Provider Reference Manual

Select Health Dental Plans

March 2024

Select Health

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1.0 The Participating Provider Partnership

Select Health is committed to all segments of the market and strives to provide excellent healthcare services to the communities we serve. To accomplish this, we need quality providers to participate in our network, and participation is voluntary.

1.1 BENEFITS OF PARTICIPATION

Providers contracted with Select Health benefit from:

- Listings in provider directories
- Patient referrals from Select Health Member Advocates
- Direct payment for submitted claims
- Provider Relations representatives available to assist you and your office staff
- Financial incentives for Select Health members to receive care from in-network providers

1.2 RESPONSIBILITIES OF PARTICIPATION

Select Health members should be directed to facilities and other healthcare providers who are participating on Select Health panels, whenever possible.

Select Health participating providers agree to not bill the member for covered services provided to the member. Members should not be asked to submit their own claims.

Provide a copy of dental records and attachments when requested for claims processing and payment.

Once you have been credentialed and approved to participate with Select Health Dental, a copy of your fully executed Dental Participating Provider Service Agreement will be mailed to your office.

1.3 OUR CODE OF ETHICS

Every day, patients, members, and their families come to us in times of need, trusting that we will give them our very best medical care and service. We are committed to honoring their trust by providing excellent clinical care and superior service with the highest standards of integrity. This commitment applies to every aspect of our work, and is fundamental to our mission, vision, and values. At Intermountain Health, we expect every employee, clinician, trustee, vendor, contractor, and volunteer who is part of our organization to understand and follow the rules and requirements that apply to their work.

General Ethics Standards

1. We are committed to Intermountain's values of Trust, Excellence, Accountability, and Mutual Respect.
2. We perform our jobs and assignments with the highest standards of honesty and integrity. We treat each other, our patients and members, business partners, vendors, and competitors fairly.
3. We know, abide by, and understand the specific laws, policies, and procedures that apply to our jobs and assignments, and to us as individuals.

4. We speak up with concerns about compliance and ethics issues. Specifically, we report observed and suspected violations of laws or policies, and we agree to report any requests to do things we believe may be violations. Furthermore, we cooperate with any investigation of potential violations.
5. We recognize that our daily work gives us each the opportunity to see problems in our local areas before they become apparent to others or to management. We are empowered and responsible to raise questions about potentially non-compliant or unethical practices.
6. If we have questions about a situation, we ask for help. We may talk to our supervisor or director, the facility/entity compliance coordinator, a company attorney, the Corporate Compliance Officer, or call the 24-hour Compliance Hotline at **800-442-4845**.

For more information, download our **Code of Ethics booklet**.

1.4 CONFIDENTIALITY STANDARDS

Select Health members entrust the organization with their health information, and as a health plan, Select Health is committed to properly protecting member information. In addition, certain regulations, such as the privacy and security rules in the Health Insurance Portability and Accountability Act (HIPAA), require specific measures to be taken to protect the privacy of members' health information.

Additional Parameters for Maintaining the Confidentiality of Information. To safeguard members' health information, Select Health has developed agreements to define the responsibilities of those accessing health information. The requirements outlined in these agreements extend to all staff or employees who work with a dental provider who may have access to confidential information. Participating dental providers must ensure that individuals accessing health information understand that they:

- Are responsible to safeguard health information in accordance with applicable laws
- Must report activities that may compromise the confidentiality of health information
- May be sanctioned for the misuse of health information
- Must safeguard their electronic record systems or other information needed to access Select Health's confidential information

1.5 NOTICE OF PRIVACY PRACTICES

The HIPAA privacy rule requires Select Health to notify members of their legal rights and Select Health's legal duties, with respect to health information. This notice generally describes how members' health information may be used and disclosed, including the manner in which Select Health may share health information as appropriate with our participating providers.

Our Notice of Privacy Practices is available at **selecthealth.org/privacy notice**. You can also request a hard copy by contacting the Intermountain Privacy Office via:

- **Phone: 800-442-4885**
- **Email**: **privacy@imail.org**
- **Postal Mail**:
  Select Health
  Attention: Privacy Office
  P.O. Box 30192
  Salt Lake City, UT 84120-8212

2.0 Dental Credentialing Process

Each provider making application for the Select Health dental network must complete the credentialing process. The purpose of the credentialing process is to ensure that all providers meet minimum requirements and to establish uniform guidelines for provider credentialing. A provider must meet the following requirements to participate, unless granted an exception by the Select Health Dental Advisor:

