



2024 Medicare Advantage Dental Manual

*A Dental Administrative
Guide*



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

June 2024

Dear Participating Medicare Advantage Dentist:

We are excited to bring you our first ever Dental Manual dedicated solely to Medicare Advantage. This administrative guide is designed to help you and your staff easily navigate the Medicare Advantage verification and claims process, which allows you to provide your patients with the best possible service.

This Medicare Advantage Dental Manual, along with the CDT Dental Procedure Guidelines, provides you with the policies and procedures necessary to support your practice when doing business with us. The Medicare Advantage Dental Manual is an accompaniment to your Participating Provider Agreement (“Agreement”), providing comprehensive details regarding the terms of your Agreement. Both the Medicare Advantage Dental Manual and the CDT Dental Procedure Guidelines are located on our website at: www.arkansasbluecross.com.

Your Dental Network Manager is available to assist you with any questions you have relative to your Agreement, the Medicare Advantage Dental Manual or the CDT Guides.

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 as to the content you would like to see included in the Dental Manual, please contact your Dental 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,



Christy Hockaday
Senior Vice President, Provider Networks

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Section 1: Definitions

The definitions of capitalized terms that are not otherwise defined in the body of the Participating Provider Agreement are set forth in this section of the Dental Manual.

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| Applicable Laws | Any statutes, regulations or other legal requirements applicable to the matter being referenced in the Agreement. |
| Allowable Expense | The maximum amount of payment allowed by Arkansas Blue Medicare for Dental Benefits covered under the applicable Insured's Dental Program. |
| 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 Charges | The amount you bill for a specific dental service or procedures. |
| Benefit Plan | The written agreement entered into 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 federal agency within the Department of Health and Human Services responsible for administration of Medicare. CMS language may be different than conventional insurance contracts. |
| 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 considered to be clean when it requires no further information, adjustment or alteration in order to be processed and paid by the Responsible Payor. |
| Co-insurance | The sharing of expenses of Dental Benefits between the members and Arkansas Blue Medicare. The amount of any such expense is set forth in the applicable Dental Program. |
| Conditions of Participation | The minimum qualifications and standards required to be credentialed to participate in a Provider Network, including: <ol style="list-style-type: none"> 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 Arkansas Blue Medicare in a timely manner of any material changes in that information. |

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| Confidential Information | <ol style="list-style-type: none"> 1. Any and all data, reports, interpretations, forecasts, documents, records and other information fixed in a tangible medium, which contain information concerning a party that: 2. Is marked, otherwise identified as, or legally entitled to protection as confidential, proprietary, privileged or trade secret information; and 3. Is disclosed by or on behalf of a party (the “Disclosing Party”) to the other party (the “Receiving Party”). |
| | <p>Confidential Information does not include information that:</p> <ol style="list-style-type: none"> 1. Is based on documents in the Receiving Party's possession prior to disclosure of Information that was not acquired directly 2. or indirectly from the Disclosing Party; or 3. 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 4. 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 5. Was independently developed by the Receiving Party without reliance on or knowledge of the Disclosing Party's Confidential Information. |
| Coordination of Benefits (COB) | <p>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.</p> |
| Copayment | <p>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.</p> |
| Cost Sharing | <p>Any and all charges that a Dentist may collect directly from a Member in accordance with the terms of the Member's Benefit Plan; which includes Copayments, Deductibles or Coinsurance.</p> |
| Covered Services | <p>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.</p> |
| Denied | <p>Dental services that are not covered under the applicable Medicare Advantage Plan will be denied. If a claim is denied, you can bill and collect your billed charge from the member, if the member has agreed to pay for the service(s).</p> |
| Downstream Entity | <p>Downstream Entities include Dentist and any of Dentist's subcontractors and their subcontractors down to the level of the ultimate provider of health and administrative goods and services to Medicare Advantage members under the terms of the Agreement.</p> |

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| Emergency Dental Care | Dental services necessary to treat a sudden onset and severity of a dental condition that leads to an immediate dental procedure to relieve pain or eliminate infection. |
| Exchange or Health Insurance Marketplace | A governmental agency or non-profit entity that meets the applicable standards of 45 C.F.R. § 155 subpart D and makes QHP available to individuals and employers. This term includes both state and Federally-Facilitated Exchanges. |
| First Tier Entity | First Tier Entities consist of Medicare Advantage Plan's subcontractors, including Arkansas Blue Medicare, that provide administrative services or health care services to Medicare Advantage members. |
| Governing Body | The person(s) who have authority over a business entity. |
| Grievance | Dissatisfaction from or on the behalf of an Enrollee or Dental Service provider about any action taken by Arkansas Blue Medicare may include dissatisfaction about the quality of care, services provided or professionalism of the dental provider or staff. |
| HIPAA | The Health Insurance Portability and Accountability Act of 1996 and its regulations. |
| HITECH | The Health Information Technology for Economic and Clinical Health Act and its implementing regulations. |
| Insured | Each individual covered under a Dental Program. |
| Late Claim | The submission of a Claim for Covered Services to Arkansas Blue Medicare Responsible Payor that is more than 180 days (6 months) from the date of service or the completion of a course of treatment. Arkansas Blue Medicare may deny a Late Claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim. |
| Medicare Advantage Plan | Arkansas Blue Medicare, a Medicare Advantage Organization offering Medicare Advantage Programs through a Medicare Advantage Contract. |
| Medicare Advantage Organization | An insurance company or health maintenance organization that holds a contract with CMS and the Medicare Advantage Plan. |
| 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. |
| Medicare Advantage Maximum Allowable Charge Fee Schedule | The amount that Arkansas Blue Medicare 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 in Exhibit A of the Responsible Payor's Agreement. |
| Member | A person eligible to receive Covered Services under a Benefit Plan. |

