DELTA DENTAL®

DELTA DENTAL MEDICARE ADVANTAGE PROVIDER MANUAL

JANUARY 1, 2019

Thank You

For Being a Delta Dental Medicare Advantage Participating Dentist

---

Delta Dental of Arkansas is pleased to present you with this Delta Dental Medicare Advantage Provider Manual. This manual will serve as a useful source of information for you and your office staff. Please take the opportunity to review the manual in its entirety. We look forward to serving you.

TABLE OF CONTENTS

1.0 WELCOME

Delta Dental of Arkansas (Delta Dental) is pleased to welcome you into our Medicare Advantage Network of dentists and oral healthcare professionals.

As a 501(c)(4) not-for-profit company, Delta Dental's mission is "To improve the Oral Health of Arkansans." We work towards fulfilling this mission every day.

It is for this reason Delta Dental is excited to have the opportunity to work with you to encourage and guide individuals in Medicare Advantage Plans to obtain quality oral health services.

We are appreciative of the Arkansas dental community and dentists like you who play a critical role in ensuring that Enrollees get the diagnostic, preventive, and therapeutic treatment they need. Thank you for your participation!

This manual covers all aspects of your rights and responsibilities as a Participating Dentist, from enrolling and credentialing, to verifying eligibility, submitting claims, understanding the remittance advice, receiving payment, submitting Grievances and Appeals, and other information to help you and your office provide services in accordance with program guidelines.

We may need to modify this manual from time to time. Any changes to this manual will be made consistent with the requirements of your Participation Agreement. The most up-to-date version of this manual can be viewed on our Dental Office Toolkit at deltadentalar.com. You will be notified of updates via email.

Please read this manual carefully and be sure you and your staff are familiar with and understand its contents. If you have questions about or suggestions for improvements, we welcome your input. Please contact Delta Dental Professional Relations at 501-992-1710 Monday through Friday, 8:00 a.m. to 5:00 p.m. (CT), or email us at profrelations@deltadentalar.com.

1.1 Important Terms and Definitions

The following is a list of terms and definitions frequently used throughout this manual to assist you in understanding the information provided here and to better understand an Enrollee's dental benefits.

Adverse Benefit Determination (also known as an Adverse Organization Determination)
An adverse decision made by us related to any of the following:

- Payment for temporarily out of area emergency dental services or urgently needed dental services.
- Payment for dental services furnished by a Non-Participating Dentist that the Enrollee believes should have been furnished, arranged for, or reimbursed by us.
- Our refusal to provide or pay for dental services, in whole or in part, including the type or level of dental services, that the Enrollee believes should have been furnished or arranged for by us.
- The reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.
- Failure by us to approve, furnish, arrange for, or provide payment for dental services in a timely manner, or to provide the Enrollee with timely notice of an Adverse Benefit Determination, such that a delay would adversely affect the dental health of the Enrollee.

Appeal
The process used to have an Adverse Benefit Determination reviewed. The process may also be known as a request for Reconsideration of an Adverse Organization Determination.

Billed Charge
The amount you bill for a specific dental service or procedure.

CMS
The Centers of Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services responsible for overseeing the Medicare Advantage Program.

Covered Service(s)
Dental services reimbursable under the applicable Medicare Advantage Plan, provided in accordance with professional standards and appropriately documented.

Denied
Dental services that are not reimbursable under the applicable Medicare Advantage Plan will be Denied. For example, teeth whitening is considered purely cosmetic and is not reimbursable. If your claim is Denied, you can bill and collect your Billed Charge from the Enrollee only if the Enrollee has agreed to pay for the service(s) as described in Section 7.3 of this manual.

In certain limited circumstances, dental services that are not reimbursable may be allowed as a different Covered Service. For example, esthetic crowns are not reimbursable but will be allowed and paid at the stainless steel rate.

You cannot collect the difference between your normal Billed Charge and the Maximum Allowed Amount for these services from the Enrollee.

Dental Office Toolkit (DOT)
Our free online portal that allows you and your staff to sign on to our secure, HIPAA compliant online system. This can be accessed at www.deltadentalar.com.

Dental Service Provider
Licensed facilities or professionals providing dental services.

Delta Dental Medicare Advantage Fee Schedule
As a Participating Dentist you agree to accept as payment in full the lesser of the Delta Dental Medicare Advantage Fee Schedule or the Billed Charge for Covered Services rendered.

DHHS
The U.S. Department of Health and Human Services.

Disallow/Disallowed
Covered Services may be Disallowed in whole or in part for a variety of reasons. In some cases Covered Services may be Disallowed and cannot be billed to the Enrollee. Examples include the following:

(i) reimbursement for the procedure or service was either included as part of a payment of a more global service provided; and/or

(ii) the procedure or service is still within the time frame for which it should be warranted by you as a Participating Dentist; and/or

(iii) you did not follow rules and regulations of your Participation Agreement.

In other cases Covered Services may be Disallowed in whole or in part but can be billed to the Enrollee if the Enrollee agrees in advance to pay for the services in accordance with Section 7.3 of this Manual. For example, a Covered Service may be subject to frequency limitations in which case the entire charge may be Disallowed. Likewise, reimbursement for a Covered Service may exceed the Enrollee's Contract Year Maximum Benefit.

The Explanation of Payment (EOP)/Remittance Advice (RA) will indicate whether a Disallowed amount may be billed to the Enrollee, subject to the requirement to obtain an agreement from the Enrollee in advance of the Covered Service being provided.

Downstream Entity
Any subcontractor of a Participating Dentist that is providing services related to a Medicare Advantage Plan.

Emergency Dental Care (also referred to as "Palliative" care)
Dental services necessary to treat a dental condition of sudden onset and severity which would lead a prudent layperson to conclude the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. The dental procedures will identify the source of the patient's significant pain, extent of trauma, source of infection, with palliative measures, or treat a traumatic clinical condition to the teeth and/or supporting structures.

Enrollee
A person who is enrolled in and eligible to receive services under a Medicare Advantage Plan for which Delta Dental provides or arranges for supplemental dental benefits.

Governing Body
The person(s) who have authority over a business entity. For example, a corporation's board of directors.

Grievance
An expression of dissatisfaction from or on behalf of an Enrollee or Dental Service Provider about any action taken by Delta Dental or a Dental Service Provider other than an Adverse Benefit Determination. Grievances may include, but are not limited to, expressions of dissatisfaction about the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Dental Service Provider or employee, or failure to respect the Delta Dental Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by Delta Dental to make an authorization decision.

Major Shareholder
A person or entity that owns five percent (5%) or more of a business entity.

Medical Necessity/Medically Necessary
A Covered Service that satisfies all the following criteria:

- It directly relates to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- It is consistent with currently accepted standards of good dental practice, including our defined criteria;

- It is the most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
- It is not primarily for the convenience of the patient, family, or Dental Service Provider.

Medicare Advantage Organization
An insurance company or health maintenance organization that holds a contract with CMS to offer Medicare Advantage Plans. Delta Dental contracts with Medicare Advantage Organizations to provide coverage for dental benefits for Enrollees. We will identify, in advance of the effective date, each Medicare Advantage Organization with whom we contract.

Medicare Advantage Plan
Health benefits coverage offered under a policy or contract by a Medicare Advantage Organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in a specific service area.

Medicare Advantage Program
An alternative to the traditional Medicare program authorized by Part C of Medicare in which health insurance companies or health maintenance organizations provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Network
All Participating Dentists who have a contract with Delta Dental for the delivery of Medically Necessary Covered Services to Enrollees.

Participation Agreement
The document that defines the contractual rights and obligations between you as a Participating Dentist and Delta Dental for your participation in the Medicare Advantage Plans. If you also contract with Delta Dental to participate in its Premier Network, PPO Network and/or other Networks (our "Standard Contract"), your Participation Agreement is made up of your Standard Contract and your Medicare Advantage-specific Amendment.

Non-Participating Dentist
A dentist who has not entered into a Participation Agreement with Delta Dental for Medicare Advantage Plans.

