]	25	25	25	25	25	NTCV	25
D1120	prophylaxis - child	28	5	0	0	0	0	0	0
--------	Prophylaxis -Child[2] **Additional Prophy within 6 months**	0[1]	25	25	25	25	25	NTCV	25
D1206	topical application of fluoride varnish	13	0	0	0	0	0	0	0
D1208	topical application of fluoride - excluding varnish	13	0	0	0	0	0	0	0
D1310	nutritional counseling for control of dental disease	0[1]	0	0	0	0	0	0	0

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D1320	tobacco counseling for the control and prevention of oral disease	0[1]	0	0	0	0	0	0	0
D1330	oral hygiene instructions	0[1]	0	0	0	0	0	0	0
D1351	sealant - per tooth	16	10	8	8	5	5	18	12
D1352	preventive resin restoration in a moderate to high caries risk patient - permanent tooth	16	12	10	10	8	8	NTCV	NTCV
D1353	sealant repair - per tooth	16	10	8	8	5	NTCV	18	12
D1510	space maintainer - fixed, unilateral	80	35	25	25	25	15	85	80
D1516	space maintainer - fixed - bilateral, maxillary	160	35	25	25	25	15	135	117
D1517	space maintainer - fixed - bilateral, mandibular	160	35	25	25	25	15	135	117
D1520	space maintainer - removable - unilateral	100	45	40	40	35	20	100	80
D1526	space maintainer - removable - bilateral, maxillary	140	45	40	40	35	20	140	117
D1527	space maintainer - removable - bilateral, mandibular	140	45	40	40	35	20	140	117
D1550	re-cement or re-bond space maintainer	12	15	15	15	5	0	15	26
D1555	removal of fixed space maintainer	10	15	15	15	10	10	12	18
D1575	distal shoe space maintainer - fixed - unilateral	80	35	25	25	25	15	85	80
III. RESTORATIVE									
D2140	amalgam - one surface, primary or permanent	40	15	8	0	0	0	35	8
D2150	amalgam - two surfaces, primary or permanent	60	20	15	0	0	0	40	15
D2160	amalgam - three surfaces, primary or permanent	75	25	22	0	0	0	50	22
D2161	amalgam - four or more surfaces, primary or permanent	90	30	28	0	0	0	55	28
D2330	resin-based composite - one surface, anterior	40	20	10	0	0	0	40	20
D2331	resin-based composite - two surfaces, anterior	60	25	20	0	0	0	60	28
D2332	resin-based composite - three surfaces, anterior	70	30	30	0	0	0	75	30

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	80	40	38	0	0	0	90	38
D2390	resin-based composite crown, anterior	85	70	45	40	25	20	NTCV	104
D2391	resin-based composite - one surface, posterior	40	65	50	40	30	25	70	50
D2392	resin-based composite - two surfaces, posterior	60	85	55	45	40	35	80	55
D2393	resin-based composite - three surfaces, posterior	75	105	85	75	55	45	105	85
D2394	resin-based composite - four or more surfaces, posterior	90	120	95	75	55	45	120	95
D2510	inlay - metallic - one surface	125	200	185	175	150	115	325	276
D2520	inlay - metallic - two surfaces	150	200	185	175	150	115	335	276
D2530	inlay - metallic - three or more surfaces	175	200	185	175	150	115	345	283
D2542	onlay - metallic - two surfaces	205	250	225	225	150	115	NTCV	270
D2543	onlay - metallic - three surfaces	205	250	225	225	150	115	NTCV	361
D2544	onlay - metallic - four or more surfaces	205	250	225	225	150	115	NTCV	361
D2610	inlay - porcelain/ceramic - one surface	125	305	250	250	175	125	350	212
D2620	inlay - porcelain/ceramic - two surfaces	150	305	250	250	175	125	360	229
D2630	inlay - porcelain/ceramic - three or more surfaces	175	305	250	250	175	125	375	244
D2642	onlay - porcelain/ceramic - two surfaces	205	305	250	250	175	125	NTCV	254
D2643	onlay - porcelain/ceramic - three surfaces	205	305	250	250	175	125	NTCV	264
D2644	onlay - porcelain/ceramic - four or more surfaces	205	305	250	250	175	125	NTCV	264
D2650	inlay - resin-based composite - one surface	110	305	250	250	175	125	NTCV	283
D2651	inlay - resin-based composite - two surfaces	125	305	250	250	175	125	NTCV	283
D2652	inlay - resin-based composite - three or more surfaces	145	305	250	250	175	125	NTCV	283
D2662	onlay - resin-based composite - two surfaces	115	305	250	250	175	125	NTCV	303
D2663	onlay - resin-based composite - three surfaces	150	305	250	250	175	125	NTCV	303

