CLAIMS PAYMENT POLICY

Non Participating Provider liability – Balance Billing

Non-participating Provider services are not covered services. Claim payments are based on the Plan's Payment Obligation, which for nonparticipating providers is the treating dentist's submitted charge, or allowances established by Sele-Dent, whichever is less. Allowances is a schedule of fixed dollar maximums established by Sele-Dent for services rendered by a licensed dentist who is a nonparticipating provider. You may be balance billed for any amount that is over the allowed amount. Balance billing occurs when a nonparticipating provider bills a subscriber or responsible party for charges other than copayments, coinsurance, or any amounts that may remain on a deductible. The covered person is responsible for all treatment charges made by the nonparticipating provider. When services are obtained from a nonparticipating provider, any benefits payable under the contract are paid directly to the covered person. With Sele-Dent, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating provider with the plan. There may also be a difference in the payment amount if your dentist is not a participating provider with Sele-Dent. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to Sele-Dent's maximums.

CLAIMS SUBMISSION

A member, instead of the Provider submits a claim requesting payment for services that have been received. There is a one year time limitation to submit a claim. **Important** claim form fields that **must** be filled out are detailed below:

Patient Name

Member Information

Member's Signature

Assignment of Benefits

Provider Name and Location

Provider's Signature

Services Rendered

Other Insurance Carrier Information

Claim forms can be submitted by mail, email or fax to the following;

- Sele-Dent, Inc. One Huntington Quadrangle, Suite 1S03 Melville, NY 11747 (1-800-520-3368)
- Phone Number 516-887-7566, Fax 516-887-7896

Medical Necessity, Prior Authorization Timeframes, Enrollee Responsibilities

Prior authorization is recommended for all major services (Crowns, Dentures, etc.). If prior authorization is not received and approved before services are rendered, the member is responsible for full payment. The turnaround time for a prior authorization request is 10 business days. Once approved, they are valid for one (1 year).

PLEASE NOTE, some services may require prior authorization and/or be subject to review for medical necessity.

INFORMATION AND EXPLANATION OF BENEFITS (EOB'S)

An EOB is a statement issued by the insurer that explains what treatments and/or services it paid for on an enrollee's behalf, the amount paid, and the enrollee's financial responsibility pursuant to the terms of the policy. An EOB may also be generated when a claim is pended for additional information necessary to process the claim. (Pending for additional information will also be issued to the treating dentist as listed in the next paragraph regarding Pre-Authorizations).

In the case of a pre-authorization of services, an EOB will also be issued to the treating dentist providing a "pre-estimate" of coverage before the services are actually rendered. An EOB will be sent out by the issuer after it receives and adjudicates a claim or claims. The EOB will provide a description of dental benefits and/or denial codes. Data provided on the EOB include: Description of service/benefit, ADA Code, Date of Service, Fee Charged, Allowed Amount, Deductible Applied, Other Insurance, Net Patient Responsibility and Remarks. Also provided on the EOB (where applicable) Current year totals, Previous year totals, Allowance Limitations and additional comments.

COORDINATION OF BENEFITS (COB)

Coordination of benefits exists when an enrollee is also covered by another insurance plan.
Primary of coverage is determined by:

1. Workers comp, no fault and liability are usually primary.
2. Birthday Rule: Dependent children are covered as "primary" under the family coverage of the spouse whose month and day of birth is earliest.
3. Medicare eligibility; subject to age or disability. You should not have marketplace coverage if already on Medicare. If you have marketplace coverage before your Medicare coverage starts, you may keep it. If you age into Medicare and decide to keep your marketplace coverage, then Medicare is primary.