- Hold a current, unrestricted professional license(s) in the State(s) where the provider will practice.
- If applicable, hold a current State Controlled Substance license(s), schedules II-V, in the State(s) where the provider will practice and a current Federal DEA certificate, registered in the State(s) where the provider will practice, schedules II-V.
- Have and maintain professional liability insurance through an admitted carrier in the State of Utah as applicable to the provider's specialty and location of practice, in an amount of not less than $1 million/$3 million with an effective date on or before the approval date.
- The following credentialing elements require primary verification directly from the applicable source:
  - Current, unrestricted professional and controlled substance licenses in the State(s) where the provider will practice. Written verification from the appropriate State or verification via the Internet is acceptable.
  - If applicable, valid DEA certificate and unrestricted State Controlled substance License (a legible photocopy of an unexpired DEA certificate is acceptable).
  - Query of the National Practitioner Data Bank (NPDB).
  - Written verification from the malpractice carrier(s) of current and, as applicable, previous malpractice insurance with appropriate coverage amounts and effective dates, as well as professional liability claims history.
  - Other: By virtue of the consent form signed by the provider, other entities or agencies thought to have knowledge of the provider's clinical competence, professional conduct, and/or ethics may be contracted as deemed appropriate.

3.0 Select Health Fraud and Abuse Program

3.1 FRAUD AND ABUSE OVERSIGHT PROTECTION PROGRAM

The Select Health Special Investigations Unit (SIU) investigates fraud and abuse for Select Health, working very closely with the State of Utah Insurance Fraud Division to share issues of concern, refer insurance fraud and abuse cases for investigation, and comply with Utah mandatory reporting requirements for fraud. The SIU also works with the State of Utah Division of Professional Licensing (DOPL) to review issues that pertain to providers and members, including potential fraud and abuse case investigation.

Audits and reviews of provider claims include, but are not limited to:

- Appropriate coding procedures
- Appropriate supporting documentation for claims
- Any ordered tests or other procedures
- Retention of medical records and supporting documentation
- Excessive charges
- Documented benefits and exclusions
- Preauthorization requirements
- Timeliness of claims submissions
- Inappropriately reporting a billing provider as the treating provider when another provider performed the services
- Panel vs. non-panel status and reimbursements
- Member eligibility

3.1 MANDATORY REPORTING OF FRAUD OR ABUSE

Select Health is very supportive of the SIU and its efforts to detect fraud and abuse in its many forms. Select Health policy requires all employees report any situations where the employee has a good-faith belief that a fraudulent insurance act is being, will be, or has been committed. Employees report to their immediate supervisor, the Select Health Compliance Department, or the Select Health SIU. This good-faith belief may also include situations that appear to be acts of insurance abuse, also considered by the SIU.

All referrals to the SIU are reviewed and investigated where appropriate, and subsequently, all pertinent referrals are provided to the SIU Steering Committee, which:

- Is composed of representatives from Executive Management and various departments throughout Select Health who ensure that Select Health complies with the State Mandatory Reporting Act and Select Health's own policies and procedures
- Oversees Select Health fraud and abuse efforts, ensuring that they are appropriate and within established guidelines and applicable laws
- Determines if information meets the guidelines of the State Mandatory Reporting laws for reporting to the State Insurance Fraud Division

4.0 Claims Submission

4.1 REQUESTS FOR INFORMATION

Select Health will request information on all codes that require review to determine benefits. The following information may be requested if not submitted with the claim:

- **Narrative**. The provider's written explanation of necessity for treatment including any unusual conditions that would aid in determining coverage.
- **Pre-Operative X-Rays.** Select Health will no longer return film or digital print X-rays submitted by dental offices. To maintain accurate records of your patients, always send a duplicate and retain the original so that the members' clinical information remains complete. When duplicate X-rays are submitted, they must be properly labeled, indicating the right or left side of the mouth, and show the member's name and ID number indicated on the member's ID card. The date the film was taken must also be indicated. The film must be readable and of diagnostic quality. Photographic images will be accepted but will not be considered a replacement to X-rays.
- **Periodontal Charting.** Periodontal charting refers to reporting cases with the following data:
  - Identification of the quadrants and sites involved.
  - A minimum of three pocket measurements per involved tooth.
  - Indication of recession, furcation involvement, mobility, and mucogingival defects.
  - Identification of missing teeth
  - An exam date where the required tissue measurements were taken no more than 6 months prior to the procedure being performed. **NOTE:** Perio charts where the pocket depths were measured on the same day as a procedure coded as, "**D4355 - full mouth debridement**," will not be allowed for review of periodontal codes.
  - Additional information can be included if the provider feels services are necessary but guidelines listed in the coding policy are not met.