Participating Dentist
A dentist who holds a current license to practice dentistry, who has entered into a Participation Agreement with Delta Dental for Medicare Advantage

Plans. You are a Participating Dentist because of your Participation Agreement with Delta Dental.

Pretreatment Estimate
A voluntary and optional process where we issue a written estimate of dental benefits that may be available to an Enrollee for proposed dental treatment. A Pretreatment Estimate is for informational purposes only and is not required before an Enrollee is treated. The estimate we provide on a Pretreatment Estimate is based on benefits available on the date we issue the notice. Availability of benefits at the time of treatment depends on several factors, for example, continued eligibility for benefits, available annual or lifetime maximum payments, coordination of benefits, plan limitations, and changes in an Enrollee's treatment. Your request for a Pretreatment Estimate is not a claim, preauthorization, precertification, or other reservation of future benefits.

Stabilization Services
Services to restore basic human function and prevent an existing clinical condition from further deterioration in an immediate time frame to a more serious and costly situation.

State
The State of Arkansas.

Uniform Requirements
A component of the "Delta Dental of Arkansas Standards" referenced in your Participation Agreement and are incorporated into the Participation Agreement by reference and describe mutual operational rules between you and Delta Dental.

Urgent Care
Dental services that do not constitute Emergency Dental Care but are needed to treat pain. Urgent Care is designed to provide services that minimize the potential for Emergency Dental Care and is needed to treat pain.

We, Us, Our
This refers to Delta Dental of Arkansas.

You, Your

This refers to you as a Participating Dentist in the Medicare Advantage Network.

2.0 CONTACT INFORMATION

2.1 Delta Dental of Arkansas

Important Contact Information:

Customer Service.....1-855-253-4706
Professional Relations Phone Number.....501-992-1710
Language Translation Service.....1-844-648-5669
Email Address.....profrelations@deltadentalar.com
Website.....www.DeltaDentalAR.com/medicare-advantage

2.2 Delta Dental Customer Service

Our Customer Service Representatives are available at 1-855-253-4706 from 7:00 a.m. to 7:00 p.m. Central.

Contact Customer Service for the following:

- Benefits
- Eligiblity
- Filing a claim
- Claim processing
- Claim status
- Report fraud, waste and abuse
- Grievance and Appeals

Any calls where Protected Health Information (PHI) is discussed are authenticated.

Mailing address for Customer Service (items listed above):

For Claims & Pretreatment Estimates:
Delta Dental Medicare Advantage
PO 9298
Farmington Hills, MI 48333

For Inquiries:
Delta Dental Medicare Advantage
PO Box 9230
Farmington Hills, MI 48333

Please be prepared with the following:

- Your name
- The dentist or office name
- Dentist tax ID number
- Enrollee ID number
- Enrollee name, date of birth, and address

2.3 Delta Dental Professional Relations

Certain questions should be directed to the Professional Relations staff. Please contact Professional Relations at 501-992-1710 or e-mail profrelations@deltadentalar.com if you:

- Change your office address or phone number
- Have a change in your credentialing information
- Are a new dentist opening an office or have a new associate dentist joining your practice
- Are leaving a practice due to retirement, relocation, etc.
- Change your tax identification number (TIN)
- Have questions about your Participation Agreement, credentialing and processing policies
- Would like to schedule an office visit with a Delta Dental Professional Relations Representative regarding office training needs, Network participation, claims processing guidelines, attachment requirements, or any other area of concern
- Need information regarding your Network participation
- Have questions about DOT or about registering for DOT
- Need to add additional staff access to DOT
- Forgot your DOT password

Mailing address for Professional Relations (items listed above):

Delta Dental of Arkansas
Professional Relations
PO Box 15965
Little Rock, AR 72231

2.4 Provider Data Accuracy and Validation

It is important for you to make sure Delta Dental has accurate information about you and your practice. Accurate information allows us to better support and serve you, our other Participating Dentists, and our Enrollees.

Our having current information is critical for timely and accurate claims processing. Invalid information can negatively impact Enrollee access to care, and referrals. An Enrollee may request a printed copy of the provider directory at any time.

You should validate our Provider Online Directory information regularly to be sure your information is correct and complete. This directory is available at www.DeltaDentalAR.com/medicare-advantage.

Whenever possible, you should notify Professional Relations in writing at PO Box 15965, Attn: Professional Relations, Little Rock, AR 72231 or at profrelations@deltadentalar.com at least thirty (30) days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax or email
- Addition or closure of office location(s)
- Addition or termination of a dentist within an existing clinic/practice
- Change in tax ID and/or NPI number
- Opening or closing your practice to new patients
- Any other information that may impact Enrollee access to care

We are required to audit and validate our Network data and provider directories on a routine basis. As part of our validation efforts, we may reach out to you as a Participating Dentist through various methods, such as letters, telephone campaigns, face-to-face contact, fax and fax-back verification, etc. Please provide timely responses to these communications from us.

3.0 PARTICIPATION AND PROVIDER ROLES

3.1 Dentist Acknowledgements

You shall participate in and comply with Delta Dental's Compliance Plan which is available at www.DeltaDentalAR.com/medicare-advantage. If you delegate any obligations related to the Medicare Advantage Plans, you must provide reasonable assurance, as evidenced by a written contract, that the Downstream Entity shall comply with the same Medicare Advantage Program requirements and obligations that are applicable to you as a Participating Dentist with a Medicare Advantage Participation Agreement.

As a Participating Dentist with a Medicare Advantage Participation Agreement, you acknowledge and agree to the following:

(1) The following are true for you and any employee, subcontractor, member of your Governing Body, Major Shareholder or Downstream Entity that is involved in the administration and delivery of services to Enrollees:
- To the best of your knowledge, information and belief no such person appears on (a) the list of excluded individuals/entities as published by the DHHS, Office of the Inspector General ("OIG List"), (b) the list of debarred contractors as published in the System for Award Management by the General Services Administration ("GSA List"), or (c) the CMS Medicare Preclusion List.
- You will review the OIG List and the GSA List prior to the hiring of any new employee, contractor, or the appointment or election of a person to your Governing Body.
- You will review the OIG List and GSA List on a monthly basis to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

(2) You will notify Delta Dental of any change in circumstance which would require you to then respond affirmatively to any of the issues identified in Item 1 above.

You and your Downstream Entities shall annually attest to compliance with Items 1 and 2 above. Delta Dental has the right to audit you and/or your Downstream Entities for compliance with these obligations.

3.2 Dentist Participation

As a Participating Dentist with a Medicare Advantage Participation Agreement, you agree to:

- Abide by your Participation Agreement (including the Addendum to Participation Agreement for Medicare Advantage Plans) and Uniform Requirements, the Medicare Advantage rules, regulations, and this manual.
- Not require Enrollees to prepay any portion of Covered Services.
- Accept from us as payment in full for Covered Services the lesser of:
    - The applicable amount set forth in the Delta Dental Medicare Advantage Fee Schedule or
    - Your Billed Charge
- Furnish us credentialing information by completing a Confidential Credentialing Information Form when requested.
- File claims for completed services to us within 12 months of the date-of-service and include all documentation necessary for us to review, process and finalize the claim. Documentation includes, but is not limited to:
    - Clinical rationale/narrative
    - Radiographs
    - Periodontal chart
    - Patient treatment records
    - Coordination of benefits information, as applicable

  If the claim is not received and finalized within this time period, the claim may be Disallowed as your responsibility and not billable to the Enrollee.
- Follow the Delta Dental processing policies and claim filing guidelines for Medicare Advantage Plans.
- When required, provide information and patient office records for the purpose of conducting reviews and/or in-office audits.
- Furnish services that meet the criteria for Medical Necessity.
- Comply with all applicable State and federal laws and regulations.
- Promptly notify Delta Dental of Arkansas if either you or your organization are ever placed on the OIG List, the GSA List, and/or CMS Medicare Preclusion List.
- Cooperate with us to disclose to the Medicare Advantage Organization or CMS all information necessary to evaluate and administer the Medicare Advantage Plans.
- Submit all information related to the Medicare Advantage Plans, as we may request within the timeframes specified and in a form that meets the Medicare Advantage Program requirements. When submitting data

you will certify in writing, that the data is accurate, complete and truthful based on your best knowledge, information and belief.

- Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. This includes checking the HHS-OIG websites (http://exclusions.oig.hhs.gov/ or https://oig.hhs.gov/exclusions/index.asp) by the name of any individual or entity for their exclusion status before you hire or enter into any contractual relationship with the person or entity. In addition, you agree to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. You must report to us any exclusion information discovered through a search.

  We are prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under the Medicare Advantage Plans that are furnished by an excluded individual or entity, and extends to:

  - All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system.
  - Payment for administrative or management services not directly related to patient care, but are a necessary component of providing items and services to Enrollees, when those payments are reported on a cost report or are otherwise payable by a Medicare Advantage Plan.
  - Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by a Medicare Advantage Plan.

  In addition, no payments can be made for any items or services directed or prescribed by an excluded individual or entity or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion.

  This prohibition applies even when Delta Dental's payment is made to another individual, entity, practitioner, or supplier that is not excluded. See 42 C.F.R. §1001.1901(b).

3.3 Do Not Opt Out of Medicare

Opting out of Medicare is an option for providers. However, if you opt out you will not be able to participate in any Medicare networks, including Medicare

Advantage. If you do decide to or have opted-out, you have 90 days to change your status. Once the 90 days has passed, you will continue to be listed at opt-out status for two years.

If you become an opt-out provider you cannot be paid for services provided under Medicare or Medicare Advantage Plans. Payment cannot directly or indirectly be made to you except in certain emergency or Urgent Care situations. Delta Dental may terminate your Medicare Advantage Participation Agreement immediately if you opt out of Medicare.

You must contact CMS to have yourself removed from the opt-out list.

3.4 Downstream Entities

If you delegate any obligations related to the Medicare Advantage Plans, you must provide reasonable assurance, as evidenced by a written contract, that the Downstream Entity shall comply with the same Medicare Advantage Program requirements and obligations that are applicable to you as a Participating Dentist with a Medicare Advantage Participation Agreement. You are responsible for the oversight of any Downstream Entities and should have a compliance plan or adopt the Delta Dental Compliance Plan.

3.5 Participating Dentist Audit

As a Participating Dentist you agree to give Delta Dental, DHHS, the U.S. General Accounting Office ("GAO"), the Comptroller General, CMS, and their authorized designees, the right to audit, evaluate, collect directly from, and inspect any books; contracts; computer or other electronic systems; records, including medical records and documentation; patient care documentation; and other records involving transactions related to Medicare Advantage Plans.

This right will exist through ten (10) years from the final date of the Medicare Advantage Organization's contract period or from the date of completion of any audit, whichever is later. You also agree to maintain such records for a period of ten (10) years following termination or expiration of your participation in the Medicare Advantage Plans, or until completion of an audit, whichever is later. You agree to take appropriate corrective actions in response to any potential noncompliance or potential fraud, waste or abuse ("FWA") identified via audit, monitoring or otherwise, by Delta Dental, DHHS, GAO, or CMS.

3.6 Credentialing

As a Participating Dentist you agree to accurately and thoroughly complete the Confidential Credentialing Information Form and Provider Facility Profile Form at our request and provide the following credentialing elements:

- Proof of graduation from an accredited dental school and completion of specialty training, as applicable.
- A copy of your active state issued dental license.
- Board certification status.
- Clinical privileges in good standing at the hospital designated as the primary admitting facility, if any.
- Individual NPI Number (NPI Type 1).
- W-9 Form.
- Dentist Authorized Signature Form.
- Corporate Authority Form to authorize us to pay the corporation directly for services rendered by the treating provider.
- A copy of your Federal DEA license, if applicable.
- A copy of your liability declaration page reflecting you have at least the minimum required malpractice liability coverage.
- Disclose any licensing board actions, malpractice claims, and other adverse personal or professional background information.
- Federally mandated ownership control form.
- Work history, including a minimum of the most recent five years of work history as a health professional.

Network participation will only be backdated at our discretion 30 days prior to the date that all required credentialing and signed Participation Agreement information is received.

Please notify our Professional Relations staff immediately of any changes in your credentialing elements at 501-992-1710 or e-mail profrelations@deltadentalar.com.

Return documents to:

Delta Dental of Arkansas
PR Department
PO Box 15965
Little Rock, AR 72231

If you are already a Participating Dentist with Delta Dental in its Premier, PPO, and/or Delta Dental Smiles Network(s), you will not have to be separately

credentialed to participate in the Delta Dental Medicare Advantage Network. However, there are some additional credentialing requirements for participation in the Delta Dental Medicare Advantage Network.

Additional steps you need to complete to join the Medicare Advantage Network are:

1. Confirm that you have not opted-out of Medicare.
2. Review and sign a Network contract addendum.
3. Complete the Compliance Attestation document. Only one of these is required for your office(s). If your office operates under multiple Tax ID number, please list all that apply.

3.7 Terminations

Your ability and our ability to terminate your Participation Agreement are set out in your Participation Agreement. In the event there is a conflict between the terms of the Participation Agreement and this summary, the Agreement controls.

You Terminate Your Participation Agreement

You can terminate your Participation Agreement by giving us at least ninety (90) days written notice in the manner required by the Participation Agreement. You must also inform Enrollees if there is a termination of your Participation Agreement.

If you are also a participating dentist with Delta Dental in its Premier and/or PPO Network(s), you can terminate your participation in the Delta Dental Medicare Advantage Network without terminating your participation status in the other Delta Dental Networks. This option is described more fully in your Participation Agreement.

Delta Dental Terminates Your Participation Agreement

Termination without Cause

We may terminate your Participation Agreement without cause at any time by sending a notice of termination with the termination being effective sixty (60) days after the date of the notice.

Termination for Cause

Delta Dental may terminate your Participation Agreement for cause if you breach or violate any of the provisions of your Participation Agreement, including the Uniform Requirements, your license to practice dentistry issued by the Arkansas Board of Dental Examiners (or the equivalent Governing Body of the state in which you practice) is suspended or terminated, or your

conduct is determined to be unprofessional and/or your conduct could be detrimental to Delta Dental or Enrollees.

Any termination for cause will be effective on the date designated by us in the notice of termination (which may be immediate), as determined by us. The notice will state the reason(s) for the termination and your right to request a hearing on the termination.

Notices of Termination; Other Notices

Any notice of termination or other required or permitted notices will be given to you from us as described in the Participation Agreement.

Appealing a Termination Notice

You may Appeal a termination of participation for cause as set forth in the Uniform Requirements.

3.8 Provider Rights

As a Participating Dentist, you have the following rights:

- Communicate with Enrollees regarding dental treatment options.
- Recommend treatment even if the treatment is not a Covered Service or approved under the Medicare Advantage Plan.
    - If recommended treatment is not a Covered Service or approved by Delta Dental, you must notify the Enrollee if you intend to charge the Enrollee for the services. See the Covered Services Section for more information about getting the Enrollee's agreement for you to provide the service.
- Provide correct, pertinent, factual information to an Enrollee when a complaint has been filed by the Enrollee against you.
- Receive information from us on Grievances and Appeals.
- File an Appeal about an action or decision we make.
- Know:
    - How Delta Dental decides whether a service is covered and/or Medically Necessary
    - Who in Delta Dental's office makes the decision
- Advise Enrollees about their:
    - Health status
    - Dental care
    - Treatment
- Recommend changes in policies and services by writing to us or calling us at 501-992-1710.
- Exercise these rights without adversely affecting the way Delta Dental treats you.
- Be notified by us regarding a decision to deny a service.

- Make recommendations about these rights and responsibilities.

