2025 PPO Standard Dental Manual

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

This publication is subject to periodic revisions and additions. For questions about these materials, please contact your Provider Network Manager.

Edition 01: 01-2025

Dear Valued Dentist:

We are pleased to provide you with the Hawaii Medical Service Association (HMSA) 2025 Dental Manual – (Edition 1-2025), an administrative guide to assist you and your staff in servicing our members - your patients.

This **Dental Manual**, along with the **CDT Dental Procedure Guidelines** that follow it, provides you with the policies and procedures necessary to support your practice when doing business with us. The Dental Manual is an accompaniment to your Dental Network Participation Agreement ("Agreement"), which provides comprehensive details regarding the terms of your Agreement. The Dental Manual and Agreement became effective September 1, 2012 and is updated as needed.

The Agreement supports HMSA's operating structure and relationship with its affiliate and partner, Life and Specialty Ventures and its subsidiary USAble Life. LSV and USAble Life, through their affiliate, LSV Dental Management, LLC (LSVDM) will continue to serve as administrator for HMSA's dental plans.

The applicable year's CDT Guide lists all ADA codes and their applicable claim guidelines as they relate to our Benefit Plans, including covered and non-covered codes, any criteria that must be met for coverage, and any coverage limitations. You may use the CDT Guide immediately.

Your dedicated **Provider Network Manager** is available to assist you with any questions you have relating to your Agreement, the Dental Manual, or the CDT Guide. You can find your Manager's contact information along with a map of assigned territories in Section 2 of this Dental Manual.

Thank you for the role you and your staff play in providing a welcoming and professional experience for our members who are seeking care for their dental health. From time to time, you can expect to see updates to this Dental Manual to keep you apprised of changes and additional information as it becomes available. If you have any suggestions for what you would like to see included in the Dental Manual, please contact your Provider Network Manager.

We appreciate the quality service you provide to our members and look forward to continuing our mutually beneficial relationship with you and your staff.

Sincerely,

Greg Poulakos
Executive Vice President, Market Solutions
USAble Life

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SECTION 1: DEFINITIONS

The definitions of capitalized terms that are not otherwise defined in the body of the Agreement are set forth in these sections of the Dental Manual.

Account	An employer, union, association, or other group that has entered into an insurance policy or agreement with a HMSA or a Network Plan to provide Covered Services to Members of that Account.
Administrator	LSVDM performs administrator services for Responsible Payors in accordance with the terms of its contracts with such Responsible Payors and the Agreement.
Affiliated Parties	Dentist's employees, affiliates, subsidiaries, members of its board of directors, key management, executive staff, or persons owning 5% or more of Dentist's practice.
Agreement	The "Dental Network Participation Agreement" between a Network Dentist and LSVDM, as Administrator for HMSA's dental plans.
Applicable Laws	Any statutes, regulations, or other legal requirements applicable to the matter being referenced in the Agreement.
Application	The form that a Dentist has completed setting forth requested information concerning his or her professional qualifications, experience, and other relevant credentialing information.
Benefit Plan	The written agreement entered by a Responsible Payor with an Account or an individual which specifies the terms, conditions, limitations, and exclusions applicable to the Member's Covered Services.
Centers for Medicare and Medicaid Services ("CMS")	The agency within the Department of Health and Human Services that administers the Medicare program.
Clean Claim	A claim for Covered Services that is submitted for adjudication in accordance with applicable terms and conditions of this Dental Manual. A claim is clean when it requires no further information, adjustment, or alteration in order to be processed and paid by the Responsible Payor.

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Co-insurance	The percentage that a Network Dentist is required to collect directly from a member as a portion of the Maximum Allowable Charge for Covered Services rendered to that Member.
Conditions of Participation	The minimum qualifications and standards required to be credentialed to participate in a Provider Network, including: 1. Any information set forth or referenced in the Dentist's Application, which is incorporated into the Agreement by reference, shall be true, accurate and correct in all material respects throughout the term of the Agreement, and 2. The Dentist shall notify LSVDM in a timely manner of any material changes in that information.
Confidential Information	All data, reports, interpretations, forecasts, documents, records, and other information fixed in a tangible medium, which contain information concerning a party that: • Is marked, otherwise identified as, or legally entitled to protection as confidential, proprietary, privileged or trade secret information; and • Is disclosed by or on behalf of a party (the "Disclosing Party") to the other party (the "Receiving Party"). Confidential Information does not include information that: • Is based on documents in the Receiving Party's possession prior to disclosure of Information that was not acquired directly or indirectly from the Disclosing Party; or • Was in the public domain at the time of disclosure or subsequently became part of the public domain through no fault of the Receiving Party; or • Was legally received on a non-confidential basis from a third party, who is not known to be bound by a confidentiality agreement preventing the disclosure of such information; or was independently developed by the Receiving Party without reliance on or knowledge of the Disclosing Party's Confidential Information.

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Coordination of Benefits (COB)	The determination of which payors have primary and secondary responsibilities for paying for Covered Services in accordance with the rules set forth in the Member's Benefit Plan when that Member is eligible for Covered Services from more than one payor, including from a governmental or self-funded payor
Copayment	A fixed-dollar amount that a Network Dentist must collect directly from a member as a portion of the Maximum Allowable Charge for Covered Services
Covered Services	Necessary and Appropriate dental care services and supplies rendered to Members in accordance with the terms of the Member's Benefit Plan, the applicable Dental Manual, and the Agreement.
Deductible	The aggregate dollar amount that a member must pay in accordance with the Member's Benefit Plan before the Responsible Payor is required to pay for Covered Services. The Member must pay 100% of the Dentist's Maximum Allowable Charges for Covered Services until the Member satisfies the applicable Deductible.
Dental Group	Group entity that chooses to participate with HMSA Dental under a Participating Group Dental Contract, (rather than under an Individual Provider Contract for each provider affiliated to this group). The Dental Group desires to contract with HMSA Dental to provide and arrange Covered Service to Members.
Dependent	A Member who is eligible and enrolled in a Benefit Plan based upon his or her relationship with a Subscriber
Downstream Entity	The meaning set out in 42 C.F.R. § 422.500(b) and includes any party that enters a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage Organization (or applicant) and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. For purposes of this Section, the Dentist is a Downstream Entity.

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First Tier Entity	First Tier Entities meaning is set out in 42 C.F.R. § 422.500(b) and includes any party that enters a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program. For purposes of this Section, LSVDM is a First Tier Entity. Medicare Advantage program. For purposes of this Section, LSVDM is a First Tier Entity.
HIPAA	The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations
HITECH	The Health Information Technology for Economic and Clinical Health Act and its implementing regulations
HMSA Dental Manual	This document which sets forth the policies, procedures, and requirements applicable to Network Dentists providing dental services to Members
Late Claim	The submission of a Claim for Covered Services to LSVDM, as the Administrator for the Responsible Payor, more than 365 days (one year) from the date of service or the completion of a course of treatment. LSVDM may deny a Late Claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim. Member should NOT be liable for claims denied due to timely filing.
LSVDM	LSV Dental Management LLC
Maximum Allowable Charge Schedule	The amount that LSVDM has determined to be the maximum amount payable for a Covered Service rendered to a member as set forth in the applicable Maximum Allowable Charge Schedule contained on our dental website, at hmsa.com/dental.
Medicare Advantage ("MA")	An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

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Medicare Advantage Organization (“MAO”)/ MA Plan	Hawaii Medical Service Association (“HMSA”), a Medicare Advantage Organization offering Medicare Advantage Programs through an MA Contract and certified by CMS as meeting the MA contract requirements.
Member	A person eligible to receive Covered Services under a Benefit Plan
Member Payments	All charges that a Dentist may collect directly from a member in accordance with the terms of the Member’s Benefit Plan, which include Copayments, Deductibles, or Co-insurance
National Provider Identifier (NPI)	The government-issued, 10-digit identification number for individual healthcare providers and entities
Necessary and Appropriate	Dental services and supplies that are: 1. Rendered consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases). 2. Furnished in accordance with standards of good dental practice. 3. Provided in the most appropriate site and at the most appropriate level of service based upon the Member's condition. 4. Not provided solely to improve a member’s condition beyond normal variation in individual development and aging, including improving physical appearance that is within normal individual variation. 5. As beneficial as any established alternative; and 6. Not rendered solely for the Dentist’s, Member’s or a third party’s convenience
Network Dentists	Dentists who participate in the Provider Network
Network Plan	A UCCI Advantage Plus Plan and Blue Cross and Blue Shield dental plan with which HMSA has a reciprocity or alliance arrangement which permit members of the plan to access care rendered by the Provider Network.

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Non-Covered Services	Services and supplies that are not covered by or limited in coverage pursuant to the Member's Benefit Plan; also, services or supplies, other than Non-Reimbursable Services, for which the Dentist does not receive reimbursement from a Responsible Payor after exhausting the Dispute Resolution Procedure set forth in the applicable dental manual
Non- Reimbursable Services	Services that would have been Covered Services but for the fact that the Dentist: 1. Rendered services that were not Necessary and Appropriate, or 2. Failed to comply with applicable requirements of the Dental Manual in connection with the provision of such Services, or 3. Failed to submit a claim for such services within the submission deadlines established by the applicable Dental Manual
Out of Country Services	Dental services rendered by a dental provider that is not contracted with us nor has any contracts with our affiliated networks and located outside the United States and its territories. The services are not covered and the patient responsible for the provider charges.
Plan	An HMSA dental plan or a Network Plan.
Predetermination of Benefits	A Dentist's submission of information to the Responsible Payor prior to rendering services, to request that the Responsible Payor inform the Dentist if services may be Covered Services and what Allowable Charge, Copayment, Co-insurance, and Deductible amounts may apply. A Predetermination of Benefits is not a commitment and does not create any obligation to pay any amount for services rendered. A Predetermination is subject to: • The accuracy and completeness of the Dentist's submission of information, • Such services being Necessary and Appropriate, • The Member's eligibility at the time services is rendered, • The Responsible Payor's allowed payment for such services, and • The terms of the Member's Benefit Plan at the time services are rendered

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Provider	(1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in the activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.
Provider Network	The group of Dentists who contract with LSVDM/HMSA to render Covered Services to Members.
Related Entity	Any entity that is related to the MA organization by common ownership or control and (1) performs some of the MAO's management functions under contract or delegation (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAO at a cost of more than $2,500 during a contract period.
Responsible Payor	The Plan responsible for paying benefits for Covered Services rendered to a member.
Subscriber	A Member who is eligible and enrolled in a Benefit Plan as an individual or as an employee or member of an Account
Teledentistry	The use of electronic information, imaging, and communication technologies, such as interactive audio, and video to provide dental care delivery, diagnosis, consultation, treatment, transfer of dental information and education.
Unbundling	The use of more than one procedure code to bill for a procedure that can be adequately described by a lesser number of codes, filing for services that are an integral part of a procedure, and filing for procedures (such as "sterilization", services, or PPE supplies) that are required in rendering dental services.
Utilization Management Program	The review process used to evaluate if services rendered to Members are Necessary and Appropriate

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SECTION 2: CONTACT INFORMATION

A. Customer Service and Claims

At HMSA, one of our most important goals is to nurture a relationship with you defined by mutual respect and responsiveness. Please do not hesitate to contact us with any questions about your plan, claims or other issues.

Plan	Schedule of Allowances	Customer Service	Claims Address	Electronic Claims Payor ID
• HMSA PPO • HMSA Plan for Federal Employees	PPO Fee Schedule	(808) 948-6440 Toll free: 1-800-792-4672	HMSA Dental P.O. Box 69436 Harrisburg, PA 17106-9436	HMSA1
• HMSA DHMO	DHMO Fee Schedule	(808) 948-6440 Toll free: 1-800-792-4672	HMSA Dental P.O. Box 69436 Harrisburg, PA 17106-9436	HMSA1
• Medicare Advantage	Medicare Advantage Fee Schedule	(808) 948-6440 Toll free: 1-800-792-4672	HMSA Dental P.O. Box 69436 Harrisburg, PA 17106-9436	HMSA1
Federal Employee Program (FEP)-Standard and Basic Option Plans	PPO Fee Schedule	(808) 948-6281 Toll free: 1-800-966-6198	HI FEP Claims P.O. Box 69401 Harrisburg, PA 17106-9401	HMSA1
BCBS FEP Dental Plans (Supplemental)	PPO Fee Schedule	In the U.S.: (855) 504-2583 International Call Collect: 1-651-994-2583	BCBS FEP Dental Claims P. O. Box 75 Minneapolis, MN 5544 0-0075	Not Available
Out of State BCBS GRID or GRID+ Member Plans	PPO Fee Schedule	See member ID card	See member ID card	Not Available

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B. Provider Network Managers

Jessica Chang and Leimomi Kiyono are available to answer any questions you have about working with HMSA Dental. Please refer to the territory maps below to determine the Provider Network Manager for your area.

Jessica Chang, RDH BA Phone: **808 538-8904** Fax: **808 538-8996** E-mail: Jessica.Chang@usablelife.com		
96720	Hawaii	Hilo
96749	Hawaii	Keaau
96772	Hawaii	Naalehu
96778	Hawaii	Pahoa
96714	Kauai	Hanalei
96716	Kauai	Hanapepe
96722	Kauai	Princeville
96741	Kauai	Kalaheo
96746	Kauai	Kapaa
96754	Kauai	Kilauea
96766	Kauai	Lihue
96796	Kauai	Waimea
96763	Lanai	Lanai City
96748	Molokai	Kaunakakai
96701	Oahu	Aiea
96706	Oahu	Ewa Beach
96707	Oahu	Kapolei
96707	Oahu	Makakilo
96712	Oahu	Haleiwa
96717	Oahu	Hauula
96731	Oahu	Kahuku
96782	Oahu	Pearl City
96786	Oahu	Wahiawa
96789	Oahu	Mililani
96792	Oahu	Waianae
96797	Oahu	Waipahu

Leimomi Kiyono, RDH Phone: **808 538-8933** Fax: **808 538-8996** E-mail: Leimomi.Kiyono@usablelife.com		
96704	Hawaii	Captain Cook
96727	Hawaii	Honokaa
96738	Hawaii	Waikoloa
96740	Hawaii	Kailua-Kona
96743	Hawaii	Kamuela
96750	Hawaii	Kealakekua
96755	Hawaii	Kapaau
96713	Maui	Hana
96732	Maui	Kahului
96753	Maui	Kihei
96761	Maui	Lahaina
96768	Maui	Pukalani
96768	Maui	Makawao
96779	Maui	Paia
96790	Maui	Kula
96793	Maui	Wailuku
96734	Oahu	Kailua
96744	Oahu	Kaneohe
96795	Oahu	Waimanalo
96813	Oahu	Honolulu
96814	Oahu	Honolulu
96815	Oahu	Honolulu
96816	Oahu	Honolulu
96817	Oahu	Honolulu
96818	Oahu	Honolulu
96819	Oahu	Honolulu
96821	Oahu	Honolulu
96822	Oahu	Honolulu
96825	Oahu	Honolulu
96826	Oahu	Honolulu

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SECTION 3: YOUR RELATIONSHIP WITH HMSA

A. Dentist's Responsibilities

As a participating Dentist, you are solely responsible for making treatment recommendations and decisions for your patients. You are also responsible for ensuring that all claims you submit are accurate, complete and in adherence with recognized standards of coding.

B. HMO Participation Facility Evaluation Requirements

As a DHMO provider, our network managers will be conducting site assessment and facility visits annually. These site assessments follow the CDC guidelines. For more information, please visit the CDC at the link provided. Non-compliance with these standards may result in the denial or termination in HMSA DHMO network participation.

cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf

C. Confidentiality of Patient Information

The Privacy Rule enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strengthened the protections already in place at HMSA to safeguard our members' protected health information (PHI). Since the Privacy Rule applies to payors and providers, HMSA shares with you the responsibility of protecting privacy.

The HIPAA Privacy Rule allows for HMSA to share PHI with other parties without members' authorization under certain circumstances, including when we have a business relationship with the third party and to the extent, we need to share the information to support treatment, payment, or health care operations, as defined by the Privacy Rule. If you have questions about the Privacy Rule, seek advice from your attorney or business counselor.

We are sensitive to concerns about confidentiality and will take every precaution to protect the privacy of your patients' dental records, including validating your provider information when you call us. As your Agreement with HMSA states, we may require access to or copies of members' dental records. Our members' subscriber certificates and benefit descriptions advise members of our right to access and handle their records to support treatment, payment, and healthcare operations.

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D. CMS Required Notices/Provisions

The following provisions will only apply to services rendered to MA Members. These provisions may be supplemented by MA policies, procedures, and other provisions in this Manual, as the same may be updated from time to time. Nothing in these terms will be construed to relieve Dentist of any obligation or requirement established by the Provider Agreement, except to the extent the obligation or requirement is inconsistent with these Medicare Advantage Requirements, in which case these Medicare Advantage Requirements will control as to the MA Program only. To the extent that any greater rights or obligations between the parties are created in these provisions than are in the Provider Agreement, such rights and obligations will only apply to services provider under the MA Programs. If there is any conflict between the Provider Agreement, this Section, or any other Section in the Provider Manual, the Medicare Advantage laws, regulations and CMS instructions will control.

CMS Required Notices/Provisions for Medicare Advantage

Compliance with MA Plan Policies and Procedures. To the extent permitted by law, Dentist shall comply and shall contractually obligate its Downstream Entities to comply with MA Plan's relevant written policies and procedures, including policies and procedures for the control of fraud, waste, and abuse in the MA Programs.

1. Consistency with MA Contract. Dentist shall perform services and shall ensure that Downstream Entities perform services in a manner that complies and is consistent with MA Plan's obligations to CMS set forth in the MA Contract or MA Plan's contract with its First Tier Entity.

2. Confidentiality and Privacy. Dentist agrees to comply with safeguarding MA Members' and beneficiaries' privacy and confidentiality and assure accuracy of health records, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of health records, or other health and enrollment information, (2) ensuring that health information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuing timely access by enrollees to the records and information that pertain to them. Dentist further agrees to safeguard the privacy of any information that identifies a particular MA Member and have procedures that specify: (i) for what purposes the information will be used within the Dentist's organization: and (ii) to whom and for what purposes it will disclose the information outside the Dentist's organization.

3. Rendition of Care; Nondiscrimination. Dentist agrees to render all necessary dental services to each Member, during Dentist's regular office hours; provided, however, that Dentist shall have the right within the framework of professional ethics to reject any Member seeking Dentist's professional services. Dentist agrees (a) not to discriminate in the treatment of Members or in the quality of services delivered to Members based on race, sex, sexual orientation, age, religion, place of residence, health status, national origin, disability, or source of payment, and (b) to observe, protect, and promote the rights of Members as patients. Factors related to health status include, but are not limited to, the Member's medical condition, claims experience, medical history, and evidence of insurability or genetic information. Dentist also ensures that services are provided in a culturally competent manner to all MA Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

4. Hold Harmless.
   a. Dentist agrees that in no event, including but not limited to non-payment by HMSA or LSVDM, insolvency of HMSA or LSVDM or breach of the Provider Agreement or violation of this Section of the Manual, shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against a MA Member or a person acting on behalf of a MA Member for services provided pursuant to this Section. This section does not prohibit Dentist from collecting MA Member Cost Sharing, as specifically provided in the Benefit Plan, or fees for non-covered services if a MA Member has been informed in advance that services that are not covered and that MA Member is financially responsible for any non-covered services. This Section 5 will remain in-force and will survive termination of the Provider Agreement, regardless of the reason for termination, including the insolvency of HMSA or LSVDM and shall supersede any oral or written agreement between Dentist and a MA Member.

   b. Dentist agrees that in no event, including but not limited to non-payment by the State, shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against a Dual Eligible MA Member for Cost Sharing that is the responsibility of State Programs. To ensure compliance, Dentist agrees to either (1) accept HMSA's or LSVDM's payment as payment in full, or (2) bill the State for the amounts that are the responsibility of the State Program.

   Contracts with Downstream Entities. If Dentist contracts with a Downstream Entity to fulfill Dentist's obligations hereunder, Dentist shall require the Downstream Entity, by written agreement, to comply with all provisions of these CMS Required Notices/Provisions. HMSA and LSVDM retain the right to approve, suspend, or

terminate any arrangement between Dentist and a selected Downstream Entity with respect to services provided under these CMS Required Notices/Provisions.

5. Excluded Persons. Dentist represents and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Dentist shall check appropriate databases regularly, but no less than annually and upon hiring and subcontracting, to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare program or any other federal health care program. Databases include the U.S. Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals/Entities (http://www.oig.hhs.gov/fraud/exclusions.html) and the *General Service Administration Lists of Parties Excluded from Federal* Procurement and Nonprocurement Programs (http://www.epls.gov/FAQEPLS.html).

   Dentist shall notify LSVDM immediately in writing if Dentist, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal program monitored as described in this section. Dentist shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the delivery or administration of Covered Services to MA Members. HMSA and LSVDM reserve the right to require Dentist to demonstrate compliance with this provision upon reasonable request.