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D2664	onlay - resin-based composite - four or more surfaces	175	305	250	250	175	125	NTCV	308
D2710	crown - resin-based composite (indirect)	160	180	150	150	125	90	175	157
D2712	crown - ¾ resin-based composite (indirect)	160	180	150	150	125	90	175	312
D2720	crown - resin with high noble metal*	320	250	250	250	175	125	390	283
D2721	crown - resin with predominantly base metal	240	250	250	250	175	125	375	246
D2722	crown - resin with noble metal*	272	250	250	250	175	125	405	246
D2740	crown - porcelain/ceramic	320	350	300	300	225	215	475	360
D2750	crown - porcelain fused to high noble metal*	352	305	250	250	175	125	405	322
D2751	crown - porcelain fused to predominantly base metal	256	305	250	250	175	125	375	322
D2752	crown - porcelain fused to noble metal*	288	305	250	250	175	125	405	322
D2780	crown - ¾ cast high noble metal*	304	305	250	250	175	125	NTCV	250
D2781	crown - ¾ cast predominantly base metal	288	305	250	250	175	125	NTCV	250
D2782	crown - ¾ cast noble metal*	290	305	250	250	175	125	NTCV	250
D2783	crown - ¾ porcelain/ceramic	352	305	250	250	175	125	NTCV	272
D2790	crown - full cast high noble metal*	304	305	250	250	175	125	405	309
D2791	crown - full cast predominantly base metal	240	305	250	250	175	125	375	309
D2792	crown - full cast noble metal*	256	305	250	250	175	125	405	309
D2794	crown - titanium*	304	305	250	250	175	125	475	309
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	24	10	0	0	0	0	24	26
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	24	10	0	0	0	0	24	26
D2920	re-cement or re-bond crown	24	10	0	0	0	0	24	26
D2921	reattachment of tooth fragment, incisal edge or cusp	20	5	55	55	55	NTCV	NTCV	NTCV
D2930	prefabricated stainless steel crown - primary tooth	64	60	25	25	25	10	65	71
D2931	prefabricated stainless steel crown - permanent tooth	96	60	25	25	25	10	65	77

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D2932	prefabricated resin crown	48	45	40	40	35	10	95	86
D2933	prefabricated stainless steel crown with resin window	75	60	40	40	35	20	NTCV	76
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	64	65	45	45	40	25	NTCV	NTCV
D2940	protective restoration	24	10	0	0	0	0	24	26
D2950	core buildup, including any pins when required	96	70	50	50	25	10	85	75
D2951	pin retention - per tooth, in addition to restoration	16	15	10	10	10	8	25	15
D2952	post and core in addition to crown, indirectly fabricated	128	50	50	40	35	20	125	103
D2953	each additional indirectly fabricated post - same tooth	40	50	50	40	25	10	NTCV	102
D2954	prefabricated post and core in addition to crown	80	30	30	25	20	10	75	82
D2955	post removal	86	10	10	10	10	10	40	64
D2957	each additional prefabricated post - same tooth	40	30	30	30	30	15	NTCV	62
D2960	labial veneer (resin laminate) - chairside	150	300	300	300	300	300	NTCV	NTCV
D2961	labial veneer (resin laminate) - laboratory	200	450	450	450	450	450	NTCV	NTCV
D2962	labial veneer (porcelain laminate) - laboratory	194	550	550	550	550	550	NTCV	NTCV
D2971	additional procedures to construct new crown under existing partial denture framework	45	50	50	50	35	25	NTCV	50
D2980	crown repair necessitated by restorative material failure	62	55	55	55	40	30	NTCV	NTCV
D2981	inlay repair necessitated by restorative material failure	62	5	5	NTCV	NTCV	NTCV	NTCV	NTCV
D2982	onlay repair necessitated by restorative material failure	62	5	5	NTCV	NTCV	NTCV	NTCV	NTCV
D2983	veneer repair necessitated by restorative material failure	62	550	550	NTCV	NTCV	NTCV	NTCV	NTCV
D2990	resin infiltration of incipient smooth surface lesions	16	0	0	NTCV	NTCV	NTCV	0	0
IV. ENDODONTICS									

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D3110	pulp cap - direct (excluding final restoration)	20	5	5	0	0	0	22	17
D3120	pulp cap - indirect (excluding final restoration)	16	5	5	0	0	0	18	17
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	48	25	5	0	0	0	52	43
D3221	pulpal debridement, primary and permanent teeth	48	55	30	30	15	5	NTCV	45
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	48	55	30	30	15	5	75	NTCV
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	66	40	40	40	25	5	65	53
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	55	40	40	40	25	5	85	60
D3310	endodontic therapy, anterior tooth (excluding final restoration)	170	125	125	95	75	45	240	206
D3320	endodontic therapy, premolar tooth (excluding final restoration)	240	215	175	175	150	75	350	277
D3330	endodontic therapy, molar tooth (excluding final restoration)	400	365	325	305	275	115	400	335
D3331	treatment of root canal obstruction; non-surgical access	52	115	85	85	85	65	NTCV	147
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	48	115	85	85	65	45	110	146
D3333	internal root repair of perforation defects	55	115	85	85	65	45	NTCV	51
D3346	retreatment of previous root canal therapy - anterior	220	155	145	115	100	70	500	232
D3347	retreatment of previous root canal therapy - premolar	290	245	195	175	170	100	600	296
D3348	retreatment of previous root canal therapy - molar	450	415	345	300	295	140	725	354
D3351	apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	42	70	70	70	65	50	NTCV	125