3.9 Provider Responsibilities

As a Participating Dentist you have the following responsibilities:

- Emergency Dental Care must be provided within 24 hours.
- Engage in provider education, feedback activities and review of referral patterns as required by DMS.
- Provide Medically Necessary Covered Services to Enrollees with the same quality level and practice standards and with the same level of fairness, dignity, and respect as provided to non-Medicare Advantage patients.
    - Including provide hours of operation to Enrollees which are no less than those offered to other Medicare patients.
- Assist Enrollees in making decisions regarding treatment including: information on the nature of treatment options, or information on alternative treatment options.
- Do not discriminate against Enrollees based on race, color, national origin, language/language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy or hospitalization, or the expectation for frequent or high cost care.
- Have on-call coverage after hours, during your absence or unavailability.
- Participate in Delta Dental's Grievance program and cooperate in identifying, processing and promptly resolving all Enrollee complaints, Grievances or inquires; refer to the Grievance and Appeals section of this manual.
- Comply with activities as set forth in Program Integrity section of this manual.
- Assess the dental needs of Enrollees for referral to a Specialist and provide referrals as needed.
- If a referral is needed, make it on a timely basis based on the urgency of the Enrollee's dental condition, but no later than 30 days.
- As a Participating Dentist, you must make necessary and appropriate arrangements for Covered Services to be available for Enrollees on a 24 hours per day, 7 days per week basis when Medically Necessary. If your arrangements include the Enrollee seeking treatment from another Dental Service Provider, you must make certain the other provider is a Participating Dentist.
- Maintain facilities (including treatment rooms), equipment, personnel and administrative services:
    - At a level and quality necessary to perform duties and responsibilities to meet all applicable federal, State and local laws.

- In compliance with laws and regulations relating to privacy (HIPAA), waste management (OSHA & EPA), environmental hazards (OSHA & EPA) and the Centers for Disease Control (CDC) infection control and sterilization guidelines.
- In accordance with the principles and ethics of the American Dental Association (ADA), the Dental Practices Act and the Arkansas State Board of Dental Examiners or Governing Body of the licensing state where services are rendered.
- In compliance with the Americans for Disabilities Act.

3.10 Access to Care

In our efforts to overcome barriers in access to care for our Enrollees, we expect you as a Participating Dentist to be responsive to the linguistic, cultural and other unique needs of any minority or disabled Enrollees. This includes the capacity to communicate with Enrollees in a language other than English. We offer free translation services to our Participating Dentists to assist them with this. See the Additional Resources section of this manual for specific information on how to access these free translation services.

3.11 Appointment Scheduling

As a Participating Dentist, if you are accepting new patients, you must accept all new patients and make appointments equally available regardless of payer source.

3.12 Marketing Activities

As a Participating Dentist, you are subject to the Medicare Marketing Guidelines. You may not engage in marketing of Medicare Advantage Plans except as set forth herein.

You are not permitted to offer inducements to persuade a patient to enroll in a particular Medicare Advantage Plan, to distribute marketing materials or applications in areas where dental care is being given, or to offer anything of value to induce Medicare Advantage Enrollees to pick you as their dental provider.

You are permitted to make available Medicare Advantage Plan marketing materials and enrollment forms developed by us or the Medicare Advantage Organization outside of the areas where dental care is delivered.

4.0 HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and implementing regulations) is a federal law intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs. Since electronic transactions are significantly more cost effective than paper for Providers, patients and health plans, HIPAA includes a major provision (Administrative Simplification) that is designed to encourage the use of electronic transactions, while safeguarding patient privacy.

To do so, HIPAA created a universal language or standard for electronic transmissions used in the health care industry.

It also established standards governing the privacy/security of health information, which is an extremely important issue for consumers today. Specific requirements are detailed in rules issued by the federal Department of Health and Human Services (DHHS). Please refer to end of this section for important HIPAA websites.

All health plans, health care clearinghouses and health care Providers who maintain or transmit protected health information in electronic form standardized by DHHS are referred to as **"Covered Entities."** If you file electronic claims, submit electronic attachments or use the Internet to check benefits, eligibility or claims status, you are considered a Covered Entity.

"Health Information" is any information, whether oral or recorded in any form or medium, that:

- Is created or received by a health care Provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse; and
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

"Individually Identifiable Health Information (IIHI)" is information that is a subset of Health Information, including demographic information collected from an individual, and;

- Is created or received by a health care Provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual;

or the past, present or future payment for the provision of health care to an individual;
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

"Protected Health Information (PHI)" is Individually Identifiable Health Information maintained or transmitted by electronic media or transmitted or maintained in any other form or medium by a Covered Entity.

A "Business Associate" is defined as a person or organization that performs a function or activity on behalf of a Covered Entity and has access to PHI, but is not part of the Covered Entity's work force.

Covered Entities must comply with the HIPAA Transactions and Code Sets Standards. To comply with these standards, you need to ensure that the format you are using for submitting claims electronically is HIPAA compliant. Covered Entities transferring data electronically have to adopt the use of the Current Dental Terminology (CDT), which is periodically updated by the American Dental Association.

The Privacy Standards are intended to streamline the flow of information integral to the operation of the health care system while protecting confidential health information from inappropriate access, disclosure and use.

The Security Standards are intended to provide safeguards for data storage, protection of information transmission systems and the establishment of chain-of-trust agreements between Covered Entities and their business partners.

Dentists who are Covered Entities are required by law to obtain a **National Provider Identifier (NPI)** number and use a National Provider Identifier with which Delta Dental must comply. The NPI is a ten digit unique identifier for health care providers and organizations. There are two basic types of NPIs available: (i) Individual and (ii) Organizational.

Individual NPIs (Type 1) are for health care providers, such as dentists.

Organizational NPIs (Type 2) are for use by incorporated businesses, such as group practices and clinics.

Be sure to notify us of your NPI number(s) by contacting our Professional Relations at 501-992-1710 or e-mail profrelations@deltadentalar.com.

The HITECH Act amends HIPAA and is a part of the American Recovery and Reinvestment Act (Federal Stimulus Package). The HITECH Act required the DHHS to issue regulations for breach notification by Covered Entities and their Business Associates subject to HIPAA. HITECH rules require Covered Entities (and their Business Associates) to notify affected individuals, the media and the Secretary of HHS following a breach of unsecured PHI. Consequently, Covered Entities must implement security breach detection and notification programs (or alternatively, ensure that PHI is "secured" in accordance with the guidance.)

Delta Dental maintains a toll-free, HIPAA-compliant customer service call line for Enrollees and dentists. Dentists and their office staff can call this number for assistance with claims submissions or questions about an Enrollee's benefits.

You and your office staff can utilize the Delta Dental online Provider portal called the Dental Office Toolkit (DOT) to easily submit claims with real-time adjudication and to access education-focused materials. By using DOT, you have around-the-clock, HIPAA-compliant access to us. Submission of documentation through the DOT, online portals or the Delta Dental fax line is HIPAA compliant.

This information is for instructional and educational purposes only. It does not constitute legal advice. You are strongly urged to contact legal counsel for advice with respect to the interpretation of HIPAA and its applicability to you.

Visit the official HIPAA website at http://aspe.hhs.gov/admnsimp/.

Access the Office for Civil Rights website at http://www.hhs.gov/ocr/hipaa/.

You may not enter into a contract with an offshore subcontractor for services related to the Medicare Advantage Plans without Delta Dental's prior written consent.

5.0 ELIGIBILITY AND ENROLLMENT

5.1 Enrollee Eligibility Verification

Delta Dental does not perform enrollment functions for Enrollees. Eligibility information available to and provided by us is the eligibility information we received from the Medicare Advantage Organization. The Medicare Advantage Organization determines whether an individual is eligible for a Medicare Advantage Plan.

Because eligibility can vary, your office should confirm eligibility of scheduled Enrollees prior to the appointment or providing service.

