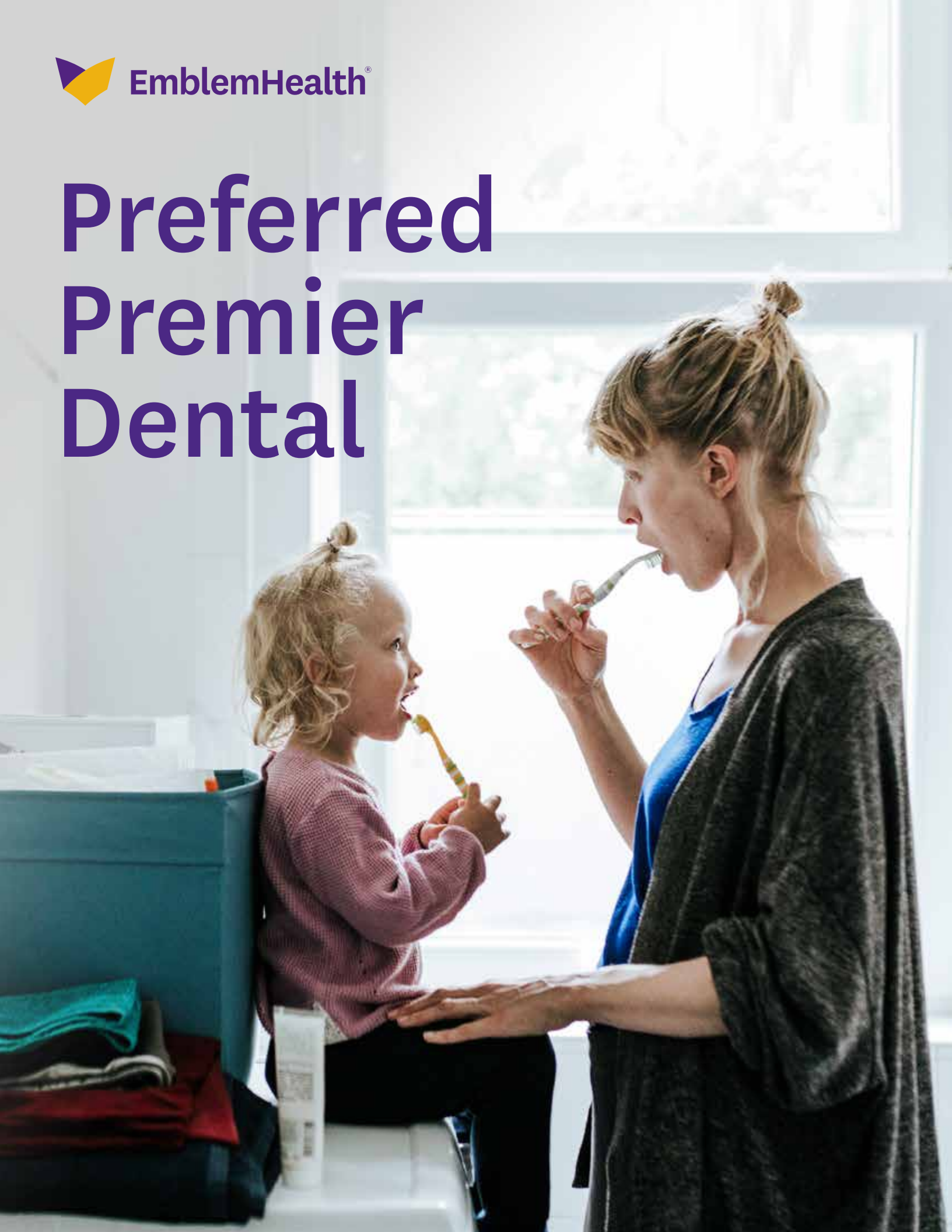
EmblemHealth®

Preferred Premier Dental



About the EmblemHealth Dental Network

The EmblemHealth dental network is growing and we are glad you are a part of it! We see our dental providers as our partners in offering quality dental care to our members.

Our provider relations representatives are focused on individual customer service that meets your practice's needs. Our goal is to streamline and simplify your day-to-day interactions with us.

EmblemHealth* has made many technological and process enhancements to improve your experience working with us including:

- Our provider portal, an advanced technology solution, is easy to use:
  - Create, search for, and view claims and predeterminations online.
  - Check member eligibility, patient history, ask questions, and more.
- Timely payments made directly to you by EmblemHealth.
- Easy-to-understand, straightforward benefit plans.

Provider resources are available on **emblemhealth.com/provider** under Dental Corner. There you will find our Office Manager's Handbook, a quick reference guide to the EmblemHealth dental network guidelines and policies that gives you an overview of our plans and how to work with us. This handbook addresses topics such as:

- Advantages of network participation.
- Patient eligibility.
- Claims and pretreatment estimates.
- Electronic claims submissions.
- Diagnostic x-ray submissions.
- Coordination of benefits.
- Member ID cards.

