OFFICE MANAGER'S HANDBOOK

Information on Your Dental Network Relationship with EmblemHealth

EmblemHealth®

CONTENTS

1.0 INTRODUCTION

Thank you for participating with the EmblemHealth dental networks. Dental practices today interact with many benefits programs, each with their own procedures and administrative guidelines. Sorting out all the details can be challenging.

Our goal is to streamline and simplify your day-to-day activities with us.

This handbook for office managers and their staffs is a quick reference guide to the EmblemHealth dental network guidelines and policies. It 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

Your satisfaction with our plans and networks is important to us, and we encourage you to send your comments or suggestions to EmblemHealth Dental Professional Relations at **dentalproviders@emblemhealth.com**. We look forward to a positive, long-term relationship with your practice.

1.1 Our Dental Plans

Our current dental plans are EmblemHealth Preferred Dental, Preferred Plus Dental and Dental Access Program. These plans are preferred provider organizations (PPOs) and are underwritten by Group Health Incorporated (GHI), an EmblemHealth company. They are available to employer groups throughout New York State and to their employees who live in or out of the state. Groups range in size from as few as five employees to thousands of covered patients. Without a referral, our members can seek care from any general dentist or dental specialist who participates with their dental plan.

Over half a million patients are enrolled in our dental plans. Aggressive marketing of our dental plans throughout New York State and in New Jersey helps our network practices attract new patients and build patient referral opportunities.

1.2 Our Dental Networks

Our four dental networks — EmblemHealth Preferred Dental, Preferred Plus Dental, Dental Access Program* and legacy Spectrum** — consist of over 8,000 dentists and dental specialists practicing in New York State or New Jersey. Participants meet a high credentialing standard and agree to treat covered patients at the fees detailed in our fee schedule booklets.

Our Preferred and Preferred Plus networks are separate and unrelated, and each has distinct patient enrollment and reimbursement schedules. You may join one or both networks — the choice is yours. With so many patients enrolled in our Preferred plan, your participation in both networks may prove beneficial. Plus, when you join our Preferred network you automatically become a participant of our discounted Dental Access Program, allowing you to see and treat patients with Dental Access coverage.

Should patients contact your office asking whether you participate with EmblemHealth, be sure to ask which plan they are insured with before stating your participation status. This will help smooth relationships with patients when it comes to billing for out-of-pocket expenses.

* You must participate in the Preferred network to also participate in the Dental Access Program network.
** You must participate in the Preferred network to also participate in the Spectrum network.

1.3 Benefits of Network Participation

Your participation in the EmblemHealth dental networks gives you opportunities to:

- **Attract new patients to your practice.** Our dentist directories and online "Find a Doctor" tool make it easy for our members to find your practice and seek your services. The online directory includes maps with directions right to your practice.
- **Meet your administrative needs online.** Through our robust Web site, **www.emblemhealth.com**, you can get the administrative information you need without ever having to pick up a phone. You'll find information on patient eligibility and benefits, tooth history, deductible balances, check-issue dates/numbers, amounts paid, amounts remaining in annual maximums, and records of exams, cleanings, bitewings and X-rays. To use this service, sign in from the provider page of **www.emblemhealth.com** or register to start an account.
- **Participate with PPO dental plans.** Our dental plans are not HMO, capitation or prepaid plans. They are PPOs that reimburse network dentists on a fee-for-service basis. Patients can seek care from any dentist or dental specialist at the time care is needed. You won't have to serve as a "gatekeeper" or request our approval to refer patients to specialists.
- **Get timely reimbursement.** We pay network practices directly and make every effort to ensure you get paid quickly and accurately. Assignment of benefits is guaranteed.
- **Rely on a claims system that complies with the latest dental procedure coding.** Your submission of newly revised coding will be fully reflected in our claims processing and explanation of benefits (EOB) vouchers.
- **Submit dental claims electronically.** This no-cost service can reduce the time you spend on claims submissions and speed up claims processing on our end. To get started, sign in from the provider page of **www.emblemhealth.com** or register to start an account.