7. Fraud, Waste and Abuse Prevention.
   a. **Policies and Procedures.** Dentist shall adopt and follow, and Dentist shall require its Downstream Entities to adopt and follow policies and procedures that reflect a commitment to detecting, preventing, and correcting fraud, waste, and abuse in administration of the MA Programs. Dentist shall implement this Section 8a within a reasonable time, but not later than December 31, 2017. HMSA and LSVDM reserve the right to require Dentist to demonstrate compliance with this provision upon reasonable request. Such policies and procedures shall include but are not limited to policies and procedures regarding:

i. Dentist's code of conduct.

ii. Ensuring that Dentist's managers, officers, and directors who are responsible for the administration or delivery of MA Programs benefits are free of conflicts of interest in the delivery and administration of such benefits**.**

iii. Delivery of annual general and specialized Medicare compliance training for all persons involved in administration or delivery of MA Programs benefits. (General compliance training shall include subjects such as Dentist's compliance responsibilities, code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues. Specialized compliance training shall include prevention of fraud, waste, and abuse ('FWA"), FWA laws and regulations, recognizing and reporting FWA, consequences and penalties of FWA, available FWA resources, and areas requiring specialized knowledge of applicable MA Programs procedures and requirements for Dentist to Perform or provide services under this Section).

iv. Prompt reporting of compliance concerns and suspected or actual misconduct in the administration or delivery of MA Programs benefits to HMSA and LSVDM, including non-retaliation against any Affiliated Party or Downstream Entity for reporting in good faith compliance concerns and suspected or actual misconduct. Dentist acknowledges that violation of such non-retaliation policy constitutes a material breach of the Provider Agreement and a direct violation of this Section of the Manual.

v. Monitoring and auditing of Dentist's performance of its obligations under these CMS Required Notices/Provisions.

b. Cooperation with Compliance Activities. Dentist shall cooperate with First Tier Entity's compliance program, including, but not limited to inquiries, preliminary and subsequent investigations, and implementation of corrective actions. Dentist shall cooperate with CMS's compliance activities, including investigations, audits, inquiries by CMS or its designees, and implementation of any corrective action. Upon completion of any audit that Dentist performs pursuant to the Provider Agreement or this Section of the Manual, Dentist shall provide LSVDM a copy of audit results and shall make all audit materials available to LSVDM upon request.

Fraud and Abuse Statutes. Dentist shall comply with federal statutes and regulations designed to prevent fraud, waste, and abuse, including without limitation applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.), the Anti-Kickback statute (42 U.S.C. § 1320a- 7b(b)), and the Anti-Influencing Statute (42 U.S.C. § 1320a-7a(a)(5)).

8. Inspection, Evaluation, Audit and Document Retention.

a. **Access to Records.** Dentist shall permit LSVDM, HHS, and the Comptroller General, or their designees, to inspect, evaluate, and audit any books, contracts, records, including dental records, and documentation of the Dentist and Downstream Entities that pertain to any aspect of services performed, reconciliation of benefits, and determination of amounts payable under the CMS Contract, or that HHS may deem necessary to enforce the contract (the "Records"). Dentist shall provide Records to LSVDM for provision to HHS, the Comptroller general, or their designees, unless otherwise mutually agreed upon. Dentist may not make the access described in this paragraph contingent upon a confidentiality statement or agreement. The above- described rights to inspect evaluate, and audit will extend through the period during which Dentist is required to maintain the Records established in paragraph (c) below.

b. Dentist shall maintain all records and reports reasonably requested by HMSA or LSVDM and shall provide such records and reports to HMSA or LSVDM as reasonably requested, to enable HMSA to meet its obligation to submit such information to CMS and to disclose certain information to MA Members as required by applicable law and regulations.

c. Dentist shall maintain records related to MA for ten (10) years from the longer of (i) the termination or expiration of the Provider Agreement or (ii) completion of final audit by CMS, unless otherwise required by law.

9. Offshore Operations. Dentist shall not disclose any of HMSA's enrollees' health or enrollment information, including any dental records or other Protected Health Information (as defined in 45 C.F.R. § 160.103), to, or allow the creation, receipt, or use of any of HMSA's or LSVDM's Protected Health Information by any Downstream Entity for any function, activity, or purpose to be performed outside of the United States, without HMSA's or LSVDM's prior written approval.

10. Compliance. Dentist shall comply with all applicable Medicare laws, regulations and CMS instructions and shall contractually obligate any Downstream Entity or related entity to comply with all applicable Medicare laws, regulations, and CMS instructions. CMS instructions include additional contract terms required by CMS. Dentist shall comply with the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act and all other applicable laws and regulations pertaining to recipients of federal funds.

11. First Tier Entity Monitoring. LSVDM may monitor the performance of Dentist on an ongoing basis. LSVDM's monitoring activities include assessing Dentist and Downstream Entities' compliance with applicable MA Programs provisions including the CMS Required Notices/Provisions. LSVDM reserves the right to request and obtain from Dentist copies or executed contracts or letters of agreement between Dentist and its Downstream Entities.

12. Prompt Payment. LSVDM shall pay Dentist for Covered Services rendered to MA Members within an average of sixty (60) calendar days of LSVDM's receipt of a Clean Claim. LSVDM will pay or deny claims that are not Clean Claims within sixty (60) calendar days of receipt of the request.

14. Termination for Material Breach. Notwithstanding any termination provision in the Provider Agreement, in the event Dentist materially breaches this Section of the Provider Manual and fails to cure the breach within thirty (30) days after LSVDM gives Dentist written notice of the breach, LSVDM may terminate the Provider Agreement upon five (5) days' written notice to Dentist. For purposes of these CMS Required Notices/Provisions, a material breach will have occurred upon the following events including, but not limited to (a) a material violation of HMSA's or LSVDM's policies and procedures, or (b) a determination by CMS that Dentist has not satisfactorily performed its obligations under this Section of the Provider Manual.

15. Accountability. HMSA oversees and is ultimately accountable to CMS for adhering to and complying with all terms and conditions of the MA Contract and that HMSA or LSVDM may only delegate functions to Dentist or a Downstream Entity pursuant to a written agreement specifying the activities and responsibilities of each party, including provisions for revocation of delegation activities, and reporting requirements.

E. HMSA's Responsibilities

HMSA will not interfere with your judgment with respect to a patient's treatment or the Dentist/Patient relationship. However, we do reserve the authority to make eligibility and coverage determinations and to make claims-processing decisions that may include re-bundling or down-coding. You can find additional information on claim requirements in the CDT Manuals located via the Plans, Manuals, and Training page at hmsadental.com.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. Relationship between HMSA and LSVDM

LSV Dental Management, LLC is a Delaware limited liability company. LSVDM is acting as a support company providing administrative services to independent licensees of the Blue Cross and Blue Shield Association (BCBSA), including HMSA. LSVDM is not licensed by BCBSA and is not a joint venture, agent, or representative of BCBSA. LSVDM is solely responsible for the provision of administrative support services in accordance with the terms of the Agreement.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 4: WORKING WITH HMSA

A. What We Offer You

At HMSA, we are committed to helping you provide the best care to your patients and manage a successful business practice. We have built a reputation based on trust and excellent customer service, the same qualities you deliver to your patients.

We offer:

- Fast, reliable, and direct electronic claims-processing
- Dedicated Provider Network Managers
- Competitive reimbursement rates driven by the market
- The HMSA Dental network, which gives you:
- Access to insured members

A listing in our online Provider Directory, which members can use to search for you by location, specialty, gender, or language. They can even print a map with directions to your office. Visit the directory at hmsadental.com and click on Find a Dentist.

We are now using our website, hmsadental.com for all communication with our participating dental providers. Fee schedules, updates and announcements are now available to you at your convenience 24/7.

B. Servicing Family Members

Can providers service their family members and bill HMSA? Yes, you can service your immediate family members, but you cannot bill HMSA for payment. *Immediate* family members include spouses, children, and parents.

HMSA's policy denies benefits for such services. If a payment is made in error, HMSA will recover all payments, and the member will be responsible for 100% of the charges.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 5: CONDITIONS OF PARTICIPATION IN OUR NETWORK

A. Overview

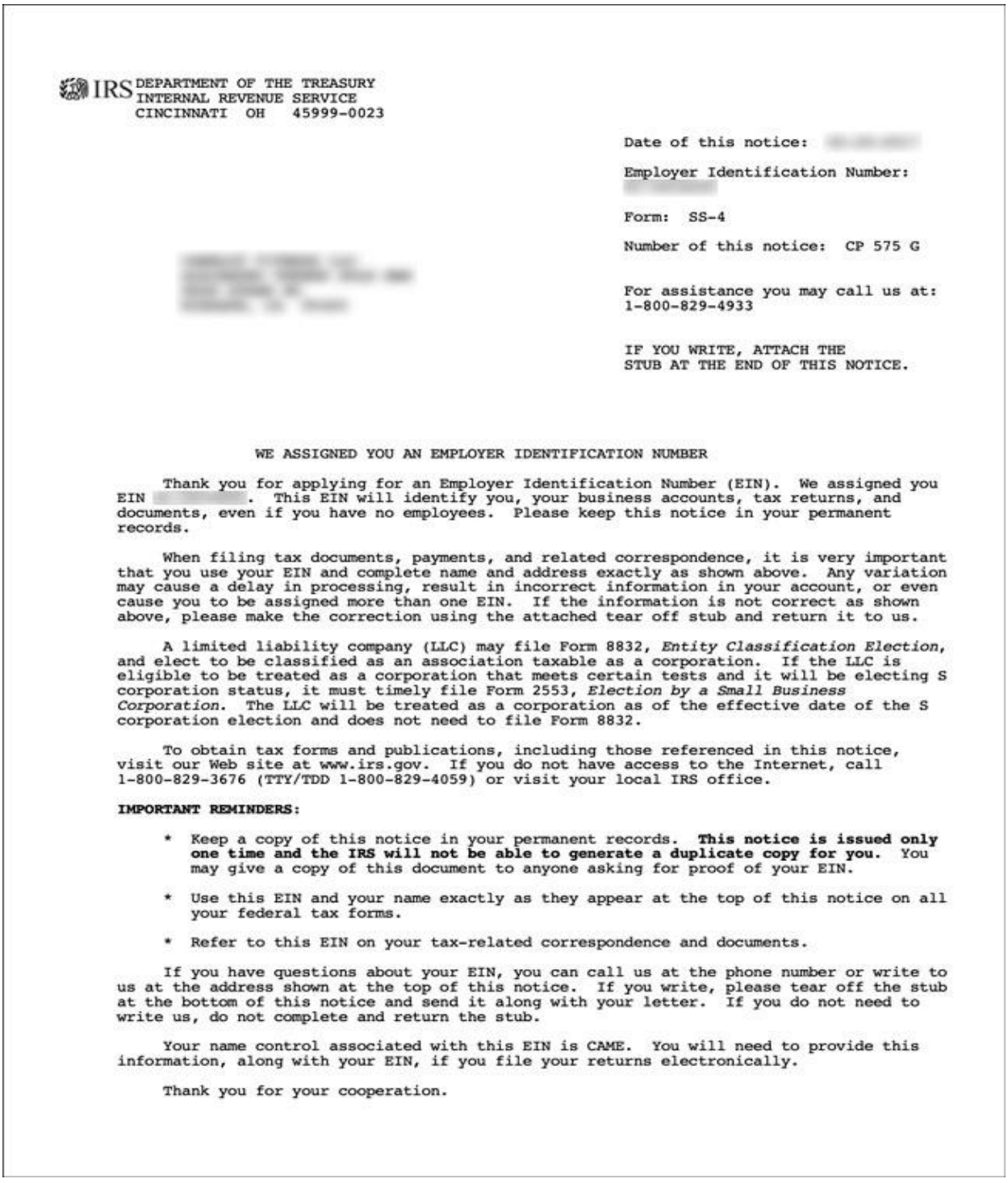
To participate in HMSA's dental network, each dentist must meet the General Conditions, Standards and Requirements, and Contractual Conditions described below.

General Conditions	• You must complete a Provider Application with associated attachments and meet and comply with all HMSA Credentialing requirements. • Submit a W-9 or a tax coupon or letter from the Department of Treasury (IRS) CP 575C. • Sign the LSVDM Dental Network Participation Agreement.
Standards and Requirements	• You must be licensed in Hawaii. If you practice in a state other than Hawaii, you must comply with the license requirements of the state where you are located and where services are rendered to members. • You must maintain individual liability insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in aggregate to insure you against any claim for damages arising by reason of personal injury or death caused directly or indirectly by you. • You must maintain appointment hours which are sufficient and convenient to service members; and at all times, at your expense, provide or arrange for twenty-four (24) hour-a-day emergency on-call service. • You must maintain all appropriate records concerning the provision of and payment for Covered Services rendered to Members. Such records are to be maintained in accordance with customary industry record- keeping standards, Dental Manual requirements, and Applicable Laws. You must maintain dental, financial, and administrative records concerning the provision of services to Members for at least seven (7) years from the date those services were rendered.
Contractual Conditions	• You shall notify HMSA of your intent to terminate or alter your participation. Furthermore, any individual provider wishing to join an existing group practice shall notify HMSA. To the extent that services that otherwise meet the requirement of the LSVDM Dental Network Participation Agreement are rendered by a dentist not located in Hawaii, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of HMSA.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

B. Example of IRS Tax Coupon

For verification, HMSA will accept a W-9, a tax coupon or letter from the Department of Treasury (IRS) CP 575C. See the sample below:



IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice:

Employer Identification Number:

Form: SS-4

Number of this notice: CP 575 G

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN . This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
* Refer to this EIN on your tax-related correspondence and documents.

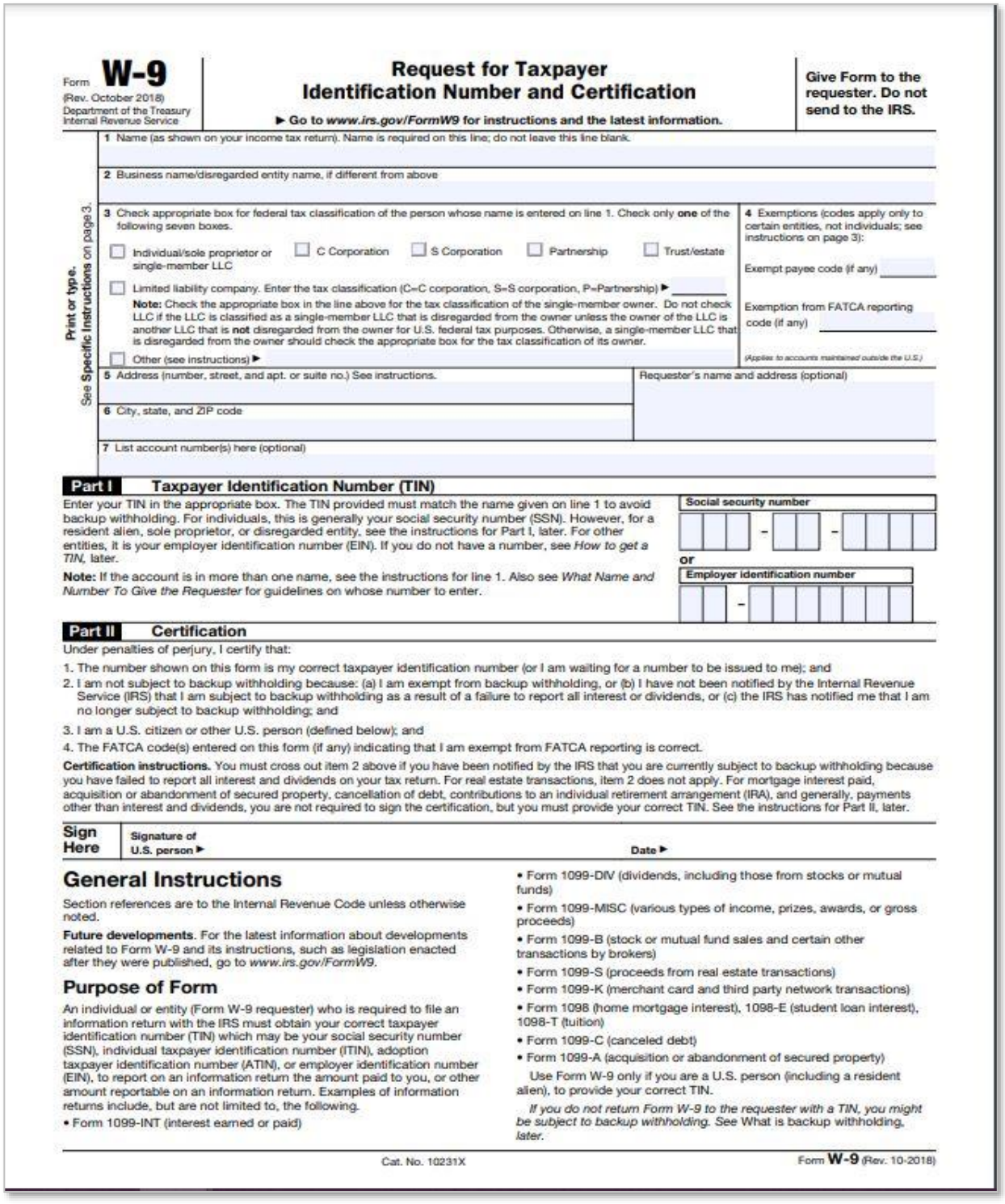
If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

C. Example of W-9 Form



Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

Print or type. See Specific Instructions on page 3.

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ - ___ - ____

or

Employer identification number

__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 6: NATIONAL PROVIDER IDENTIFIER (NPI)

A. NPI Overview

The National Provider Identifier (NPI) is a government-issued, 10- digit identification number for individual healthcare providers and organizations. The numbers are randomly assigned and contain no coded information about the individual or organization. The NPI will never expire, and your individual NPI will remain the same even if you change jobs or locations.

All dentists are required by federal law to obtain an NPI. HMSA requires each Network Dentist to have an NPI regardless of whether the dentist submits claims electronically. We encourage you to obtain an NPI as soon as possible; getting your NPI now will help eliminate issues with claims administration.

B. How to Apply for an NPI

You can apply for an NPI at no charge through CMS' National Plan and Provider Enumeration System website at nppes.cms.hhs.gov. You can choose to either 1) apply online receiving your NPI via email in one to five (5) business days, or 2) download a printable application and submit by mail, processing takes about twenty (20) business days.

Once you have received an NPI, fax a copy of your confirmation to our Provider Network Relations department at **808-538-8996** and we will update your provider record. If you have questions about NPI, contact your HMSA Provider Network Manager, Jessica Chang at 808-538-8904 or Leimomi Kiyono at 808-538-8933

Practice Type	NPI Type
Sole Proprietor or Solo Practitioner	Type 1 NPI only, if claims are transmitted in the dentist's name and social security number.
Individual Dentist at one practice location	Type 1 for the dentist and Type 2 for the practice, if claims are transmitted in the practice's name and Tax Identification Number (TIN)
Multiple dentists, one practice location	Type 1 for each dentist and Type 2 for the practice, if claims are transmitted in the practice's name and TIN
Multiple dentists, one practice location	Type 1 for each dentist and Type 2 for each practice with a separate TIN

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 7: FILING PROVIDER OR PRACTICE CHANGES

Occasionally, you may need to submit changes to us concerning relocation, adding, or changing an Employer Identification Number (EIN) or Tax Identification Number (TIN), adding or terminating an associate, or closing a plan panel. For guidance on how to notify us, please contact your Provider Dental Network Manager. Contact information can be found on the following page of this manual.

A. Changes Requiring Notification to Provider Network Relations

Changes to your practice that require immediate notification include:

- Transfer of ownership (TIN change)
- Change of practice name
- Relocation
- Adding dentists to your practice

Changes to your status that require immediate notification include:

- Licensure
- Accreditation
- Certification
- Qualification

B. Documents Required for Processing

Type of Change	Supporting Documentation Needed for Processing
Add a new associate dentist/orthodontist to your practice	Request a packet from your Dental Network Manager or complete the online application on our website at hmsadental.com under Providers / Join Our Network
Employer Identification Number (EIN) or Taxpayer Identification Number (TIN)	Copy of letter from the IRS (CP 575) or your tax coupon receipt
General location/contact information (telephone, fax, etc.)	Address Change –Closed Location-Additional Location Form located on our website at hmsadental.com under Providers/ Update Your Status.
Add additional practice locations	Address Change –Closed Location-Additional Location Form located on our website at hmsadental.com under the Providers / Update Your Status

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Associate dentist/orthodontist who has left your practice	Address Change –Closed Location-Additional Location Form located on our website at hmsadental.com under the Providers / Update Your Status
Add or Change Tax ID or NPI	Tax ID and NPI Add or Change hmsadental.com under the Providers / Update Your Status.
Terminate participation in the network	A letter of termination and/or an Address Change – Closed Location-Additional Location Form located on our website at hmsadental.com under Providers / Update Your Status

C. Submission Methods Accepted

Status change forms may be obtained from hmsadental.com and emailed to HMSAdentalPR@usablelife.com or faxed to **808-538-8996**.

You may also submit a change by mail to the address listed below. Please refer to the following contact information page to verify the designated Provider Network Manager in your area should additional assistance be needed.

HMSA Dental
Attn: Provider Relations
P.O. Box 1320
Honolulu, HI 96807-1301

Network Manager Emails:
Jessica.Chang@usablelife.com
Leimomi.Kiyono@usablelife.com

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 8: TERMINATION

Your Dental Network Participation Agreement shall remain in effect until terminated in accordance with such Agreement. The two (2) types of termination are:

A. Term Agreement Overview

1. **Without cause:** either party may terminate the Agreement with an effective date after the initial one-year term without cause by giving at least ninety (90) days written notice to the other party at their address on file. For LSVDM, that address is:

   HMSA Dental
   Attn: Provider Relations
   PO Box 1320
   Honolulu, HI 96807-1320

   The effective date of the termination will be as of 12:01am on the first day of the month following the 90-day notice period. During this 90-day period the dentist will be responsible for sending all patients of record written notification that (s)he will no longer be an in-network provider with LSVDM. The parties may also terminate the Agreement at any time by written mutual consent.