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D3352	apexification/recalcification - interim medication replacement	40	70	70	70	65	45	NTCV	125
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	75	70	70	70	65	45	NTCV	125
D3355	Pulpal regeneration - initial visit	42	70	70	70	70	NTCV	NTCV	125
D3356	Pulpal regeneration -interim medicament replacement	40	70	70	70	70	NTCV	NTCV	125
D3357	Pulpal regeneration - completion of treatment	75	70	70	70	65	NTCV	NTCV	125
D3410	apicoectomy - anterior	112	115	95	95	95	75	470	167
D3421	apicoectomy - premolar (first root)	224	125	95	95	95	75	535	193
D3425	apicoectomy - molar (first root)	336	140	95	95	95	75	575	206
D3426	apicoectomy (each additional root)	144	95	55	55	55	35	145	90
D3427	periradicular surgery without apicoectomy	144	95	55	55	55	NTCV	145	90
D3430	retrograde filling - per root	134	60	55	55	55	35	135	64
D3450	root amputation - per root	96	110	95	95	95	75	315	122
D3910	surgical procedure for isolation of tooth with rubber dam	40	25	15	15	15	15	NTCV	20
D3920	hemisection (including any root removal), not including root canal therapy	96	90	90	90	90	75	95	122
D3950	canal preparation and fitting of preformed dowel or post	50	15	15	15	15	15	NTCV	90
V. PERIODONTICS: Includes pre-op and post-op evaluations and local anesthetic; charting must be performed in conjunction with these procedures									
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	96	150	130	115	115	50	265	174
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	48	95	85	80	75	35	150	52
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	16	31	28	26	25	12	NTCV	17

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	96	160	150	150	140	115	350	225
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	64	115	110	95	85	85	280	52
D4245	apically positioned flap	100	175	165	165	165	155	NTCV	348
D4249	clinical crown lengthening - hard tissue	95	175	150	145	115	115	275	309
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	320	385	355	325	325	225	650	201
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	211	300	275	225	215	155	525	299
D4263	bone replacement graft - retained natural tooth - first site in quadrant	175	235	205	175	175	175	NTCV	299
D4264	bone replacement graft - retained natural tooth - each additional site in quadrant	175	90	90	90	75	75	NTCV	234
D4270	pedicle soft tissue graft procedure	192	255	235	225	215	195	295	328
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	100	100	90	85	65	50	NTCV	161
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	192	255	235	225	215	195	315	307
D4320	provisional splinting - intracoronal	95	95	95	95	95	95	NTCV	NTCV
D4321	provisional splinting - extracoronal	75	75	75	75	75	75	NTCV	NTCV

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D4341	periodontal scaling and root planing - four or more teeth per quadrant	70	55	55	45	40	25	80	71
D4342	periodontal scaling and root planing - one to three teeth per quadrant	50	55	50	45	28	15	65	32
D4346	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	55	40	40	30	30	15	65	53
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	60	55	55	50	40	25	80	55
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular								
tissue, per tooth	25	65	65	55	35	55	NTCV	50	
D4910	periodontal maintenance	55	40	40	30	30	15	65	53
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	18	0	0	0	0	0	NTCV	25
D4921	gingival irrigation - per quadrant	13	0	0	0	NTCV	0	0	0
VI. PROSTHODONTICS (REMOVABLE): Full and partial dentures; includes fabrication and/or repair of prosthesis and routine post-delivery care									
D5110	complete denture - maxillary	500	425	350	275	225	150	450	452
D5120	complete denture - mandibular	500	425	350	275	225	150	450	452
D5130	immediate denture - maxillary	540	440	400	315	250	150	495	464
D5140	immediate denture - mandibular	540	440	400	315	250	150	495	464
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	350	400	325	250	275	115	425	452
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	350	400	325	250	275	115	425	452
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	400	450	425	325	275	165	475	464

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	400	450	425	325	275	165	475	464
D5221	immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	160	160	145	115	115	45	195	276
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	160	170	145	115	115	45	195	276
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	160	160	145	115	115	45	195	276
D5224	immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	160	170	145	115	115	45	195	276
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	350	450	425	325	350	325	475	650
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	350	450	425	325	350	325	475	650
D5282	removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	125	330	300	275	260	150	415	257
D5283	removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	125	330	300	275	260	150	415	257
D5410	adjust complete denture - maxillary	16	15	10	10	0	0	22	20
D5411	adjust complete denture - mandibular	16	15	10	10	0	0	22	20
D5421	adjust partial denture - maxillary	27	15	10	10	0	0	22	20
D5422	adjust partial denture - mandibular	27	15	10	10	0	0	22	20

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D5511	repair broken complete denture base, mandibular	48	15	10	10	10	0	22	20
D5512	repair broken complete denture base, maxillary	48	15	10	10	10	0	22	20
D5611	repair resin partial denture base, mandibular	48	15	10	10	10	0	22	20
D5612	repair resin partial denture base, maxillary	48	15	10	10	10	0	22	20
D5621	repair cast partial framework, mandibular	96	15	10	10	10	0	22	20
D5622	repair cast partial framework, maxillary	96	15	10	10	10	0	22	20
D5630	repair or replace broken clasp - per tooth	96	40	35	30	25	15	65	69
D5640	replace broken teeth - per tooth	48	40	35	30	25	15	65	56
D5650	add tooth to existing partial denture	48	40	40	30	25	15	55	56
D5660	add clasp to existing partial denture - per tooth	80	50	40	30	25	15	90	59
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	315	165	150	150	150	125	350	145
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	315	165	150	150	150	125	350	145
D5710	rebase complete maxillary denture	160	105	75	65	55	45	185	188
D5711	rebase complete mandibular denture	160	105	75	65	55	45	185	188
D5720	rebase maxillary partial denture	128	105	75	65	55	45	185	188
D5721	rebase mandibular partial denture	128	105	75	65	55	45	185	188
D5730	reline complete maxillary denture (chairside)	96	90	55	55	35	0	100	94
D5731	reline complete mandibular denture (chairside)	96	90	55	55	35	0	100	94
D5740	reline maxillary partial denture (chairside)	80	90	55	55	35	0	100	151
D5741	reline mandibular partial denture (chairside)	80	90	55	55	35	0	100	151
D5750	reline complete maxillary denture (laboratory)	128	115	75	75	55	40	175	151
D5751	reline complete mandibular denture (laboratory)	128	115	75	75	55	40	175	151