1.4 Our History of Providing Dental Coverage

With over six decades of experience, we have established ourselves as an important dental carrier in New York.

We launched our first dental plans in the 1950s: indemnity-style benefits for large labor and government accounts. In the 1960s our first PPO plans — the M plans — were established to address labor market needs. We expanded our presence in the early 1980s, when the Spectrum plan was developed and first marketed.

In 1988 we introduced our Preferred network. This network supports the State of New York plan and now most of our dental plan enrollments. It is also the foundation of our Dental Access Program, which in 2000 debuted as a discounted dental plan for federal employees enrolled in GHI medical plans. From 2003 to 2004, we developed the Preferred Plus network and introduced the Preferred Plus plans.

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 to approximately 2.8 million people. Our dental plans arrived on the marketplace in summer 2009, and sales activity began that fall.

1.5 Fee Schedules

We publish separate fee schedule booklets for our Preferred and Preferred Plus plans and Dental Access Program. The dollar amounts in the booklets represent the fee schedule applicable to the procedure codes and related services listed for the respective EmblemHealth dental network. Network fee schedules are revised periodically.

- **Our Preferred and Preferred Plus networks** have pre-established maximum fees that network dentists can charge for covered services rendered to EmblemHealth patients. Network dentists may charge their normal fees for noncovered services. For example, normal fees may be applied to tooth bleaching and voluntary cosmetic services.
- **Our Dental Access Program** features coverage for preventive and diagnostic services, as well as coverage for denture, crown and bridge repairs — all set at the Preferred fee level. The Dental Access fee schedule establishes maximum allowable charges for all other listed services, and members pay network offices directly based on allowances for these other listed services. Covered patients receiving treatment from network practices are responsible for the office's normal fees for services not listed in the fee schedule booklet.

As a network practice, you agree to accept the dollar amounts charged for procedures, as listed in the fee schedule booklets, as total compensation from the plan and patient. This applies with few exceptions, such as where an alternate benefit can be applied to a covered service. In cases where an alternate benefit is applied, the patient is responsible for the difference between your normal submitted fees and the EmblemHealth payment amounts. In accordance with our participation agreement, patients and network dentists must agree in advance to treatment plans and payment methods for noncovered services.

In summary:

- Patients are responsible for your normal charges for services not listed in the fee schedule booklets or that are not covered under the patient's benefit plan.
- If a payment is reduced or not made because patients have reached the annual maximum or a deductible has been applied, the patient is responsible for, and a dentist may only charge up to, the applicable plan allowance, as described in the fee schedule.
- Services that cannot be reimbursed because they exceed frequency limitations are subject to your normal charges.

2.0 COMMUNICATING WITH US

2.1 Contacting Customer Service

We are committed to promptly resolving claims-related issues for your practice. Our Customer Service team is available to assist you with most of your inquiries, as well as the following:

- **Status of submitted claims:** Questions about claims we are currently processing.
- **Conditions of settled claims:** Questions about claims we have already processed.
- **Benefits determination or rejection:** Requests for us to review the allowance, determination or rejection of a claim.
- **Patient eligibility:** Verification of the patient's active coverage and effective date of coverage.
- **Plan design information:** Review of the patient's coinsurance, deductibles and maximums.

We invite you to contact us:

Through our Web site or by e-mail
For fast, easy access to administrative information and resources, sign in to our secure provider Web site from the provider page of **www.emblemhealth.com** or register to start an account. Once signed in, you'll be able to verify a member's eligibility and benefits, submit and track claims and predeterminations, and review patient utilization history, among several other administrative tasks. Please see section 2.3 for more information about our online capabilities. To contact Dental Professional Relations, you can also send an e-mail to **dentalproviders@emblemhealth.com**.