4.2 SUBMITTING DOCUMENTATION FOR SELECT HEALTH DENTAL CLAIMS

Predetermination. Predetermination is available, but not required, for all services with a total billed charge exceeding $300.00. The predetermination will show a cost estimate of coverage for services, but should not be considered a pre-service benefit determination, or a guarantee of coverage. Review for all services that are considered "possibly covered" will take place after services are performed at the time claims are submitted. To submit a predetermination, call Member Services or submit a predetermination request via box 1 on the ADA dental claim form.

Corrected Claim Submission. Claims submitted for correction must be submitted in their entirety (instead of submitting only the corrected line item).

Claims Filing Deadline. Claims must be submitted on the most current version of the ADA Dental Claim Form within 12 months of the date of service. Claims received by Select Health more than 12 months after the date of service will be denied unless the provider can show that notice was given or proof of loss was filed as soon as reasonably possible.

4.3 COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) determines which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. COB seeks to prevent duplication of benefits when a member is covered by more than one insurance carrier, including other health/dental insurance, retiree benefits, auto insurance, workers' compensation, etc.

COB payments, when Select Health is the secondary payer, will be made only if the information supporting the payment is submitted to Select Health within 12 months after the claim was processed by the primary plan, unless the provider shows that the information was supplied or proof of loss was filed as soon as reasonably possible.

According to the Utah Insurance Department's COB rule, if a claim is filed to the wrong primary insurer, the claim can be refiled to the appropriate primary plan within 24 months of the date of service without penalty.

4.4 ORTHODONTIC CLAIMS PAYMENTS

Select Health will provide a benefit for orthodontic treatment to members when **ALL** of the following conditions are met:

- Member's contract includes orthodontia coverage.
- Member is eligible (e.g., age limitations—most plans provide coverage under age 20).
- Treatment is to reduce or eliminate an existing malocclusion.

Billing Guidelines. The benefit of orthodontic treatment is provided in monthly installments and is determined by the anticipated length of treatment. When submitting the initial claims for orthodontia, include the following information:

- Banding date
- Length of treatment (in months)
- Total charge for the treatment

Dentists will submit one claim for the entire orthodontic course of treatment.

Orthodontic Lifetime Maximum. Orthodontic benefits are optional and based on the member's contract. The orthodontic lifetime maximum amount may vary by group.

4.5 CLAIMS SUBMISSION: ELECTRONIC DATA INTERCHANGE (EDI)

Instead of submitting claims by mail, consider the advantages of submitting them electronically or through your Practice Management Software (PMS). Claims can be sent electronically through an Electronic Data Interchange (EDI) claims transaction. Claims submitted electronically are typically more accurate and allow us to reimburse you more quickly. EDI is more than just claims, however. Through EDI transactions, you can also receive remittance advice, eligibility, and claim status information.

Questions?

Contact our EDI team at **801-442-5442** or by email at **edi@selecthealth.org.**

The Select Health EDI team can provide you with assistance and support for the following transactions:

- **Healthcare Claim (837):** The transaction for submitting claims electronically that allows for faster claims adjudication and payment. Accuracy increases because the claim information received is loaded directly into our system. Select Health can also receive coordination of benefits (COB) claims and corrected bills electronically. Access more information in the **EDI area** of our website. Responses to the 837 include:
  - **Functional Acknowledgment (997/999):** This provides information regarding the syntactical and implementation guide quality of an electronic claims submission (837). It contains information on submitted claims, such as accepted/rejected statuses and reasons for rejections, if applicable. Claims may reject at this level if they contain invalid characters or are missing information. A rejected claim requires correction of the inaccurate data and resubmission to be considered. Select Health does not reject entire batches of claims unless every claim in that batch has an error. If you are unsure which claim an error applies to, please contact the EDI team.
  - **Healthcare Claim Acknowledgment (277FE):** For all claims accepted in the 997, this transaction provides information regarding the accept/reject claim statuses based on our internal requirements. As with the Functional Acknowledgment, if a claim rejects on the Healthcare Claim Acknowledgment, it requires inaccurate data correction and resubmission to be considered.
- **Healthcare Claim Payment/Advice (835):** Like the paper remittance advice, the electronic remittance advice details payment information on claims. However, the ERA allows payments to auto post and is faster and more efficient than waiting for a paper remittance advice. Access more detailed information on Select Health's 835 and payment on our **website.**
- **Eligibility Benefit Inquiry and Response (270/271):** This transaction allows for the verification of a member's eligibility and benefit information without the inconvenience of a call. The 271 response will contain information such as eligibility, eligibility dates, copay, coinsurance, deductible, out of pocket, visit limits, and benefit limits. View and download the Centers for Medicare and Medicaid Services (CMS) **270/271 Health Care Eligibility Benefit Inquiry and Response Companion Guide for Mandatory Reporting Non-GHP Entities**.
- **Claim Status Request and Response (276/277):** This transaction allows for verifying specific status of a submitted claim and includes:
  - Current claim status
  - Whether the claim has been received, pended, or finalized
  - When the claim entered that status
  - (If a finalized claim status response) Any paid amounts and payment information (e.g., check number)