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D5760	reline maxillary partial denture (laboratory)	128	115	75	75	55	40	175	151
D5761	reline mandibular partial denture (laboratory)	128	115	75	75	55	40	175	151
D5810	interim complete denture (maxillary)	192	160	145	115	55	45	300	NTCV
D5811	interim complete denture (mandibular)	192	170	155	115	55	45	300	NTCV
D5820	interim partial denture (maxillary)	160	160	145	115	55	45	195	276
D5821	interim partial denture (mandibular)	160	170	155	115	55	45	195	276
D5850	tissue conditioning, maxillary	24	35	20	20	10	10	40	40
D5851	tissue conditioning, mandibular	24	35	20	20	10	10	40	40
D5863	overdenture - complete maxillary	500	425	350	275	225	NOR	450	452
D5864	overdenture - complete mandibular	500	450	425	325	275	NOR	475	464
D5865	overdenture - partial maxillary	400	425	350	275	225	NOR	450	452
D5866	overdenture - partial mandibular	400	450	425	325	275	NOR	475	464
D5876	add metal substructure to acrylic full denture (per arch)	160	105	75	65	55	45	185	188
VIII. IMPLANT SERVICES									
D6010	surgical placement of implant body: endosteal implant	0[1]	1,950	1,950	1,950	1,950	1,950	NTCV	NTCV
D6013	surgical placement of a mini-implant	0[1]	1,950	1,950	150	195	NTCV	NTCV	NTCV
D6051	connecting bar - implant supported or abutment supported	0[1]	368	368	368	368	368	NTCV	NTCV
D6052	semi-precision attachment abutment	0[1]	368	368	368	275	NTCV	NTCV	NTCV
D6055	prefabricated abutment - includes modification and placement	0[1]	540	540	540	540	540	NTCV	NTCV
D6056	custom fabricated abutment - includes placement	0[1]	368	368	368	368	368	NTCV	NTCV
D6057	abutment supported porcelain/ ceramic crown	0[1]	610	610	610	610	610	NTCV	NTCV
D6058	abutment supported porcelain fused to metal crown (high noble metal)*	0[1]	1,050	1,050	1,050	1,050	1,050	NTCV	NTCV
D6059	abutment supported porcelain fused to metal crown (predominantly base metal)	0[1]	915	915	915	915	915	NTCV	NTCV

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D6060	abutment supported porcelain fused to metal crown (noble metal)*	0[1]	1,050	1,050	1,050	1,050	1,050	NTCV	NTCV
D6061	abutment supported cast metal crown (high noble metal)*	0[1]	946	946	946	946	946	NTCV	NTCV
D6062	abutment supported cast metal crown (predominantly base metal)	0[1]	981	981	981	981	981	NTCV	NTCV
D6063	abutment supported cast metal crown (noble metal)*	0[1]	854	854	854	854	854	NTCV	NTCV
D6064	implant supported porcelain/ ceramic crown	0[1]	1,168	1,168	1,168	1,168	1,168	NTCV	NTCV
D6065	implant supported metal crown (titanium, titanium alloy, high noble metal)*	0[1]	1,144	1,144	1,144	1,144	1,144	NTCV	NTCV
D6066	abutment supported retainer for porcelain/ceramic FPD	0[1]	1,083	1,083	1,083	1,083	1,083	NTCV	NTCV
D6067	abutment supported retainer for porcelain fused to metal FPD (high noble metal)*	0[1]	962	962	962	962	962	NTCV	NTCV
D6068	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0[1]	1,026	1,026	1,026	1,026	1,026	NTCV	NTCV
D6069	abutment supported retainer for porcelain fused to metal FPD (noble metal)*	0[1]	1,050	1,050	1,050	1,050	1,050	NTCV	NTCV
D6070	abutment supported retainer for cast metal FPD (high noble metal)*	0[1]	965	965	965	965	965	NTCV	NTCV
D6071	abutment supported retainer for cast metal FPD (predominantly base metal)	0[1]	984	984	984	984	984	NTCV	NTCV
D6072	abutment supported retainer for cast metal FPD (noble metal)*	0[1]	997	997	997	997	997	NTCV	NTCV
D6073	implant supported retainer for ceramic FPD	0[1]	910	910	910	910	910	NTCV	NTCV
D6074	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)*	0[1]	967	967	967	967	967	NTCV	NTCV
D6075	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)*	0[1]	1,018	1,018	1,018	1,018	1,018	NTCV	NTCV

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D6076	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	0[1]	992	992	992	992	992	NTCV	NTCV
D6077	repair implant supported prosthesis, by report*	0[1]	962	962	962	962	962	NTCV	NTCV
D6080	replacement of semi-precision or precision attachment (male or female component) of implant/ abutment supported prosthesis, per attachment	0[1]	55	55	55	55	55	NTCV	NTCV
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	64	1,950	1,950	NTCV	NTCV	NOR	NTCV	NTCV
D6090	re-cement or re-bond implant/ abutment supported crown	0[1]	135	135	135	135	135	NTCV	NTCV
D6091	re-cement or re-bond implant/ abutment supported fixed partial denture	0[1]	410	410	410	410	410	NTCV	NTCV
D6092	abutment supported crown (titanium)	0[1]	79	79	79	79	79	NTCV	NTCV
D6093	repair implant abutment, by report*	0[1]	124	124	124	124	124	NTCV	NTCV
D6094	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)*	0[1]	810	810	810	810	810	NTCV	NTCV
D6095	implant removal, by report	0[1]	55	55	55	55	55	NTCV	NTCV
D6096	remove broken implant retaining screw	86	55	55	55	55	55	NTCV	NTCV
D6100	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0[1]	600	600	600	600	600	NTCV	NTCV
D6101	interim abutment	64	115	110	95	85	85	NTCV	NTCV