2. **With cause:** may occur immediately with written notice to the dentist. Causes include but are not limited to material breach, fraud, misrepresentation, and loss, limitation, or suspension of licensure. You must conspicuously post or provide members with notice that you no longer participate with the plan.

   With cause: may occur if you do not consent to any change(s) to the Agreement made by LSVDM. The "Agreement" consists of the Dental Network Participation Agreement, Dental Manual, any Amendments to the Dental Network Participation Agreement, and any updates to the Dental Manual. LSVDM will provide you with ninety (90) days advance written notification of any proposed change(s) to the Agreement. If you fail to reject the change(s), in writing within thirty (30) days of receiving notification of the change(s), the amendment will be deemed to have been accepted. However, if you reject the amendment, in writing during that thirty (30) day period, LSVDM has the right to either: (1) notify you that it has elected to not amend the Agreement, or (2) terminate the Agreement upon ninety (90) days written notification.

Changes to administrative policies, procedures, rules and regulations, conditions of participation, or the Maximum Allowable Charges (fee schedule) do not require an amendment to the Agreement.

LSVDM may terminate your Dental Network Participation Agreement immediately, upon written notice, if you fail to satisfy the requirements set forth in the Conditions of Participation

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 9: DENTAL PLANS OFFERED AND ADMINISTERED BY HMSA

Plan Name	Administration	Reimbursement	Copayments	Plan-Year Maximum	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
• **HMSA PPO – Includes the following Plans:** **A Codes** **C Codes** **D Codes** **L Codes** **M Codes** **P Codes** **V Codes** **Costco Dental Plan** • **HMSA PPO Plans for Federal Employees**	Plan offered and administered by HMSA	Current HMSA Fee Schedule	None	Variable by plan. Frequency. Limitations apply to some services	HMSA1	HMSA Dental Claims P.O. Box 69436 Harrisburg, PA 17106-9436	HMSA Dental Oahu-(808) 948-6440 Neighbor Island- (800) 792-4672 Online tools: My Patients' Benefits @mydentalcoverage.com/dentists.shtml
• **HMSA DHMO Plans**	Plan offered and administered by HMSA	Current HMSA DHMO Fee Schedule	None	Variable by plan. Frequency. Limitations apply to some services	HMSA1	HMSA Dental Claims P.O. Box 69436 Harrisburg, PA 17106-9436	HMSA Dental Oahu-(808) 948-6440 Neighbor Island- (800) 792-4672 Online tools: My Patients' Benefits @mydentalcoverage.com/dentists.shtml
Federal Employee Program (FEP) – Basic and Standard	Program offered by the Federal Government and administered by HMSA	Current FEP Dental Fee Schedule	Copayments are listed for Standard Option under column titled: "Member Pays Provider." Basic Option members pay only a $30 copayment for all covered services rendered during any one evaluation	Frequency limitations apply to some services	HMSA1	HI FEP Claims P.O. Box 69401 Harrisburg, PA 17106-9401	HMSA Dental Oahu-(808) 948-6281 Neighbor Island- (800) 966-6198 Online tools: My Patients' Benefits @mydentalcoverage.com/dentists.shtml
BCBS FEP Dental (Supplemental)	Program offered by the Federal Government and administered by Blue Cross Blue Shield FEP Dental	Current HMSA Fee Schedule	None	Program offered by the Federal Government and administered by the Blue Cross and Blue Shield Association partnered with the GRID Dental Corporation	BCAFD	BCBS FEP Dental Claims P.O. Box 75 Minneapolis, MN 55440-0075	BCBS FEP Dental (In the U.S) – (855) 504-BLUE or (855) 504-2583, TTY: 711 (International) – Call Collect – (651) 994-BLUE or (651) 994-2583

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Plan Name	Administration	Reimbursement	Copayments	Plan-Year Maximum	Electronic Claims Payor ID	Claim Address	Customer Service Contact Numbers
BCBS FEP Dental Plans	Program offered by the Federal Government and administered by the national GRID	Current HMSA Fee Schedule	None	Program offered by the Federal Government and administered by the Blue Cross and Blue Shield Association partnered with the GRID Dental Corporation	None	See members ID card for address information	(855) 504-2583
HMSA Akamai Advantage Dental Plans	Plan offered and administered by HMSA	Current HMSA MA Fee Schedule	None	Variable by plan. Frequency. Limitations apply to some services	HMSA1	HMSA Dental Claims P.O. Box 69436 Harrisburg, PA 17106-9436	HMSA Dental Oahu-(808) 948-6440 Neighbor Island- (800) 792-4672 Online tools: My Patients' Benefits @mydentalcoverage.com/ dentists.shtml

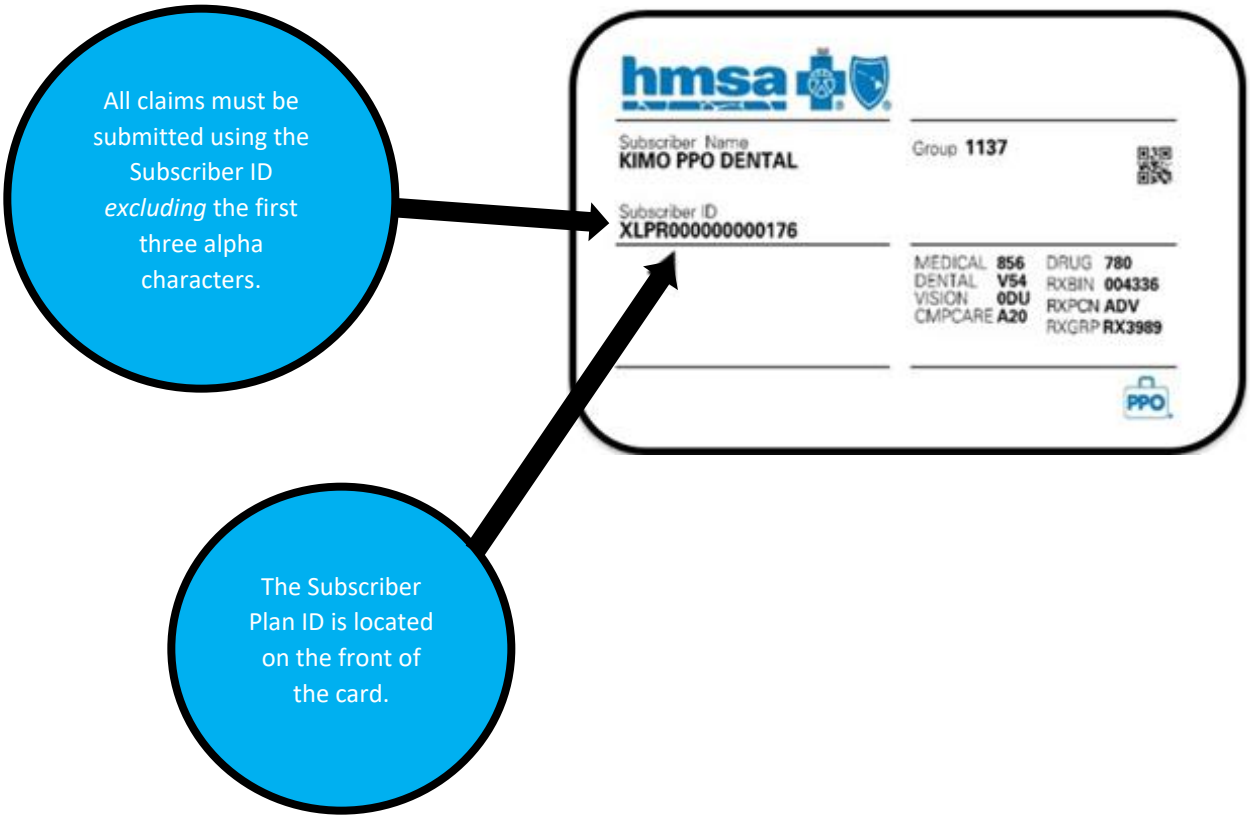
Members will be provided with a Member Identification Card (ID card) by their plan.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

A. Preferred Provider Organization (PPO)

The PPO plan provides access to a large network of general dentists and specialists who have agreed to provide services at negotiated rates. The PPO plans also offer routine cleanings and other preventive services at little or no cost to the member, in addition to a wide range of basic and major services for which the member's out of pocket expense is limited to an annual deductible and affordable coinsurance up to the calendar year maximum. Members also have the option of using non-participating providers at a higher level of out-of-pocket cost.

To identify HMSA's members to providers, our member ID cards include alpha prefixes for Hawaii (A, XLL, XLM, R, HFP, XLA, XLC, XLE, XLH, XLP, and XLT). The prefix is positioned in front of the member's current HMSA member ID number as shown below:

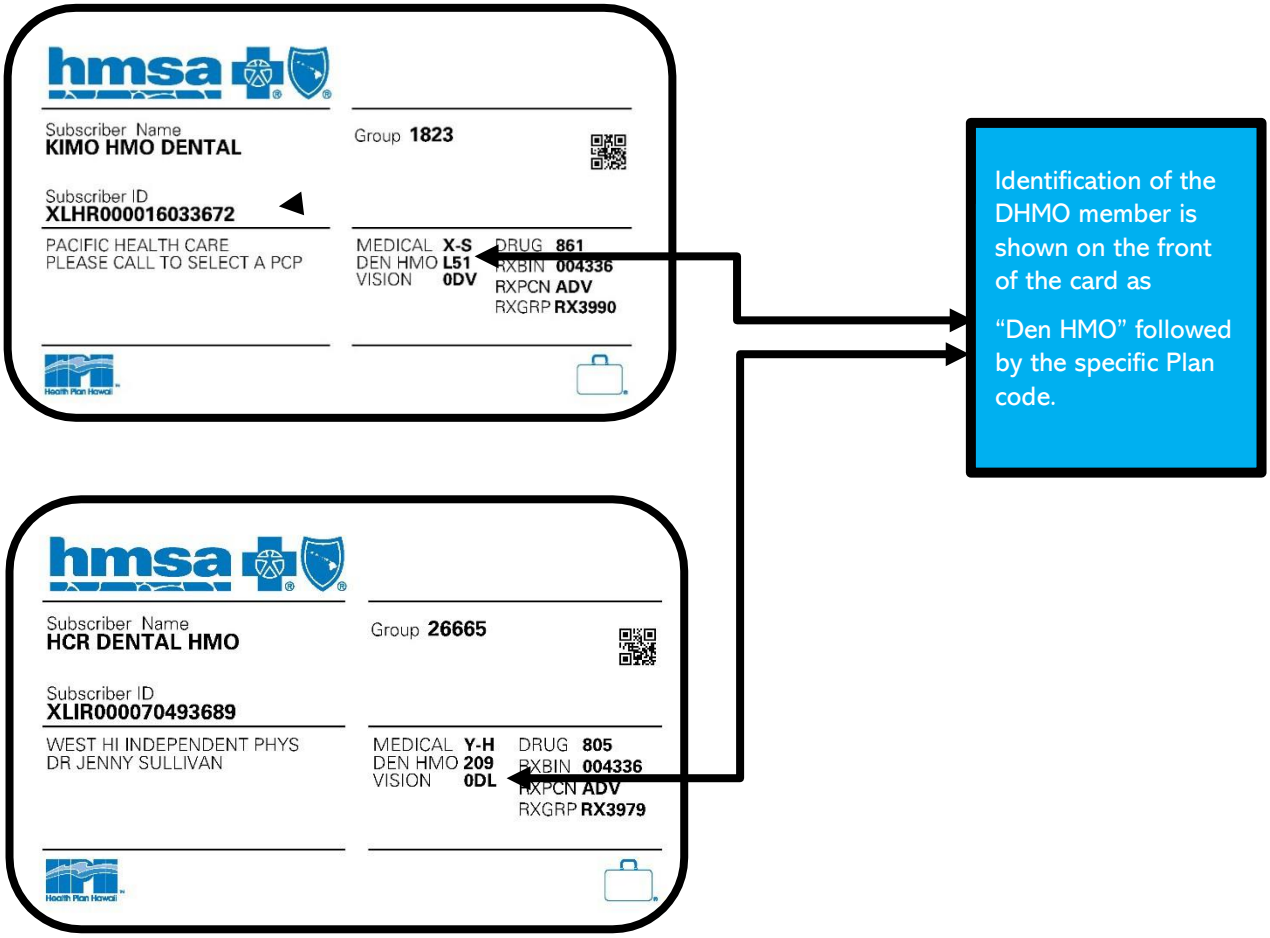


NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

B. Dental Health Maintenance Organization (DHMO)

The DHMO plan provides access to a select network of dentists from which members can choose a general dentist to perform or coordinate all their dental care. Routine cleanings and other preventive services are provided at little or no cost to the member, and many basic and major services are available at low, affordable copayments. Prior authorizations are required prior to rendering Major Services.

To identify DHMO Plan members, the member ID cards include “Den HMO” next to the dental coverage code. If a member has HMSA DHMO, they must seek dental services from a DHMO provider.



NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber’s plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

C. HMSA Plans for Federal Employees

Fed Plan 87, F27, F29, and F34 are HMSA's Federal Plan for employees who are eligible to participate in the Federal Employees Health Benefits (FEHB) Program. Please visit the **U.S. Office of Personnel Management webpage** for more information on the FEHB Program.

Important Note: We use assigned subscriber identification numbers in place of Social Security numbers. Be sure to use the member's current identification number when submitting claims (excluding the first three alpha characters) to avoid delays in payment and comply with HIPAA.

For federal plans, the group is identified as FED. To identify HMSA Federal member's plan, look at the 3-digit code next to DENTAL. They offer standard options (F27/F34) or high options (F87/F29) to their employees. Please review the benefits on MyDentalCoverage or call dental customer service at **808-948-6440**, or toll free **1-800-792-4672**.

Member ID Card – Standard Option

Member ID Card – High Option

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. Hawaii General Excise Tax Reimbursements

Effective November 22, 2019, for Federal Plans, Hawaii general excise tax (GET) is calculated and paid when tax procedure code D9985 is submitted on a claim. The GET displays on the explanation of benefits (EOB) and is included with the claim payment. This process applies to both paper and electronic claims.

Here are some key points to know:

1. GET is only covered for FED 87, FED 29, FED 34, and FED 27 plans.
2. Billing providers must be participating with HMSA to receive GET payment.
3. GET is calculated based on the performing provider's location.
4. GET processing applies to all claim submission types (paper and electronic).
5. GET is calculated when the tax procedure code D9985 is submitted on the claim.
    a. If there are multiple dates of service on a claim, D9985 must be submitted per date of service.
    b. If the D9985 is omitted in error on a claim form, the providers' office will need to call HMSA Dental customer service at 948-6440 or 1 (800) 792-4672 to have the procedure code D9985 added to their claim and include the provider's charge.
6. GET is calculated based on allowance of taxable services and not the provider's charge for D9985.
7. GET payment will not exceed the provider's charge for D9985.
8. GET will not be payable on non-covered/ineligible services.
9. If D9985 is submitted on a predetermination, GET will be calculated.
    a. If all services from the predetermination are subsequently submitted with the same date of service (for payment), the GET will apply to all services.
    b. If services from the predetermination are subsequently submitted with different dates of service (for payment), the GET will only apply to one date of service. To obtain GET payment for the other dates of service, submit the procedure codes and D9985 on a new claim form or call HMSA Customer Service to request to have the D9985 added to the claim.

E. Comparison of Benefits

The table below shows the dental provider network a member can use for dental services covered under HMSA's dental insurance plans.

Type of Plan	PPO Network	HMO Network (Hawaii Family Dental Centers)	DHMO Community Dentist	Medicare Advantage Network
HMSA PPO	✓	✓	✓	✓
HMSA HMO		✓	✓	
HMSA Akamai Advantage				✓

Questions regarding your participation with any of the above plans may be directed to your Provider Network Manager via email at HMSAdentalPR@usablelife.com.

F. Our Dental Benefit Designs

In general, HMSA's traditional dental plans categorize dental procedures into four benefit groups as shown in the grid below.

Important Note:
With the introduction of the 2014 Affordable Care Act (ACA) - compliant plans, please note that Service Type variations do apply to these plans (including D91, and the Qualified Dental Plans, PPO/FFS/HMO). Benefit levels vary for ages 0-18 and 19 and older.
Refer to detailed CDT manuals and plan matrices located on our website, hmsadental.com via the Plans, Manuals, and Training page & within the Provider Secured Site.

Akamai Advantage dental plans N08, N09, N10, and N11 have a limited number of dental benefits. Refer to Section 11 of this manual for specific benefits of this plan or the HMSA Medicare Advantage Manual and Guidelines located online.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

G. Dental Benefits by Network

Benefits	HMSA Dental PPO	HMSA Dental HMO/DHMO	Medicare Advantage Networks
Preventive Services • Diagnostic • Preventive	✓	✓	✓
Basic Services • Restorative • Oral Surgery • Periodontics • Endodontics • Prosthetic Maintenance • Other Services	✓	✓	✓
Major Services • Prosthodontics Fixed • Prosthodontics Removable	✓	✓	
• Other Optional Services • Orthodontics	Some plans may include coverage for Orthodontics	Coverage for this optional service may be included in some DHMO plans	Some plans include select basic services

H. Benefit Descriptions

Annual Maximum: Your patient's coverage is limited to an annual maximum selected by their employer. When patients exhaust their annual maximum, as well as any additional maximum rollover benefit that may have been accumulated, they are responsible for payment up to your actual charge. Annual maximums typically range from $600 to $2,000; however, there are a select few that have no maximum. The ACA compliant plans follow different Annual Maximum guidelines for members' ages 0 through 18. Refer to Qualified Dental Plan matrices for applicable plan details.

1. **Deductible Amount:** Your patient's plan may include an annual deductible. Deductibles are limited to each individual patient, not to exceed the overall family deductible. The deductible does not apply to orthodontic services.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

2. **Lifetime Maximum:** Orthodontic coverage typically has a lifetime maximum. Services for orthodontics are excluded from the basic annual maximum (see the *CDT Dental Procedure Guidelines and Submission Requirements* for more information about orthodontic benefits, limitations and claim submission).
3. **Implant Coverage**: Benefits for endosteal dental implants, abutments and implant/abutment-supported crowns are available in some plans.
4. **Calendar Year Rollover**: Benefits for calendar year roll over are available in most PPO plans. This benefit rewards members who practice good dental care by allowing them to roll over a portion of their unused benefits from year to year. To be eligible, members must have:
5. **Received at least one covered service** during the benefit period,
6. **Been an active member** of the plan on the last day of the benefit period, and
7. **Not exceeded the claims payment threshold**, determined by their benefit plan, in the calendar year.
8. **We recommend that you check HMSA members' eligibility** to determine whether members have this benefit, as it may change the remaining total amount of members' annual maximums and reduce their out-of-pocket expenses.
9. **The chart below summarizes the services available for the HMSA PPO plans**. Coverage for these benefits is subject to our dental policy, which includes limitations and guidelines related to: Time (frequency of performance), Age (specified age qualifications), Utilization guideline policies, and Requirements for consultant review for necessity and appropriateness of care.

I. Policies and Conditions

Dependent Care Coverage	Dependent children aged 26 or younger as of the effective date of the policy—including divorced dependents—may continue their coverage by completing a new HMSA application within 30 days of becoming ineligible for coverage under their existing policy. At that time, the policyholder will be credited for any satisfied waiting periods and will begin a new benefit year; however, credit will not be given for a
Waiting Periods	Some HMSA plans contain waiting periods prior to certain services being covered. Once the waiting period is satisfied, those services are payable, subject to all other terms, conditions, exclusions, and limitations of the policy.
Benefits and Service Exclusions	Services, procedures or supplies not Necessary and Appropriate; services or procedures not prescribed or rendered by a dentist; services or supplies collectible under Workers' Compensation or any law providing benefits for dependents of military personnel; services for conditions for which treatment is provided by federal or state government or are provided without cost; intentional self-inflicted injuries; accidental injuries; injuries or diseases caused by war; cosmetic services; prescription drugs; local or block anesthesia when billed separately; experimental or investigational services; services provided by an immediate relative. Any services not covered by the members benefit plan.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 10: AFFORDABLE CARE ACT (ACA), ALSO KNOWN AS HEALTH CARE REFORM (HCR)

A. ACA Plans - Benefits Overview

The Affordable Care Act (ACA), also known as health care reform, was signed into law in 2010. New health plans for individuals and small businesses (with 50 or fewer employees) must include 10 essential health benefits, including pediatric dental services. Many of HMSA's current commercial and traditional dental plans, including dental plans for large employer groups (with more than 50 employees), remain unchanged. We've updated our qualified dental plans (QDPs) to include pediatric services that comply with the ACA.

Pediatric dental benefits, as required by the ACA, cover children ages 0 through 18 years of age. Eligible services are covered at 100 percent once patients meet their maximum out- of-pocket costs ($400 per child, $800 for two or more children). For plan benefit details, refer to the current ACA PPO Plan Matrix and ACA CDT Manuals – located via the Plans, Manuals, and Training page of our provider dental website, hmsadental.com.