You can access your patients' benefits and verify their eligibility in the following ways:

- You may access Enrollee benefits and eligibility via our Dental Office Toolkit (DOT).
  - Go to www.deltadentalar.com and click Log In/Register in the top right corner
  - Register for an account if you do not already have one
  - Once you have an account, log in to the site and select Patient Benefits on the left side of the screen. Enter the Enrolee's identification number, name and date of birth
  - By using DOT, you can verify Enrollee eligibility 24/7 (See section 9.1 for information about DOT and registering for toolkit access)
- You can also utilize the Fax Back system to verify eligibility or claim status
  - Dial 1-855-253-4760. Press 1, and enter your tax ID
  - Choose 1 for Eligibility and Claim Status or 2 for Claims. Enter the Enrolee's identification number and date of birth
  - Press 1 for a Fax Back
- Our Customer Service Representatives are also available Monday through Friday from 7:00 a.m. to 7:00 p.m. at 1-855-253-4760 to assist you and your staff

Please note that due to possible eligibility status changes, the information provided by us does not guarantee payment. You and your office should confirm eligibility at time of treatment.

5.2 Renewal/Re-enrollment

Enrollee's may change plans annually. We recommend you verify an Enrollee's eligibility at each dental visit to determine their current status.

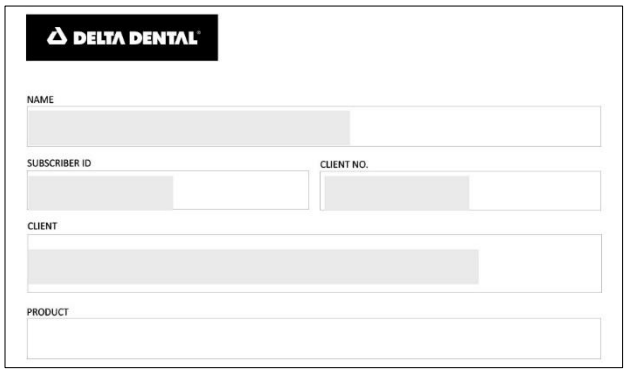
5.3 Enrollee Disenrollment

Enrollees may select to disenroll from the Medicare Advantage Plan. Again, we recommend you verify an Enrollee's eligibility at each dental visit to determine their current status. You may not take retaliatory action against an Enrollee for disenrolling from a Medicare Advantage Plan.

5.4 ID Cards

Delta Dental will mail ID cards following enrollment. We strongly recommend your office request each Enrollee present their ID card and confirm eligibility at each appointment. We also suggest you keep a copy of each Enrollee's ID card on file in the Enrollee's chart.

The ID Card looks like:



6.0 UTILIZATION MANAGEMENT

6.1 General

Delta Dental defines Utilization Management (UM) as the evaluation of Medical Necessity, appropriateness and efficiency of dental services to determine whether they are Covered Services. .

The primary purpose of Utilization Management is to provide the structure and organization for performing comprehensive review of the access to and appropriateness of care delivered by Participating Dentists. Delta Dental maintains a detailed plan to establish utilization review standards and procedures.

The determination of Medical Necessity is a necessary component of Utilization Management. Our staff includes Dental Consultants who are qualified, clinically trained personnel whose primary duties are to assist in evaluating Medical Necessity for Dental Services on a case-by-case basis, as well as performing clinical reviews. Our Dental Consultants consider all submitted documentation in the final determination of Medical Necessity.

6.2 Decision-Making Criteria

Delta Dental clinical review standards comply with recognized practice standards as they apply to dentistry. The standards and criteria our Dental Consultants use in conducting Utilization Management are based on current scientific evidence, clinical principles and processes, including the following:

- Evidence-based guidelines of leading nationally recognized public health organizations, health research agencies and professional organizations.
- Credible scientific evidence published in peer-reviewed medical and dental literature, including journals and textbooks generally recognized by the relevant medical and dental communities.
- Resources from accredited dental schools.
- The regulatory status of relevant technologies.
- Appropriate cumulative professional expertise and experience, including Providers with current knowledge relevant to the criteria under review.

Delta Dental's Utilization Management plan keeps up with industry trends and new standards, both from a clinical perspective as well as new technology. Nationally recognized criteria and standards are applied when adopting any new guidelines or standards. New standards of care proposed for adoption by Delta Dental are evaluated by appropriately licensed dentists with current

knowledge relevant to the criteria being reviewed. Some of the resources used to evaluate new standards of care are:

- Guidelines related to the medically complex patient affecting diagnosis and management of medical conditions of the oral and maxillofacial regions by the American Academy of Oral Medicine.
- Clinical guidelines, parameters, positions and statements published by the American Academy of Periodontology.
- Clinical guidelines and positions published by the American Association of Endodontists.
- Parameters of care published by the American Association of Oral and Maxillofacial Surgeons.
- Dental practice parameters and clinical practice guidelines published by the American Dental Association.
- Dental procedure code, nomenclature and descriptor information contained in the current version of the Code on Dental Procedures and Nomenclature published by the American Dental Association.
- Guidelines related to the medically complex patient affecting diagnosis and management of medical conditions of the oral and maxillofacial regions by the American Academy of Oral Medicine.

6.3 Medically Necessary Dental Guidelines

Delta Dental will cover Medically Necessary Covered Services on a timely basis based on the urgency of the Enrollee's dental condition consistent with DDAR's Utilization Management Policies and Procedures document, appropriate dental guidelines and with generally accepted practice parameters.

Delta Dental will begin covering Medically Necessary Covered Services to Enrollees beginning on the Enrollee's date of enrollment, regardless of pre-existing conditions. Such date of enrollment may include a retroactive eligibility period.

7.0 CLAIMS REQUIREMENTS

7.1 Image Quality

We expect radiographic images you submit to us will meet the American Dental Association's Dental Radiographic Examination Guidelines.

7.2 Quality of Dentures

Denture benefits, if any, will vary depending on the Enrollees Medicare Advantage Plan. Denture benefits should be confirmed by you prior to treatment.

If covered, we allow Participating Dentists the ability to choose the lab from which dentures and partial dentures are fabricated for an Enrollee. The fee we pay you for providing dentures and partial dentures will include the cost of the lab from which you fabricated the prosthesis. You will be responsible for lab costs associated with the prosthesis from the fee we pay you.

In order to ensure the quality of the dentures and partial dentures provided to our Enrollees, we will require the appliances to meet the quality standards described in this section.

Dentures/Partials

You must verify dental coverage and eligibility on each Enrollee prior to completing an order for a denture. The lab must have a system that prevents the lab from processing duplicate orders received on the same Enrollee.

The following materials (or materials with equal or higher quality) must be used:

- Premium heat-cured acrylic comparable to Lucitone 199 or Ivocap Injected.
- Premium denture teeth comparable to Myerson DB or Dentsply IPN.

Full Dentures (ADA Procedure Codes D5110 and D5120) shall include:

- Model work and articulation
- Baseplate / Biterim
- Setup for try-in
- Premium hardened plastic teeth
- Resetting of teeth (unlimited)
- Process and finish, high impact heat-cured acrylic
- One (1) year unlimited warranty

Partial Dentures (ADA Procedures Code D5211 and D5212) shall include:

- Model work and articulation
- Baseplate / Biterim
- Duplicate model for processing
- Setup for try-in
- Premium hardened plastic teeth
- Resetting of teeth (unlimited)
- Process and finish, high impact heat-cured acrylic
- Two (2) cast metal clasp standard or up to three (3) wrought wire clasps at doctor request
- One (1) year unlimited warranty

Verification of Quality

We reserve the right to verify the quality of dentures supplied to Enrollees through periodic and random requests for records from you that must demonstrate the appliances meet the standards described here. If records you supply do not demonstrate an appliance meets these required quality standards, you will be required to refund the fee paid to you for the services and appliance so we can assist the Enrollee obtain a denture that does meet these quality standards; if you do not refund the fee, we will recoup the amount from you from future payments.

Shipping Charges

The Enrollee cannot be charged for shipping associated with providing the services outlined in this manual. This includes shipping charges for the shipment of new dentures, shipping charges for you to send dentures to the lab, and all shipping charges associated with repair and warranty work.

7.3 Billing and Collecting for Services Not Paid By Delta Dental

After a claim is processed we issue you an Explanation of Payment (EOP)/Remittance Advice (RA). If some procedures or services on your claim are Denied or Disallowed, the EOP/RA will state whether you can bill and collect payment from the Enrollee.