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	211	1,950	1,950	NTCV	NTCV	NOR	NTCV	NTCV
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure	175	1,950	1,950	NTCV	NTCV	NOR	NTCV	NTCV
D6110	implant /abutment supported removable denture for edentulous arch - maxillary	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV
D6111	implant /abutment supported removable denture for edentulous arch - maxillary	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV
D6112	implant /abutment supported removable denture for partially edentulous arch - maxillary	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV
D6113	implant /abutment supported removable denture for partially edentulous arch - mandibular	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV
D6190	radiographic/surgical implant index, by report	0[1]	265	265	265	265	265	NTCV	NTCV
D6194	abutment supported retainer crown for FPD - (titanium)*	0[1]	835	835	835	835	835	NTCV	NTCV
IX. PROSTHODONTICS, FIXED: Includes diagnosis/models; preparation, temporization, fabrication and cementation of final restoration									
D6205	pontic - indirect resin based composite	200	180	150	150	125	90	NTCV	NTCV
D6210	pontic - cast high noble metal*	304	305	250	250	175	125	405	309
D6211	pontic - cast predominantly base metal	240	305	250	250	175	125	375	309
D6212	pontic - cast noble metal*	256	305	250	250	175	125	405	309
D6214	pontic - titanium*	304	305	250	250	175	125	NTCV	309
D6240	pontic - porcelain fused to high noble metal*	352	305	250	250	175	125	405	322
D6241	pontic - porcelain fused to predominantly base metal	256	305	250	250	175	125	375	322
D6242	pontic - porcelain fused to noble metal*	288	305	250	250	175	125	405	322
D6245	pontic - porcelain/ceramic	320	350	300	300	225	215	NTCV	357
D6250	pontic - resin with high noble metal*	320	250	250	250	175	125	405	283

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D6251	pontic - resin with predominantly base metal	224	250	250	250	175	125	375	283
D6252	pontic - resin with noble metal*	288	250	250	250	175	125	405	283
D6253	provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	95	95	95	90	80	50	NTCV	NTCV
D6545	retainer - cast metal for resin bonded fixed prosthesis	128	125	115	110	95	75	NTCV	NTCV
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis	375	375	350	325	315	275	NTCV	NTCV
D6549	resin retainer - for resin bonded fixed prosthesis	128	125	115	110	110	NOR	NTCV	NTCV
D6600	retainer inlay - porcelain/ceramic, two surfaces	150	325	270	270	195	145	NTCV	133
D6601	retainer inlay - porcelain/ceramic, three or more surfaces	175	325	270	270	195	145	NTCV	142
D6602	retainer inlay - cast high noble metal, two surfaces*	150	200	185	175	150	115	350	147
D6603	retainer inlay - cast high noble metal, three or more surfaces*	175	200	185	175	150	115	360	173
D6604	retainer inlay - cast predominantly base metal, two surfaces	150	200	185	175	150	115	255	95
D6605	retainer inlay - cast predominantly base metal, three or more surfaces	175	200	185	175	150	115	260	121
D6606	retainer inlay - cast noble metal, two surfaces*	150	200	185	175	150	115	350	119
D6607	retainer inlay - cast noble metal, three or more surfaces*	175	200	185	175	150	115	360	129
D6608	retainer onlay - porcelain/ ceramic, two surfaces	175	335	280	280	205	155	NTCV	145
D6609	retainer onlay - porcelain/ ceramic, three or more surfaces	185	335	280	280	205	155	NTCV	152
D6610	retainer onlay - cast high noble metal, two surfaces*	200	200	185	175	150	115	NTCV	173
D6611	retainer onlay - cast high noble metal, three or more surfaces*	225	200	175	175	150	115	NTCV	186
D6612	retainer onlay - cast predominantly base metal, two surfaces	185	200	175	175	150	150	NTCV	121

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	200	200	175	175	150	150	NTCV	133
D6614	retainer onlay - cast noble metal, two surfaces*	185	200	175	175	150	115	NTCV	129
D6615	retainer onlay - cast noble metal, three or more surfaces*	195	200	175	175	150	115	NTCV	138
D6624	retainer inlay - titanium*	175	305	250	250	175	125	NTCV	309
D6634	retainer onlay - titanium*	175	305	250	250	175	125	NTCV	309
D6710	retainer crown - indirect resin based composite	160	180	150	150	125	90	NTCV	NTCV
D6720	retainer crown - resin with high noble metal*	320	250	250	250	175	125	405	283
D6721	retainer crown - resin with predominantly base metal	240	250	250	250	175	125	375	283
D6722	retainer crown - resin with noble metal*	272	250	250	250	175	125	405	283
D6740	retainer crown - porcelain/ ceramic	352	350	300	300	225	215	475	357
D6750	retainer crown - porcelain fused to high noble metal*	352	305	250	250	175	125	405	322
D6751	retainer crown - porcelain fused to predominantly base metal	256	305	250	250	175	125	375	322
D6752	retainer crown - porcelain fused to noble metal*	320	305	250	250	175	125	405	322
D6780	retainer crown - ¾ cast high noble metal*	304	305	250	250	175	125	405	309
D6781	retainer crown - ¾ cast predominantly base metal	288	305	250	250	175	125	405	261
D6782	retainer crown - ¾ cast noble metal*	290	305	250	250	175	125	405	267
D6783	retainer crown - ¾ porcelain/ ceramic	352	305	250	300	175	175	NTCV	272
D6790	retainer crown - full cast high noble metal*	304	305	250	250	175	125	405	309
D6791	retainer crown - full cast predominantly base metal	240	305	250	250	175	125	NTCV	309
D6792	retainer crown - full cast noble metal*	272	305	250	250	175	125	405	309
D6794	retainer crown - titanium*	304	305	250	250	175	125	405	309
D6930	re-cement or re-bond fixed partial denture	32	10	0	0	0	0	35	41
D6940	stress breaker	80	150	125	125	50	110	80	150