By phone
A Customer Service representative will answer your call in a timely fashion and, if necessary, route you to the appropriate department. When calling, please have ready the patient's member ID number and date of birth, and use the number appropriate to your office location:

1-212-501-4444	Practices in New York City
1-800-624-2414	Practices outside New York City
1-877-842-3625	Practices in all areas

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

EmblemHealth
Correspondence
PO Box 1701
New York, NY 10023

2.2 Updating Your Practice Records

We maintain all information we have about your practice in our secure computer database. Much of this data appears in network dentist directories. Accurate claims processing requires accurate data about your practice, so it is imperative you notify us of any updates to your practice information.

Whenever one of the following situations occurs, please contact Dental Professional Relations at the appropriate number listed in section 2.1:

- The address of your practice changes
- The telephone number of your practice changes
- You wish to add or delete a dentist from your practice
- Your Internal Revenue Service Taxpayer Identification Number (TIN) changes. (In this case, you will need to complete an IRS W-9 Form and return it to our Dental Professional Relations department.)
- You are reporting your National Practice Identifier (NPI) number to EmblemHealth

For your protection, all changes to your file* must be submitted in writing, either by mail or fax:

EmblemHealth
Dental Professional Relations
PO Box 12365
Albany, NY 12212-2365
Fax: **1-212-615-4953**

* Note: Accuracy is essential. If any information provided is inaccurate, we may be required to withhold 31 percent from all payments to your account and forward this amount to the IRS. In addition, your practice would be subject to a penalty by the IRS for failure to provide your correct name/TIN combination. **To avoid unnecessary withholding, please be sure to contact us when your records require updating**.

2.3 Using Our Online Self-Service Capabilities

From our Web site, you can instantly access information and resources designed to simplify your interactions with us. To use our self-service capabilities, sign in from the provider page of **www.emblemhealth.com** or register to start an account. Once registered, you'll be able to:

Verify eligibility

Find out which services patients are eligible for under their benefit plan. Also find effective dates of coverage, termination dates of coverage and whether coverage is primary or secondary.

Review plan design

Review EmblemHealth policies on:

- Network benefits.
- Preventive and diagnostic services.
- Prosthetics, crowns and other major services.
- Restorative and other basic procedures.
- Orthodontic benefits.
- Out-of-network coverage.

Research patient utilization history

Double-click on the patient's name on the dental eligibility screen to access information on:

- Current year benefits usage.
- Tooth and service history for the past 60 months (some services have frequency limitations).

Check claims status

Enter the service date to find out:

- Whether we have received your claim.
- The date we received your claim.
- Whether the claim has been paid, denied or is in process.

Check predetermination status

Enter the member ID number, date of service and/or predetermination number to find out whether:

- Your request is on file with us.
- Your request has been approved.

Identify network specialists for referrals

To locate network specialists in your region, use our online "Find a Doctor" tool at **www.emblemhealth.com**. It lets you search for specialists who practice within 100 miles from your office location or from the patient's home. Simply select the correct dental network and enter a ZIP code to identify the following specialists:

- Endodontists
- Oral surgeons
- Orthodontists
- Pediatric dentists
- Periodontists
- Prosthodontists

Submit electronic claims

To help expedite claims processing and reimbursement, submit your claims online at **www.emblemhealth.com**. See section 3.2 for instructions on setting up an account.

2.4 Using Our AnswerLine Phone Service

Most of our Web site services are also available through AnswerLine, our automated touch-tone telephone system. It guides you through a menu of options, letting you access information about your patients' coverage anytime.

Simply call **1-212-501-4444** (callers in New York City) or **1-800-624-2414** (callers outside New York City) and enter the member ID number when prompted by the recorded voice.

Have handy your tax ID number filed with us, along with the patient's member ID number and date of birth.

3.0 CLAIMS

3.1 Claims Submission Process

To help us process claims promptly, please submit claims within the established time frames. Claim forms should be filed within 30 days of the service date, and no later than within 18 months of the service date. If you do not file a claim on time, we may still pay the claim if we determine it was not reasonably possible for you to have filed the claim on time and that the claim was filed as soon as it became possible to do so.