If the EOP/RA does not expressly state you can bill and collect payment from the Enrollee, then you are not allowed to seek payment from them.

However, if the EOP/RA states you can bill and collect payment from the Enrollee, you may do so only if the Enrollee has agreed in writing to pay for that procedure or service before the service is provided. The Enrollee's signed agreement must include a statement that:

1. Describes the service(s) to be provided;
2. Explains the Enrollee is responsible for paying you for the service(s); and
3. Reflects Delta Dental of Arkansas will not pay for the service(s).

You should keep the Enrollee's signed agreement in your files in case there is ever a concern raised by the Enrollee about a billing statement they receive from you. You should be ready to share a copy of the signed agreement with us if we request it.

For Covered Services, the fee you charge the Enrollee plus any amount paid by us cannot exceed the Maximum Allowed Amount[1]. Even if you believe that a Covered Service will be Disallowed in whole or in part because of a frequency limitation, or because the Enrollee has exceeded their Contract Year Maximum, you must still submit the claim to Delta Dental of Arkansas so that the Maximum Allowed Amount can be calculated.

For services that were Denied because they were not reimbursable, the fee you charge the Enrollee cannot exceed your normal Billed Charge for the service. We may ask you for supporting documents that confirm your normal Billed Charge if we have questions.

If you do not have a signed agreement from the Enrollee, then you cannot seek payment from them.

You may not bill or otherwise seek to collect payment from an Enrollee for any amount that is our legal obligation. If an Enrollee is also enrolled in Medicaid, you may not bill or otherwise seek to collect from the Enrollee the Medicare Part A or Part B cost-sharing when the State is responsible for paying such amounts.

If we or the Medicare Advantage Organization is deemed to be insolvent, you must continue to provide Covered Services through the end of the month for which premium has been paid by or on behalf of the Enrollee. You may not bill or otherwise seek to collect payment from an Enrollee for any amount that is the legal obligation of the insolvent entity.

[1] "Maximum Allowed Amount" is defined in the Uniform Conditions of your Network Participation Agreement.

8.0 CLAIMS

8.1 Claim Filing

You must use an American Dental Association (ADA) claim form (or another form as prescribed and as may be modified by Delta Dental from time to time, see Appendix A) for all Covered Services rendered to Enrollees for which a charge is made. Each claim form may contain charges for only one Enrollee.

Additionally, your Participation Agreement requires you to follow Delta Dental's claims and payment requirements, which cover billing instructions and claim filing timelines.

You must complete and submit to us the ADA claim form when:

- Billing for services using ADA procedure codes
- Requesting a Pretreatment Estimate

Claims should be submitted electronically whenever possible. Submitting claims electronically generally reduces processing time and makes the billing and tracking of documents easier. Claims can be submitted electronically using a claims clearing house or via our online portal, the Dental Office Toolkit (DOT). To access DOT go to www.deltadentalar.com and click Login at the top right of the page. For more information on DOT see section 9.1.

If you are unable to submit claims electronically, you may mail paper claims to the address below:

Delta Dental of Arkansas
Attn: Claims
PO Box 9298
Farmington Hills, MI 48333-9298

You should carefully read and follow the instructions outlined in this manual so that your claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Handwritten claims must be completed neatly and accurately.

8.2 Electronic Claims

Electronic claims can be submitted through DOT. To see a full explanation of how to use DOT or setting up a DOT account see the Additional Resources section of this manual.

You will find the correct payor ID for the Delta Dental Medicare Advantage Network on the Enrollee's ID card.

To submit an electronic claim via DOT:

- Log in to the toolkit at www.deltadentalar.com
- Locate the "Patient Info/Enter Claims" link on the Navigation Bar
- Look up the Patient
- Click the "Add Claim" icon
- Enter the applicable information for the claim in the fields

All types of requests can be submitted via DOT, including but not limited to:

- Claims submitted for payment
- Pretreatment Estimates

Claims with radiographs and/or other attachments can be submitted electronically through NEA or RSS. Or you can submit the claim via DOT and wait for an Information Request requesting the additional information required for claim processing. For more information, see section 8.2 regarding Electronic Attachments.

With direct deposit, you can check DOT daily to access the information necessary to reconcile your accounts. For more information on Direct Deposit see section 8.10.

8.3 Paper Claims

Paper claims must be submitted on an ADA approved claim form. The patient's name, identification number and date of birth must be listed on all claims filed. If this information is missing, the patient cannot be identified which could result in the claim being returned and cause a delay in payment.

Paper claims you submit must have your signature along with your valid tax identification number, license number, and a treating address. The date of service must be provided on the claim form for each service line submitted, and each line must have an approved ADA dental code used to identify all services. (Dates of service are not required for Pretreatment Estimates.)

8.4 Claim Attachments

Delta Dental accepts electronic attachments through National Electronic Attachments (NEA) and Tesia Clearinghouse. The attachment must be sent with an electronic claim filed either through the Dental Office Toolkit (DOT) or an electronic clearinghouse. If you receive a "Request for Additional

Information" (Information Request) from us, you may submit an electronic attachment without a claim if you submit the claim number within the NEA/Tesia attachment. For best results, submitting the Information Request will speed up the processing.

For more information about NEA visit www.welcometonea.com. For more information about Tesia Clearinghouse visit www.tesia.com.

Delta Dental will not return radiographs unless submitted with a self-addressed, stamped envelope. When radiographs are needed, please send duplicates only; do not send us the originals. Be sure to properly identify and date the copy of the image.

8.5 Reconsideration of Claims

If you do not agree with a decision we made in processing a claim or with respect to a Pretreatment Estimate, you may consider asking us to reconsider our initial decision. To request a reconsideration you should:

- Send an inquiry requesting the reconsideration. The most convenient way to submit your request is through the Inquiry feature in our Dental Office Toolkit (DOT).
- Document the reasons why we should reconsider the original decision and outline what new information, if any, is being submitted.
- Provide all appropriate review documentation (e.g., narrative, patient treatment record, radiographs, etc.).
- Include your name, patient's name and the patient identification number on all documents.

You can also send the reconsideration request and supporting documents via the following:

- By Mail:

  Delta Dental Medicare Advantage Inquiries
  PO Box 9230
  Farmington Hills, MI 48333

- Call Customer Service: 855-253-4607

8.6 Payment of Claims

We pay for Covered Services provided to Enrollees, up to the maximum Benefit amounts, including Covered Services that are Denied by Delta Dental's Utilization Management process but are later overturned by us, an

independent entity contracted by CMS, an administrative law judge, or upon judicial or appellate review.

An Enrollee who receives Covered Services is not responsible for paying the costs of such services, other than applicable copayments or coinsurance, unless the Enrollee has exhausted their annual maximum benefit and you have obtained a written agreement from the Enrollee prior to the performance of the service in accordance with Section 7.3 of this Manual.

If you recommend treatment that is not reimbursable under the Enrollee's plan or policy, you are prohibited from collecting any amount from the Enrollee for such a service unless you have complied with Section 7.3 of this Manual.

A "clean claim" is a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment. If a Clean Claim is not paid within 30 days Delta Dental will pay interest in accordance with applicable prompt pay regulations.

8.7 Third Party Liability

If an Enrollee has other coverage that is primary to the Enrollee's Medicare Advantage Plan, that coverage will pay before we pay unless there is an exception under the law. We do not pay co-payments for other coverage. As the Enrollee's dentist, you should be alert to the possibility of there being other sources of payment and you must bill the dental carrier before you bill us.

When the Enrollee's Medicare Advantage Plan is secondary, we will reduce our coverage payments so that the total benefits paid or provided by all applicable dental carriers during a plan year are not more than the total amount you bill us for a specific treatment or service. In determining the amount to be paid by us, we will calculate the benefits we would have paid in the absence of other health care coverage (Maximum Approved Fee) and then apply that amount to the remaining amount the Enrollee owes following their primary plan's payment. The amount paid by us will not exceed the Maximum Approved Fee.

We may not pay anything after the Enrollee's other carrier pays. You may not bill or collect from the Enrollee.