View and download the CMS **Standard Companion Guide Health Care Claim Status Request and Response (276/277).**

4.6 DENTAL PROVIDER REMITTANCE ADVICE

Utah Health Information Network (UHIN) has requested all payers report Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and associated Group Codes (GC) for each claim billed. The CARCs and RARCs allow providers to more easily bill COB for secondary claims. Additional fields have been added to the Remittance Advice to make it easier to read and understand:

- **CARCs, RARCs, & Group Codes.** These code sets are a national standard, and are maintained by the Health Care Code Maintenance Committee. For more information, visit www.wpc-edi.com. The CARC, RARC, and GC code sets were created for use with the Electronic Claim Remittance Advice (835 transaction) to explain why an "Adjustment" was made to a claim line.

  An "Adjustment" is any amount that is not considered for payment (e.g., contractual obligations, deductible, coinsurance, copay, other carrier payments, denied services, etc.).

- **Improved Summary and Recovery Section.** This section includes simplified Line, Claim, and Payment Summary Balancing as well as "Forward Balance" information for claims that were not fully recovered on the remittance advice.

  All Corrections and Reversals made on the current payment will appear in the Recovery Section with Recovery and/or Forward Balance detail.

The Remittance Advice (RA)/Explanation of Payment (EOP) will reflect a line-by-line reversal of the claim and also a repayment or denial, on a new claim if necessary. This claim reversal information will appear as a negative in the RA claim detail section. The reason for the adjustment will be explained with the remark codes on the reversed and/or the reprocessed claim.

4.7 AUTO RECOVERY

Claims will only be auto recovered if there is enough money being paid out to your office to offset (in full or partially) the amount being recovered. If no payment is being made, a notification of the recovery will be sent and the amount will appear as a forward balance. Forward balances may be paid with a credit card or electronic funds transfer by contacting the Recovery Team by phone at **801-442-5687** or **800-538-5038**.

The dollar amount associated with the actual recovery is located at the end of the RA in the "Recovery and Forward Balance Detail for This Payment" section. The dollars listed as a "Recovery Amount" should be subtracted from the account as the actual amount recovered on this payment. Any amount listed as a "Forward Balance" was not recovered from this payment and will be recovered from a future payment.

On electronic postings (835), when a claim is paid incorrectly, the original claim will be reversed, and the corrected data will be sent all on the same transaction. The payment and the reversal will post directly to the billing office's system.

Future Refund Requests

All claims adjusted by Select Health will be set up to auto recover from the next payment. However, there may be times when Select Health may request a refund check instead of being able to auto recover a claim. Some of these instances are:

- The address or tax identification number for the office have changed and payments are no longer being sent to allow a recovery to occur.
- There is not enough payment activity in a timely period to allow a recovery to occur.

Payment Options and Contact Information

If a refund is requested from your office, you may mail a check to:

Select Health Recovery Team
P.O. Box 27368
Salt Lake City, UT 84127-0368

You may also contact the Recovery Team by phone and make either a credit card or check payment to ensure same-day posting and avoid a check and recovery crossing in the mail.

Questions? Contact the Select Health Recovery Team at:

- **801-442-5687** in Salt Lake City
- **800-538-5038, ext 5687,** elsewhere in the Continental US

5.0 Dental Coding/Reimbursement Policies

Select Health Dental Coding and Reimbursement policies include the policy and criteria each is based on, applicable codes, references and sources, and relevant disclaimers.

Access and download these policies by clicking on the linked titles below:

- Anterior Crowns and Labial Veneers
- Anterior Multiple Surface Fillings
- Collection and Application of Autologous Blood Concentrate Product
- Complicated Suturing
- Core Buildup
- Crown, Inlay, Onlay, and Veneer Repairs
- Crown Lengthening
- Crown Revisions
- Crown/Veneer Placement Date
- Dental Anesthesia Coverage
- Dental Record Documentation
- Fixed Partial Dental Procedures: Pontics and Crowns
- Guided Tissue Regeneration
- Inraoral-Occlusal Radiographic Image
- Periodontal Codes
- Pulp Caps
- Scaling and Debridement of a Single Implant
- Treatment for Post-surgical Complications
- Treatment of Root Canal Obstruction; Non-surgical Access
- Unspecified Procedures

6.0 Dental Provider Appeals

The Select Health Provider Appeals process addresses disputes that arise between a health care provider and Select Health.