To expedite claims processing, we use a claim scanning feature, available for dental claim receipts. It scans typed, single-page documents submitted on the most current ADA forms. While we will continue to accept the alternate forms listed in section 3.3, outdated or handwritten forms will go through the routine claims processing workflow rather than through this more efficient scanning workflow.

To optimize claim turnaround time, you should aim to submit:

- Typed claims.
- Current ADA forms.
- Individual claim forms, limiting attachments whenever possible.

Mail your claims to:

EmblemHealth
Dental Claims
PO Box 2838
New York, NY 10116-2838

3.2 Electronic Claims Submissions

By submitting your claims electronically, you can enjoy the benefits of a paperless claims submission process and speedier claims reimbursement. If you have the capability, we request you submit electronic claims for procedures that do not require diagnostic review. Please note that paper claims are still required for procedures that need coordination of benefits statements from a primary carrier. To learn more, please contact our Electronic Data Interchange (EDI) Help Desk at **1-212-615-4EMC**.

For diagnostic submissions, we recommend using services available through National Electronic Attachment (NEA). Through an agreement with NEA, our network dentists may submit X-rays electronically using NEA's *FastAttach*™ system. For more information on *FastAttach* or to register for an account, please visit **www.nea-fast.com**, call **1-800-782-5150**, **ext. 2**, or send an e-mail to **sales@nea-fast.com**.

Advantages of electronic claims submissions and diagnostic submissions include:

- Fewer paper claim forms to stock or print out, and fewer claims to mail.
- Quicker claims submission, leading to faster reimbursement.
- Fewer opportunities for misplaced documentation, reducing staff time spent on follow-up.
- Reduced costs and clerical time.
- Replacement of mailed X-rays with electronic attachments.

Please note that while we do not charge you for electronic claims submissions, you will be charged fees by clearinghouses, software vendors and/or billing services.

3.3 Paper Claims Submissions

Although many practices favor electronic claims submission, some claim reimbursements are still initiated with paper claim forms.

To ensure prompt adjudication, please be sure your paper claims contain all the information required for claims processing. Please note the following about paper claims submissions:

- We will accept the following paper claims submissions:
  - Standard and most current ADA claim form.
  - Computer-generated claim form with ADA format. (Please submit the ADA's most recent claim form whenever possible. Be sure that the rendering provider's full name is clearly legible on all paper claim submissions.)
  - Typewriter-generated claim forms.
- For claims involving prosthetics (dentures, bridges and crowns) and orthodontics, submit claims to us only after insertion or final cementation is complete.
- When treating patients for injuries resulting from automobile- or work-related accidents or illnesses, please indicate this on the ADA claim form. These claims require special handling.
- Always include your tax ID number on claim forms.
- Always include your NPI number on claim forms.
- When entering the procedure code on a claim, please use the most recent CDT coding.

Please be sure to complete the Description of Services section on the claim form.

3.4 Predeterminations and Claims Review

Through our predetermination of benefits process, network dentists work with us to verify the necessity and cost effectiveness of a proposed treatment plan. Predeterminations, or pretreatment estimates, are valuable when it comes to proposing treatment, arranging funding with patients and avoiding billing disputes with patients, since the projected payment amount for the proposed treatment plan appears right on the predetermination. Predetermination is not promise of payment and is processed up to the plan maximum.

We suggest predetermination of benefits for procedure codes, including surgeries, prosthetics, major restorations, orthodontics and other high-dollar treatments. This lets you assess benefit amounts and determine whether alternate benefits apply. Emergency treatment is excluded from the predetermination process.

Please check off the predetermination field on the electronic or paper submission.