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D6980	fixed partial denture repair necessitated by restorative material failure	80	80	75	75	70	50	80	NTCV
X. ORAL AND MAXILLOFACIAL SURGERY: Nonsurgical and surgical extractions (including sutures, if necessary) and related procedures; includes pre-op and post-op evaluations and treatment under local anesthetic									
D7111	extraction, coronal remnants - primary tooth	21	10	10	8	0	0	30	96
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	32	15	10	8	0	0	40	35
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	64	50	30	30	25	15	70	79
D7220	removal of impacted tooth - soft tissue	112	65	65	55	50	25	110	101
D7230	removal of impacted tooth - partially bony	128	95	85	85	75	50	190	105
D7240	removal of impacted tooth - completely bony	160	135	125	125	115	75	210	138
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	176	155	150	150	135	90	230	131
D7250	removal of residual tooth roots (cutting procedure)	64	40	40	40	40	0	75	90
D7261	primary closure of a sinus perforation	105	105	0	0	0	0	NTCV	NTCV
D7270	tooth re-implantation and/ or stabilization of accidentally evulsed or displaced tooth	102	80	50	50	50	50	NTCV	124
D7280	exposure of an unerupted tooth	160	120	85	85	85	85	NTCV	64
D7282	mobilization of erupted or malpositioned tooth to aid eruption	55	120	90	90	90	85	NTCV	43
D7285	incisional biopsy of oral tissue - hard (bone, tooth)	80	150	150	150	0	0	NTCV	169
D7286	incisional biopsy of oral tissue - soft	80	60	60	60	0	0	125	150
D7288	brush biopsy - transepithelial sample collection	40	0	0	0	0	0	NTCV	
D7290	surgical repositioning of teeth	115	0	0	0	0	0	NTCV	NTCV
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant	115	0	0	0	0	0	NTCV	NTCV

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D7297	corticotomy - four or more teeth or tooth spaces, per quadrant	115	0	0	0	0	0	NTCV	NTCV
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	67	60	40	40	25	0	150	72
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	44	45	15	15	10	0	150	44
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	85	80	60	60	40	0	200	72
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	56	60	25	25	20	0	200	35
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	175	175	175	175	165	125	NTCV	NTCV
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	275	200	200	200	175	150	NTCV	NTCV
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	185	185	185	185	165	135	NTCV	NTCV
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	295	295	295	295	275	225	NTCV	NTCV
D7471	removal of lateral exostosis (maxilla or mandible)	165	100	85	85	75	75	NTCV	150
D7472	removal of torus palatinus	275	100	65	65	50	25	NTCV	152
D7473	removal of torus mandibularis	165	100	65	65	50	25	NTCV	134
D7485	reduction of osseous tuberosity	225	100	65	65	50	25	NTCV	171
D7510	incision and drainage of abscess - intraoral soft tissue	64	40	35	35	25	15	45	50
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	64	60	35	35	25	15	NTCV	50
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	80	80	80	80	80	80	NTCV	NTCV

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D7881	occlusal orthotic device adjustment	160	15	10	10	10	0	22	20
D7910	suture of recent small wounds up to 5 cm	20	25	25	25	25	15	NTCV	35
D7960	frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	64	90	45	45	25	0	160	109
D7963	frenuloplasty	64	90	45	45	25	0	NTCV	85
D7970	excision of hyperplastic tissue - per arch	80	55	55	55	35	25	NTCV	456
D7971	excision of pericoronal gingiva	72	40	40	40	30	20	NTCV	224
D7972	surgical reduction of fibrous tuberosity	175	100	100	100	100	40	NTCV	110
XI. ORTHODONTICS: Orthodontic treatment; related procedures to improve a patient's craniofacial dysfunction and/or dentofacial deformity									
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (24 Month Case)	N/A	2,900	2,900	2,900	2,900	2,900	3,100	3,304
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (24 Month Case)	N/A	2,900	2,900	2,900	2,900	2,900	3,100	3,304
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (24 Month Case)	N/A	3,050	3,050	3,050	3,050	3,050	3,100	3,658
D8660	Pre-Orthodontic Treatment Visit (Orthodontic Consultation)	N/A	NTCV	NTCV	NTCV	NTCV	NTCV	0	NTCV
D8670	Periodic Orthodontic Treatment (In Conjunction With Comprehensive Orthodontic Treatment)	N/A	0	0	0	0	0	0	0
D8680	Orthodontic Retention - Per Arch (Removal of Appliances, Construction and Placement of Retainers (s)	N/A	150	150	150	150	150	250	412
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	N/A	150	150	150	150	150	250	412
D8999	Start Up Fee	N/A	250	250	250	250	250	150	150
D8999a	Post Treatment Records	N/A	NTCV	NTCV	NTCV	NTCV	NTCV	NTCV	150
XII. ADJUNCTIVE GENERAL SERVICES									
D9110	fixed partial denture sectioning	26	10	10	10	10	5	35	33