Prior authorization is required for medically necessary orthodontic care. Qualified patients must have cleft lips and palates or other severe facial birth defects or injuries that affect speech, swallowing, or chewing.

To provide our members with a consistent experience when they shop for coverage, HMSA ACA dental plans are being renamed using metal categories (Bronze, Silver, Gold, and Platinum). Renaming our dental plans allows us to align more closely with HMSA medical plans, which also use metal classifications, and it more clearly emphasizes the value of each plan. The chart below outlines the changes.

These new plan names are being introduced in conjunction with the existing names for 2021 plans, to aid with the transition. The new names will be filed as official plan names for the 2024 dental plans.

Coverage Code	Initial Plan Name	Official Name with Metal Level Since 2022
207	HMSA Individual Dental PPO Basic	HMSA Individual Dental PPO Bronze
211	HMSA Individual Dental HMO Basic	HMSA Individual Dental HMO Silver
220	HMSA Individual Dental PPO Basic II	HMSA Individual Dental PPO Silver
206	HMSA Individual Dental PPO High I	HMSA Individual Dental PPO Gold
D91	HMSA Dental Plus Plan	HMSA Individual Dental PPO Platinum
202	HMSA Small Business Dental PPO Basic	HMSA Small Business Dental PPO Bronze 1000
208	HMSA Small Business Dental HMO Basic	HMSA Small Business Dental HMO Silver
209	HMSA Small Business Dental HMO High I	HMSA Small Business Dental HMO Gold
204	HMSA Small Business Dental PPO High II	HMSA Small Business Dental PPO Gold 1500
216	HMSA Small Business Dental PPO High V	HMSA Small Business Dental PPO Gold 1500 Plus
203	HMSA Small Business Dental PPO High I	HMSA Small Business Dental PPO Platinum 1000
214	HMSA Small Business Dental PPO High III	HMSA Small Business Dental PPO Platinum 1000 Plus
215	HMSA Small Business Dental PPO High IV	HMSA Small Business Dental PPO Platinum 1500 Plus

Note: Standard dental plans (coverage codes: L, V, C, D, and A) for large businesses (more than 50 employees) remain unchanged.

B. ACA Plans – Pediatric Dental Benefits

All ACA dental plans were designed to qualify as stand-alone dental plans, which include pediatric dental benefits in compliance with the ACA. (Note that some of these services may not be covered when received from out-of-network providers.)

Effective Date: ACA plan coverage went into effect on JAN 1, 2014, for patients with individual plans and upon their plan renewal date for patients with group (small business) plans.

Collecting Copayments and Cost Shares: You must collect patient deductibles, copayments (fixed fee), and/or cost shares and coinsurance (percentage of cost) at the time of the visit. To check your patients' eligibility and coverage, go to mydentalcoverage.com/dentists or call HMSA Dental Customer Service at **808-948-6440** on Oahu or **1-800-792-4672** toll-free on the Neighbor Islands.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Deductible and Maximum Out-of-Pocket (MOOP) Amount: Patients with an ACA-compliant dental plan may have a deductible and a MOOP amount that includes dental costs. Once the deductible is met, patients pay copayments and coinsurance, according to their dental plan. Once the MOOP amount is met, HMSA pays 100 percent of the eligible cost.

Reimbursement: We'll pay HMSA participating dentists for pediatric dental benefits, using the fee you submitted or the Maximum Allowable Charge (MAC), whichever is less, minus the patient's deductible, copayment, or coinsurance.

Claims Submission: Continue to submit all claims for these services to:

- **Mail to** HMSA Dental, PO Box 69436 Harrisburg, PA 17106-9436
- **Electronically** through our free online claims processing system, on MyDentalCoverage, called **Speed eClaim®**
- **Electronic (837D)** Payer ID — HMSA1

C. Submission Guidelines – Pediatric Essential Health Benefits under Healthcare Reform Plans

Orthodontic treatment is limited to medical necessity for all Healthcare Reform Plans. Members under age 19 who have a severe and handicapping malocclusion may qualify for orthodontic care under the Essential Health Benefit mandate if the member belongs to a plan that includes these benefits.

To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed because of cleft palate, with or without cleft lip. Treatment must be rendered by an orthodontist and prior authorization and approval is required before services are rendered. Please go to **mydentalcoverage.com** to download the authorization form and instructions. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

Review of the Member's orthodontic benefits and treatment planning are essential to the timely and accurate payment of claims for Orthodontic treatment. Orthodontic treatment plans are based upon the type of dentition involved – transitional, adolescent or adult; as well as the treatment of a particular patient depending on circumstance:

Limited Orthodontic Treatment- treatment with a limited objective, not involving the entire dentition	
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Comprehensive Orthodontic Treatment Phase II - multiple phases of treatment provided at different stages of dentofacial development	
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
Other Orthodontic Services	
D8660	Pre-orthodontic treatment examination to monitor growth and development

D. ACA Plans – Pediatric Dental Services Requiring Prior Authorization

There are select pediatric dental services that require prior authorization (PA) for patients ages 0 through 18. If you don't get a PA before you render these selected services, your patient will be financially responsible for the entire cost of the procedure.

To obtain this detailed list of CDT Codes Requiring a PA (for patients, ages 0 through 18), refer to our dental website, hmsadental.com under the Provider tab, within the Provider Secured Site, under the Healthcare Reform header. The HCR CDT Manuals also include this information.

For additional HMSA Healthcare Reform Plan resources: Please refer to our dental website, hmsadental.com. Here you will find HCR plan matrices, HCR CDT Manuals, and HCR Prior Authorization guidelines.

E. The Essential Health Benefit Plans FAQs

Question: How does Health Care Reform (HCR) affect dental providers?

Answer:

Effective JAN 1, 2014, for individuals, and upon groups' renewal date, HMSA will include coverage for pediatric dental benefits (Essential Health Benefits or EHBs) for children ages 0 through 18 with our small group and individual plans. Members using these mandated benefits do not have to have dental insurance. They do need to have HMSA medical coverage to access these mandated benefits. Pediatric dental benefits for children ages 0 through 18 will include:

Type 1 services: Preventive and diagnostic services, including oral exams, x-rays, and routine dental care.

Type 2 services: Basic restorative services, including fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Medically necessary orthodontic services that have been prior-authorized and approved for qualified members. To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed because of cleft palate, with or without cleft lip. Member must meet the 24-month waiting period. Treatment must be rendered by an orthodontist.

Please verify member's eligibility and benefits on mydentalcoverage.com, Essential Health Benefits (EHB) that cover dental services typically will have member co-insurance and member copays that are different than services covered under traditional dental plans. It will be important for the dentist to know the member's financial responsibility for services covered under EHB. Members covered for dental services under EHB will have a limitation on their financial responsibility after they have reached a dollar threshold in payment for services. Once the member's out of pocket maximum are met, claims pay at 100% of the dentist's charge or the HMSA dental allowance, whichever is lower.

Question: How do pediatric dental benefits covered under a member's essential Health Benefits differ from traditional dental benefits covered under a dental insurance plan?

Answer:

There are several significant differences between dental insurance benefits and the pediatric dental benefits covered under a member's medical plan:

Maximum Out-of-Pocket. Pediatric dental benefits covered under the member's medical plan include an annual in- network out-of-pocket maximum (the most a member could pay during the plan year for covered in-network services.) The in-network out-of-pocket maximum is $400.00 per member under age 19 and $800.00 for two or more members under age 19 enrolled under the same family plan.

Medically necessary Orthodontic services. To qualify for medically necessary orthodontic services, treatment must result from congenital or developmental malformations related to or developed because of cleft palate, with or without cleft lip. Only orthodontists are allowed to perform EHB orthodontic services. A prior authorization must be requested and approved.

Question: I am an orthodontist. What do I need to know about providing medically necessary orthodontic services?

Answer:

To qualify for the medically necessary orthodontic services, a child must have a severe and handicapping malocclusion or misalignment of teeth. Only orthodontists are allowed to

perform EHB orthodontic services. Prior authorization is required before the services are rendered.

Medically necessary orthodontic services rendered without obtaining a prior authorization approval may not be covered.

Question: What orthodontic codes require prior authorization?

Answer:

The following codes are the only orthodontic services covered under the EHB plans and they all require prior authorization:

CDT Code	Description of Service
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8660	Pre-orthodontic treatment examination to monitor growth and development

Please refer to the **HMSA Prior Authorization Document** for more information.

Question: What is the process for requesting a prior authorization for orthodontic services?

Answer:

1. Submit the services requested on the most current version of the ADA dental claim form with the Pre-Treatment Estimate box checked.

   Include the appropriate documentation for review e.g., pre-treatment claim form, x-rays, study models, and photographs for orthodontic cases.

2. When your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.

3. Send the prior authorization request electronically, if possible. Paper prior authorization requests should be mailed to:

   HMSA – Dental
   P.O. Box 69436
   Harrisburg, PA 17106-9436

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

All prior authorization requests will be reviewed for appropriateness and medical necessity. Prior authorized services will not be approved for payment until they are determined to meet the guidelines for coverage. Any required prior authorized service that does not have a prior authorization in HMSA's claim system will be denied and NO insurance payment will be made.

Please provide a self-addressed, postage paid envelope or packaging if you would like your x-ray, study models or other documentation returned.

Question: How can I check to see if my request for prior authorization has been approved?

Answer:
To check if a Prior Authorization is approved, you can go online to MyDentalCoverage.com or call our **Dental Customer Service 808-948-6440 on Oahu** or **1-800-792-4672 toll-free on the Neighbor Islands** as you do today to verify eligibility and benefits.

Question: Who is responsible for payment if prior authorization is not obtained?

Answer:
The member is held liable if prior authorization is not obtained or approved.

Question: Will the appeals process be the same for HCR plans?

Answer:
Yes, all appeals should be sent to:

HMSA Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 11: MEDICARE ADVANTAGE (MA) PLANS

A. 2025 HMSA Akamai Advantage Plans

As of JAN 1, 2023, select Akamai Advantage Medical plans include preventative and basic dental coverage.

If you are a participating dentist in HMSA's Medicare Advantage network, you are considered in-network for members of the HMSA Akamai Advantage plans. You will be reimbursed at your current HMSA contracted MA fee schedule. Please refer to the Medicare Advantage Manual.

To check eligibility and benefits, Providers may go online to mydentalcoverage.com or contact Dental Customer Service from Oahu at **808-948-6440** or from neighboring islands at **1-800-792-4672**.

Dental Claims should be submitted electronically using Payor ID HMSA1 or mailed to the following address:

HMSA Dental Claims
P.O. Box 69436
Harrisburg, PA 17106-9436

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

B. Covered services **embedded in member's HMSA Akamai Advantage Plans**

PROC CODE	CLASS	PROCEDURE DESCRIPTION	FREQUENCY/LIMITATION	Standard (N07) Complete (N09) PAR / NONPAR	Standard Plus (N08) Complete Plus (N10) PAR / NONPAR	D-SNP (N11) PAR / NONPAR
0120	DIAG	Periodic oral evaluation – established patient	2 per calendar year (combined frequency with 0140 and 0150)	100%/60%	100%/60%	100%/70%
0140	DIAG	Limited oral evaluation – problem focused	1 per calendar year (combined frequency with 0120 and 0150)	100%/60%	100%/60%	100%/70%
0150	DIAG	Comprehensive oral evaluation – new or established patient	1 per lifetime (combined frequency with 0120 and 0140)	100%/60%	100%/60%	100%/70%
0270	DIAG	Bitewing – single radiographic image	1 set per calendar year (any of these codes 0270, 0272, 0273, 0274, 0277 constitute a set, except when done within 12 months of 0210 or 0330) NOTE: Bitewings done within 12 months of an FMX **or Pano** will not be covered.	100%/60%	100%/60%	100%/70%
0272	DIAG	Bitewings – two radiographic images				
0273	DIAG	Bitewings – three radiographic images				
0274	DIAG	Bitewings – four radiographic images				
0277	DIAG	Vertical bitewings – 7-8 radiographic images				
0210	DIAG	Intraoral – complete series of radiographic images	1 set per five years (any of these codes 0210 or 0330 constitute a set)	100%/60%	100%/60%	100%/70%
0330	DIAG	Panoramic radiographic image				
1110	PREV	Prophylaxis - adult	2 per calendar year (Combined with D4346 - Max of 2 cleanings total)	100%/60%	100%/60%	100%/70%
1206	PREV	Topical application of fluoride varnish	2 per calendar year (No age limit)	100%/60%	100%/60%	100%/70%
1208	PREV	Topical application of fluoride – excluding varnish				
1354	PREV	Application of caries arresting medicament – per tooth	2 treatments of caries arresting medicament per tooth, per calendar year	100%/60%	100%/60%	100%/70%
2140	BASIC	Amalgam – 1 surface, primary or permanent	Two (2) restorations per calendar year (Combined with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	100%/60%	100%/60%	100%/70%
2150	BASIC	Amalgam – 2 surfaces, primary or permanent				
2160	BASIC	Amalgam – 3 surfaces, primary or permanent				
2161	BASIC	Amalgam – 4 surfaces, primary or permanent				
2330	BASIC	Resin-based composite – 1 surface, anterior				
2331	BASIC	Resin-based composite – 2 surfaces, anterior				
2332	BASIC	Resin-based composite – 3 surfaces, anterior				

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

PROC CODE	CLASS	PROCEDURE DESCRIPTION	FREQUENCY/LIMITATION	Standard (N07) Complete (N09) PAR/ NONPAR	Standard Plus (N08) Complete Plus (N10) PAR / NONPAR	D-SNP (N11) PAR / NONPAR
2335	BASIC	Resin-based composite – 4 or more surfaces, or involving incisal angle (anterior)	Two (2) restorations per calendar year (Combined with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	100%/60%	100%/60%	100%/70%
2391	BASIC	Resin based composite – 1 surface, posterior				
2392	BASIC	Resin based composite – 2 surfaces, posterior				
2393	BASIC	Resin based composite – 3 surfaces, posterior				
2394	BASIC	Resin based composite – 4 or more surfaces, posterior				
2740	MAJOR	Crown – porcelain/ceramic	One (1) crown per calendar year following root canal procedure on the same tooth Does not have to be done in the same calendar year Replacement crowns once every 5 yrs with history of root canal	**Not Covered**	100%/60%	**Not Covered**
2750	MAJOR	Crown – porcelain fused to high noble metal				
2751	MAJOR	Crown – porcelain fused to predominantly base metal				
2752	MAJOR	Crown – porcelain fused to noble metal				
2790	MAJOR	Crown – full cast high noble metal				
2791	MAJOR	Crown – full cast predominantly base metal				
2792	MAJOR	Crown – full cast noble metal				
3310	BASIC	Endodontic Therapy, anterior tooth	One (1) root canal treatment per calendar year.	**Not Covered**	100%/60%	**Not Covered**
3320	BASIC	Endodontic Therapy, premolar tooth				
3330	BASIC	Endodontic Therapy – molar tooth				
4346	PREV	Scaling in the presence of generalized moderate or severe gingival inflammation	2 per calendar year Combined with D1110 - Max of 2 cleanings total	100%/60%	100%/60%	100%/70%
7140	BASIC	Extraction, erupted tooth or exposed root	Four (4) extractions per calendar year	100%/60%	100%/60%	100%/70%
7210	BASIC	Extraction, (surgical removal of) erupted tooth requiring removal of bone and/or sectioning of tooth				

PROCEDURE CODES NOT LISTED ABOVE ARE NOT COVERED FOR THIS PLAN

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

C. Key Highlights

All services for plans N07, N08, N09, and N10 are payable at 100% for PAR providers and 60% for NON-Par providers. All services for plan N11 are payable at 100% for PAR providers and 70% for NON-Par providers. This maximum applies to in-and out-of-network preventive and additional comprehensive dental services.

HMSA Akamai Advantage Dental Plans offer Oral Health for Total Health enhanced dental benefits as of JAN 1, 2023.

D. Sample – HMSA Akamai Advantage Card

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 12: MEMBER INFORMATION

A. Verifying Member Eligibility, Benefits and Claims Status

You can obtain patient eligibility, benefits, claims status, maximums, deductibles, service history, allowance information, procedure code information, and orthodontic information via:

B. Our Dental Call Center

You may reach us at **808-948-6440** or **toll free 1-800-792- 4672**. Please have the patient's name, subscriber ID number, and date of birth ready when you call. In addition, please have the provider's Tax ID or NPI and phone number ready as part of our ID verification process.

C. Dental Fax Request

You can complete a Dental Fax Request Form and fax it to us at 808-538-8966. The information will be faxed/e-mailed back to the fax number/e- mail address indicated on the Dental Fax Form within one hour of receipt. Dental Fax Forms received after 3:00 p.m. will be faxed back the following business day. Please see an example of the Dental Fax Request Form in the Technology Solutions Section.

D. Our website

Providers can access member information through our website at hmsa.dental.com, select Online Services and registering for My Dental Coverage to obtain immediate, up-to-the-minute member information 24 hours a day, 7 days a week.

E. HMSA Akamai Advantage Dental Plans

Providers can access member information through My Dental Coverage and obtain immediate, up-to-the-minute member information 24 hours a day, 7 days a week. You may call us at **808-948-6440** or **toll free 1-800-792-4672.**

F. Federal Employee Program (FEP) Standard and Basic Options

Basic and Standard members: Call **808-948-6281 in Oahu** and **1-800-966-6198 for the Neighbor Islands**. You may also access information through the BCBS FEP Dental website, fepblue.org

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

G. BCBS FEP Dental and the GRID

Blue Cross Blue Shield FEP Dental members: Call **808-948-6281 in Oahu** and **1-800-966-6198 for the Neighbor Islands**. You may also access information through the BCBS FEP Dental website, bcbsfepdental.com

For additional technology options See Section 23: Technology Solutions.

H. Emergency Dental Care with a Virtual Dentist

HMSA dental plans include virtual dental visits through TeleDentistry.com at no additional cost. This added member benefit is available 24 hours a day, 7 days a week. If necessary, a virtual dentist will write prescriptions or refer the member to a nearby participating HMSA dentist or their regular dentist for further care. Members are limited to two TeleDentistry.com visits per calendar year. Virtual visits do not count towards the member's plan frequency limitation for in-person oral exams.

Member advisement on how to get started.

1. Visit teledentistry.com/hmsa or call 1-866-256-1871
2. Take photos of the problem area, if necessary
3. You'll be connected to a dentist for an emergency dental consultation.

If necessary, your virtual dentist will write prescriptions or refer you to a participating HMSA dentist near you or your regular dentist for further care as needed.

SECTION 13: PREDETERMINATIONS AND CLAIMS

Download the most current ADA claim form at adacatalog.org. To order a hard copy, contact your dental office supplier or software administrator, or call the ADA at 800-947-4746.

A. Predeterminations Overview

A predetermination is a written request by a provider for verification of benefits prior to rendering services. This request helps us determine how we will process a claim based on a member's benefits. A predetermination is not a guarantee of payment, but is designed to determine:

- If a service is covered under the member's plan
- If the procedure meets our utilization review guidelines and dental policy
- If any time limitations apply on a procedure
- The projected estimated payment for the procedure

Although not required, you may submit a predetermination for prosthetics and crowns, inlay/onlay restorations, and periodontal services totaling more than $300 in allowable expenses.

We process a predetermination as if it were an actual claim and respond via a pre-treatment estimate. You and the member will be notified of all approvals and denials.
It is important to note that we do not hold funds even when a predetermination has been approved.

B. How to submit a Predetermination

Complete the most current version of the *ADA Dental Claim Form* as if you were submitting an actual claim for services. **Do not enter a date of service on the claim.**

Remember to:

- Enter an X in Box 1 of the claim form next to "Request for Predetermination/Preauthorization".
- List only the services to be included in the predetermination.
- Send the predetermination electronically via Speed eClaim® or your office's electronic claims submission vendor. If possible, to Payor ID HMSA1

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

For HMSA plans, paper requests may be mailed to:

HMSA Dental Services
P.O. 69436
Harrisburg, PA 17106-9436

C. Filing claims

All standard HMSA Commercial and Individual plan claims for covered services should be submitted to LSVDM within the 365 days (one year) from the date of service or the completion of a course of treatment. LSVDM may deny a Late Claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim. Member should NOT be liable for claims denied due to timely filing.

All FEP and HMSA federal plans (FED 87, FED 29, FED 34, and FED 27) claims must be filed by December 31st of the year following the date of service. (E.g., for a service rendered on APR 1, 2024, the timely filing deadline would be DEC 31, 2025).

D. Overview of Claim form fields

Please follow the instructions below to complete the most current *ADA Dental Claim Form*, which you can find on the ADA website or in the most current ADA Practical Guide to Dental Procedure Codes. *A sample form follows these instructions.*

Header Information (blocks 1 and 2)

1. Enter an X in the appropriate box to indicate if this claim is a request for Predetermination/Preauthorization or a claim for actual services rendered
2. Predetermination/Preauthorization Number is not required.