We will provide predeterminations for your practice for the following procedures:

Restorative

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

Endodontics

- Root canal therapy
- Apicoectomy/periradicular surgery
- Root amputation
- Hemisection

Periodontics

- 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
- Scaling and root planing
- Combined connective tissue and double pedicle graft

Prosthodontics

- Dentures
- Inlays/onlays
- Fixed bridgework
- Post and core

Oral Surgery

- Removal of impacted tooth
- Surgical removal of residual tooth roots
- 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
- Transseptal fiberotomy/supra crestal fiberotomy

Orthodontics

- Orthodontic study models should only be submitted upon request.

Please mail your predetermination requests to:

EmblemHealth
Dental Claims
PO Box 2838
New York, NY 10116-2838

3.5 X-Ray Submissions

We strive to review and return your X-ray submissions as quickly and efficiently as possible and ensure proper benefit determination for your patients. Please note that X-rays which are submitted without clear labeling, are poorly attached to the claim form or are of poor diagnostic quality may delay claims processing. **We recommend that you keep a copy of your patients' X-rays in your files**.

You can send EmblemHealth your X-rays electronically once you have a *FastAttach* account with National Electronic Attachment (NEA). See section 3.2 for information on setting up an account.

The following steps will 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 appear on the label. Also include a notation indicating right and left and top and bottom. In the case of single films, the label should be on the frame or on an envelope containing the X-ray.
- **Affix the claim form to the X-ray.** We recommend stapling the X-ray to the claim form.
- **Ensure duplicate X-rays are of good diagnostic quality.** Our dental consultants cannot make an accurate benefit determination with duplicate X-rays of poor diagnostic quality.

The following procedures require the submission of X-rays:

Restorative

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

Endodontics

- Root canal therapy
- Apicoectomy/periradicular surgery
- Root amputation
- Hemisection

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

Periodontics (periodontal charting only)

- Scaling and root planing
- Periodontal maintenance
- Localized delivery of chemotherapeutic agents
- All periodontal surgeries require both charting and X-rays.

Prosthodontics

- Inlays/onlays
- Fixed bridgework
- 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

Orthodontics

- Your office may elect to submit duplicate X-rays of high diagnostic quality.

3.6 Standard Exclusions, Limitations and Guidelines

Plan sponsors, which are typically very large groups, often customize plans. This presents a challenge for insurance carriers and dental practices in defining plan designs and covered services. Services covered by some benefit plans may not be covered by others. However, most of our plans share plan design features and claims processing guidelines. In this section, we provide a summary of these plan design elements to help familiarize you with our plans.

Claims Processing Guidelines:

- **Composite and amalgam restorations:** We use the following guidelines for minor restorative services:
  - Temporary fillings are not covered, and are considered part of the complete service allowance.
  - Posterior composite fillings on molars are reimbursed at the amalgam level.
- **Comprehensive oral evaluations:** We consider a comprehensive oral evaluation (code D0150) to include the creation of a new patient record. Nonemergency evaluations performed on patients of record are considered periodic oral evaluations (code D0120).
- **Crown lengthening:** Crown lengthening is a payable service only when performed by a specialist who is not the dentist providing the crown itself.
- **Endodontics:** EmblemHealth considers treatment of root canal obstruction, nonsurgical access (code D331) inclusive of the endodontic therapy (codes D3310, D3320 and D3330). The patient should not be billed for treatment of root canal obstruction, nonsurgical access.
- **General anesthesia:** The licensed dentist or surgeon must hold a certificate issued by the State Education Department for the administration of general anesthesia and parenteral sedation. During the administration of general anesthesia, a minimum of three individuals must be present. These individuals should include the qualified dentist or surgeon administering the anesthesia and

two individuals with Basic Life Support (BLS) course completion cards. At least one individual must be trained in patient monitoring.

