

| WHO MANAGES YOUR MANAGED CARE? |

Trojan Professional Services empowers you to stay on top of Managed Care with minimal stress.

Trojan summarizes the most critical features of each plan, providing you with:

- Co-payment schedules
- Supplemental payments
- Visit fees/Broken appointment fees
- Pertinent lab reimbursement information
- Highlights of exclusions (Notes and Limitations)
- Referral information

Trojan also provides specific exclusions and limitations that are unique to each plan, including perio frequency guidelines and detailed specialty referral information.

This information is displayed in an easy-to-read format that can be printed for your patient's chart. **Also listed are important fees and co-pays to be collected at time of visit.** Supplemental information is listed when available.

Centralize Your Managed Care Plans

Eliminate the laborious task of having to pull a manual, find a plan, find the plan exclusions and limitations to determine their benefits.

With Trojan, there's no need to go to different places for co-pays, supplemental payment, and yet another place for exclusions, limitations, and specialty referrals.


Trojan's Managed Care program is compatible with any Windows-based computer. It is also Internet compatible, so updates can be done online, although Internet is not required.



Managed Care Benefits

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		TROJAN MGD CARE - SO CA	
Trojan ID	M007255	Patient Name	Sample
Plan Number	A1234	Mail Encounters / Pre-Approvals to:	Dental Health Various Locations, See Notes
Plan Name	A1234		
Carrier	Dental Health	Administrative Phone:	(800) 451-9723
Eligibility Phone	(800) 451-9723		

Payment Base	Schedule
Limitations	Tx. not listed not covered, but can be done at addl. pt. cost or alternate provision applies. See notes.
Cap Fee	Yes.
Visit Fee	\$5.
Supplemental Pmt	Yes. See schedule for General DDS. Minimum chair hour rate guaranteed by Dental Health. See notes.
Lab Reimbursement	\$80 additional co-pay, per unit, for procelain fused to metal crowns or pontics on molar teeth. See notes.
Broken Appointment	Established office policy if not notified within 24 hours.
C.O.B.	The policy of the other plan determines which plan is primary. Patient responsible up to this fee schedule.
Specialty Referrals	Perio if pockets are 5mm or more, Endo, O.S. with pathology, Pedo to age 7 & Ortho.
Pre Approval	General Dentist refers to Specialist for consult. Specialist must pre-auth Perio, Pedo & Oral Surgery.
Xrays Required	Send to specialists for referrals.
Perio Charts Required	Specialist when pre-authorizing treatment.
Dependent Coverage	Verify eligibility test.
FMX Frequency	1 FMX or Panorex per 36 months. Limitation may vary for state of Texas, verify with administrator.
Prophy Frequency	1 x 6 mos., Verify frequency for TX. D4910 limited to 2 within the 1st 12 mos. after active therapy. See notes.
Flouride	To age 19. Verify limitation for Texas residents. 1 per 6 months.
Sealants	To age 14. Verify limitation for Texas residents. No frequency limit given. Virgin primary & permanent molars within 4 years of eruption.
Perio Limitations	Perio scaling & root planing limited to 4 quads per 12 consecutive months. See notes.
Prior Extractions Cov	Yes.
Prosthetic Replacement	5 years. Limitation does not apply for crowns & bridges in California if medically necessary. See notes.
Reline Frequency	Once per arch every 36 months.
General Anesthesia	Not covered.
T.M.J.	Not covered.
Ortho	Co-pay \$1500 to age 19, \$2000 age 19 & over. Patient co-pay \$150 for records and treatment plan. Pre-orthodontic visit fee \$50. Retention fee \$300. Treatment period 24 months. Ortho age verify with eligibility. Additional patient co-pay if active treatment exceeds 24 months.
Notes & Limitations	Co-pay zero for D1110/D1120 with \$1.50 supplemental from Dental Health, addl. tx. copay \$41 for D1110, \$30 for D1120. Codes D2740, D6245 or D6740 not a benefit for molar teeth copay UCR. D4355 1x lifetime, D4910 2x 1st 12 mos. Patient co-pay \$30 for crown exposure of impacted or unerupted tooth to aid eruption, use code D7281. No charge for first 4 adjustments on dentures or partials if within 6 months of insertion. Denture copay includes the cost of characterization. Some tx. may fall under "alternate provision" see manual. 6/6+ units of crown/bridge in same treatment plan requires complex rehabilitation. Addl. co-pay \$125 per unit.

How to Reach Us

Trojan's Service Department: 800-633-3060. Office hours: Monday through Thursday, 6 a.m. - 5 p.m. PST, and Friday from 6 a.m. - 4 p.m. PST.

(We are closed every Friday 1 - 2 p.m. for training, to continually improve our service to you.)



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Plan Number	A1234	Trojan ID M007255	Patient	Sample
Plan Name	A1234		Carrier	Dental Health

Fee Schedule

Code	Description	Modifier	Copay	Supplemental	Lab Cost	Lab Paid
D2510	Inlay Metallic 1 Surface		220.00			
D2520	Inlay Metallic 2 Surface		220.00			
D2530	Inlay Metallic 3/3+ Surface		220.00			
D2542	Onlay Metallic 2 Surface		220.00			
D2543	Onlay Metallic 3 Surface		220.00			
D2544	Onlay Metallic 4/4+ Surface		220.00			
D2740	Crown Porcelain Ceramic Substra.		185.00			
D2750	Crown Porcelain High Noble		255.00		See Notes	By Patient
D2751	Crown Porcelain Base Metal		185.00		See Notes	By Patient
D2752	Crown Porcelain Noble Metal		245.00		See Notes	By Patient
D2780	Crown-3/4 Cast High Noble		255.00			
D2781	Crown-3/4 Cast Metal Base		185.00			
D2782	Crown-3/4 Cast Noble Metal		245.00			
D2790	Crown Full Cast High Noble		255.00			
D2791	Crown Full Cast Base Metal		185.00			
D2792	Crown Full Cast Noble Metal		245.00			
D2910	Recement Inlay/Onlay/Part. Cover.		0.00			
D2920	Recement Crown		0.00			
D2930	Crown Stainless Steel Primary		0.00			
D2931	Crown Stainless Steel Permanent		0.00			
D2932	Crown Resin Prefabricated		0.00			
D2933	Crown Stainless Steel With Resin		0.00			
D2940	Sedative Filling		0.00			
D2950	Crown Buildup Including Pins		70.00			
D2951	Pin Retention		10.00			
D2952	Post & Core Cast		140.00			
D2954	Post & Core Prefabricated		60.00			
D3110	Pulp Cap Direct		0.00			
D3120	Pulp Cap Indirect		0.00			
D3220	Pulpotomy Therapeutic		10.00			
D3221	Gross Pulpal Debridement		10.00			
D3310	RCT Anterior		0.00	85.00		
D3320	RCT Bicuspid		0.00	100.00		
D3330	RCT Molar		150.00	150.00		
D3331	Tx of Root Canal Obstruction		0.00			
D3332	Incomplete Endoconic Therapy		0.00			
D3333	Internal Root Repair- Perforation		0.00			
D3346	RCT Anterior Retreatment		100.00			
D3347	RCT Bicuspid Retreatment		100.00			

indicates a non-standard code. A Modifier indicates that the carrier has changed the definition for the code.