This process does not apply to appeals dealing with credentialing decisions, contract terminations, member appeals initiated by a provider, or fee schedule issues. If you have questions about any of these issues, contact your Select Health Provider Relations representative.

6.1 FILING A PROVIDER APPEAL

Follow these steps to file an appeal:

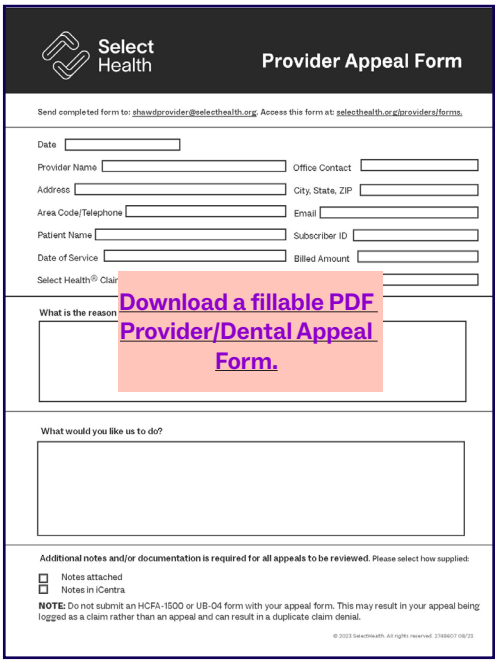
Download the **Provider Appeal form**.

Complete the online fillable form (see below), and save it to your computer/device.

Mail or fax the form to Select Health within **180 days** from the date the claim was processed to:

Select Health Provider Appeals
P.O. Box 30192
Salt Lake City, UT 84130-0192
Fax: **801-442-6708**

NOTE: You will receive a written acknowledgment via mail upon receipt of the appeal.


Select Health

Provider Appeal Form

Send completed form to: shawdprovider@selecthealth.org. Access this form at: selecthealth.org/providers/forms.

Date

Provider Name | Office Contact

Address | City, State, ZIP

Area Code/Telephone | Email

Patient Name | Subscriber ID

Date of Service | Billed Amount

Select Health® Clair

What is the reason

Download a fillable PDF Provider/Dental Appeal Form.

What would you like us to do?

Additional notes and/or documentation is required for all appeals to be reviewed. Please select how supplied:

☐ Notes attached
☐ Notes in iCentra

NOTE: Do not submit an HCFA-1500 or UB-04 form with your appeal form. This may result in your appeal being logged as a claim rather than an appeal and can result in a duplicate claim denial.

6.2 UNDERSTANDING THE REVIEW PROCESS

Review requirements include these steps:

1. Complete and submit all appeals within 180 days of the date the claim was processed.
2. Only submit a provider appeal once to Select Health; it will be routed to the appropriate individual/department for a determination.
3. You will receive a written response within 60 days of receipt of the appeal, indicating the review result.
4. If you do not agree with the result, contact your Provider Relations representative.

7.0 Member Appeals and Grievances

Select Health is committed to making sure that all member concerns or problems are investigated and resolved as soon as possible.

Most member issues can be resolved informally through Member Services by calling **800-538-5038**. If a member is not satisfied after attempting to resolve the problem with Member Services, they may choose to:

- Initiate a formal appeal themselves (access **Member Appeal Form**).
- Authorize someone else (such as a provider) to do so on their behalf (see **page 16** for more information about filing an appeal on behalf of a member). **Note:** A member can designate their provider to represent them through the formal appeals process without having to provide a written authorization to do so. A written authorization is required if a member wants to designate anyone other than a provider (for example, a spouse, family member, or an attorney). You can request this form from the Appeals Department or Member Services.

7.1 THE FORMAL APPEAL PROCESS

Formal appeals must be filed within **180 days** from the date of denial notification to be eligible for review through the formal appeal process.

Members can:

- Upon request, receive, free of charge, reasonable access to and copies of relevant documents and other information relating to the appeal.
- Submit written comments, documents, records, and other related information, which will be considered without regard to whether such information was submitted to or considered in the initial benefit determination.

7.2 DECISION MAKING

In the complaint process, no deference will be given to the initial benefit determination, and decisions will be made by appropriately named fiduciaries of Select Health. Appeals involving dental judgment, medical necessity, or an experimental/investigational treatment, drug, or other item require consultation with a dental professional with appropriate training and experience. All decision makers must not have previously been involved in nor report to anyone previously involved in the decision. Any such experts will be identified to a member upon request.