* Note: EmblemHealth was established in 2006 with the affiliation of GHI and HIP Health Plan of New York (HIP), through which it provides quality health care coverage and administrative services.

The EmblemHealth Dental Plan

We have four dental plans available to groups throughout New York state and to their employees who live in and outside of the state: Preferred Dental, Preferred Premier Dental, Preferred Plus Dental, and the Discounted Dental Access Program.

Members can visit any general dentist or dental specialist who participates in their dental plan without a referral. If your practice is part of the EmblemHealth Preferred Network, you are eligible to see EmblemHealth patients with Preferred dental coverage.

EmblemHealth Preferred Premier Fee Schedule

The dollar amounts in the fee schedule represent the fees applicable to the procedure codes listed for the EmblemHealth Preferred Premier dental network.

The amounts listed in the fee schedule represent the maximum sum Preferred Premier Network dentists can receive for services rendered to a covered EmblemHealth patient. Patients may be responsible for charges for the implant and orthodontic services depending on his/her plans' maximum allowance.

Plan designs — including the benefits covered, benefit maximums, deductibles, and the percentage of the fee schedule that applies — will vary among EmblemHealth group members. The EmblemHealth Preferred Premier plan allowances always apply to patients covered under the Preferred Premier plan, regardless of the level of reimbursement from the patient's group benefit plan. Please note:

- Patients are responsible for your normal charges for services listed with a zero-dollar amount or that are not covered under the patient’s benefit plan.
- It is recommended to use the predetermination process prior to submission of a "By report" code. Any code that is listed as "By report" is subject to fee variation, clinical and benefit limitations, and consultant review. Please submit appropriate x-rays, narratives, and progress notes to justify use of the code.
- Services considered inclusive in another procedure cannot be billed to the patient.
- In situations where payment is reduced or not made because the patient has reached their annual maximum or a deductible has been applied, the patient is responsible for, and a dentist may only charge up to, the applicable Preferred Premier plan allowance as described in the fee schedule.
- Services not payable when exceeding frequency limitations are subject to your normal charges.
- The implant benefit under the Preferred Premier plan varies from group to group.
  - — 1199 SEIU National Benefit Fund members have a paid in full D6010 benefit at a maximum allowable charge of $1,000. You may not balance bill the patient for this covered service.
  - — Some groups pay an allowance towards the implant placement. In these cases, the patient is responsible for the difference between the amount allowed and the maximum allowable charge of $1,800.

Reimbursement Methods and Related Billing

We make payments to Preferred Premier Network participants for covered services according to the Preferred Premier fee schedule and our claims processing policies.

Under your participating provider agreement, you have agreed to accept the Preferred Premier fees as payment in full for most covered services with an exception for the implant and orthodontic services. To help avoid any billing disputes with patients, we require that you enter a written agreement with the patient or the patient's guardian when providing services not listed in the fee schedule where patients will have out-of-pocket expenses. The patient or the patient's family needs to be informed of all treatment options available through your office, expected out-of-pocket fees, and patient responsibility.

When contacting EmblemHealth about claims status or member eligibility for the Preferred Premier plan, be sure to have the insured's member ID number that can be found on the member's ID card. Information about eligibility, claims, predeterminations, and payments can be found on the secure provider portal on **emblemhealth.com/providers**.

Refer to the CDT code and fee schedule for more information on what services this applies to.

Please note: EmblemHealth will be unable to support your billing for these services without the existence of a written agreement that includes the above information. The member's signature on this form will indicate that the member agrees to the cost. It will also help to eliminate any confusion over payment policies.