Insurance Company/Dental Benefit Plan Information (block 3)

For Individual and Commercial HMSA plans	**For Federal Employee Program: Basic and Standard Option**	**For Federal Employee Program: Blue Cross Blue Shield FEP Dental**
Hawaii Medical Service Association P.O. Box 69436 Harrisburg, PA 17106-9436 Payor ID: HMSA1	HI FEP Claims P.O. Box 69401 Harrisburg, PA 17106-9401 Payor ID: HMSA1 ***Effective 07/01/2022**	BCBS FEP Dental Claims P.O. Box 75 Minneapolis, MN 55440-0075 Payor ID: Not Available

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

- Other Coverage (blocks 4-11) refers to the possible existence of other medical or dental insurance policies, relevant for coordination of benefits.
- Policyholder/Subscriber Information (blocks 12-17) documents information about the insured person (subscriber), who may or may not be the patient.
- Patient Information (blocks 18-23) refers to the patient receiving services or treatment.
- Record of Services Provided (blocks 24-35) regards the treatment performed or proposed. For a predetermination of benefits, complete this area in the same way as for an actual service, but omit the date of service. Ten lines are available for reporting.
- Authorizations (blocks 36 and 37) is where the patient or subscriber signs to provide consent for treatment and authorization for direct payment. It is HMSA's policy to pay a participating provider directly. All payments for services performed by a nonparticipating provider are paid directly to the member.
- Ancillary Claim/Treatment Information (blocks 38-47) asks for additional information regarding the claim and the member's prior dental history. Some of these questions may be left blank if the service is not orthodontic or prosthetic.
- Billing Dentist or Dental Entity (blocks 48-52A) provides information on the dentist or group/corporation responsible for billing and receiving payment, which may or may not be the treating dentist. *Block 49 is specific to reporting the associated National Provider Identifier (NPI). An NPI Type 1 or NPI type.*
- Treating Dentist and Treatment Location Information (blocks 53-58) asks for information specific to the provider. Block 54 asks for the treating dentist's NPI. To obtain an NPI, visit the Centers for Medicare & Medicaid Services' National Plan and Provider Enumeration System (NPPES) website at nppes.cms.hhs.gov/NPPES/Welcome.do.

You must submit all claims with your NPI information. See **Section 6** *of this manual for details.*

Billing with a National Provider Identifier (NPI)
If you have a Type 1 NPI (Sole Proprietor), submit your claim using the Type 1 NPI in block 49 and block 54. If you have a Type 2 NPI (Professional Corporation, Limited Liability Corporation or Incorporated – PA, PC, LLC, or INC), submit your claim using the Type 2 NPI in block 49 and the rendering provider's NPI (Type 1) in block 54. *For offices with mixed par status, please confer with your Dental Network Manager.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

E. Sample Dental Claim form

ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

Send Completed Claim Form To:
Hawaii Medical Service Association
P.O. Box 69436
Harrisburg, PA 17106-9436

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F ☐ U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F ☐ U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F ☐ U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A")
A ____ C ____
B ____ D ____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. American Dental Association (ADA) General Instructions

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's website (ADA.org/en/publications/cdt/ada-dental-claim-form).

a. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
b. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).
c. Enter the full name of an individual or a full business name, address, and zip code when a name and address field is required.
d. All dates must include the four-digit year.
e. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.
f. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

Coordination of Benefits (COB)

When a claim is being submitted to the secondary payer, complete the entire form, and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

Diagnosis Coding

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Place of Treatment

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:
11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:

cms.gov/Medicare/Medicare-Fee-forServicePayment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

Provider Specialty

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 14: COORDINATION OF BENEFITS (COB)

A. Determining the Primary Payor

The first of the following rules applicable shall be used by HMSA to determine the primary payor.

1. The plan that covers the person as an employee or member, other than as a dependent, is determined to be primary before the dental plan that covers the person as a dependent.

   However, if the person is also a Medicare beneficiary, Medicare is secondary to the dental plan covering the person as a dependent of an active employee. The order in which dental benefits are payable will be determined as follows:

   a. Dental benefits of a plan that covers a person as an employee, member, or subscriber.
   b. Dental benefits of a plan of an active employee that covers a person as a dependent
   c. Medicare benefits

2. When two or more dental plans cover the same child as a dependent of different parents:
   a. The dental plan of the parent whose birth month (excluding birth year) falls earlier in the year will be the dependent's primary plan.
   b. If both parents have the same birthday, the dental benefits of the plan that has covered the parent for the longest are determined before those of the plan that has covered the parent for the shorter period of time.

   However, if one of the plans does not have a provision that is based on the birthday of the parent, but instead on the gender and these results in each plan determining its benefits before the other, the plan that does not have a provision based on a birthday will determine the order of dental benefits.

3. If two or more dental plans cover a dependent child of divorced or separated parents, dental benefits for the child are determined in this order:
   a. The plan of the parent with custody of the child
   b. The plan of the spouse of the parent with custody of the child
   c. The plan of the parent not having custody of the child

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

However, if the specific terms of a court decree make one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the dental benefits of the dental plan of that parent has actual knowledge of those terms, the dental benefits of that plan are determined first.
This does not apply with respect to any claim determination period or dental plan year during which any dental benefits are actually paid or provided before that entity has the actual knowledge.

4. The dental benefits of a dental plan that covers a person as an employee other than as a laid-off or retired employee, or as a dependent of such a person, are determined before those of a dental plan that covers that person as a laid off or retired employee or as a dependent of such a person. If the other dental plan is not subject to this rule, and if, as a result, the dental plans do not agree on the order of dental benefits, this paragraph shall not apply.

5. If an individual is covered under a COBRA continuation plan and under another group dental plan, the following order of benefits applies:
    a. The dental plan which covers the person as an employee or as the employee's dependent
    b. The coverage purchased under the dental plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

    If none of the above rules determines the order of dental benefits, the dental benefits of the plan that has covered the employee, member or insured the longest period of time are determined before those of the other dental plan.
    Coordination of Benefits shall not be permitted against the following types of policies:

    a. Indemnity
    b. Excess insurance
    c. Specified illness or accident.
    d. Medicare supplement

B. Determining Your Patient's Liability in a COB Situation

1. If the HMSA Plan is the Secondary Plan in accordance with the order of benefits determination rules outlined above, the benefits of the Plan will be reduced when the sum of:
    a. The benefits that would be payable for the allowable expense under the HMSA Plan in the absence of this COB provision; and
    b. The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB

provision, whether a claim is made, exceeds those Allowable Expenses in a claim determination period. In that case, the benefits of the HMSA plan will be reduced so that its benefits and the benefits payable under the other plans do not total more than those Allowable Expenses.

2. When the benefits of the HMSA Plan are reduced as describe above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the HMSA Plan.

C. Helpful Tips

In situations where you believe your patient may be covered by more than one payor, the following hints may help you manage the claim more efficiently:

- Determine your patient's primary payor and submit the claim to that payor first.
- Note: It is not necessary to submit secondary information if HMSA is the primary payor. Doing so will delay the primary payment process.
- Submit the primary payor's Explanation of Benefits (EOB) to the secondary payor (even if both payors are HMSA Plans.)
- Always calculate your patient's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary payor's EOB may not correctly reflect the patient's balance and that your patient's liability may be affected by contracts that you hold with the primary carrier.
- When a member has two plans, you should file the primary plan and expect the claim to be processed under the secondary plan. Note that there is typically a week before the secondary claim is processed and may be reflected in separate weekly check cycles.
- Claim questions and issues may be directed to Dental Customer Service, Monday-Friday, 8 am – 5pm HST at **808-948-6440 on Oahu** and **Toll free 1-800-792-4672 for Neighbor Islands.**

SECTION 15: REIMBURSEMENT

A. Overview

HMSA will always reimburse claim payments for covered members directly to the participating provider. If an unassigned claim is submitted on behalf of the member, we will still pay the claim directly to the participating dentist.

In accordance with the HMSA Dental PPO Fee Schedule, participating dentists agree to accept as payment in full the lesser of either their regular charges or the Maximum Allowable Charge for dental services provided under the applicable dental program, less any applicable member cost-share, such as a deductible, co-insurance, or copayments. **You may not bill your patient for the difference between our Maximum Allowable Charge amount and your actual charge.**

The “unbundling” of charges has been recognized on a national level as a contributing factor to the increasing cost of healthcare. Examples of unbundling include the use of more than one procedure code to bill for a procedure that can be adequately described by a lesser number of codes, filing for services that are an integral part of a procedure, and filing for procedures (such as “sterilization”, services, or PPE supplies) that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or refund requests will result.

Maximum Allowable Charge will apply, and balance billing is not permitted.

NON – COVERED SERVICES
The procedure is non-covered. If a service is not considered an eligible service under the member’s benefit plan (i.e., it is not listed on the Schedule of Allowances), you can collect your actual charge. You should verify with your patient’s plan to ensure that services are covered. For any services that are non-covered, please inform the patients that they will be responsible for your actual charge.

A member has exhausted their annual maximum benefit and any roll-over benefit if applicable. In this instance, you can collect your actual charge. Please verify that the patient has exhausted all benefits and inform them of their responsibility for your actual charge.

Here is an example of how we calculate the member's cost-share for a non-covered service:

Procedure Code	Your Charge	Coverage Level	Allowed Amount	Member's Cost-share
D0460	$50	0%	$0	$50

Co-insurance is a type of member cost-share representing a percentage of the allowed amount for covered services. If the member's dental plan covers a procedure at less than 100%, the member is responsible for the difference between what we pay and the Maximum Allowable Charge, as shown in this example:

Procedure Code	Benefit Type	Coverage Level	Allowed Amount	Member's Co-insurance
D2150	Basic	80%	$100	$100 X 20% = $20

The member's co-insurance is based on a percentage of your HMSA Maximum Allowable Charge Schedule and the member's benefit structure. The member is responsible for all non- covered services. You can collect the member's co-insurance at the time of the visit or bill the member after you receive payment from us.

B. Deductibles

Most HMSA plans with deductibles are identifiable as those coverage codes that start with '**D**'. There are a few exceptions to this guideline. Patients with these deductible plans will need to pay the first $25 (individual Deductible) of eligible charges before reimbursements begin. For patients with a family plan, benefits will begin after the individual Deductible of $25 is met or the Family Maximum Deductible of $75 is met.

For most of our plans that have Deductibles, the deductible applies to only Basic and Major services and does not apply to Preventive and Orthodontic services, except for Plans 202 & 207 where the deductible does apply to Preventive, Basic, and Major. The deductibles restart each calendar year and there are no carryovers of the amounts of the deductibles from the prior year to satisfy the deductible requirement in the new year. The claims filing process will be the same. The only difference will be that when Basic and

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Major services are incurred, the patient will be responsible for the first $25 (or $75 Family Maximum Deductible) of eligible charges before benefits begin.

C. Sample Dental EOB

PROVIDER: ABC DENTAL INC. TIN: XXXXX8888 PROVIDER #: 002792716 DATE: 12/12/13 PAGE 1 OF 1

FIRST DATE OF SVC	LAST DATE OF SVC	NUM OF SVCS	PROCEDURE CODE	TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODES(S)	CLAIM NUMBER
PATIENT ACCT #: FAX123456789-0				**SALLY SMILES**					**ID NUMBER: R0000123456789**				**APPL/SUB NAME: SALLY SMILES**		
09/12/13	09/12/13	1	D0220		20.10	20.10			6.03	C1		14.07		J9752	13259234154
09/12/13	09/12/13	1	D9999		39.63				39.63	H1				U5002AJ1018	
09/12/13	09/12/13	1	D3330	31	821.15	821.15			246.34	C1		574.81		J9752	
														J9752	
				CLAIM TOTALS			.00		292.00		.00	588.88	.00		

CLAIM SPECIFIC MESSAGE(S):
0500A No payment can be made. This Routine Dental Care Service is not included on the patient's plan benefit schedule, and therefore, is not a covered service.

FIRST DATE OF SVC	LAST DATE OF SVC	NUM OF SVCS	PROCEDURE CODE	TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODES(S)	CLAIM NUMBER
PATIENT ACCT #: FAX143584585-0				**MAT MOLAR**					**ID NUMBER: R0000123456788**				**APPL/SUB NAME: MAT MOLAR**		
09/21/13	09/21/13	1	D0220		20.10	20.10			6.03	C1		14.07		J9752	13259234154
09/21/13	09/21/13	1	D9999		39.63				39.63	H1				U5002AJ1018	
09/21/13	09/21/13	1	D3330	31	821.15	821.15			246.34	C1		574.81		J9752	
														J9752	
				CLAIM TOTALS			.00		292.00		.00	588.88	.00		

CLAIM SPECIFIC MESSAGE(S):
0500A No payment can be made. This Routine Dental Care Service is not included on the patient's plan benefit schedule, and therefore, is not a covered service.

EOB TOTALS: TOTAL SUBSCRIBER PAYMENTS = $.00 TOTAL PROVIDER PAYMENTS = $2,410.99 PAYMENT NUMBER: 12345678

MESSAGE(S):
J1018 This amount represents tax.
J9752 If you have any questions, call the Dental Customer Service Unit at 808-948-6440 on Oahu or toll free 1-800-792-4762.
X5022 No payment can be made. The maximum benefit amount available under the patient's coverage has been paid.

NON-CHARGEABLE AMOUNT CODES:
NO1 = MAC Differential

SUBSCRIBER LIABILITY CODES:
C1 = Coinsurance
E1 = Benefit maximum has been reached
H1 = Rejected Billable Non-Covered Service
NO1 = MAC differential

EXPLANATION OF BENEFITS

PO Box 69436
Harrisburg PA 17106-9436

DC0007047

1105-P

Current Dental Terminology © American Dental Association

005739
00020004

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. Common Reasons for Non-Payment

To familiarize yourself with HMSA reimbursement requirements, please refer to the list below of messages commonly found on dental remittances to explain non-payment:

- *No payment can be made. The reported procedure is covered once in a 3-year period. Benefits have been provided previously for a similar service within this time period.*
- *No payment can be made. The patient's coverage does not provide for this service.*
- *No payment can be made. The reported service is covered twice in a contract year period.*
- *No payment can be made. The maximum benefit amount available under the patient's coverage has been paid.*
- *No payment can be made. An incomplete dental claim has been received in our office. Please submit a dental claim form with the tooth number(s) for the procedure(s) reported, include x-ray(s), periodontal charting and any narrative if required.*
- *This patient cannot be identified from the identification number reported above. Please verify the name and number shown on the ID card. If the patient is covered, please resubmit the claim.*
- *No payment can be made. This service is subject to a waiting period as required under the patient's coverage.*
- *The maximum allowance for bitewing radiographs (x-rays) has been paid.*

If you have questions about your remittance, please call Customer Service at 808-948-6440 or toll free 800-792-4672.

Monday through Friday from 8:00 a.m. to 5:00 p.m. HST.

E. Add X-Rays Electronically to a Rejected claim

To enhance the claims processing experience, HMSA Dental has recently implemented a new functionality that provides dental offices the ability to upload new attachments and/or attachment control numbers (ACN's) to claims that were rejected due to a missing X-ray.

There are two methods available to utilize this feature by signing into HMSA Dental's "My Patient's Benefits" Log in section at https://www.hmsadental.com/providers/online-services/.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

- **Option 1: Access the New Tile Available on our Dentist Portal Landing Page**

  *After clicking on **Add X-rays to a Rejected Claim**, follow the below steps:*

  1. Enter the claim number and click **Search**. **Please note that currently this enhancement can only be used for rejected claims with a "Rejection Code" beginning with a "C".**
  2. Click **Browse** to add an attachment. Select the attachment to be uploaded and click **Open**. *A maximum of five attachments can be added*.
  3. To add an ACN, key the ACN in the **Electronic Attachment #** field. *A maximum of five ACN's can be added.*
  4. When finished, click **Review and Submit**.
  5. Click **Submit** on the summary page. A new claim number will be generated.
  6. Click **Done** to search for another claim.

- **Option 2: Use the Functionality within MyPatients' Benefits**

  Go to "My Patient's Benefits" via mydentalcoverage.com/dentists and follow the below steps:

  1. Enter your United Concordia **Provider ID** and click **Continue.**
  2. Enter the patient's **Member ID** and **Date of Birth** and then click **Search**.
  3. Click the **Claims Status** tab to identify the applicable rejected claim. **Please note that currently this enhancement can only be used for rejected claims with a "Rejection Code" beginning with a "C".**
  4. Click the **Attachment Icon** to key an ACN or browse to add an attachment. *A maximum of five attachments can be added*.
  5. Once all attachments and/or ACN's have been added, click **Review and Submit**.
  6. Click **Submit** on the Summary page. A new claim number will be generated.
  7. Click **Done** to search for another claim.

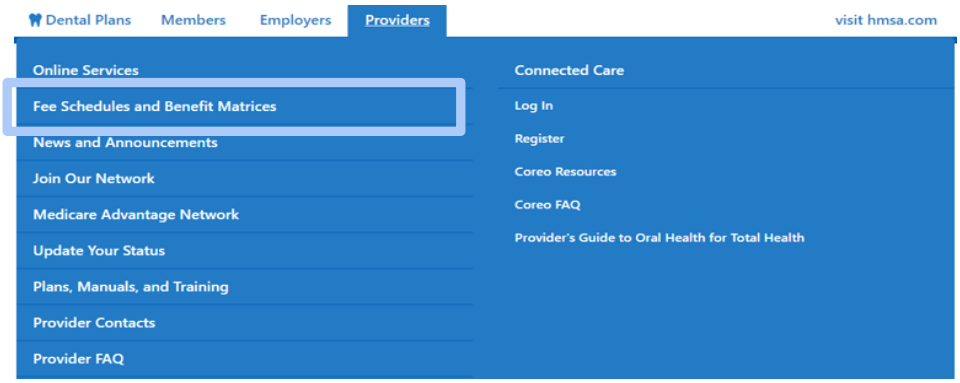
This new functionality is part of our commitment to making dental insurance easier for you and your patients. If you have any questions or need additional information about uploading electronic attachments, please call Dental Customer Service at **808-948-6440 on Oahu** or toll free on the **Neighbor Islands at 1-800-792-4672** from 8 a.m. – 5 p.m. (HST) Monday – Friday.

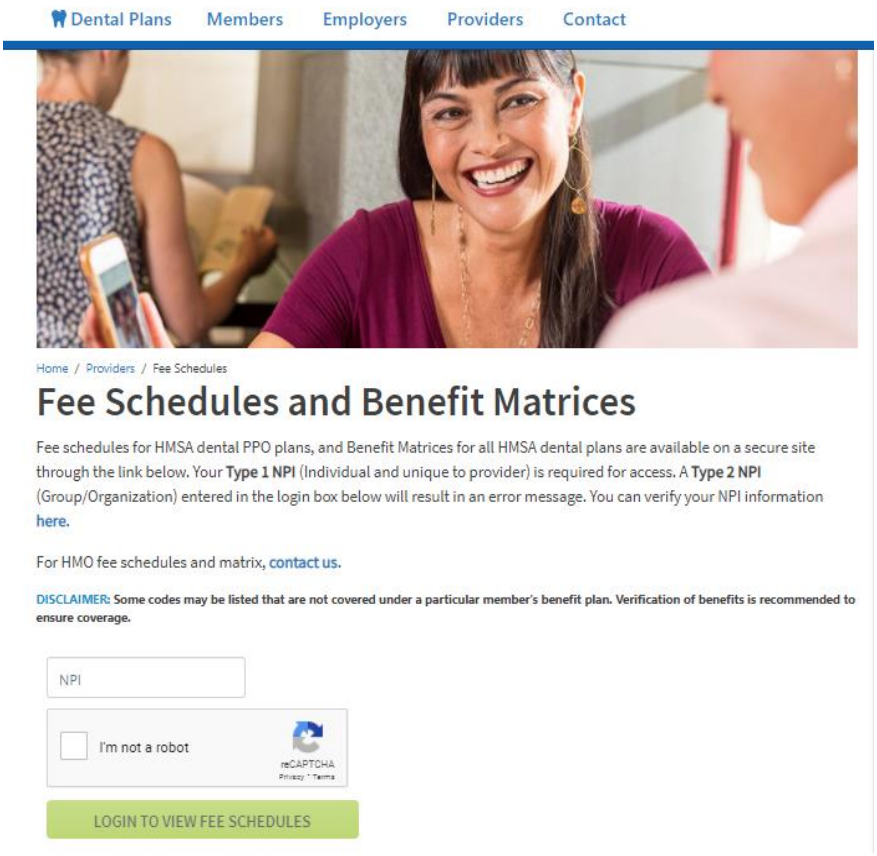
NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. How to Obtain a Fee Schedule

The current PPO fee schedules are located on a secure site within our HMSA website. To access the fee schedules:

1. Go to hmsadental.com
2. Select “Providers”
3. Select “Fee Schedules and Benefit Matrices.”
4. You will be required to enter your Type 1 NPI for access.





NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber’s plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 16: HANDLING OVERPAYMENT REQUESTS

A. Reasons for Overpayment

Occasionally, HMSA may overpay a dental claim. Some reasons for overpayment include:

- Processing under an incorrect procedure code
- Paying a claim for a member who is not a patient of record with the provider's office.
- Paying a claim without coordinating benefits

In these circumstances, we are required to correct the action and issue a Request for Refund (invoice) to you, which includes information needed for you to refund to the Payor the overpayment.

This section does not apply to FEP overpayments. If you discover an FEP overpayment, please call Customer Service at (808) 948-6281 for Oahu and (800)-966-6198 for Neighbor Islands Monday through Friday from 8:00 a.m. to 4:00 p.m. HST.

B. Follow Up Action for when you Receive a Request for Refund

If you receive a letter requesting a refund, please:

- Make a copy of the letter and include it with your refund.
- Make the check payable to HMSA.