- **IV sedation:** The licensed dentist or surgeon must hold a certificate issued by the State Education Department for the administration of general anesthesia and parenteral sedation or for dental parenteral conscious sedation. During the administration of parenteral conscious sedation, at least one additional person who is competent in Basic Life Support (BLS) or its equivalent must be present with the dentist or surgeon. This may be a chairside assistant.
- **Infection control:** Infection control, sterilization and other OSHA-related costs are not considered dental procedures or services. Patients with EmblemHealth dental coverage are not responsible for costs related to OSHA (Occupational Safety & Health Administration) regulation, infection control or other items and services required to comply with federal and state environmental laws and regulations.
- **Laboratory costs and materials:** In developing our plan allowances, 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 is reflected in submitted procedure codes. Our network dentists may not bill patients with EmblemHealth dental coverage separate charges for these expenses.
- **Localized delivery of chemotherapeutic agents:** This service must be performed in conjunction with periodontal scaling and root planing or periodontal maintenance.
- **Major restorative services:** The following guidelines apply to major restorative procedures:
  - EmblemHealth reimburses onlays based upon the allowance for the inlay code for the same materials and corresponding number of surfaces.
  - One-surface inlays will be reimbursed as one-surface fillings.
  - EmblemHealth reimburses crowns, abutment crowns and pontics with noble and high noble metal based upon the allowance for predominantly base metal.
  - EmblemHealth considers core buildups (code D2950) inclusive of the crown restoration. The patient should not be billed for a core buildup.
  - Crowns over implants are reimbursed based upon the allowance for a single crown, porcelain fused to predominantly base metal.
- **Oral examinations:** Plan allowances for clinical oral evaluations include charting, if necessary. The covered patient should not be billed an additional fee for these services.
- **Orthodontics:** Orthodontic benefit plan designs differ among networks. Please refer to the appropriate network fee schedule for an explanation of orthodontic benefits specific to that plan.
- **Periodontics:** A periodontal maintenance procedure (code D4910) must follow active periodontal therapy.
  - **Periodontal treatments:** Covered patients are eligible for a maximum of five periodontal treatments per calendar year. For example, a patient's benefit plan would cover four quadrants of scaling and root planing and one periodontal maintenance procedure in a single calendar year, **provided the patient is eligible for these procedures under the patient's dental plan. Please see below for frequency limitations for specific periodontal procedures**.
  - **Charting:** Patients should not be billed a separate charge for charting that occurs during the evaluation process.
  - **Periodontal surgery/osseous surgery, including flap entry and closure (codes D4260 and D4261):** Coverage applies to necessary* periodontal surgery performed on up to two quadrants on a single date of service. Periodontal surgery on any given quadrant is covered only once in a three-year period.

*__Criteria__: Periodontal surgery is considered necessary when the following are present:
- Inflammation of gingival tissue
- Bleeding upon probing
- Changes in contour and/or consistency
- Pocket depths of 5 mm or greater
- Moderate-to-advanced periodontitis characterized by loss of supporting periodontal hard and soft tissue and loss of clinical attachment
- Mucogingival defects
- History of related symptoms, including drug-induced gingival hyperplasia

***Claims and predeterminations*:** Both types of submissions must include 1) radiographs and 2) periodontal charting within six months of the date of service that reflects six points of pocket-depth measurement per tooth.

- **Periodontal scaling and root planing (codes D4341 and D4342):** Coverage applies to necessary** periodontal scaling and root planing performed on up to two quadrants on a single date of service. Scaling and root planing on any given quadrant is covered only once in a three-year period. When a prophylaxis and a periodontal scaling and root planing occur on the same date of service, the prophylaxis is covered when the scaling and root planing is performed on one to three teeth per quadrant (D4342) but not on four or more teeth per quadrant (D4341). Scaling and root planing is not covered when performed on the same quadrant and on the same date of service as periodontal osseous surgery.