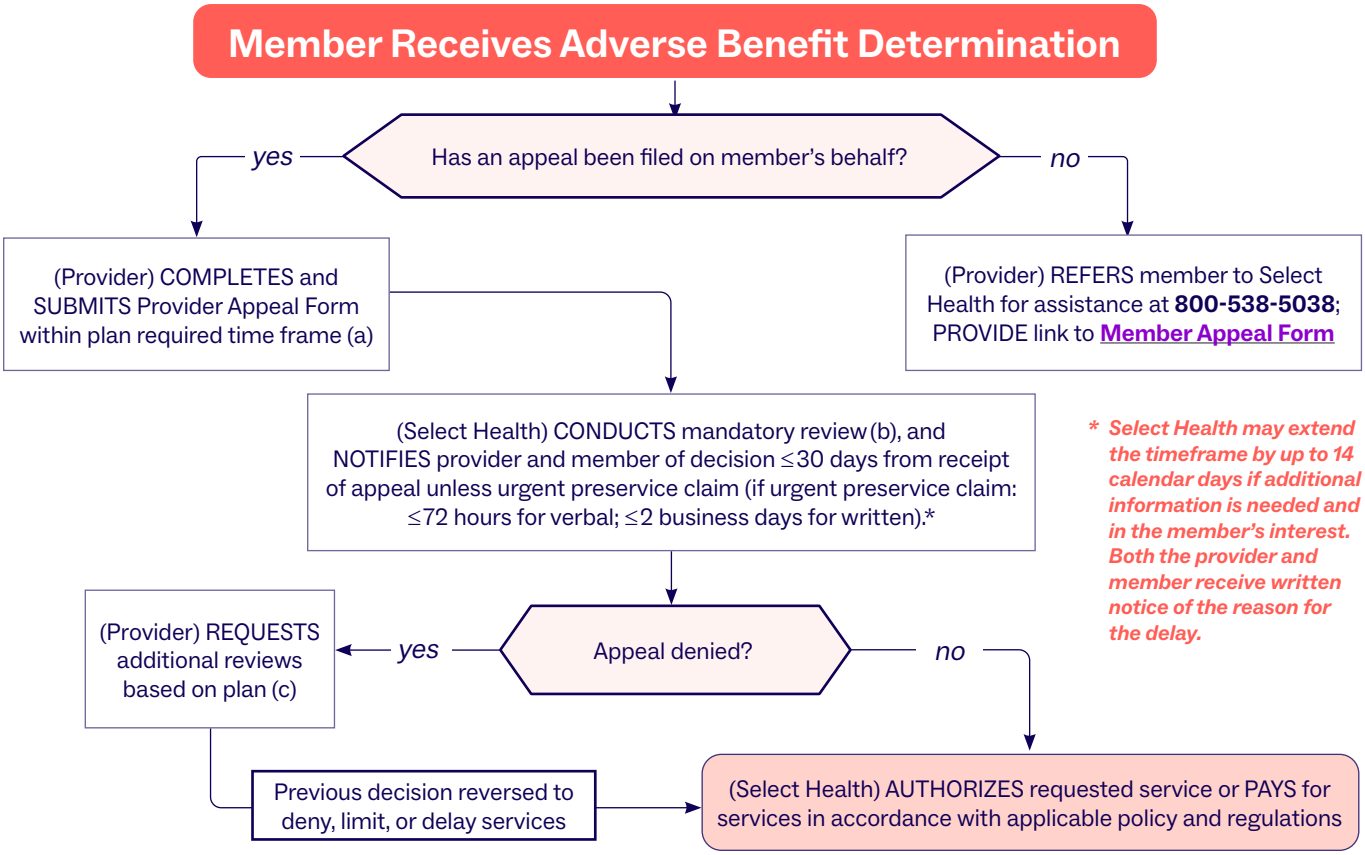
7.3 EXPEDITED REVIEW CRITERIA

Appeals qualify for expedited review if the appeal:

- Involves coverage of a service/treatment that, if delayed, might seriously jeopardize the life or health of the member or the member's ability to regain maximum function
- Is based on EITHER:
  - A prudent layperson's judgment

    OR
  - The opinion of a practitioner with knowledge of the member's medical condition is that denial would subject the member to severe pain that cannot be adequately managed without the subject care/treatment
- Is requested by oral or written notification to Select Health.