To ensure prompt and accurate posting, send your payment within fifteen (15) days of receipt to:

HMSA Cashier
Customer Collection Services
P.O. Box 69402
Harrisburg, PA 17106

Please note: If payment is not received by the invoice due date, the Payor will collect the money by deducting the overpaid amount from future payments made to you by the Payor. This is called an offset. These payments may be deducted from different claims for claimants other than those who incurred the overpayment.

If you discover that HMSA has overpaid you, please call Customer Service at **808-948-6440** or toll free **800-792-4672**; provide the amount of the claim, the claim number and the patient's subscriber ID number. The representative will confirm the overpayment and, if necessary, have a Request for Refund mailed to your office. After that, you may do one of the following:

- **Cash the check and wait for the Request for Refund letter**, then follow the steps above for “If You Receive a Request for Refund.”
- **Return the check.** To ensure we credit the refund to the appropriate account, we recommend that you wait for the Request for Refund letter to arrive and attach it to the check you are returning.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber’s plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 17: ORTHODONTIC SERVICES

A. Preliminary work-up Appointments (Records)

For preliminary work-up appointments (records), submit claims listing each service performed separately.

Billing separately for these services will maximize the members' orthodontic benefit, since the services (except cephalometric films) will be deducted from the member's annual dental benefit, instead of the orthodontic benefit. **Bill only for services performed**. Use the following codes:

B. 2025 CDT Narrative

ADA Code	Description
D0150	Comprehensive oral evaluation
D0210	Intraoral complete series of radiographs images
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image – acquisition, measurement, and analysis
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally
D0470	Diagnostic casts

C. Criteria for Orthodontic Treatment

Orthodontic treatment is covered under the orthodontic portion of the Member's benefit plan when all the following conditions exist:

1. The patient has orthodontic coverage (and qualifies based upon eligibility at time of treatment).
2. The orthodontic treatment is for the correction of a malocclusion.
3. The orthodontic treatment involves appliance therapy.

Review of the Member's orthodontic benefits and treatment planning are essential to the timely and accurate payment of claims for Orthodontic treatment. Orthodontic treatment plans are based upon the type of dentition involved – transitional, adolescent or adult; as well as the treatment of a particular patient depending on circumstance.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. Cosmetic Orthodontic Treatment

Payment for the following orthodontic services is limited to the Orthodontic Lifetime Maximum specific to the Member's Benefit Plan. Elective cosmetic orthodontic services will not be held to HMSA's allowable, and participating providers may charge up to their usual and customary fees.

E. Treatment Types and Claims Submission Guidelines

If you are billing for:	Please include the following on your claim:	We will reimburse you:
Limited, Interceptive or Minor Treatment	Itemized claim for services rendered	One-time payment deducted from patient's overall lifetime ortho maximum
Comprehensive Treatment (when patient's ortho benefit coverage is in effect when treatment begins)	Appropriate CDT procedure codes Treatment start date Total case fee Length of treatment plan or estimated end date The monthly visit fee	One installment of 25% of the treatment liability. Pro-rated payments continue monthly until the treatment has ended or benefits are exhausted. Note: One lump sum for all new cases in which the total allowable charge is $750 or less.
Comprehensive Treatment (when patient's ortho benefit coverage becomes effective after treatment begins, or if there is a change in providers mid treatment)	Appropriate CDT procedure codes Treatment start date Total case fee Length of treatment plan or estimated end date The monthly visit fee	A prorated payment will be calculated by comparing the banding date to the effective date of coverage and remaining length of treatment. Benefit dollars provided by a prior carrier will be considered in determining the patient's available benefit. Payments will be generated monthly.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. Policies and Limitations for Orthodontic Procedures

- Initial payment for orthodontic services will not be made until a banding date has been submitted to HMSA Dental.
- All retention and case finishing procedures are integral to the total case fee.
- Observations and adjustments are integral to the payment for retention appliances.
- The replacement of a lost or missing appliance is not a covered benefit.
- Periodic orthodontic treatment visits are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service.
- Re-cementation of an orthodontic appliance is not covered by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient. However, re-cementation by a different dentist will be considered for payment as a palliative emergency treatment.

G. How to Submit claims

Please follow these guidelines when submitting claims for orthodontic treatment:

Limited, Interceptive and Minor Treatment. Submit a claim with the appropriate CDT procedure code, including the total treatment fee and the placement date of the appliance. We will make payment after receipt of initial claim for treatment.

Comprehensive Treatment. One (1) installment equal to 25% of the lifetime maximum; pro- rated payments continue monthly until the treatment has ended or a new treatment plan including complete treatment plan information is submitted. For patients whose comprehensive treatment started after their orthodontic benefits became effective, submit the claim with the appropriate CDT procedure code, including the treatment charge and the date treatment began.

Payment will be prorated by comparing the banding date to the effective date of coverage and remaining length of treatment. (Accumulation transfers will be considered if provided by prior carrier.) If comprehensive treatment began before the patient's orthodontic benefits became effective, submit the monthly visits and your monthly fee using the appropriate CDT procedure code. When submitting claims for the services included in orthodontic records, itemize the appropriate CDT procedure code for each service (e.g., radiographs, evaluation, study models) with your usual fee. If you have questions regarding a patient's coverage, effective dates, or benefits, call our Dental Customer Service at **808-948-6440** or toll free **808-792-4672**. Diagnosis, banding date and estimated length of treatment must be submitted with the claim. Please refer to Submission Guidelines – Pediatric Essential Health Benefits under Healthcare Reform Plans for more information on how to submit claims for these plan types.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 18: GENERAL POLICIES AND PROCEDURES

A. Utilization Review

While we continue to conduct utilization review on submitted claims, as a participating dentist, you are no longer required to submit radiographs or periodontal charting, except in specific cases or unless requested by the Plan**.**

From time to time, we may require that your practice participate in utilization management programs that may include, an on-site review of facilities, onsite review of dental records, providing copies of member dental records, audit of dental records, dental care evaluation studies, practice pattern studies and/or analysis based on claims data.

B. Necessary and Appropriate Care

Our members' Subscriber Certificates or Guide to Benefits specify that all dental care—including services, procedures, supplies and appliances–must be "necessary and appropriate to diagnose or treat [the] dental condition." Necessary and appropriate care must meet these criteria:

The care must be:

- Rendered consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
- Furnished in accordance with standards of good dental practice.
- Provided in the most appropriate site and at the most appropriate level of services based upon the Member's condition.
- Not provided solely to improve a member's condition beyond normal variation in individual development and aging, including improving physical appearance that is within normal individual variation.
- As beneficial as any established alternative; and
- Not rendered solely for Dentist's, Member's or a third-party convenience.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

C. Information Needed to Review a Procedure

Please refer to the appropriate HMSA CDT Guide for information you must submit for procedures requiring review. *In cases where we request a detailed narrative, please supply details about the patient's condition that will help us evaluate your claim and reimburse you appropriately.*

Please refer to the appropriate HMSA CDT Guide for any specific requirements needed when submitting claims for treatment. Any radiographs you submit must be:

- Preoperative periapical that are current and dated.
- Labeled – left or right side – if duplicates
- Mounted, if they are a full series.
- Of diagnostic quality
- Labeled with the patient's name and ID number.
- Labeled with the dentist's name and address.

Return of Radiographs

Radiographs or attachments will not be returned unless specifically requested by the dental office and accompanied by a pre-addressed, Postage-paid envelope.

D. Services that are Not Covered

Some services are not covered regardless of whether the procedure is listed as a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate or Guide to Benefits under "Limitations and Exclusions." Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture, or an exploratory service.

E. HMSA Dental Advisory Committee

HMSA has a Dental Advisory Committee that provides valuable guidance and counsel to HMSA regarding various dental issues related to operations and programs. Our committee members are dental providers from various specialties with representation from Oahu and neighbor islands. HMSA will consider recommendations for new committee members from individual dentists and dental organizations in the community.

F. Compliance and Anti-Fraud Program

The Dentist will maintain throughout the term of their Agreement, a compliance and anti-fraud program to detect and prevent the incidence of fraud and abuse relating to the provision of Services, including without limitation, maintaining, and complying with internal controls, policies and procedures that are designed to prevent, detect and report known or suspected fraud and abuse activities.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 19: APPEALS AND DISPUTE RESOLUTION

A. Claims Appeal Process for Patients

If we deny payment of a claim, you or your patient has the right to appeal. Please refer to SECTION 15: REIMBURSEMENT for a list of reasons commonly found on dental remittances to explain non-payment.

The appeal must be in writing and received by HMSA within a specific time period of the denial, depending on the patient's plan (see chart below). We will immediately acknowledge the appeal and respond in writing within a specific period, depending on the patient's plan. You may request an expedited appeal if you feel that any delay would prevent a patient from receiving urgently needed services.

	PRIVATE BUSINESS	FEDERAL PLAN 87	FEP Basic and Standard	Blue Cross Blue Shield FEP Dental
Submission Period to file appeal	One year from the date of denial	Six (6) months from the date of denial	Six (6) months from the date of denial	Six (6) months from the date of denial
Response time by HMSA *(non-urgent claims)*	60 calendar days from receipt of appeals information	30 days from the date of written request to pay claim, deny claim or request for more information	30 days from the date of written request to pay claim, deny claim or request for more information	30 days from the date of written request to pay claim, deny claim or request for more information
Response time by HMSA (*urgent claims)*	72 hours	72 hours: if more information is needed, we will respond within 24 hours after receipt of claim	72 hours	72 hours
Mailing Address for Appeals	Dental Claims Administrator P.O. Box 69437 Harrisburg, PA 17106-9436 Or Fax to 1-888-667-8388	Dental Claims Administrator P.O. Box 69437 Harrisburg, PA 17106-9436	HI FEP Claims P.O. Box 69437 Harrisburg, PA 17106-9436 Or Fax to 1-888-667-8388 ***Effective 07/01/2022**	BCBS FEP Dental Claims Appeals P.O. Box 551 Minneapolis, MN 55440-0551
Customer Service Contact Number	**HMSA Dental** Oahu – (808) 948-6640 Neighbor Island – (800) 792-4672	**HMSA Dental** Oahu – (808) 948-6640 Neighbor Island – (800) 792-4672	Oahu – (808) 948-6281 Neighbor Islands (800) 966-6198	In the U.S.- (855) 504-BLUE or (855) 504-2583, TTY: 711 (International) Call Collect – (651) 994-BLUE or (651) 994-2583

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 20: FEDERAL EMPLOYEE PROGRAM (FEP) – BASIC AND STANDARD OPTIONS

A. Overview

The Federal Employee Program (FEP) is a nationwide Federal Employees program administered through the local Blue Cross and Blue Shield Association. ***This program should NOT be confused with HMSA's Plan for Federal Employees.*** The FEP membership card is identified by coverage codes 104, 105 and 106 for the Standard Option and 111, 112 and 113 for the Basic Option.

As of January 2014, dentists who participate in the HMSA Dental network, may provide care to members of both the FEP Basic Option and Standard Option plans. You can determine which plan a member has by looking at the ID card. (See samples on the following pages.) The card will have a unique ID number beginning with an "R" to indicate FEP, as well as one of these enrollment codes.

As of January 2014, members may receive their dental services from any of our HMSA participating dentists and receive their covered services at the HMSA Maximum Allowable Charge.

HMSA is responsible for servicing the Participating Dentist Network for FEP, and for ensuring the accuracy of the online provider directory and the provider file used for claims processing.

For services performed by participating dentists and specialists in our HMSA Dental Provider Network, the member will owe the difference between the benefit amount and the HMSA Maximum Allowable Charge (MAC).

Providers should always verify member eligibility via HHIN Blue Exchange Eligibility or by calling HMSA Dental Customer Service at **808-948-6281** on Oahu or **808-966-6198 toll-free** on the Neighbor Islands.

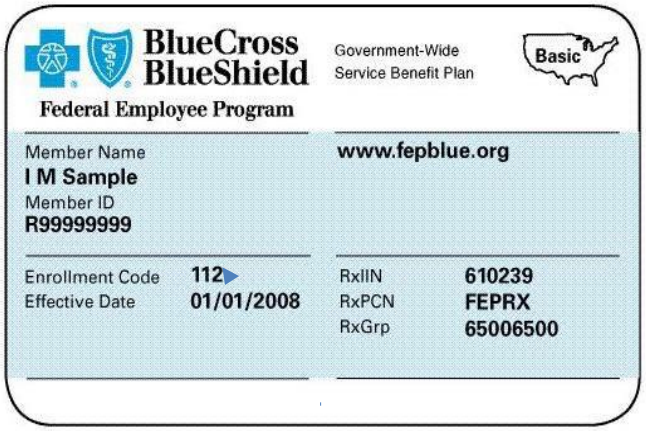
For current FEP plan benefit details, brochures, and guidelines, please refer to the fepblue.org website. For your convenience, we have included the applicable year's benefit details within this section on the following pages.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

B. Highlights of Basic and Standard Options

Feature	Basic and Standard Options
Covered Services	Separate lists for each option
MAC (Maximum Allowable Charge)	Same for both options
Procedures Not Covered	Charge usual and customary fee
Procedures Not Covered Under FEP	Do not bill to FEP (unless rejection is required for coordination of benefits)
Deductible	No deductible required
Customer Service	Oahu: (808) 948-6281, Neighbor Islands: (800) 966-6198 Toll Free
FEP Customer Service	(808) 948-6281 & 1 (800) 966-6198
PSHB Customer Service	(808) 948-5500 & 1 (800) 577-4672
Benefit Information	Complete details in FEP Service Benefit Plan Brochure on fepblue.org (FEHB: Pages 121–124, PSHB: Pages 123–126)
2025 Dental Benefit Details	Included in HMSA dental manual

C. FEP Basic Option – Sample Member ID Card



Basic Option identified by a 111, 112 or 113

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. FEP Basic Option – Benefits and Limitations

Benefits

- **Benefits are available only when a participating dentist renders treatment.**
- **Coverage is limited to basic and preventive services. Covered codes are listed in detail on the FEP schedule, located at www.fepblue.com**
- **A fixed copayment of $35 is applicable when a covered evaluation is billed (D0120, D0140, D0150). The $35 copayment is payable by the member at the time of service.**
- **There is a fixed MAC for each covered procedure.**
- **FEP pays MAC for each covered procedure less any applicable $35 copayment.**
- **Members may not be billed more than the $35 copayment for covered services.**
- **Sealants are covered.**

Limitations

- **Clinical Oral Evaluations (ADA codes: D0120, D0150): Benefit limited to a combined total or two evaluations per person, per calendar year.**
- **Radiographs:**
  - **Intraoral complete series, including bitewings (D0210): Benefit limited to one complete series every three (3) years.**
- **Preventive:**
  - **Prophylaxis (ADA codes D1110, D1120): Prophylaxis benefits limited to two (2) per calendar year.**
  - **Fluoride (ADA codes D1206, D1208). Fluoride benefits limited to children only, two per calendar year**
  - **Sealants: (D1351) Benefit is available for covered children up to age sixteen (16) at a limit of one (1) per tooth for the first and second molars only.**
- **Complete benefit information and limitations are outlined in the FEP Service Benefit Plan Brochure, located on the fepblue.org website, (FEHB: Pages 121–124, PSHB: Pages 123–126). For your convenience, we have included the applicable year's dental benefit details within this section of this HMSA dental manual.**

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

E. FEP Standard Option – Sample Member ID Card

Standard Option identified by a 104, 105 or 106

Standard Option Features
Benefits • There is a fixed MAC for each covered procedure. • There is a fixed copayment (a portion of MAC) for each covered procedure dependent upon the patient's age. Copayments are payable by the member at the time of service. • Sealants are not covered. You may bill Standard Option members at your usual and customary charge for this procedure.
Limitations • Clinical Oral Evaluations (ADA Code: D0120): Benefit is limited to two evaluations per person, per calendar year. • Prophylaxis (ADA Codes: D1110, D1120): Benefit is limited to two per person, per calendar year. • Fluoride (ADA Codes: D1206, D1208): Benefit is limited to two per person, per calendar year

Listed below are the 2025 benefits.

Plan Option	Self Only	Self + 1	Self + Family
Standard Option	104	106	105
Basic Option	111	113	112

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. FEP Standard Option (Medical Plan) Benefit Table

Dental Benefit Covered Service	We Pay		You Pay
Clinical Oral Evaluations	To Age 13	Age 13 & Over	All charges more than the scheduled amounts listed to the left. NOTE: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluations *(Up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive Oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic Imaging	To Age 13	Age 13 & over	
Intraoral complete series	$36	$22	
Palliative Treatment	To Age 13	Age 13 & over	All Charges
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive	To Age 13	Age 13 & over	
Prophylaxis – adult (*Up to 2 per person per calendar year)*	--	$16	
Prophylaxis – child (*Up to 2 per person per calendar year)*	$22	$14	
Topical application of fluoride or fluoride varnish (*Up to 2 per person per calendar year)*	$13	$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

G. FEP Basic Option (Medical Plan) Benefit Table

Dental Benefit Covered Services	We Pay	You Pay
Clinical Oral Evaluations	Preferred: All charges more than your $35 copayment Participating/ Non-participating: Nothing	Preferred: $35 copayment per evaluation Participating/Non-participating: You pay all charges
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
Benefits are limited to a combined total of 2 evaluations per person per calendar year		
Diagnostic Imaging		
Intraoral – complete series including bitewings *(limited to 1 complete series every 3 years)*		
Preventive		
Prophylaxis – adult *(up to 2 per calendar year)*		
Prophylaxis – child (*up to 2 per calendar year)*		
Topical application of fluoride or fluoride varnish – for children only *(up to 2 per calendar year)*		
Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*		
Not covered: Any service not specially listed above	Nothing	All charges

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

H. Accidental Injury Benefit

Accidental injury benefit	You Pay	
	Standard Option	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required because of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses. **Note:** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. **Note:** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount. **Note:** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$35 copayment per visit **Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. **Note:** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

I. Coordination of Benefits (FEP)

As explained in Section 14, coordination of benefits (COB) involves two or more payors plan identified as working together to share the cost of healthcare expenses, with one primary (this plan pays first) and the other plan as secondary (this plan pays second). COB allows payors to help manage the cost of healthcare by avoiding payment of more than the total reasonable expenses incurred.

When FEP is the secondary payor, we will adhere to these guidelines.
We will pay the difference between the primary Payor's payment and the lower of the MAC allowance or the dentist's charge.

If the primary Payor's payment is equal to or greater than the Allowable Charge (MAC) allowance, FEP will not owe a Maximum payment.
If the primary Payor's payment is less than our allowance, we will coordinate and process up to the fee schedule not to exceed the MAC.

J. How to File a Claim (FEP)

When filing claims for FEP Basic and Standard plan members, please do the following:

1. Include the policy subscriber's ID number—an R followed by eight digits—in block 15 of the ADA claim form.
2. Make sure the provider has signed the claim form.
3. FEP Dental claims should be mailed to the following address to ensure timely processing:

   HI FEP Claims
   P.O. Box 69401
   Harrisburg, PA 17106-9436

4. FEP's late claim/timely filing limitation is defined as December 31st of the year following the date of service. (E.g., for a service rendered on April 1, 2024, the timely filing deadline would be December 31, 2025). This filing limitation is outlined in the FEP Service Benefit Plan Brochure, located on the fepblue.org website.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

K. Reconsideration of an FEP claim

FEP Dental Claims are paid by your local Blue Cross Blue Shield Plan (hereinafter referred to as the Local Plan). Within six (6) months of the initial claim decision, you may ask the Local Plan in writing to reconsider the claim decision. Follow Step 1 of the disputed claims process below.

Step 1: To request reconsideration of a claim decision you must:

- Write to the Local Plan within six (6) months from the date of the decision; and
- Send your request to the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim; and
- Include a statement about why you believe the initial decision was wrong, based on specific benefit provisions; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, dental records, and explanation of benefits (EOB) forms.

The Local Plan will provide you, in a timely manner, with any new or additional evidence considered, relied upon, or generated at its direction in connection with the claim and any new rationale for the claim decision. The Local Plan will provide you with this information sufficiently in advance of the date that it is required of the reconsideration decision to allow you a reasonable opportunity to respond before that date. However, the Local Plan's failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate its decision on reconsideration. You may respond to that new evidence or rationale at the Office of Personnel Management (OPM) review stage described in Step 3.

Step 2: In the case of a post-service claim, the Local Plan has thirty (30) days from the date it receives your request to:

- Pay the claim or
- Write to you and maintain its denial or
- Ask you or your patient for more information.

You or your patient must send the information so that we receive it within 60 days of our request. The Local Plan will then decide within 30 more days. If the Local Plan does not receive the information within 60 days, a decision will be made within 30 days of the date the information was due. The decision will be based upon the information already on file. The Local Plan will provide a written response regarding its decision.

Step 3: If you do not agree with the decision, you may ask OPM to review it. You must write to OPM within:

- 90 days after the date of the Local Plan's letter upholding the initial decision; or
- 120 days after you first wrote to OPM – if they did not answer that request in some way within 30 days: or
- 120 days after OPM asked for additional information – if OPM did not send you a decision within 30 days after receiving the additional information.