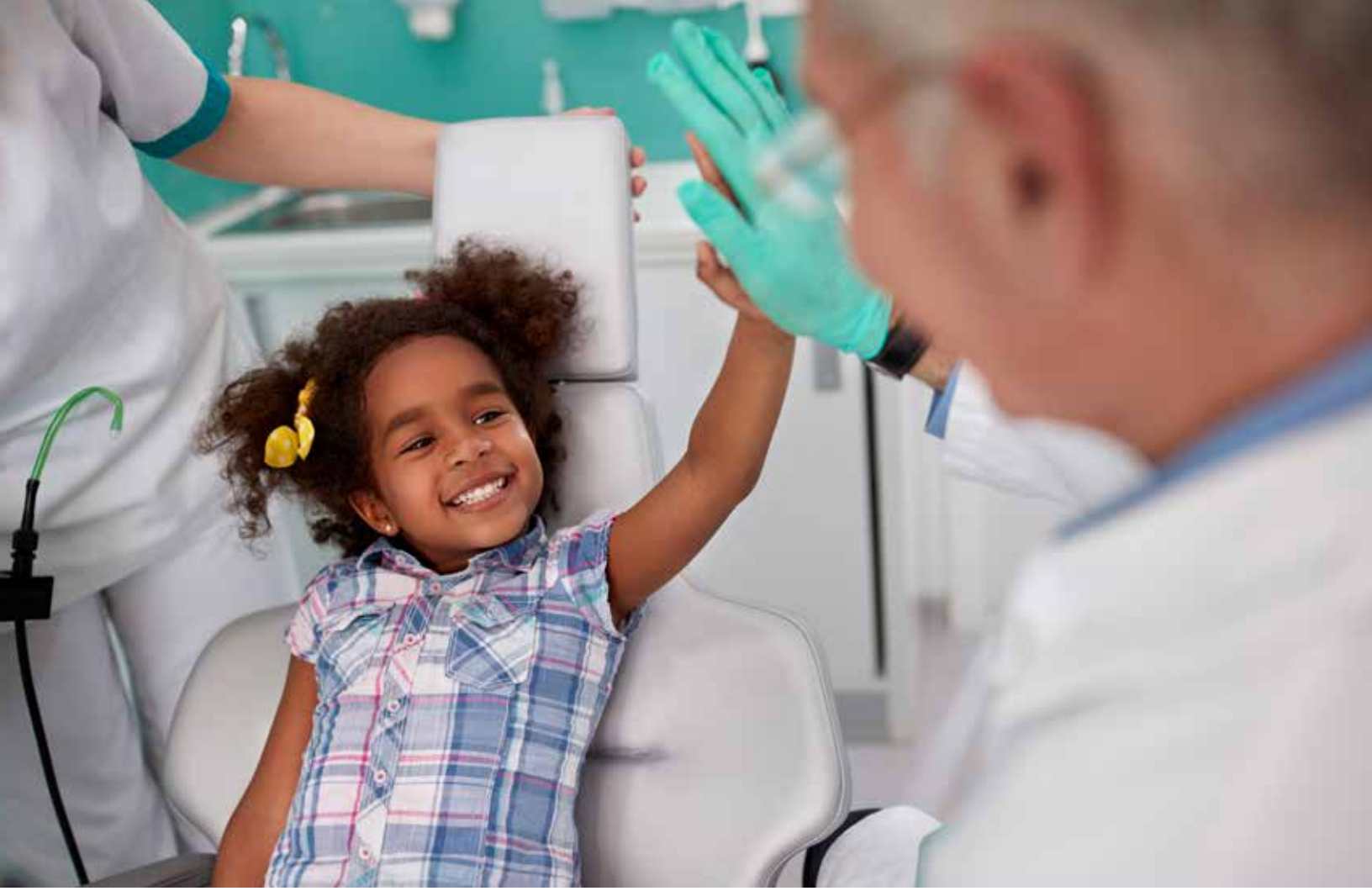
EmblemHealth Staff To Serve You

EmblemHealth maintains all information regarding your practice. This data is routinely updated and appears in network dentist directories and is used in claims processing. We need your help keeping our records current. Contact EmblemHealth when any of the following occurs:

- The address of your practice changes.
- The telephone number of your practice changes.
- You wish to add or delete a dentist from your practice.
  If you are adding a provider to your practice, please confirm with EmblemHealth that the provider has been added as a participating provider. If you submit claims for a provider as the treating dentist who has not been added, claims will be processed as out-of-network until the provider is officially participating.
- Your Internal Revenue Service (IRS) taxpayer identification number (TIN) changes.
  In this case, you will need to complete an IRS Form W-9 and return it to our Dental Professional Relations department.
- You are reporting your National Practice Identifier (NPI) number to EmblemHealth.

To maintain proper claims payments, all changes to your file must be submitted in writing to **dentalproviders@emblemhealth.com** or mailed to:

EmblemHealth
Dental Provider Operations
P.O. Box 2818
New York, NY 10116



Contacting Us

We are committed to supporting you and your practice and appreciate your partnership in caring for our members.

Our provider portal can give you the information you need for claims-related inquiries. When you sign in to the provider portal through our secure website, **emblemhealth.com** using your TIN, your provider demographic information will be prepopulated for you.

Please use the "Ask a Question" option specific to the claim on the provider portal if you need further information.

Our Customer Service team is also available to assist you with anything you need additional clarification on. A representative will answer your call in a timely fashion and, if necessary, route you to the appropriate department. When calling, please have the patient's member ID number and date of birth and use the number appropriate to your office location:

- **212-501-4444** practices in New York City
- **800-624-2414** practices outside New York City
- **877-842-3625** practices in all areas

Written correspondence involving claims — such as requests for payment clarification or adjustment, check returns, or consultant rereview — should be sent to the following address:

EmblemHealth
Correspondence
P.O. Box 1701
New York, NY 10023

When you sign in through our secure website using your TIN, your provider demographic information will be prepopulated for you. You only need to enter your applicable NPI number to complete the electronic transaction.