Figure 1. Process for Filing Appeal on Behalf of a Member



ALGORITHM NOTES

(a) Submitting appeals on behalf of members	(b) Reviewing Adverse Benefit Determinations
• Filing deadlines by plan type are: **Commercial:** 180 days from date of denial notification **Medicare/Medicaid:** 60 days from Adverse Benefit Determination **CHIP:** 90 days from Adverse Benefit Determination **FEHB:** 6 months from date of denial notification • A provider may appeal an Adverse Benefit Determination of an urgent preservice claim in one of two ways: 1. Appeal verbally by calling **844-208-9012**. 2. Appeal in writing by mailing documentation to the address below. If expedited appeal is denied, appeal will be managed according to standard timeframe. • Send request via mail or email the completed form and all other pertinent information to: Appeals & Grievances Department P.O. Box 30192 Salt Lake City, Utah 84130-0192 Fax: 801-442-0762 Email: appeals@imail.org	• If the Adverse Benefit Determination was based on medical judgment (including determinations that services are experimental and/or investigational or not medically necessary), the individual reviewing the appeal will be a health care professional who has the appropriate clinical expertise in treating the condition or disease. • Upon request, Select Health will identify any medical expert(s) whose advice was obtained in connection with the Adverse Benefit Determination, whether or not the advice was relied on to make the Adverse Benefit Determination.

8.0 Eligibility and Plan Coverage Information

A member's coverage status can change at any time; therefore, we recommend checking member eligibility and benefits before each visit.

This information may be viewed through our secure Provider Benefit Tool. Eligibility and benefits are based on the information available at the time the request is made.

If you prefer, you may receive eligibility and benefit information via phone by calling Member Services at **800-538-5038**.

Note: Verification of eligibility is not a guarantee of payment.

Accessing the Provider Benefit Tool

Participating providers contracted with Select Health can access secure member information via our Provider Benefit Tool by:

- Logging in to an existing account via the Secure Content Login link.

  OR

- Registering as a new user on either a new account or an existing one as follows:
  - **For a new account**, complete and submit BOTH:
    - Information Technology Services Agreement (**downloadable PDF file**)
    - Login Application (**downloadable PDF file**)
  - **For a new user on an existing account**, submit **ONLY** the Login Application

* Access to online claims and eligibility information is available to participating providers only. (Noncontracted providers can call Member Services at **800-538-5038** for benefits, eligibility, and claims information).

9.0 Dental Product Overview

Select Health Dental offers three commercial dental networks: Classic, Prime, and Fundamental and Dental Advantage plans. See **Figure 3** on page 20 for an overview of these plans.

9.1 MEMBER ID CARD

ID Cards identify the dental network members should use for participating benefits. The front of the card provides a summary of the member's coverage including subscriber name and ID number. The deductible, annual maximum, coinsurance by benefit category, and orthodontia coverage, if applicable, appear on the card back. Plan benefits may vary by individual or employer; however, the card is intended to provide you with a general overview of a member's coverage. Download the **Dental ID Card Guide** shown in **Figure 2** below.

Figure 2. Dental ID Card Guide

Dental ID Card Guide

These ID card samples will help you identify Select Health members and their network. A subscriber's ID card covers all enrolled dependents.

Our **Member Services** representatives are available to answer your questions about benefits and eligibility. Call us at **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m to verify benefits.

Commercial Networks

The back of the ID card
The back of the ID card includes in-network dental benefits and plan information

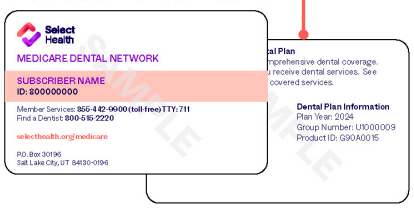
SELECT HEALTH COMMERCIAL DENTAL NETWORKS
- Select Health Classic℠
- Select Health Prime℠
- Select Health Fundamental℠

Classic network providers are in all Utah counties and represent the majority of dental providers in Utah. Prime and Fundamental network providers are only in Davis, Salt Lake, Weber, and Utah counties.

Individual and Small Employer plans include embedded preventive pediatric benefits for cleanings, fluoride applications, oral exams, sealants, and x-rays on our Classic network.

Verify coverage by contacting Member Services.

Medicare Dental Network



As part of Select Health Medicare plans, members have preventive, basic, and major dental benefits "embedded" in their medical coverage.

Check with Member Services to verify coverage for services not listed in the table below.