If the Enrollee receives Covered Services that are also covered under State or federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan (including a self-insured plan) (the "Other Carrier"), we may authorize you to bill the Other Carrier, or the Enrollee, to the extent

the Enrollee has been paid by the Other Carrier for the Covered Services received.

If both the Enrollee's other dental carrier and we pay for the same service, you must reimburse us the amount we paid.

8.8 Provider-Preventable Conditions

We will not pay claims for any conditions that meet the definition of provider-preventable conditions as identified by the State for its Medicaid plan including but not limited to performing the wrong procedure or unintended retention of a foreign object.

8.9 Payment to Federally Qualified Health Care Centers (FQHCs)

We are not responsible for cost settlements with Federally Qualified Healthcare Centers (FQHCs). Instead, CMS has retained responsibility for ensuring that FQHCs receive the rate required under the prospective payment system.

8.10 Direct Deposit

You have the option of receiving payment from us via paper check or electronic funds transfer (EFT). Our EFT process offers many benefits such as faster payment, lower overhead for your office because payment goes right into your designated account, with no risk of lost, stolen, counterfeit, or altered checks.

If you elect payment by direct deposit, after a claim is paid you can access electronic copies of the Explanation of Payment (EOP)/Remittance Advice (RA) via DOT. You can check DOT daily to access the information necessary to reconcile your accounts. For more information on the DOT see section 9.1.

You also have the option of receiving the EOP/RA in the form of an electronic remittance advice (ERA 835 ANSI X12N 5010A1 format). Contact us for more information on the availability of receiving these files.

8.11 Record of Services

Delta Dental uses the Universal Tooth numbering system to identify tooth numbers, mouth quadrants and tooth surfaces for both children and adults.

The numbering system identifies permanent and supernumerary teeth and an alpha arrangement to identify both regular and deciduous supernumerary teeth. Specifically:

- Valid values for regular permanent teeth include the numbers 1 through 32.
- Numbers 51 through 82 indicates supernumerary permanent teeth.
- Alpha letters A through T indicate regular deciduous teeth.
- AS through TS indicate supernumerary deciduous teeth.

The mouth is divided into four quadrants: upper right (UR), upper left (UL), lower right (LR) and lower left (LL). When filing a claim, use the following codes to identify the quadrants of the mouth:

Quadrant	Code
Upper right	10
Upper left	20
Lower left	30
Lower right	40

In addition to identifying the tooth number, some Dental Services require identification of the tooth surface. The following single letter codes are used to identify surfaces:

Surface	Code
Buccal	B
Distal	D
Facial	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

When completing a claim form, list all tooth numbers, quadrants and surfaces for dental codes that necessitate identification. Otherwise, there may be a delay in or denial of claim payment. Refer to the Current Dental Terminology (CDT) Manual for a tooth chart.

8.12 Pretreatment Estimates

A Pretreatment Estimate is not required to be done. If you would like, you can have an estimate done by us prior to your providing treatment to an Enrollee by filing a claim with us and leaving the date of service blank.

We process Pretreatment Estimates like a claim submitted for payment. We then advise you of the expected results via a Pretreatment Estimate voucher. Once the treatment is performed, simply date, sign and return the voucher to us for processing.

A Pretreatment Estimate issued to you with respect to an Enrollee for a particular treatment or service is valid for one (1) year from the date of our issuance.

9.0 ADDITIONAL RESOURCES

9.1 Provider Web Portal (Dental Office Toolkit)

The Dental Office Toolkit (DOT) is a free internet site that allows you as a Participating Dentist and your staff to have the ability to sign on to our secure, HIPAA compliant, online system. DOT offers the following functionality:

- View patient information
- Check eligibility and Covered Services
- Submit, review and manage claims with real-time adjudication
- Submit Pretreatment Estimates
- View claims history
- Access education-focused materials
- View Explanation of Payments (EOPs)/Remittance Advice (RA)
- Send electronic attachments to us
- Manage user accounts
- Change your email address
- Enroll in direct deposit

DOT enrollment allows you to send Pretreatment Estimates requests and claims directly from your office to Delta Dental. DOT gives you the option of receiving claims-related information, Explanation of Payments (EOP's), and EFT data electronically from us.

DOT is available 24 hours a day, 7 days a week, except during updates and maintenance, from any location where you have internet access.

To access DOT:

- Visit www.deltadentalar.com
- Click Log In/Register in the top right corner

If you do not have a DOT account, click register to create an account. To register for DOT, you must have a valid dental license number, tax ID number (TIN), and service office location. You can only have one TIN per DOT account, but you can have more than one DOT account per TIN.

9.2 Translation Services

Delta Dental provides a language translation service to all Participating Dentists at no cost. Costs for the services are billed directly to Delta Dental. If you have a language barrier with an Enrollee, Voiance will provide translation services for you. You can either conference Voiance into a call between you

and the Enrollee or use a speaker phone if the non-English speaking patient is in your office. Voice and video calls are available.

How to Access These Services:

1. Dial Voiance at 1-844-648-5669
2. Enter your 4 digit Arkansas license number
3. Say the language you need
4. Select if you would like to add an additional person to the call
5. When the interpreter comes on the line:
    - Give the interpreter a brief explanation of the call
    - Speak in the first person
    - Avoid slang, jargon or metaphors
    - Allow clarification in linguistic or cultural issues

Need assistance using these services? Say "Client Services" or press 0 at the language request prompt.

Voiance Mobile App

Voiance also offers a mobile app to assist you with translations with your Enrollees. To use the app following these steps:

1. Download the app from the app store
2. Set up an account using the following information:
   User email: Voiance@deltadentalar.com
   Password: Delta Dental2017
3. Activate the app
4. Select language (including sign language)
5. Voice or Video calls are available

10.0 ENROLLEE RIGHTS

Enrollees have rights through the Medicare Advantage Plans. These rights are:

- To be treated with respect, dignity and privacy.
- To receive care -- race, color, nationality, ethnicity, disability, health status, sex, sexual orientation, religion, age, genetic information or source of payment do not matter.
- To get correct, easy to understand information to help them make good choices.
- To file a complaint or Grievance about us, a dentist or the care received.
- To file an Appeal about an action or decision we made.
- To know:
    - How Delta Dental decides whether a service is covered and/or Medically Necessary.
    - Who in Delta Dental's office decides these things.
- To know the names of Participating Dentists.
- To pick from a list of enough dentists so that they can get the right kind of care when needed.
- To take part in all decisions about their dental care. This may include refusing treatment.
- To get a second opinion from another dentist about what kind of treatment is needed.
- To be treated fairly by us, Participating Dentists and other dentists.
- Enrollees have a right to:
    - Talk to a dentist in private
    - Have dental records kept private
    - Request a copy of dental records
    - Ask for changes to those records
- To know dentists who can advise them about:
    - Health status
    - Dental care
    - Treatment
- To know they are not responsible for paying for Covered Services. As a Participating Dentist you cannot require them to pay for Medically Necessary Covered Services.
- To receive all information, including, but not limited to, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
- To receive a spoken translation at no cost for all non-English languages, not only those identified as prevalent.
- To recommend changes in policies and services under the Medicare Advantage Plan.

- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, Emergency Dental Care, and post-Stabilization Services.
    - Emergency Dental Care does not require prior approval.
    - The process and procedures for obtaining Emergency Dental Care.
    - The locations of any emergency settings and other locations at which Providers and hospitals provide Emergency Dental Care and post-Stabilization Services covered under the contract.
    - To use any hospital or other setting for Emergency Dental Services and post-Stabilization Services.
- To be able to request and receive a copy of their medical records and to request that they be amended or corrected.
- To have their privacy protected in accordance with the privacy requirements in federal law to the extent that they are applicable.
- To exercise these rights without adversely affecting the way Delta Dental or Providers treats them.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in the federal regulations on the use of restraints and seclusion.
- To make recommendations about these rights and responsibilities.