Infection Control, Sterilization, and Other OSHA-Related Charges

Infection control, sterilization, and other Occupational Safety and Health Administration (OSHA)-related costs are not considered dental procedures or services. EmblemHealth Preferred-covered patients are not responsible for costs related to OSHA regulations, infection control, or other items and services required to comply with federal and state environmental laws and regulations.

Costs incurred to comply with these laws and regulations are considered part of your fee-for-service reimbursement for covered dental procedures and should not be billed to the patient.

Laboratory Costs and Materials

In developing the Preferred fee schedule, we have taken into consideration the expenses involved for laboratory costs and materials. We consider these costs to be part of the overall treatment plan, as reflected in submitted procedure codes. Our network dentists may not bill EmblemHealth patients separate charges for these expenses. These costs should not be billed to the patient.

Pretreatment Estimates and Claims Review

Through predetermination of benefits, dentists work with EmblemHealth to verify the necessity, cost-effectiveness, and plan design applications of a proposed treatment plan. Predeterminations, or pretreatment estimates, have always served as a valuable tool for dental practices when proposing treatment and arranging financial plans with patients. This helps to avoid billing disputes with patients.

A predetermination and benefit eligibility check are not a guarantee of payment and are subject to plan benefit limitations. A patient's maximum benefit is calculated and paid based on the date the claim is settled, not submitted. Claims may be subject to clinical review, and adherence to EmblemHealth clinical criteria may impact coverage decisions. Missing or incomplete required information on claims submissions may cause delays in processing.

We strongly suggest a predetermination of benefits for various procedure codes (including surgeries, orthodontics, prosthetics, major restorations, and other high-dollar treatments) implants, and related services to assess benefit amounts and determine if alternate benefits apply.

If the patient decides not to wait for the predetermination of benefits and clinical/medical necessity to be finalized before starting treatment, please enter into a detailed, written financial agreement prior to rendering services.

Claims Submissions and X-rays

You can submit your predetermination requests and claims electronically to our Payer ID 13551. For paper submissions, mail to:

EmblemHealth Dental Claims
P.O. Box 2838
New York, NY 10116-2838

We strive to review and return your x-rays as quickly and efficiently as possible, to ensure proper benefit determination for your patients. X-rays that are submitted without clear labeling, are poorly attached to the claim form, or are of poor diagnostic quality can delay claims processing.

Take the following steps to help us serve you better:

- Clearly label all submitted x-rays. The patient's name, date the x-ray was taken, tooth number(s), and the complete name and address of the treating dentist should all be present on the label. In the case of single films, the label should be on the frame or on an envelope containing the x-ray.
- X-rays should be clearly labeled as noted above, with a notation indicating right or left, and top or bottom. We suggest not sending original radiographs as they may not be returned.
- The x-ray should be affixed to the claim form. We recommend the x-ray be stapled securely to the claim.
- Duplicate x-rays must be of good diagnostic quality.
- Submit x-rays as attachments to electronically submitted claims whenever possible.
- For diagnostic submissions, we recommend using attachment submission services.
- We must use your unique, individual 10-digit NPI number and your name exactly as it appears on your license to practice dentistry, to process standard health care electronic transactions, as required by federal law. This information is required on paper claim submissions as well and is necessary to ensure the accurate and timely processing of your claims.
- If you are submitting a correction to a previously processed claim, the new form must clearly state "Corrected Claim."

Through an agreement with National Electronic Attachment (NEA), our network dentists may submit x-rays electronically using FastAttach™ offered through Vyne Dental. For more information on FastAttach or to register for an account, visit **vynedental.com** or call **800-782-5150**. You can also visit **dentalxchange.com** or call **800-576-6412** for more information on their available attachment services.

The following procedures require the submission of x-rays:

Restorative

- Inlays/onlays.
- Crowns.
- Post and core.
- Core buildup.
- Labial veneers.
- Crowns over implants.

Endodontics

- Root canal therapy.
- Apicoectomy/periradicular surgery.
- Root amputation.
- Hemisection.
- Pulpotomy.
- Retreatment of root canal therapy.
- Apexification/recalcification.
- Pulpal regeneration.

Periodontics
(x-rays and periodontal charting)

- Gingivectomy or gingivoplasty.
- Gingival flap procedure.
- Osseous surgery.
- Crown lengthening.
- Bone replacement graft.
- Guided tissue regeneration
- Pedicle soft tissue graft procedure.
- Distal or proximal wedge procedure.
- Combined connective tissue and double pedicle graft.
- Localized delivery of antimicrobial agents.
- Scaling and root planing.
- Scaling in presence of generalized moderate or severe gingival inflammation.

Periodontics (periodontal charting only)

- Periodontal maintenance.

All periodontal surgeries require charting and x-rays.

Prosthodontics

- Fixed bridgework.
- Dentures.
- Post and core.