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D9120	local anesthesia not in conjunction with operative or surgical procedures	39	0	0	0	0	0	NTCV	NTCV
D9210	regional block anesthesia	10	0	0	0	0	0	NTCV	NTCV
D9211	trigeminal division block anesthesia	15	0	0	0	0	0	NTCV	0
D9212	local anesthesia in conjunction with operative or surgical procedures	20	0	0	0	0	0	NTCV	0
D9215	inhalation of nitrous oxide/ anxiolysis, analgesia	8	0	0	0	0	0	NTCV	0
D9219	evaluation for deep sedation or general anesthesia	0[1]	25	0	0	0	NTCV	70	34
D9222	deep sedation/general anesthesia - first 15 minutes	125	75	75	75	75	75	70	55
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	125	75	75	75	75	75	NTCV	55
D9230	non-intravenous conscious sedation	35	35	35	35	35	35	NTCV	NTCV
D9239	intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	70	70	70	70	70	70	NTCV	70
D9243	intravenous moderate (conscious) sedation/anesthesia - each subsequent 15 minute increment	70	70	70	70	70	70	NTCV	70
D9248	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	50	50	50	50	40	35	NTCV	NTCV
D9310	office visit - after regularly scheduled hours	48	25	0	0	0	0	10	34
D9311	consultation with a medical health care professional	19	5	5	5	5	5	10	NTCV
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	19	5	5	5	5	5	70	NTCV
D9440	case presentation, detailed and extensive treatment planning	48	35	35	35	35	35	40	50
D9450	treatment of complications (post-surgical) - unusual circumstances, by report	0[1]	0	0	0	0	0	0	0

CDT CODE	CDT DESCRIPTION	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500
D9930	occlusal guard, by report	19	0	0	0	0	0	NTCV	0
D9932	cleaning and inspection of removable complete denture, maxillary	0	55	55	55	55	NTCV	NTCV	NTCV
D9933	cleaning and inspection of removable complete denture, mandibular	0	55	55	55	55	NTCV	NTCV	NTCV
D9934	cleaning and inspection of removable partial denture, maxillary	0	55	55	55	55	NTCV	22	NTCV
D9935	cleaning and inspection of removable partial denture, mandibular	0	55	55	55	55	NTCV	NTCV	NTCV
D9943	occlusal guard adjustment	16	15	10	10	10	0	NTCV	20
D9944	occlusal guard - hard appliance, full arch	75	120	100	85	85	85	NTCV	185
D9945	occlusal guard - soft appliance, full arch	75	120	100	85	85	85	NTCV	185
D9946	occlusal guard - hard appliance, partial arch	75	120	100	85	85	85	NTCV	185
D9951	occlusal adjustment - complete	40	35	35	30	30	0	40	37
D9952	external bleaching - per arch - performed in office	96	100	90	90	80	0	175	148
D9972	external bleaching for home application, per arch; includes materials and fabrication of custom trays	0[1]	125	125	125	125	125	NTCV	NTCV
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	0[1]	125	125	125	125	125	NTCV	NTCV
D9995	teledentistry - synchronous; real-time encounter	0[1]	0	0	0	0	0	0	0
D9996	teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	0[1]	0	0	0	0	0	0	0
D9999	unspecified adjunctive procedure, by report	0[1]	20	20	20	10	10	10	20

*** An additional charge for the cost of precious metal will be the responsibility of the member for any procedure using noble, high noble or titanium metal not to exceed $150.**

Appendix C: Limitations and exclusions

C.1 Direct Compensation Plan general limitations and exclusions

Limitations of benefits

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. **Dental prophylaxis** – limited to 1 time per 6 months
2. **Intraoral** – Complete series (including bitewings) – limited to 1 time in any 2 year period
3. **Intraoral bitewing radiographs** – Limited to 1 series of 4 films in any 6 month period
4. **Fluoride treaments** – Limited to 1 time per calendar year
5. **Scaling and root planing** – Limited to 4 quadrants per calendar year
6. **Periodontal maintenance procedures** – Limited to once every 6 months, following active therapy, exclusive of gross debridement
7. **Removable prothetics/fixed prosthetics/crowns, inlays and onlays (major restorative services)** – 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 5 years from initial or supplemental placement
8. **Removable prothetics/fixed prosthetics/crowns, inlays and onlays (major restorative services)** – Replacement of complete dentures, and fixed and removable partial dentures or crowns 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.
9. **Crowns – Retainers/Abutments** – Limited to 1 time per tooth per 5 years.
10. **Crowns – Restorations** – Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
11. **Temporary crowns – Restorations** – Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. **Inlays/onlays – Retainers/Abutments** – Limited to 1 time per tooth per 5 years.
13. **Inlays/onlays – Restorations** – Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14. **Stainless steel crowns** – Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown – primary tooth, are limited to primary anterior teeth.
15. **Crowns, fixed bridges, and implants** – The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12 month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
16. **Post and cores** – Covered only for teeth that have had root canal therapy.

17. **Adjustments to full dentures, partial dentures, bridges or crowns** – Limited to repairs or adjustments performed more than 6 months after the initial insertion.
18. **Intravenous sedation or general anesthesia** – Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions)
19. **Adjunctive** – Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures – Limited to 1 time per year, to Covered Persons over the age of 30.
20. **Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implants, implant crowns, implant prosthesis** – Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable orthodontic appliances.
21. All specialty referral services must be:
    a. Pre-authorized by NVPD
    b. Coordinated by Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approved by NVPD is responsible for all changes incurred.