Preventive Service	Allowable Benefit/Time Frame	Applicable Codes
Cleanings	2 cleanings/calendar year	D1110, D1120
Oral Examinations	2 exams/calendar year	D0120, D0145, D0150
Bite-Wing X-Rays	2 full series bite-wings/calendar year OR 2 vertical bite-wings in lieu of full series bite-wings/calendar year	D0270, D0272, D0273, D0274, D0277
Panorex/Complete Mouth X-rays	1 Panorex/36-month period OR 1 complete mouth x-ray/ 36-month period	D0330 D0210

Select Health

Dental Product Overview, Continued

Figure 3. Dental Plan Features Overview

Overview of Select Health Dental Plan Options				
	Commercial Plans (Classic, Prime, Fundamental Networks)*			Government Plans (Medicare, Medicaid, CHIP)
Features	Individual	Large Employer	Small Employer	Medicare (Dental Advantage®)
	• Traditional plans; network-only providers. • "Buy-up" option for non-participating providers. • Pediatric preventive dental included.	• 51+ employees. • 3 network choices.* • Optional orthodontics. • Voluntary or contributory. • Customized waiting-time options.	• Traditional plans; network-only providers. • Pediatric preventive dental included.	• Geographic-based coverage.** • **Preventive benefits** provided as part of Select Health Medicare coverage.*** • **All Medicare plans** include comprehensive dental benefits.

* **Classic network providers** are in all Utah counties and represent the majority of dental providers in Utah. **Prime and Fundamental network providers** are only in Davis, Salt Lake, Weber, and Utah counties. Contact Provider Development at **800-538-5054** for more information about these networks.

** **Wasatch Plans (Enhanced and Essential):**
Available to members in Box Elder, Cache, Davis, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber counties
Southwest and Central Plans:
Available to members in Garfield, Iron, Juab, Millard, Piute, Sevier, Washington, and Wayne counties.

*** **Dental Advantage Preventive benefits:** 2 exams, 2 cleanings, and 2 full-series bite wing x-rays per calendar year; EITHER 1 panoramic OR 1 complete mouth x-ray every 36 months.

9.2 CLASSIC

The Select Health Classic network is our largest and most popular commercial network. It is a statewide network that extends into northern and southern Utah and provides coverage in rural areas where Prime and Fundamental are not available.

9.3 FUNDAMENTAL

The Select Health Fundamental network is our smallest, but most affordable network. It provides the greatest value to members seeking dental care along the Wasatch Front. It is offered in Salt Lake, Utah, Davis, and Weber counties.

9.4 PRIME

The Select Health Prime network is our mid-sized option, providing affordability with more access to dental providers. It extends throughout the Wasatch Front to service members in the most populated counties. It covers Salt Lake, Utah, Davis, and Weber counties.

9.5 DENTAL ADVANTAGE

The Dental Advantage network gives seniors on Medicare access to dental benefits. As a Dental Advantage carrier, Select Health must comply with Centers for Medicare and Medicaid Services (CMS) regulations and requirements, many of which also apply to our network providers. Dental Advantage network providers need to:

- Complete and attest to **Fraud, Waste, and Abuse training**
- Verify that individuals being reimbursed for services on any federal healthcare program **do not appear** on either the:
  - **List of Debarred Contractors:** (published on the Excluded Parties List System by the General Services Administration)
  - **List of Excluded Individuals/Entities** (published by the Department of Health and Human Services, Office of the Inspector General).

RESOURCES

Contact Information for Select Health

At Select Health, we strive to help our members maintain good dental health while offering superior service and providing access to the highest quality of care. We are here to answer your questions, resolve your concerns, and provide a positive customer experience for both you and your patients.

DEPARTMENT	PHONE	FOR HELP WITH
Select Health Provider Development*	**801-442-3692**; **800-538-5054**	Credentialing, Contracting, Policies, Coding
Select Health EDI/Electronic Claims	**801-442-5442**; **800-538-5099**	Claims Payment
Select Health Member Advocates	**801-442-4993**; **800-515-2220**	Claim Denials
Select Health Compliance Hotline	**800-442-4845**	Fraud/Waste/Abuse
Select Health Member Services	**801-442-5038**; **800-538-5038**	Member Eligibility
Select Health Recovery Team	**800-442-5687**; **800-538-5038**, **ext. 5687**	Auto Recovery

* You can also access Provider Development at **provider.development@selecthealth.org**.

Online Resources:

- **Dental Provider Resources: Quick Guide**
- **Dental ID Card Guide**
- **Dental Provider Frequently Asked Questions**
- **Dental Payment Summary Key**
- **Dental Claims History Key**
- **Dental Fee Schedules** (available on the Provider Portal; secure login required)

Secure Access Request Forms (both forms required; complete and submit online):

- **IT Services Agreement (ITSA)**
- **Login Application** (**Note**: Access is only available to providers and facilities contracted with Select Health.)

Appeal Forms:

- **Provider/Dental Appeal Form**
- **Member Appeal Form**

Medicare Advantage (Dental Advantage) Forms:

- **Request for Redetermination of Prescription Drug Denial:** Use to request a redetermination when a prescription drug is denied.
- **Utah** or **Idaho** Notice of Medicare Non-Coverage (NOMNC): Use to inform beneficiaries/enrollees of a Notice of Medicare Non-Coverage.