Oral surgery

- Removal of impacted tooth.
- Surgical removal of residual tooth roots.
- Oroantral fistula closure.
- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- Surgical access of an unerupted tooth.
- Surgical exposure of impacted or unerupted tooth to aid eruption.
- Mobilization of erupted or malpositioned tooth to aid eruption.
- Surgical repositioning of teeth.
- Primary closure of a sinus perforation.
- Alveoloplasty - Preparation of ridge.
- Vestibuloplasty.
- Excision of intra-osseous lesions and bone tissue.

Orthodontics

Along with a narrative of medical necessity and description of malocclusion, appropriate radiographs are required for orthodontic cases. Study models should only be submitted on request.

Standard Principle Exclusions

Members and their covered dependents are not covered for:

- Cosmetic surgery or cosmetic treatment, unless otherwise medically necessary.
- Care furnished without charge to the patient.
- Services that do not conform with accepted standards of dental practice.
- Services rendered in a hospital, department, or clinic run by the subscriber's employer, labor union, or welfare fund.
- Services subject to no-fault automobile insurance.
- Services or appliances used solely as an adjunct to periodontal care or temporomandibular joint dysfunction.
- Habit-breaking devices, or adjustment thereof.
- Care for any injury, condition, or disease if payment is available under a Workers' Compensation law or similar legislation.
- Services rendered to the patient by the subscriber, the subscriber's spouse, the subscriber's domestic partner, or a child, brother, sister, or parent of the subscriber or of the subscriber's family.

Dentists participating in the Preferred Network may charge their usual fees for services not covered under the patient's benefit plan. Services considered inclusive in another procedure cannot be billed to the patient.

General Policies and Limitationss

1. Diagnostic and Preventive Services

X-rays:

- Maximum allowance of four bitewing x-rays per calendar year.
- Maximum allowance of 10–14 periapical x-rays or one panoramic film or full mouth series every three-year period.

Fluoride treatments: One topical fluoride treatment or fluoride varnish application per child, based on the plan frequency limitations.

Limited oral evaluation problem focused: If billed with any other service besides x-rays on the same date of service, The limited oral evaluation will be denied as "Inclusive to the Other Service" with no patient liability. The other services are paid. X-rays and other services are only paid when they are a covered service and frequency limitations have not been met for that service.

Pulp vitality tests: Are inclusive with all examinations and procedure codes without patient liability. The pulp vitality test will no longer deny as noncovered, but no separate allowance is payable.

2. Restorative Services

Temporary restorations: Included in all procedures and cannot be billed separately.

Pulp capping and cement bases: Included in the restoration, cannot be billed separately.

Crowns:

- Crowns or pontics for attachments or clasp purposes are not covered. Crowns are covered when the tooth is so broken down that fillings will not provide a proper restoration. A cantilever pontic, when used for attachment reasons for a partial in the same jaw, is not covered.
- Double or multiple abutments are not covered. Double cantilevered pontics are not covered.
- Splints are not covered.

Inlays/onlays: Onlays are reimbursed based on the allowance for the corresponding inlay fee for the same materials and surfaces.

Post removal: This is inclusive in the endodontic retreatment only.

Veneer procedures: Charges depend on whether the procedure is chairside or laboratory-made, with set reimbursement amounts.

3. Endodontics

Root canal therapy: X-rays films taken as part of the endodontic treatment are included in the allowance of the endodontic therapy.

Post and core: One post and core per tooth is reimbursed over a five-year period. Additional posts are not covered.

Root canal obstruction treatment: Included in endodontic treatments and retreatments, unless treatment involves removing separated files by a second practitioner.

Intraorifice barrier and decoronation of erupted tooth: Inclusive as part of the root canal procedure if billed within one year by same provider, otherwise not covered.

Retreatment of previous root canal therapy: If billed within 24 months of initial root canal therapy by the same provider, codes D3346, D3347, or D3348 are denied as «Inclusive to the root canal therapy» without patient liability.

4. Periodontics

Periodontal services: Only payable on natural teeth.

Nonsurgical procedures: Allowed up to five of these seven codes (D4341, D4342, D4346, D4355, D4910, D9951, and D9952) in a calendar year in accordance with plan frequency limitations, providing maximums have not been reached. Patient will be responsible for any additional charges.

Scaling and root planing: Coverage is subject to plan frequency limitations.

Periodontal maintenance: Coverage is subject to plan frequency limitations. This must follow active periodontal therapy.

Surgical procedures:

- Allowance is based on a per tooth basis. Multiple defects on the same tooth are considered inclusive in the per tooth fee.
- Repeated periodontal surgical services will not be covered for a period of three years in the same quadrant. (Surgical services are defined under the surgical section of the CDT manual.)

Antimicrobial agents:

- Localized delivery of antimicrobial agents must be performed in conjunction with periodontal scaling and root planing or periodontal maintenance.