    In order for specialty services to be Covered by this plan, the following referral process must be followed:

    - A Covered Person's Participating Dentist must coordinate all Dental Services
    - When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization.
    - If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question if a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service.
    - Covered Person who received authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentist in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
    - Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

Exclusion of Benefits

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. Dental Services that are not Necessary.
2. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
3. Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
4. Any Dental Procedure not directly associated with dental disease.
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
6. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
7. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Replacement of a lost, missing, or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
10. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - 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 must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.
11. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
12. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
13. 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
14. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
15. 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.
16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a specialist without referral from a Participating Dentist and our approval.
17. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
18. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. 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.
19. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

20. 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.

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

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

23. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

C.2 Individual Direct Compensation Plan Limitations and Exclusions

Limitations of benefits

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. Full Mouth X-rays – These are limited to only once in a 24 month period

2. Bitewing X-rays – These are limited to one series every 6 months.

3. Fillings (amalgams and composites) are benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.

4. The placement of a crown, inlay or onlay is a benefit only when covered in the Schedule of Benefits and when there is insufficient tooth structure to support a filling. Veneers, posterior to the second bicuspid, are considered purely cosmetic dentistry. Allowances will be made for a cast full crown. If performed the Covered Person must pay the additional fee.

5. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

- **a.** The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
- **b.** Either of the following:
  - The existing non-functional restoration /bridge/denture was placed 5 or more years prior to its replacement, or
  - If an existing partial denture is less than 5 years old but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

6. Coverage for the placement of a fixed partial denture (bridge) requires that:

(a) No cantilevered posterior pontic (prosthetic tooth) be included; and

(b) The sole tooth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture; or

-The new bridge would replace an existing, non-functional bridge; or

-Each abutment tooth be crowned meets Limitation 4.

7. Fluoride Treatments - These are limited to only per year, to the age of 19.

8. Periodontal Curettage & Root Planing - Both procedures are allowable only when the need can be demonstrated radiographically and/or by written explanation and only 2 quadrants is allowable at an appointment with a maximum of 4 quadrants during any 12 consecutive months.

9. Benefits provided by a pediatric dentist are limited to children through age 6 following an attempt by the Covered Person's Participating Dentist to treat the child, and upon prior authorization, less applicable copayments. The plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Participating Dentist.
10. Relines - Limited to only twice per year.
11. Prophylaxis - These "teeth cleaning" are allowable only once every 6 months.
12. Replacement of Missing Teeth - With complete or partial dentures or fixed bridges, using standard procedures is covered. However, treatment involving the following procedures is considered optional and, if performed, Covered Person's should be advised of his/her responsibility for the additional fee:
    a. precious metal for removable appliances
    b. precision attachments
    c. overlays and implants
    d. personalization and characterization
13. Correction of Occlusion - This is not a separate benefit, but it is considered a part of the completed restoration or fixed prosthesis.
14. Dowell Posts or PINS - These items are not covered, except where insufficient coronal structure remain to retain the crown restoration.
15. Subgingival Scaling - This procedure is allowable only when the need can be demonstrated.

Exclusion of Benefits

1. Dental Services that are not Necessary.
2. Costs for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Contract holder's home. When deemed Necessary by the Participating Dentist, the Contract holder's Physician and authorized by us, Covered Dental Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the Schedule of Covered Dental Services Hospital and medical charges of any kind, except for dental services otherwise covered.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.
7. Procedures that are considered 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 Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments, and prostheses.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. 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.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. 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.
13. 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 Dentist 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.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. 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.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming Covered under the Contract.
16. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
17. 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.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a Dentist who is a member of a Covered Person's family, including spouse, brother, sister, parent, or child.
22. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
23. Foreign Services are not Covered unless required as an Emergency.
24. 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.
25. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
26. Replacement of a lost, missing, or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
27. Any Covered Person's request for:

a. specialist services or treatment which can be routinely provided by a Participating Dentist; or

b. treatment by a specialist without referral from a Participating Dentist and our approval.

28. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a Covered course of comprehensive orthodontic treatment.

29. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

30. Consultations for non-Covered services.

31. A service started but not completed prior to the Covered Person's eligibility to receive benefits under the plan. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.

32. A service started (as defined above) by a Non-Participating Dentist. This will not apply to Covered Emergency Dental Services.

33. Procedures performed to facilitate non-Covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

34. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended, or performed for a tooth or teeth with a guarded, questionable, or poor prognosis.

35. Relative analgesia (N2O2- nitrous oxide).

36. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

37. Duplication of x-rays.

38. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

39. Porcelain crowns, porcelain fused to metal or resin with metal type crown and fixed partial denture (bridges) for children under 16 years of age.

C.3 Direct Compensation Plans Orthodontic Limitations and Exclusions

If you require the services of an orthodontics, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered.

If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. The following are not covered orthodontic benefits:

a. Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person

b. Treatment in progress prior to the effective date of this coverage

c. Extractions required for orthodontic purposes

d. Surgical orthodontics or jaw repositioning

e. Myofunctional therapy

f. Cleft palate

g. Micrognathia

h. Macroglossia

i. Hormonal imbalances

j. Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident

k. Palatal expansion appliances

l. Services performed by outside laboratories

2. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.
3. 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.
4. 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.
5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24-month period, the Copayments listed will apply. If necessary and active treatment 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.

Nevada Pacific Dental™

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.