Write to OPM at:

United States Office of Personnel Management
Federal Employee Insurance Operations, Health Insurance
1900 E Street, NW Washington, DC 20415-3610

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 21: BCBS FEDERAL EMPLOYEE PROGRAM (FEP) DENTAL

As an HMSA Dental provider, you have access to Blue Cross Blue Shield FEP Dental members, and your reimbursement for services provided to these members will be at your HMSA Dental PPO contracted rate.

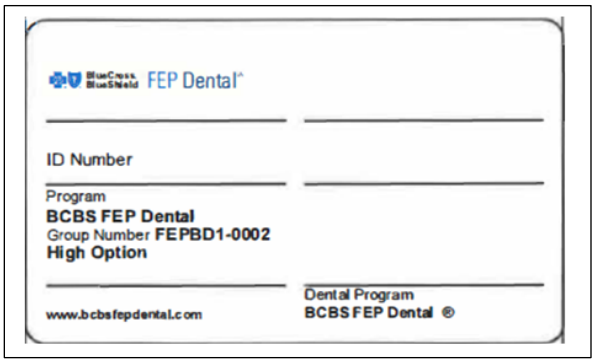
A. FEP Dental Implementation

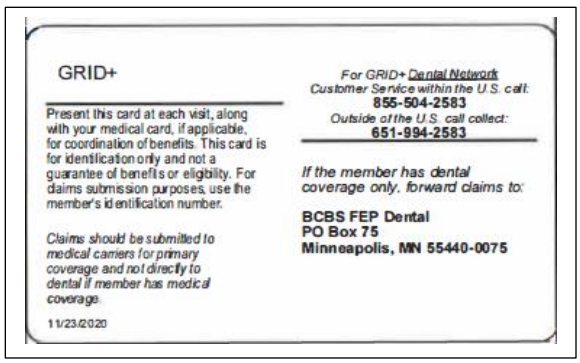
Effective JAN 1, 2019, TRICARE retirees and their dependents are eligible to select FEP Dental as their primary dental coverage. The Blue Cross Blue Shield Association (BCBSA) has partnered with the GRID Dental Corporation (GDC) to administer FEP Dental. FEP Dental members will be able to utilize the GRID+ network as an in-network provider source. By participating in your local Blue Cross and Blue Shield plan (HMSA Dental), you will now have access to FEP Dental members. The member's card will be identified with FEP Dental, along with the claim's submission address and customer service number to verify benefits.

B. Identification Cards

Each member enrolled in BCBS FEP Dental receives an identification card (ID card). The ID card will indicate provider network (GRID+), member's identification number, group number, program name, and on the reverse side the address to send the claims and the customer service telephone number. The lower left corner of the member's ID Card will display GRID+ indicating the use of the GRID+ network.

The ID card is for identification ONLY. The ID card is not a guarantee of eligibility or benefits. BCBS FEP Dental recommends that you verify coverage for the date of service. This may be done by calling the BCBS FEP Dental Customer Service Department at **855-504- BLUE** or **855-504-2583.** On the following page, is a generic sample of a BCBS FEP Dental ID Card.





NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

When a member provides your office with their BCBS FEP Dental ID Card, it is important to also ask for their medical ID Card. The medical ID card is important because by law, the member's medical plan is the primary carrier.

C. Claims Submission Tips

Accurate claims submission results in faster payment. To ensure timely claims payment, you may use the following checklist as a tool. Please check the information you are providing for completeness and accuracy.

- ✓ State-issued treating Dentist License Number and Tax Identification Number (TIN)
- ✓ Patient's birth date
- ✓ Patient's relationship to member
- ✓ Member's birth date
- ✓ Member's social security number (SSN) or identification number
- ✓ Member/patient's signature
- ✓ Current ADA procedure code(s)
- ✓ Fee for treatment
- ✓ Treatment date(s)
- ✓ Tooth number, surface, and quadrant if applicable.
- ✓ Treating Dentist's signature
- ✓ Up-to date and complete practice address details

D. Pre-Treatment Estimates

BCBS FEP Dental recommends a pretreatment estimate be submitted prior to treatment for extensive oral surgery, periodontics, endodontics, major restorative, prosthodontic, and orthodontic services. We will provide an explanation of benefits to both you and the member that will indicate if procedures are covered and an estimate of what we will pay for those specific services. The estimated Maximum Allowable Amount is based on the member's current eligibility and contract benefits in effect at the time of the completed services. Submission of other claims or changes in eligibility or the contract may alter the final payment. A pretreatment estimate is not a guarantee of benefits.

E. Pre-Treatment Review and Radiograph Submission

A pre-treatment review program will not be used by BCBS FEP Dental; instead, we have implemented a post-treatment program that monitors individual dentist utilization patterns. BCBS FEP Dental has developed the ability to modernize the process of processional review. This process has greatly improved service to our network dentists and members because pre-estimates and claims will be processed faster, and

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

radiographs will not be required prior to rendering services. You may find this new process makes FEP Dental – easy to do business with.

Post-payment review is simple and straightforward: individual dentist utilization is analyzed periodically and compared over time to determine if changes in utilization have occurred. You may be asked to periodically provide treatment information post payment as part of the post payment review process.

F. Submit for Cosmetic Service only if Necessary

Cosmetic dental services **are not** covered by the plan. If you provide cosmetic services to a member, you do not need to submit a claim to BCBS FEP Dental. If for billing purposes to show the member the service is not covered, it is important to understand that special handling of the claim is required. All claims for cosmetic services requiring a denial of payment from BCBS FEP Dental must be submitted directly to:

BCBS FEP Dental Claims
P.O. Box 75
Minneapolis, MN 55440-0075

Do not send cosmetic claims to the medical carrier.

G. Coordination of Benefits (COB)

The member's medical coverage is **always** Primary, while BCBS FEP Dental is Secondary. Submit all claims to the Primary medical plan first. Refer to the back of the member's medical ID card for submission. Pre-estimates of benefits can be submitted directly to BCBS FEP Dental. Upon completion of the dental care, submit the claim to the Primary medical plan.

Service Benefit Plan (FEP) Medical Member - Submit claims to the local Blue Cross Blue Shield Plan. Primary payment will be sent to you and then FEP Medical will forward the claim, along with the Primary payment amount, to BCBS FEP Dental. The primary benefit will be coordinated on the claim received from medical carrier and upon completion of Coordination of Benefits; BCBS FEP Dental will send the secondary payment to you.

Other Medical Member - Submit claims to the other medical carrier. Primary payment will be sent. You then submit claims and Primary remittance to BCBS FEP Dental for Secondary COB payment. Please hold Secondary claim submission until you have

received Primary Payment and remittance from the other medical plan.

H. Requirements for Federal Member ID's

The following instructions only apply if primary submission is to Service Benefit Plan (FEP) Medical. Federal Member identification numbers (ID) for FEP Medical begin with an "R" followed by eight digits (e.g., R12345678). If you do not use the correct ID format for FEP Medical, claims may be rejected. Follow all claim form instructions for the proper placement of the member ID.

I. Reconsiderations – Claim Dispute

If you and your BCBS FEP Dental patient disagree with the initial decision of how dental services were processed, please encourage your BCBS FEP Dental patient to refer to their BCBS FEP Dental Brochure on how to submit a reconsideration.

Reconsiderations or claim disputes should be sent to:

BCBS FEP Dental Claims Appeals
P. O. Box 551
Minneapolis, MN 55440-0551

J. FEP Dental Benefits Summary

BCBS FEP Dental Members have two options while choosing benefits during open enrollment, High Option, or the Standard Option. A general breakdown can be seen below. To verify benefits please contact **855-504-BLUE** or **855-504-2583** or visit bcbsfepdental.com.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

K. FEP Dental High Option Benefits Overview

Benefits	High Option	
	IN-NETWORK Member Responsibility	OUT-OF NETWORK Member Responsibility
Class A (Basic) Services e.g., exams, cleanings, X-rays, sealants[1]	0%	10%
	THREE CLEANINGS A YEAR COVERED	
Class B (Intermediate) Services e.g., oral surgery, fillings, gum scaling	30%	40%
Class C (Major) Services e.g., crowns, bridges, implants, root canals, dentures	50%	60%
Annual Deductible for Class A, B and C Services	No deductible	$50 per person
Annual Maximum Benefits for Class A, B and C Services	UNLIMITED MAXIMUM PER PERSON	$3,000 per person
Class D (Orthodontic) Services Adults & Children	50% up to $3,500 lifetime maximum	50% up to allowed amount
	NO WAITING PERIOD	

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

L. FEP Dental Standard Option Benefits Overview

Benefits	Standard Option	
	IN-NETWORK Member Responsibility	OUT-OF-NETWORK Member Responsibility
Class A (Basic) Services e.g., exams, cleanings, X-rays, sealants[1]	0%	40%
	THREE CLEANINGS A YEAR COVERED	
Class B (Intermediate) Services e.g., oral surgery, fillings, gum scaling	45%	60%
Class C (Major) Services e.g., crowns, bridges, implants, root canals, dentures	65%	80%
Annual Deductible for Class A, B and C Services	No deductible	$75 per person
Annual Maximum Benefits for Class A, B and C Services	$1,500 per person	$750 per person
Class D (Orthodontic) Services Adults & Children	50% up to $2,500 lifetime maximum	50% up to $1,250 lifetime maximum
	NO WAITING PERIOD	

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

M. BCBS FEP Dental – Contact Information

The goal is to make it as easy as possible for you to do business with BCBS FEP Dental. Please feel free to contact them with any questions.

- BCBS FEP Dental Customer Service (in the U.S.) **855-504-BLUE** or **855-504-2583, TTY: 711**

  Hours: 8 a.m. – 8 p.m. EST Monday-Friday
- Customer Service (International) Call Collect **651-994-BLUE** or **651-994-2583**
- Submit Claims to:

  BCBS FEP Dental Claims
  P.O. Box 75
  Minneapolis, MN 55440-0075

- **If you file electronically**, the Payor ID for BCBS FEP Dental is **BCAFD**.

For additional reference on FEP Dental, visit the bcbsfepdental.com **site to access:**

- Find a Dentist
- Oral Health Tips
- Benefit Information
- Claims Information
- Member FAQ
- And Much More

You may email HMSAdentalPR@usablelife.com regarding claims and out of network issues regarding your participation with the FEP Dental network. Please enclose copies of any applicable supporting documents such as EOB statement copies and other correspondence to support issue at hand.

SECTION 22: NATIONAL NETWORK GRID

Through recent negotiations, we can now provide our members and those of our Blue Cross and Blue Shield affiliates and partner, UCCI, with quality dental care through a network of participating providers. These networks of affiliated dental plans are known as the National Grid and UCCI Advantage Plus Plan, and your Agreement, now allows you access to the following membership:

National Grid
The National Grid is an alliance of dental networks managed by Blue Cross and Blue Shield affiliates throughout the United States. Since January 2014, members of these affiliate plans who either reside or are traveling outside their home networks have access to care rendered by HMSA participating providers when seeking dental care in Hawaii. Benefits for these members will be applied by the members' home Plan but paid based upon the Maximum Allowable Charge Schedule under your Agreement with HMSA.

Claims for Members of the GRID should be mailed to the member's home plan. This information should be located on the back of the member's BCBS Membership card. For more information, such as checking eligibility and specific plan benefits, where and how to submit claims, etc., please refer to the back of the member's card, and call the designated plan's customer service line. **

United Concordia Companies, Inc. members of their UCCI Advantage Plus Plan who either reside or are traveling outside their home networks will have access to care rendered by HMSA participating providers when seeking dental care in Hawaii. Claims for these members will be processed by the member's home Plan but paid based upon the Maximum Allowable Charge Schedule under your Agreement with HMSA. *
Access to these additional memberships will enable you to grow your patient base.

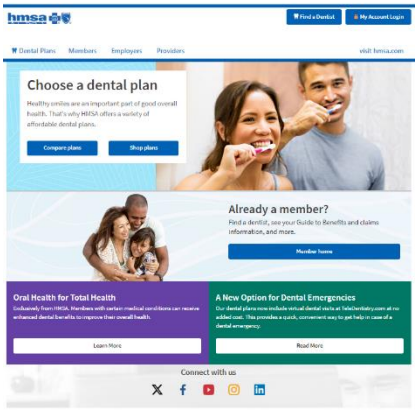
Member Plan	Services Provided by Network Management	Fee Schedule Used	Submit Claim to (Payor ID):
HMSA	HMSA	HMSA	HMSA*
UCCI Advantage Plus	HMSA	HMSA*	UCCI**
Out of State Grid Member	HMSA	HMSA	Member Home Plan**

*Unless the provider also participates with the UCCI Advantage Plus Plan in which case the UCCI Advantage Plus, Plan fee schedule supersedes the HMSA schedule.

**Coverage under the National Grid is denoted with "GRID+" on the back of the patient's membership card and a sample for reference may be found under "Identification Cards" of SECTION 21: BCBS FEDERAL EMPLOYEE PROGRAM (FEP) DENTAL

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

SECTION 23: TECHNOLOGY SOLUTIONS



A. Website Overview

We are now using our website, hmsadental.com, for all communication with our participating dental providers. Information is available to you at your convenience 24/7.

B. Provider Tabs and Resources

Links to secure web portals are provided to allow you access to the following platforms in a just a few clicks.

- MyPatientsBenefits - Online Services for HMO and PPO member/claims information
- HMSA Connected Care – Online services to Coreo platform
- FEP Dental and the GRID - Online Services for BCBS FEP Dental member/claims information

C. **Online Provider resources** available include:

- Online Services
- Fee Schedules and Benefit Matrices (*secure site requires Type 1 NPI to access)*
- News & Announcements
- Join Our Network
- Update Your Status
- Plans, Manuals, and Training *(i.e., CDT & Dental Manual)*
- Provider Contacts
- Provider FAQs
- Connected Care
- Find A Dentist *(Online Provider Directory)*

Technology can help you spend less time on paperwork and other administrative tasks, so you can spend more time caring for your patients. HMSA offers technology solutions to help you and your staff do business with us more efficiently by:

- Improving claim payment time and office cash flow
- Reducing claim errors
- Increasing productivity and efficiency by reducing time spent on billing and benefit inquiries.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. Common Terms

The following terms are important to know when using our technology solutions.

Clearinghouse	The entity that connects your office and the insurance carrier for electronic billing
Electronic Data Interchange (EDI)	The transmission of data from one computer to another
Electronic attachment	Any clinical documentation requested by the insurer to support your claim
Practice management software	The software program that allows you to manage your practice; often includes electronic-claims capability

E. Electronic Claims Submission

We encourage you to submit claims electronically to enjoy the advantages listed above. One important advantage is that your vendor automatically corrects electronic claims prior to reaching us, so they are more likely to process without delay. You will receive a report confirming that your vendor did or did not receive each claim.

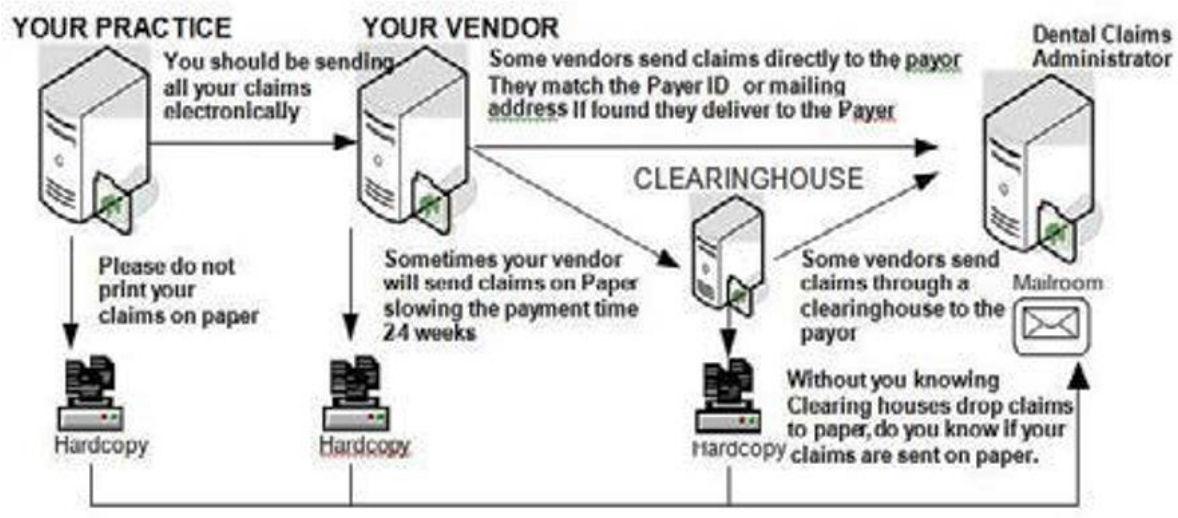
To get started, you will need:

- A computer with a modem and a printer
- Internet access
- Practice management or EDI-enabling software
- Notification to your software vendor of your provider billing number

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

F. Electronic Claims Filing Submission

The graphic below illustrates how information flows among the entities involved in electronic claims submission.



Do you know if your vendor is sending paper?
Do you know if your vendor's clearinghouse choice is sending claims on paper?
You should ask your vendor what percentage of your claims are sent to the payor electronically.

G. Our Payor ID Number and Customer Support

HMSA's payor ID number is HMSA1. If you have questions about filing claims electronically, please contact Dental Electronic Services at 800-633-5430 Monday through Friday between 8:00 am and 8:00 pm EST.

Self-Service Tools and Services for HMSA members are available through our Dental Administrator's website. Registered users will have access to all the following online services 24 hours a day, 7 days a week.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

H. Dental Fax Request Program 808-538-8966

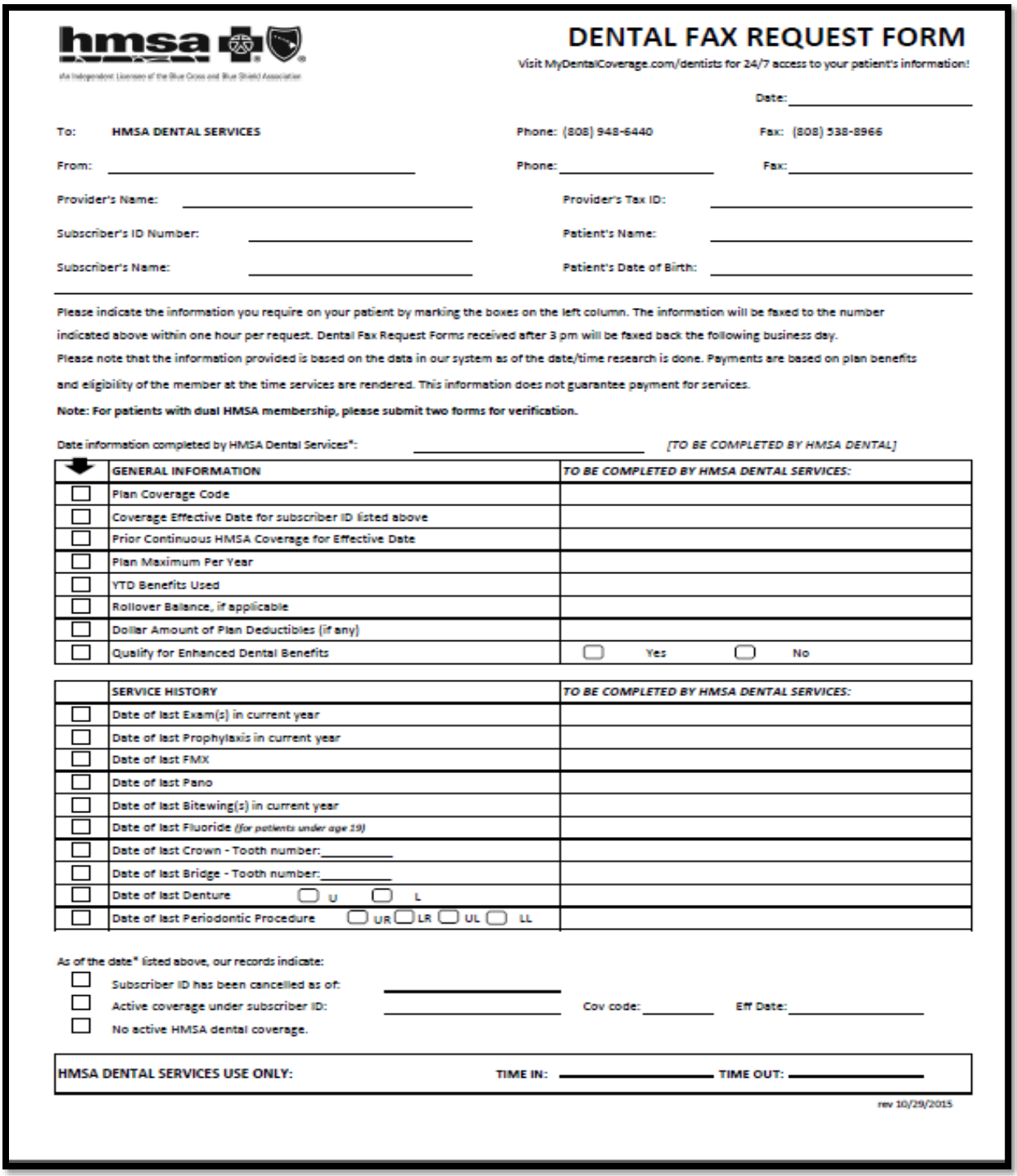
HMSA is pleased to offer its Dental Fax Request program to our participating dental providers. This program will enable you to receive eligibility and comprehensive benefit information on any HMSA PPO/FFS dental member.