- Agents are subject to clinical review criteria and are limited by frequency and by number of teeth per quadrant.

Crown lengthening: Payable service only when performed by a specialist who is not the dentist providing the crown itself.

LANAP:

- EmblemHealth considers the laser-assisted new attachment procedure (LANAP®) to be an adjunctive service and not a required procedure to complete periodontal procedures.
- Dentists must have the patient sign an informed consent and payment agreement prior to LANAP treatment. Since it is an additional service, patients may be charged for LANAP above and beyond what EmblemHealth pays for D4341/D4342.
- EmblemHealth will pay contracted benefit for D4341/D4342 if LANAP is utilized.
- EmblemHealth will not pay any other code when LANAP is utilized.
- EmblemHealth does not consider it appropriate to bill any other codes when LANAP is utilized.

5. Implant Services

Benefit variation by plan: Coverage varies by plan and is subject to clinical limitations.

Allowance and patient responsibility:

- Some groups pay an allowance toward the implant placement and the patient is responsible for the difference between the allowed amount and the maximum allowable charge of $1,800.
- 1199SEIU National Benefit Fund members have a paid-in-full D6010 benefit at a maximum allowable charge of $1,000. You may not balance bill patient for this.
- TWU Local 100 members have implant coverage and implant services for one tooth (same tooth) per 12-month period. Implant coverage and directly related services during the implant procedure (e.g., abutments, crowns, bone grafts, etc.) that are performed by a participating provider are not subject to the plan annual dollar maximum.

Predetermination: Strongly encourage requesting a predetermination before treatment and obtaining written agreements with patients regarding additional fees for procedures.

Abutment coverage: Coverage varies by plans.

Implants: Includes implant placement, uncovering implant, and all pre-prosthetic and post-prosthetic implant surgical procedures.

6. Prosthodontics

Partials and dentures:

- Duplication, rebase, or chairside reline to a denture is limited to one per denture per five-year period.
- Full upper and lower overdentures are paid for at the fee for full upper and lower dentures. There is no payment for treatment of an abutment tooth or attachment tooth.
- When a fixed bridge and partial denture are inserted at the same time, only the partial denture is covered.
- Rebase or repair of a newly inserted denture within six months of the insertion of a new denture will not be covered.
- Any repair or tooth and/or clasp addition to an existing denture within six months of the insertion of a new denture will not be covered.

Temporary services: Included in the allowance for the permanent service.

Interim partial dentures: Coverage varies by plan.

7. Oral and maxillofacial surgery

Allowance includes: The allowance includes x-ray films taken solely for the surgery, related local anesthesia, and pre-and postoperative care.

Pre/postoperative x-rays: Pre- and/or postoperative x-rays and operative reports may be requested.

Malignant lesions: The patient's medical coverage is considered the primary carrier for the excision of malignant lesions. Submit the claim for excision of malignant tumor/lesion under the medical plan.

Surgical procedures: Specific allowances for extraoral or intraoral procedures like incisions and drainage, tooth extractions, and tumor removals.

Alveoloplasty: Is not covered for post-prosthetic implant placement or uncovering the implant.

Bone replacement graft for ridge preservation:

- (D7953) Coverage varies by plan.
- Plan with coverage requires narrative.

Soft and hard tissue procedures: Several procedures related to bone grafting, sinus augmentation, and ridge preservation are reimbursed depending on the patient's plan.

8. Orthodontics

Orthodontic maximum:

- The lifetime orthodontic maximum varies by group.
- The maximum allowable charge is $4,000 per orthodontic contract.

Overview of orthodontic benefits

The orthodontic **allowance** represents the maximum amount a participating network dentist can collect for a full course of orthodontic treatment.

- All office visits for active treatment and follow-up care.
- One-time benefit for traditional appliances.
- One-time benefit for retention (passive treatment).
  - — Retainers are included in the retention allowance when covered by plan

If the patient's orthodontic benefit is lower than the maximum allowable amount, you may only charge the patient up to the **maximum allowable amount** for active treatment.

Important Guidelines for Orthodontic Treatment

a. Active treatment and retention:

- Active orthodontic treatment includes initial appliance placement, active treatment visits, and retention.
- A second phase of treatment may be necessary in some cases. If the patient exhausts their lifetime maximum during Phase 1, they are responsible for the cost of Phase 2 at your standard charges.
- Retention (passive treatment) to include follow-up visits, which cannot be billed separately.

b. Retainer coverage:

- Some Preferred Premier plans include retainer coverage.
- Removable orthodontic retainer adjustment is considered inclusive in retention and cannot be billed separately.

c. Duration of treatment:

- There is no limitation on the number of months required for a full course of orthodontic treatment.
- Reimbursement will be made according to the patient's benefits.