  **__Criteria__: Periodontal scaling and root planing is considered necessary when pocket depths are 4 mm or greater.

  ***Claims and predeterminations*:** Both types of submissions must include periodontal charting within six months of the date of service that reflects six points of pocket-depth measurement per tooth, as well as radiographs upon request.
- **Full mouth debridement (code D4355):** This procedure is not considered a prophylaxis and counts as one of the five periodontal treatments allowed per calendar year. Coverage applies only once every three years. Full mouth debridement is not covered on the same date of service that periodontal maintenance (D4910) occurs. This procedure is covered when, on a single date of service, periodontal scaling and root planing is performed on one to three teeth per quadrant (D4342), but not on four or more teeth per quadrant (D4341).
- **Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report (code D4381):** Coverage applies when necessary*** and requires evidence of recent scaling and root planing. Coverage also applies only once per site per tooth in a three-year period; for up to one site per tooth; and for up to two sites per quadrant. Coverage does not apply for multiple pockets (sites) on multiple teeth in the same quadrant.

  ***__Criteria__: This procedure is considered necessary when pocket depths are greater than 5 mm.

  ***Claims and predeterminations*:** Submissions must include 1) radiographs and 2) periodontal charting within six months of the date of service that reflects six points of pocket-depth measurement per tooth.
- **Periodontal maintenance (code D4910):** This counts as one of the five periodontal treatments allowed per calendar year. Coverage applies for patients with a history of periodontal therapy.
- **Occlusal adjustment (code D9951):** This counts as one of the five periodontal treatments allowed per calendar year. Coverage applies for patients with a history of periodontal therapy.

• **Specialist consultations:** We will cover a specialist consultation if no other service is rendered by the specialist on that date. The specialist's report must be submitted with the claim form.

- **X-rays:** The maximum allowance for bitewing X-rays is four per patient per calendar year. Our maximum allowance permits 14 periapical X-rays or one panoramic film per three-year period.

General Exclusions:

- Behavioral management (costs incurred for behavioral management).
- Care furnished without charge.
- Cosmetic surgery or treatment.
- Crowns used in splints for periodontal conditions.
- Injuries due to war or an act of war.
- Items and services required by dentists to comply with OSHA regulations.
- No-fault automobile insurance (services for which automobile no-fault insurance benefits are recovered or recoverable).
- Prescription drugs and medications.
- Services covered by the government (e.g., services covered by Medicare or workers' compensation).
- 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 the subscriber's family.
- Temporary appliances.
- Services and appliances for the treatment of temporomandibular joint dysfunction (TMJ) syndrome.
- Workers' compensation payment is available only under a workers' compensation law or similar legislation.

4.0 COORDINATION OF BENEFITS (COB)

4.1 COB Methodology

Occasionally, a patient entitled to benefits under one plan is eligible for similar benefits under another plan. If this happens, the two plans will coordinate their benefit payments so that the combined payments of both plans do not exceed the actual expenses incurred by the patient.

The order of payment is determined as follows:

1. If one plan does not have a COB provision, it will be primary.
2. The benefits of the plan that covers the patient as an employee are primary to those that cover the patient as a dependent.
3. If the patient is a dependent child covered under the plans of both parents, the plan of the parent whose birthday falls earlier in the calendar year shall be primary. If both parents have the same birthday (only the date and month are considered), the plan of the parent with longer coverage under that plan shall be primary. However, if one plan does not abide by this rule but instead follows a rule based on the gender of the parent and, as a result, the plans do not agree on which is primary, then the father's plan shall be primary.

The following policies apply when the parents are divorced or separated:

- When a court decree has established which parent has financial responsibility for the child's health care expenses, that parent's plan shall be primary.
- When financial responsibility has not been established, the plan of the parent with custody shall be primary.
- If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the primary plan is designated in this order:
    1. The plan of the parent with custody.
    2. The plan of the stepparent.
    3. The plan of the parent without custody.
    4. If none of the above apply, the plan that has covered the patient the longest will be primary.

4.2 COB Claim Filing

Claims subject to coordination of benefits where EmblemHealth is either the primary or secondary plan must be handled in the following manner:

- When EmblemHealth is the primary carrier, you may submit claims to us to receive payment, according to the plan allowance schedule. Our plan allowance for the covered service must be

accepted as payment in full and, where applicable, may be supplemented by the patient reimbursement.