On the following page, you'll find the Dental Fax Request Form which you will complete indicating the information you require by marking the boxed in the left column. The information will be faxed back to the phone number indicated on the form within one hour of receipt. Dental Fax Forms received after 3:00 pm will be faxed back the following business day.

Please note the information provided is based on data in our system as of the date/time research is done. Payments are based on the plan benefits and eligibility of the member at the time services are rendered. This information does not guarantee payment of services.

Should someone have dual membership/coverage, please submit two forms for verification.

I. Sample Dental Fax Request Form



hmsa

DENTAL FAX REQUEST FORM

Visit MyDentalCoverage.com/dentists for 24/7 access to your patient's information!

Date: _____

To: HMSA DENTAL SERVICES Phone: (808) 948-6440 Fax: (808) 538-8966

From: _____ Phone: _____ Fax: _____

Provider's Name: _____ Provider's Tax ID: _____

Subscriber's ID Number: _____ Patient's Name: _____

Subscriber's Name: _____ Patient's Date of Birth: _____

Please indicate the information you require on your patient by marking the boxes on the left column. The information will be faxed to the number indicated above within one hour per request. Dental Fax Request Forms received after 3 pm will be faxed back the following business day.
Please note that the information provided is based on the data in our system as of the date/time research is done. Payments are based on plan benefits and eligibility of the member at the time services are rendered. This information does not guarantee payment for services.

Note: For patients with dual HMSA membership, please submit two forms for verification.

Date information completed by HMSA Dental Services*: _____ *[TO BE COMPLETED BY HMSA DENTAL]*

	GENERAL INFORMATION	*TO BE COMPLETED BY HMSA DENTAL SERVICES:*
☐	Plan Coverage Code	
☐	Coverage Effective Date for subscriber ID listed above	
☐	Prior Continuous HMSA Coverage for Effective Date	
☐	Plan Maximum Per Year	
☐	YTD Benefits Used	
☐	Rollover Balance, if applicable	
☐	Dollar Amount of Plan Deductibles (if any)	
☐	Qualify for Enhanced Dental Benefits	☐ Yes ☐ No

	SERVICE HISTORY	*TO BE COMPLETED BY HMSA DENTAL SERVICES:*
☐	Date of last Exam(s) in current year	
☐	Date of last Prophylaxis in current year	
☐	Date of last FMX	
☐	Date of last Pano	
☐	Date of last Bitewing(s) in current year	
☐	Date of last Fluoride *(for patients under age 19)*	
☐	Date of last Crown - Tooth number:_____	
☐	Date of last Bridge - Tooth number:_____	
☐	Date of last Denture ☐ U ☐ L	
☐	Date of last Periodontic Procedure ☐ UR ☐ LR ☐ UL ☐ LL	

As of the date* listed above, our records indicate:

☐ Subscriber ID has been cancelled as of: _____

☐ Active coverage under subscriber ID: _____ Cov code: _____ Eff Date: _____

☐ No active HMSA dental coverage.

HMSA DENTAL SERVICES USE ONLY: TIME IN: _____ TIME OUT: _____

rev 10/29/2015

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

J. My Dental Coverage

Tool Service	What	How
MYDENTALCOVERAGE	Online tool - Provides direct, up-to-the minute access to member information and offers dental offices the ability to check patient eligibility, deductible, service history and the status of patients' claims online for free. You may even submit your claims electronically via this website, using the Speed eClaim® function. Access our hmsa.com/dental website, within the Provider Secured site, for detailed instructions on how to use MyDentalCoverage.	To Begin, log onto our website: **hmsa.com/dental** • Click on Providers tab • Click on Online Services • Click on MyPatients Benefits • Click on Create an Account Once you create an account, you may select from among several online services such as: My Patients' Benefits – real time access to member information, review eligibility, see allowances, and check claim status. Reimbursements - Payments and to view EOBs, see payments and predeterminations Speed eClaim® – submit claims FREE, real- time edits and faster payments. Electronic Funds Transfer (EFT) – this process allows funds to be transferred from HMSA directly to your bank account rather than issuing checks for services rendered: To verify patient eligibility and claim status: • Go to hmsa.com/dental. Click on the MyDentalCoverage. After being redirected to our Dental Administrator's website, click on the For Dentists link, and then click on the My Patients' Benefits link.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

Tool Service	What	How
MYDENTALCOVERAGE (Continued)	Online tool - Provides direct, up-to-the minute access to member information and offers dental offices the ability to check patient eligibility, deductible, service history and the status of patients' claims online for free. You may even submit your claims electronically via this website, using the Speed eClaim® function. Access our hmsa.com/dental website, within the Provider Secured site, for detailed instructions on how to use MyDentalCoverage.	Enter the required provider and patient information and click Search. The landing page will show you a dashboard view of your patient, without having to go to individual pages for most information. The page will display your office's participation, or non-participation in the members network, the group name and number, and policy holder information (name and address). It also allows you to switch between members on the same policy. This area also shows the Member information, dates of coverage, if they have reported a qualified medical condition, and a snapshot of common procedures. Benefits, Schedule of Allowances, & Maximum/Deductible information is also found here. Claim Status for a patient is also found here.
REIMBURSEMENTS	This MyDentalCoverage online feature allows dental office staff to view a summary of reimbursements and details of each check, including information on associated claims.	From MyDentalCoverage: Click on the Reimbursements link where you will be asked to enter a date range for a review of payments made to your office.
Speed eClaim®	Free, online electronic claims submission to HMSA Dental. Real-time explanation of benefits. Instant online editing and resubmission, reducing errors. Reduced telephone calls, faxes, postage stamps, and paperwork. Electronic reports, including daily reports that summarize your submissions.	From MyDentalCoverage: Click on the Speed eClaim® link where you will be able to enter and submit your claims directly to HMSA Dental following the prompts. Access our hmsa.com/dental website, within the Provider Secured site, for detailed instructions on how to use MyDentalCoverage.
HIPAA ELIGIBILITY AND CLAIM STATUS TRANSACTIONS USING A CLEARINGHOUSE / VENDOR	Dental offices work with a multitude of payors, and it can be difficult to determine which systems are compatible with every carrier. To make verifying eligibility and checking claim status easier for dental offices, our Dental Administrator works with numerous clearinghouses and software vendors who can provide the ability for dental offices to perform these electronic transactions with all payors, using just one system.	Contact your software vendor to find out how you can perform these transactions through your practice management software.

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SECTION 24: ORAL HEALTH FOR TOTAL HEALTH

A. Importance of Oral Health

Coronary Artery Disease & Stroke

Researchers have found that people with periodontal disease are almost twice as likely to have coronary artery disease and increased rick for stroke as those without gum disease. There are several current theories of how this happens. When bacteria from the mouth enter the blood vessels, they attach to fatty proteins which may lead to blood clots and plaque buildup. Inflammation caused by periodontal disease could also increase plaque build-up, which may cause arteries to narrow and harden. Gun disease can also exacerbate existing heart conditions.

Diabetes

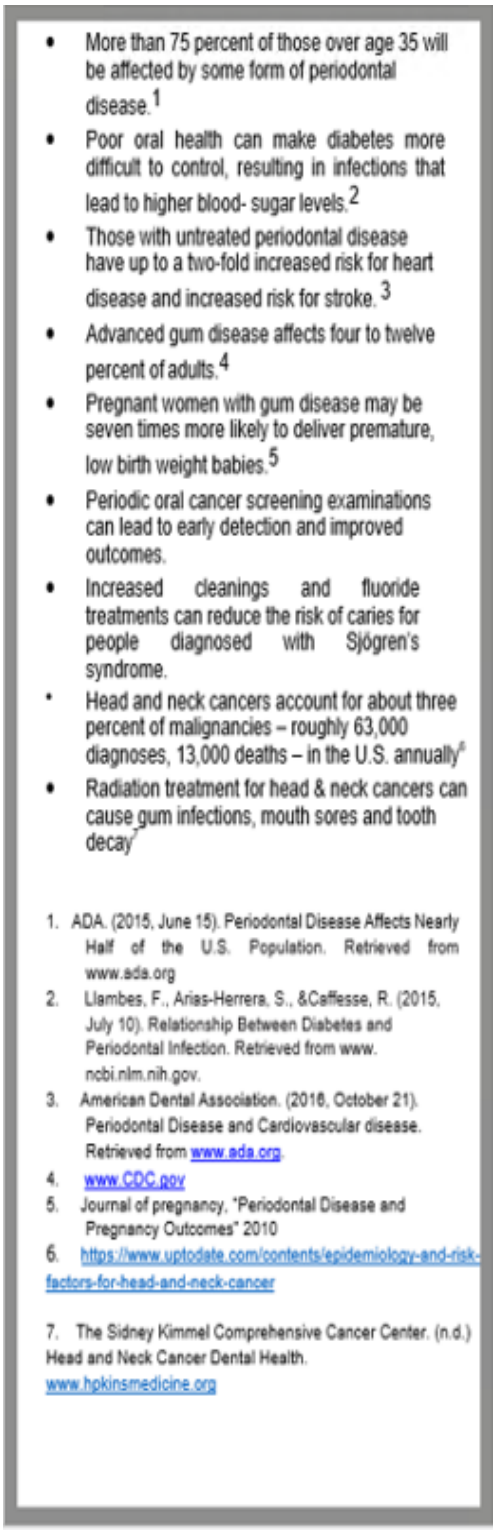
The relationship between periodontal disease and diabetes goes both ways. Those with diabetes are more susceptible to periodontal disease, and periodontal disease may increase blood-sugar levels and complications for those with diabetes. Periodontal disease may also increase the progression of prediabetes and can increase insulin resistance and disrupt glycemic control.

Pregnancy

Pregnant woman may have red, tender gums that are likely to bleed. This condition is known as pregnancy gingivitis and occurs when rising hormone levels make the gums more sensitive to plaque, the sticky film of bacteria that forms on teeth. This inflammation may increase the likely hood of a woman having a premature, low birth weight baby.

Oral Cancer

People with a history of oral cancer are at risk for developing new primary lesions. Additional benefits will help dentist's identify suspicious oral lesions early for possible treatment, as well as treat the side effects if previous oral cancer treatment.



- More than 75 percent of those over age 35 will be affected by some form of periodontal disease.[1]
- Poor oral health can make diabetes more difficult to control, resulting in infections that lead to higher blood- sugar levels.[2]
- Those with untreated periodontal disease have up to a two-fold increased risk for heart disease and increased risk for stroke.[3]
- Advanced gum disease affects four to twelve percent of adults.[4]
- Pregnant women with gum disease may be seven times more likely to deliver premature, low birth weight babies.[5]
- Periodic oral cancer screening examinations can lead to early detection and improved outcomes.
- Increased cleanings and fluoride treatments can reduce the risk of caries for people diagnosed with Sjögren's syndrome.
- Head and neck cancers account for about three percent of malignancies – roughly 63,000 diagnoses, 13,000 deaths – in the U.S. annually[6]
- Radiation treatment for head & neck cancers can cause gum infections, mouth sores and tooth decay[7]

1. ADA. (2015, June 15). Periodontal Disease Affects Nearly Half of the U.S. Population. Retrieved from www.ada.org
2. Llambes, F., Arias-Herrera, S., &Caffesse, R. (2015, July 10). Relationship Between Diabetes and Periodontal Infection. Retrieved from www.ncbi.nlm.nih.gov.
3. American Dental Association. (2016, October 21). Periodontal Disease and Cardiovascular disease. Retrieved from www.ada.org.
4. www.CDC.gov
5. Journal of pregnancy, "Periodontal Disease and Pregnancy Outcomes" 2010
6. https://www.uptodate.com/contents/epidemiology-and-risk-factors-for-head-and-neck-cancer
7. The Sidney Kimmel Comprehensive Cancer Center. (n.d.) Head and Neck Cancer Dental Health. www.hpkinsmedicine.org

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Sjögren's Syndrome

Sjögren's syndrome causes dry mouth as a result of inflammation in the glands that produce saliva and tears. Insufficient saliva production greatly increases the risk of caries and oral infection.

Head & Neck Cancers

Radiation Therapy is standard treatment for head or neck cancer patients and can cause gum infections, mouth sores, and tooth decay. Visiting a dentist prior to radiation therapy to have any needed treatment completed is necessary to prevent serious oral problems from developing after or during radiation treatment.

B. More Dental Members Can Benefit from Oral Health for Total Health® (OHTH)

OHTH is making a meaningful difference in the lives of those who live with medical conditions impacted by oral health. So, to help more members take advantage of this uniquely beneficial program, effective JAN 1, 2023, the following three conditions were added to the program.

Chronic obstructive pulmonary disease (COPD)

The drug regime used to treat COPD patients can cause dry mouth or oral candidiasis (thrush). There is also increasing evidence of a link between COPD, gastroesophageal reflux disease, and periodontal disease.

End-stage renal disease (ESRD)

A patient with ESRD is in the final, permanent stage of chronic kidney disease and must receive dialysis or kidney transplantation to survive. Poor oral health can negatively affect the health outcomes of these patients. Adults with the condition are also more likely to develop tooth decay, gum disease, and poor oral hygiene.

Metabolic syndrome (MetS)

This complex disorder is characterized by a group of five interconnected conditions that increase your risk of developing heart disease and type 2 diabetes. There is a clear relationship between poor oral hygiene, including oral inflammation, and its impact on different system disorders associated with MetS.[3]

The medical conditions currently included in the program are diabetes, coronary artery disease, stroke, oral and head and neck cancers, Sjögren's syndrome, and pregnancy. Because a majority of members who have been diagnosed with one or more of the new conditions have also been diagnosed with a condition that is currently covered under the program, the projected increase to OHTH enrollment is less than 1%.

C. HMSA Connected Care – Coreo Provider Registration Info

An undeniable relationship exists between oral health and total health. HMSA offers the Oral Health for Total Health program to members with certain medical conditions to help reduce bacteria and the risk of infection. Enhanced dental benefits care covered at 100% for enrolled members and don't count toward their calendar year maximum when seen by a participating provider.

HMSA is committed to our community and the health of its members. That's why we support a multifaceted approach to optimum oral care called Oral Health for Total Health. Because we offer medical and dental coverage, we're able to analyze claims information and identify members who can benefit from focused attention and additional dental education.

HMSA Connected Care℠ provides a flexible, scalable platform that connects your dental practice to HMSA's broad community of health care providers. Transparency between treating physicians and dentists allows for an efficient, holistic approach to addressing dental health.

Through the platform called Coreo, primary care providers (PCPs) are notified when patients are due or overdue for cleanings or checkups and advises them to refer the patients to your practice for care.

Once registered, you'll have access through Coreo to your attributed dental population. You'll be able to view preventive dental measures for each patient, including those who are enrolled in Oral Health for Total Health.

You'll also gain real-time access to your patients' medical information, such as recent visits, current and historical prescription information, diagnoses, and demographics. The system enables pre-visit planning and identifies gaps in medical care so that you can advise your patients to schedule follow-up visits with their PCP if necessary.

To register, complete and submit the HMSA Dental Coreo User Request form. Providers and support staff must each complete a registration form via hmsadental.com/providers/connected care/. Please include a distinct email address and HMSA ID number.

Questions?

View our frequently asked questions (FAQ) page, or contact Dental Network Managers Jessica Chang at 538-8904 or Leimomi Kiyono at 538-8933, both on Oahu.

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

D. Patient Criteria for OHTH Eligibility

- Have an eligible HMSA dental plan.
- Have a qualifying medical condition.
- Be Enrolled in program

E. HMSA Dental Plans Not Eligible for OHTH

- Federal Plans
- Keiki Care Plans
- ASO Plans (may choose to enroll)

F. Confirming Benefits based on OHTH Condition Enrolled

To confirm your patient is enrolled in our program, **please call 800-792-4672** or **808-948-6440 on Oahu** or login to 'MyPatientsBenefits'. If enrolled the member eligibility section will display:

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G. Confirming Qualifying Condition(s) Member is enrolled

After confirming which qualifying condition(s) the member is enrolled for, select 'Benefits' and then open the 'Wellness Benefits' tab. In this tab, you will find OHTH benefits details. Please pay special attention to the 'Limitations' column for details on which procedures/ CDTs are covered for which conditions.

Wellness Benefits

Procedure		Covered	Allowance	In-Network Coverage % or Copay $	Limitations	Applied to Deductible	Applied to Maximum
D0120	Periodic Evaluation >	Yes	$36.80	100%	In Network ~ OC, HNC, SjS Medical Conditions | 4 Per Benefit Period Total ~ OC, HNC, SjS Medical Conditions	No	No
D1110	Prophylaxis Adult >	Yes	$55.50	100%	In Network ~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions | 4 Per Benefit Period Total ~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions	No	No
D1206	Topical Fluoride Varnish >	Yes	$31.50	100%	In Network ~ OC, HNC, SjS Medical Conditions | 4 Per Benefit Period Total ~ OC, HNC, SjS Medical Conditions	No	No
D1208	Topical Fluoride >	Yes	$29.15	100%	In Network ~ OC, HNC, SjS Medical Conditions | 4 Per Benefit Period Total ~ OC, HNC, SjS Medical Conditions	No	No
D4341	Scaling/planing 4 + Teeth >	Yes	$132.10	100%		No	No
D4342	Scaling/planing 1-3 Teeth >	Yes	$75.65	100%		No	No
D4346	Perio Scaling W/inflamm >	Yes	$55.50	100%	4 Per Benefit Period Total ~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions	No	No
D4355	Full Mouth Debridement >	Yes	$111.45	100%	1 Per 24 Months ~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions	No	No
D4910	Periodontal Maintenance >	Yes	$106.50	100%	4 Per Benefit Period Total ~ DM, CAD, CVA, PG, OC, HNC, SjS, ESRD, COPD, MetS Medical Conditions	No	No

H. Root Scaling and Planing

*Root scaling and planing are only covered under enhanced dental benefits at 100% if the member's standard plan offers periodontal coverage.

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Please refer to the ‘Non-Surgical Periodontal Services’ tab in the ‘Benefits’ section to determine if periodontal scaling (CDTs D4341, D4342, D4346) is covered under a member’s standard plan

Non-Surgical Periodontal Services						D4320 - D4999	
D4341	Scaling/planing 4 + Teeth >	Yes	--	50%	In Network | 1 Per 24 Months ~ Per Area of the Mouth | more...	Yes	Yes
D4342	Scaling/planing 1-3 Teeth >	Yes	--	50%	In Network | 1 Per 24 Months ~ Per Area of the Mouth | more...	Yes	Yes
D4346	Perio Scaling W/inflamm >	Yes	--	100%	In Network | Age 18 And Older | In Combination with Cleanings | more...	No	Yes

I. Full Mouth Debridement

*Full mouth debridement involves the preliminary removal of plaque and calculus that

interferes with the ability of the dentist to perform a comprehensive oral evaluation. The need for this procedure arises when it is not possible to adequately access tooth surfaces or periodontal areas because excessive plaque and calculus. These deposits prevent a thorough evaluation of the patient’s teeth and supporting gingival structures.

Please refer to the ‘Wellness Benefit’ tab in the ‘Benefits’ (CDT D4355).

As of JAN 1, 2023, periodontal services including full mouth debridement are eligible for all members enrolled in the OHTH program.

What if My Patient Isn’t Enrolled but Qualifies for OHTH Benefits?

If your patient has one of the qualifying medical conditions and an eligible dental plan direct them to:

1. Visit hmsadental.com.
2. Hover over the section for Members.
3. Select Enroll under the Oral Health for Total Health subsection.

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J. OHTH Benefits

Oral Health for Total Health gives you the opportunity to offer preventive and or periodontal dental services to Oral Health for Total Health enrolled members at no additional cost to them and without counting toward their calendar-year maximum.

Eligible Medical Conditions	Two additional cleanings or periodontal maintenance visits, plus:			
	Enhanced cleaning to remove excess plaque build up 1 every 24 months	Periodontal Scaling covered 100%	Oral Exam 4 every 12 months	Floride Treatment 1 every 3 months
Diabetes	✓	✓		
Coronary Artery Disease (CAD)	✓	✓		
Stroke	✓	✓		
Pregnancy	✓	✓		
Oral Cancer and Head & Neck Cancer	✓		✓	✓
Sjögren's Syndrome	✓		✓	✓
Chronic Obstructive Pulmonary Disease (COPD)	✓	✓		
End-Stage Renal Disease (ESRD)	✓	✓		
Metabolic Syndrome (MetS)	✓	✓		

K. What Happens once a member is Enrolled for OHTH?

Once a member is enrolled in Oral Health for Total Health within a month, the member will receive a welcome letter in the mail. The purpose of the welcome letter is to welcome the member into the program and explain the benefits they're eligible to receive to help achieve improved total health.

About six (6) months after enrollment, we will send a follow up letter reminding the member of their enrollment in the program and to reinforce the importance enhanced dental benefits have on their total health.

Members who are not compliant with our program will receive a non-compliant letter twelve (12) months after program enrollment, and yearly thereafter if they remain non-compliant. The purpose of this letter is to advise the member that our records indicate that they haven't used their enhanced dental benefits and we remind and educate on the importance of using these benefits.

Members who are compliant with our program will receive an engagement letter twelve (12) months after program enrollment, and yearly thereafter if they remain compliant.

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The purpose of this letter to reinforce the importance of using enhanced dental benefits to achieve better overall health, keeping the member engaged and reminded of their benefits.

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