Predetermination and Submission Requirements

Pretreatment estimates are strongly recommended to clarify your billing arrangements with the patient or their family. To avoid delays in predetermination or processing, please ensure that the following information is included when submitting claims:

- Total case fee for the entire treatment.
- Cost of appliances used.
- Cost per month of active treatment, with an estimated number of treatment months.
- Cost of orthodontic retention (passive treatment).
- Type of malocclusion being treated, supported by diagnostic materials such as:
  - — Photos.
  - — Panorex.
  - — Other supporting documents.

Orthodontic Treatment Payment Process

After an initial payment for the appliance fee and diagnostic workup, EmblemHealth will issue payments either **monthly or quarterly** until the patient's available benefit or the approved number of visits has been reached. A benefit for monthly treatment is payable after 3 weeks of the last date of service.

EmblemHealth will pay your office **directly** based on the submission of monthly or quarterly claims. Please note that financial arrangements between the dentist and EmblemHealth participant, made at the time treatment begins, apply for the entire treatment period.

Inclusive Services During Active Treatment

EmblemHealth considers the following services to be **inclusive** and cannot be billed separately during active comprehensive orthodontic treatment:

- Photos.
- Diagnostic casts.
- Panorex x-rays.
- Cephalometrics.
- Cephalometric analysis.
- Additional orthodontic consultations.

Additional charges:

- Charges for missed appointments and additional cosmetic options (e.g., cosmetic banding or aligners) are the responsibility of the patient and should be billed at the office's standard charges.
- If clear aligners are chosen, the patient is responsible for the difference between the allowance for traditional banding and your full charge for clear aligners.
- Some groups may not cover the construction and placement of removable retainers, predetermination is strongly recommended.

- Replacement of lost or broken retainers, and retainer repairs are the patients' responsibility.

9. Adjunctive services

Occlusal Adjustments: Subject to additional periodontal limitations. Not payable on same date of service as related services. Procedure considered "inclusive" in other related services. Occlusal adjustments done on the same tooth and in conjunction with fillings, prosthetic services, root canal therapy or repairs, inlays and crowns are not covered. If payable, it is subject to additional periodontal limitations.

General Anesthesia:

- Deep sedation general anesthesia (D9222-D9223) is not covered on the same date of service as D9239-D9243.
- IV moderate sedation (D9239-D9243) is not covered on the same date of service as D9222-D9223.

Inhalation of nitrous oxide: Coverage varies by plan.

Additional coverage details:

- Services considered inclusive in another procedure (e.g., office visits, pre/postoperative care, and x-rays) cannot be billed separately.
- Local anesthesia is included in all procedures and should not be billed separately to the patient.
- Patients are not responsible for the cost of procedures considered "inclusive" in other treatments.
- Coverage decisions are subject to EmblemHealth's clinical criteria, and this fee schedule is not all-inclusive. Other clinical guidelines may apply.
- Services listed as "By report" require submission of additional supporting documentation, such as x-rays, narratives, and progress notes.

Important notes on billing:

Frequency limitations: Multiple services (e.g., fluoride treatments, cleanings, scaling) may be limited to a set number of treatments per calendar year.

- **Bundling of services:** Some procedures are inclusive, meaning they cannot be billed separately (e.g., pulp capping, temporary restorations).
- **Specialists vs. general dentists:** Some procedures, such as crown lengthening, must be performed by a specialist for reimbursement.

Claims and submissions:

- Submissions of claims should include detailed information about the treatment to ensure proper processing.
- EmblemHealth recommends using the predetermination process prior to submitting a "By report" code to avoid discrepancies.

For providers:

- Providers must comply with state and federal laws, including licensing requirements and all applicable regulations.
- Providers should check the EmblemHealth website and provider portal for policy updates, access to provider resources and member plan benefits.
- This booklet highlights some common limitations but is not meant to be all-inclusive.