- When EmblemHealth is the secondary carrier, the claim form you submit to us must be signed and accompanied by a copy of the claim benefit statement from the primary carrier.
- When EmblemHealth is both the primary and secondary carrier, we will pay up to the higher of the two plan allowances (minus any applicable copayment, coinsurance or deductible) for the secondary plan. Please indicate the existence of both plans on the submitted claim form.
- Where EmblemHealth is a plan that is tertiary or beyond, please submit to us all previous plan benefit statements for our consideration.

4.3 Patient Billing

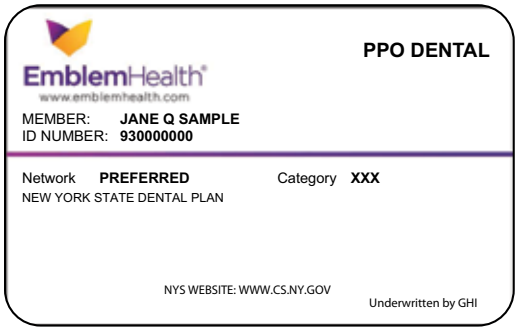
The following table details our claims administration procedure for coordination of benefits. This information should help you determine the maximum amount you may bill patients with EmblemHealth coverage.

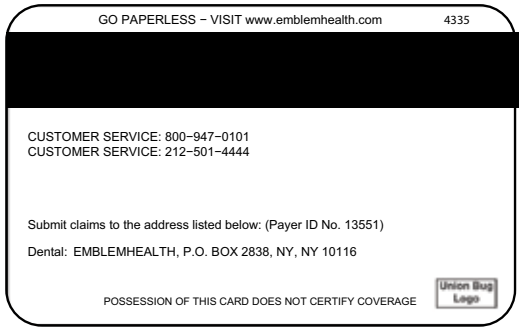
	Dentist is in one of our networks and DOES NOT participate in another PPO	**Dentist is in one of our networks and DOES participate in another PPO**
Primary	The fee is the maximum allowable charge the patient may be billed.	The fee is the maximum allowable charge the patient may be billed.
Secondary	The fee is the maximum allowable charge the patient may be billed.	The negotiated fee for the other maximum allowable PPO (including another EmblemHealth network plan) is the maximum allowable charge the patient may be billed.

5.0 MEMBER ID CARDS

To assist your practice, our dental plans feature member identification cards that provide basic plan information. These plastic ID cards are "combined," meaning they apply to dental, medical and/or hospital plan information for members with this additional coverage.

Following is a sample member ID card for the EmblemHealth Preferred Dental plan:





Front of ID card: Includes the member's name, the member's ID number and the name of the dental plan the patient is insured with. Before rendering services, please be sure the patient's coverage corresponds with your EmblemHealth network participation.

Back of ID card: For individuals with only dental coverage through EmblemHealth, the back of the ID card indicates the type of dental plan, as well as group plan information on dependent child and student age limitations, diagnostic and orthodontic coverage, and annual individual and family deductibles. Having this information should reduce your need to contact Customer Service with questions about group coverage. For groups with EmblemHealth dental, medical and hospital coverage, the back of the ID card indicates the type of dental plan and includes medical and hospital plan information.

Since our ID cards do not display the patient's effective date of coverage, you should verify patients' eligibility status on our Web site. Just sign in from the provider page of **www.emblemhealth.com** or register to start an account. Alternatively, you may also call Customer Service at **1-212-501-4444** (callers in New York City) or **1-800-624-2414** (callers outside New York City). Please be sure to have the patient's certificate number and date of birth when calling.

If a patient presents an EmblemHealth ID card that does not include dental plan information, it is possible the individual does not have coverage with an EmblemHealth dental plan. Some patients are unaware that they have dental coverage through another carrier or through a plan sponsor's self-insured program.

6.0 NOTES

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