11.0 GRIEVANCE AND APPEAL SYSTEM

Enrollees and Participating Dentists have access to a Grievance and Appeal System. This system varies based on the Enrollee's plan. We will provide you the information you need for Grievance and Appeals. For questions, call Customer Service at 1-855-253-4760.

11.1 Grievance Process

A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The Grievance can be about Delta Dental, the Enrollee's Medicare Advantage Plan, a Dental Service Provider, or services received, including the quality of those services. Grievances can also be in regards to the failure to respect an Enrollee's rights.

To file a Grievance the Enrollee must:

- Submit to us a written or verbal explanation of the Grievance within no later than 60 days after the event or incident that precipitated the Grievance
- Provide all appropriate documentation requested

The following Grievances may qualify for an expedited review:

- Complaints that involve our decision to invoke an extension related to an Adverse Benefit Determination or Appeal.
- Complaints that involve our refusal to grant an Enrollee's request for an expedited benefit determination or Appeal.

11.2 Appeal Process

An Appeal is a request for review of an Adverse Benefit Determination. You, acting on behalf of the Enrollee, or the Enrollee may request an Appeal of an Adverse Benefit Determination.

Requesting an Appeal:

- An Appeal must be filed within 60 calendar days of the Notice of Adverse Benefit Determination.
- Provide all appropriate documentation (narrative, patient treatment record, radiograph, photo, etc.).

If we affirm, in whole or in part, the Adverse Benefit Determination, the issues that remain in dispute will be reviewed by an independent outside entity that contracts with CMS.

11.3 Expedited Appeal

You, acting on behalf of the Enrollee, or the Enrollee may request an Expedited Appeal. An Expedited Appeal can be written or verbal. An Expedited Appeal can be requested if (1) we have refused to provide or pay for services, in whole or in part, including the type or level of service, that the Enrollee believes should be furnished or arranged for by us; or (2) we have reduced, or prematurely discontinued, a previously authorized ongoing course of treatment. You will receive a decision within the appropriate timeframes.

11.4 Administrative Law Judge Hearing

If the independent entity contracted by CMS does not completely reverse our reconsideration of the Adverse Benefit Determination, and you or the Enrollee is not satisfied with the decision, you, acting on behalf of the Enrollee, or the Enrollee may have the right to an administrative law judge hearing. Information regarding the right to an administrative law judge hearing will be outlined in the notice sent by the independent entity.

11.5 Medicare Appeals Council Review

Any party to the administrative law judge decision or dismissal, including us, who is dissatisfied with the decision or dismissal, may request that the Medicare Appeals Council review the decision or dismissal.

11.6 Judicial Review

Any party to the administrative law judge or Medicare Appeals Council decision, including us, who is dissatisfied with the decision may request judicial review of the decision under certain circumstances.

11.7 Extensions

We may extend the resolution of Grievances and Appeals timeframes by up to 14 calendar days if:

- You or the Enrollee requests an extension; or
- We think there is a need for more information and a delay may be in your or the Enrollee's best interest.

12.0 PROGRAM INTEGRITY

12.1 Fraud, Waste and Abuse

Delta Dental is dedicated to conducting business in an ethical and legal manner. We maintain a Program Integrity Plan for continuous monitoring of potential fraud, waste, and abuse activity. We are committed to preventing, detecting and reporting fraud, waste, and abuse and overpayments.

Definitions:

- Fraud is a knowing misrepresentation of a fact to obtain benefits whether or not successful
- Abuse refers to overused or unneeded services, which include dentist or Enrollee actions that result in unneeded costs to the Medicare Advantage Plan
- Waste is the misuse of services
- Over-payments refer to any amount paid by Delta Dental that may be a result of improper claims, unacceptable practices, errors, mistakes, fraud, waste and/or abuse

Delta Dental monitors and audits the activities of its dentists, Enrollees, employees, and vendors. The dentist activities monitored and audited may include, but are not limited to, both contract and regulatory compliance requirements. Delta Dental may periodically request the completion of a questionnaire, submission of documentation, and/or attestation to applicable policy, procedure, and compliance requirements.

Delta Dental may also perform in office or desk audits, which may include the inspection of the facilities, systems, books, procedures, and/or records related to services provided.

Disciplinary actions could result from these monitoring activities including, but not limited to, payment recoupment, education, Corrective Action Plans, and/or contract termination. A Corrective Action Plan is the written plan agreed on between us and a Participating Dentist to correct any identified problem or meet acceptable levels of performance measures.

If you suspect fraud or an overpayment was made, report it immediately to Delta Dental at 1-855-253-4760.

Some common types of fraud and abuse include:

- Billing for a service not performed
- Keeping over-payments
- Billing for a non-Covered Service as a Covered Service

- Misrepresenting dates of service, diagnosis, or procedures performed
- Misrepresenting location of a service
- Misrepresenting the Dental Service Provider of a service
- Billing twice for the same service
- Billing for inappropriate or unnecessary services
- Reporting a higher level of dental service than was actually performed
- Falsifying a patient name or their personally identifiable information to obtain payment for services
- Deliberately failing to report the existence of additional dental benefits coverage and billing two or more carriers for the full amount
- Kickbacks or bribes
- Lying about education degrees and licenses
- A patient who misrepresent themselves as another person to obtain dental benefits

Anti-Fraud Laws

In accordance with the federal Deficit Reduction Act (DRA), entities like Delta Dental that receive or make payments totaling at least $5 Million annually must comply with the "Employee Education about False Claims Recovery" requirements of the DRA. This means that as a contractor doing business with us you and your staff have the same obligation to report any actual or suspected violations of Medicare funds either by fraud, waste or abuse. You must have written policies that inform and educate your staff, contractors, and agents about the following:

- The Federal False Claims Act and State laws related to submitting false claims
- How you will detect and prevent fraud, waste and abuse
- Employee protection rights as a whistleblower, that is, someone who reports instances of fraud, waste or abuse to the government

Pursuant to the Federal False Claims Act (31 U.S.C. §§ 3729-3733), civil penalties and damages may be brought against anyone who knowingly submits, or causes another to submit, a false or fraudulent claim for payment, or knowingly makes, or causes to be made, a false statement or record in connection with a claim for payment; or knowingly retains an overpayment.

The False Claims Act defines "knowingly" to mean that a person has actual knowledge of information, acts in a deliberate ignorance of the truth or falsity of the information, or acts in a reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The Federal Fraud Civil Remedies Act (31 U.S.C. §§ 3802-3811) provides administrative remedies for false claims and false statements in connection with claims designated to federal agencies, including the U.S. Department of Health and Human Services.

Additional details about these laws and Delta Dental's policies and procedures for complying with these laws can be found in our Anti-Fraud Laws Policy, which is available upon request or at www.deltadentalar.com.

Compliance with Policies and Procedures

We require you as a Participating Dentist to comply with all laws relating to Medicare Advantage Providers as well as all of our policies and procedures distributed and made available to you. These policies and procedures include, but are not limited to, the following:

- Anti-Fraud Laws Policy
- Delta Dental's Code of Conduct
- Delta Dental's Program Integrity Plan
- Other relevant Delta Dental policies and procedures

These policies are available upon request or at any time on www.deltadentalar.com.

You agree to provide upon request immediate access to records, books, and other documents as necessary for audits to us, the U.S. Department of Health and Human Services and other State and federal governmental agencies with appropriate jurisdiction in connection with any activity involving the prevention, detection, or reporting of fraud, waste, abuse and/or overpayments.

12.2 Screening for Excluded and/or Disbarred Entities

Delta Dental, as well as Dental Service Providers, whether contracted or non-contracted, must comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening.

Any services provided by excluded individuals must be refunded to and/or obtained by Delta Dental. Where the excluded individual is the provider of services or an owner of a business entity providing the services, all amounts paid to that Dental Service Provider must be refunded to Delta Dental.

Any Dental Service Provider listed in any of these excluded or disbarred entity databases cannot be included in the Delta Dental Medicare Advantage Network.

For information about Network participation, including removal from the Network and reinstatement, see the “Participation and Provider Roles” Section of this manual.

DeltaDentalAR.com