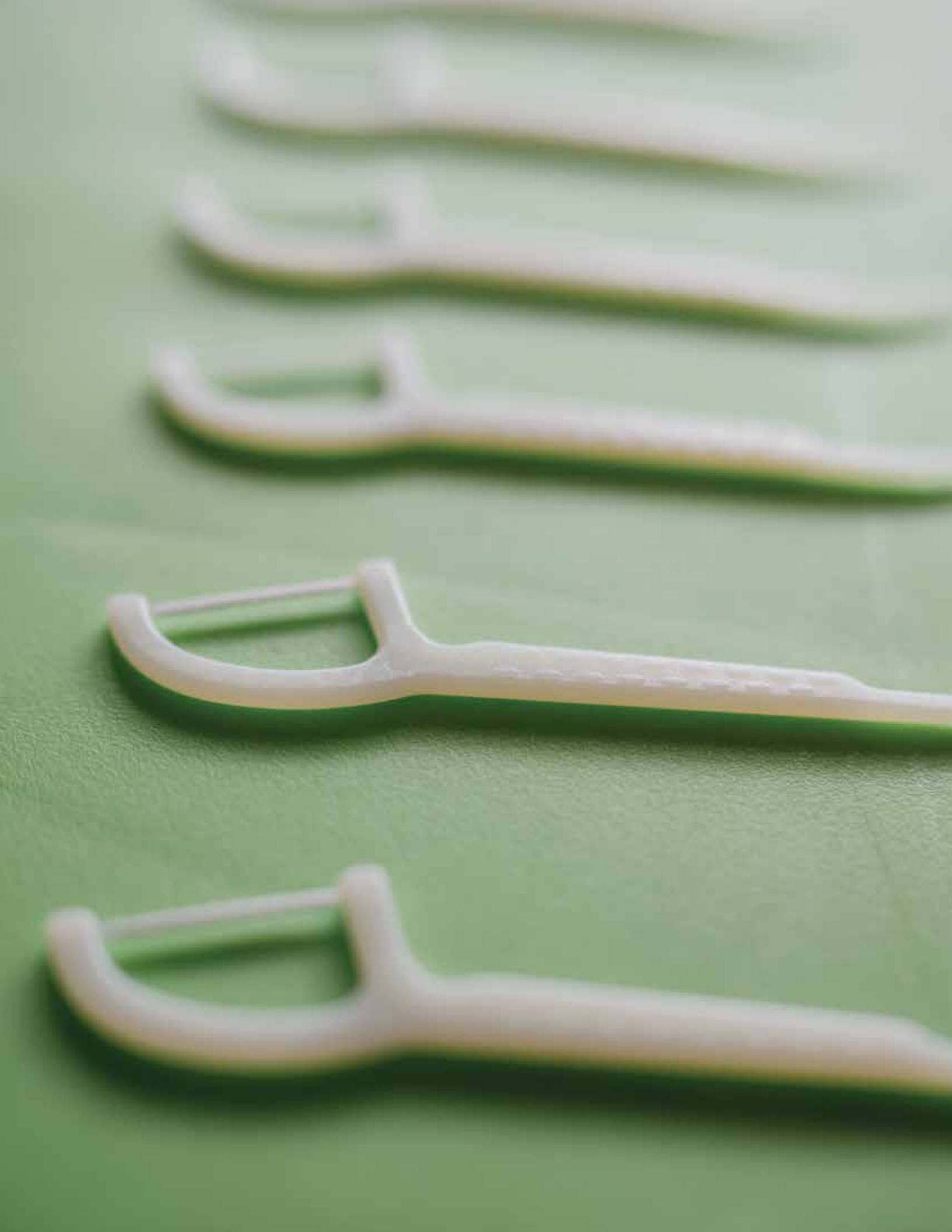
Please note: Submitted claims should reflect the completion or insertion dates of services rendered and not impression dates or the date of initiation. Submitted claims and predeterminations should also reflect your full fee, not the allowance of the applicable plan

Orthodontic Standards

EmblemHealth will not consider payment for orthodontic treatment unless the abnormal position and relationship of the teeth reflect one or more of the following conditions:

Posterior crossbite	Posterior crossbites are only compensable if they are causing a functional mandibular shift or occlusal prematurities/interferences.
Anterior crossbite	Anterior crossbites include edge-to-edge occlusions.
Anterior-posterior occlusal discrepancies	A-P discrepancies (Class II or Class III) are compensable if the occlusal discrepancy is ½ cusp or more.
Palatal impingement	This includes situations where the lower anterior teeth are in occlusion with the palatal gingival margin of the upper anterior teeth.
Anterior or posterior lateral open bite	The open bite cannot be the result of the eruption sequencing, transitioning, from the primary to the permanent dentition.
Overjet	Must be equal to or greater than 4 mm.
Excessive flaring or protrusion	The flaring or protrusion must cause lip incompetency to the extent that the upper anterior teeth are more susceptible to traumatic injury or the dental flaring/protrusion must be compromising to the dentoalveolar periodontal support.
Crowding	Must be equal to or greater than 4 mm in either arch.
Spacing	Must be equal to or greater than 4 mm in either arch not including the leeway space in the transitioning dentition.
Impacted teeth	Does not include third molars. An impacted tooth is defined as a tooth that cannot erupt into proper position without orthodontic intervention.
Ectopically erupting/ positioned teeth	If ectopically erupted, must be 3 mm or more out of labio-lingual alignment. If unerupted, ectopic position must compromise integrity of an adjacent tooth.

The number of months allowed for the treatment of any case, as well as the timing for the start of mixed dentition treatment, is dependent on the patient's contract benefits and must be in accordance with generally accepted clinical orthodontic standards.



Code Revisions

Dental procedure codes are periodically updated. EmblemHealth reserves the right to apply comparable fee schedule amounts resulting from CDT revisions. We also reserve the right to modify the schedule in accordance with the terms of the Preferred Participation Agreement.

55 Water Street, New York, New York 10041-8190 | emblemhealth.com

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