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| Member Payments | Any and all charges that a Dentist may collect directly from a Member in accordance with the terms of the Member's Benefit Plan; which includes Copayments, Deductibles or Coinsurance. |
| Necessary and Appropriate | Dental services and supplies that are: <ol style="list-style-type: none"> 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(s). |
| 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: <ol style="list-style-type: none"> 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. |
| Participating Agreement | The document that defines the contractual rights and obligations between you as a participating Dentist and Arkansas Blue Medicare for your participation in the Preferred Participating Provider (PPP) network which is made up of your standard contract and Medicare Advantage. |
| Participating Dentist | A duly licensed dentist who has contracted with Arkansas Blue Medicare to participate in its Dental Network. |
| Provider Network | A group of Dentists who contract with Arkansas Blue Medicare to render Covered Services to Members. |

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| Pre-authorization | <p>A dentist's submission of information to the responsible payor prior to rendering services, for advanced written approval for planned services for medically necessary treatment.</p> <p>Preauthorization is subject to:</p> <ul style="list-style-type: none"> • the accuracy and completeness of the Dentist's submission of information, • Medical Necessity • the Member's eligibility at the time services are 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 |
| Predetermination of Benefits | <p>A Dentist's submission of information to the Responsible Payor prior to rendering services, to request the Responsible Payor inform the Dentist if services may be Covered Services and what Allowable Charge, Copayment, Coinsurance and Deductible amounts may apply. A Predetermination of Benefits is confirmation that the member is a covered enrollee and the treatment planned is a covered benefit. It is not a guarantee of benefits and does not imply any obligation to pay any amount for services rendered. A Predetermination is subject to:</p> <ul style="list-style-type: none"> • the accuracy and completeness of the Dentist's submission of information, • the Member's eligibility at the time services are 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 |
| Responsible Payor | The Plan responsible for paying benefits for Covered Services rendered to a Member. |
| State | The State of Arkansas |
| Subscriber | A Member who is eligible and enrolled in a Benefit Plan as an individual or as an employee or member of an Account. |
| Unbundling of Procedures | <p>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 supplies) that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or refund request will result.</p> |
| Utilization Management Program | The review process used to evaluate whether a service rendered to a Member is Necessary and Appropriate. |

Section 2: Contact Information

Customer Service 1-888-224-5213

Dental Provider Relations Team.....www.dentalproviderrelations@usablelife.com

Website...www.arkansasbluecross.com/providers/dental-providers/medicare-advantage-dental

Verify benefits online at: www.mydentalcoverage.com/shared/login.shtml

- Select MyDentalCoverage
- Verify benefits and eligibility
- Check frequency limitations, deductibles and plan maximums met to date
- Check claims status
- Submit Speed eClaim

Customer Service:

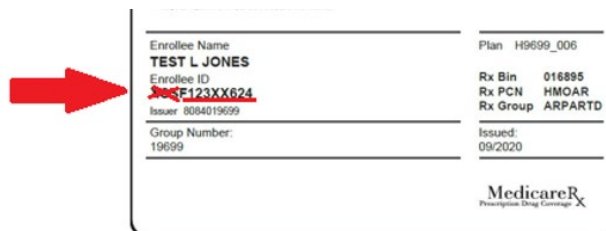
You may contact our customer service department by phone at 1-888-224-5213 Monday through Friday from 8 a.m. to 8 p.m.

Claims mailing address:

Please submit your Medicare Advantage dental claims electronically using Arkansas Blue Cross and Blue Shield's Payor ID (TLY26) or mail your dental claims to the following address:

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

Note: When verifying benefits and eligibility or filing a claim, you will need to drop the first three alpha prefix from the members medical ID card.



Section 3: Filing Provider or Practice Changes

Occasionally, you may need to submit changes to us associated with relocation, adding or changing an Employer Identification Number (EIN) or Tax Identification Number (TIN), adding or terminating an associate. Forms are located on our website at <https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms>. For assistance with the forms, please contact us at www.dentalproviderrelations@usablelife.com.

Changes Requiring Notification

Changes to your status that require immediate written notification include:

- License to practice dentistry is suspended or revoked
- Professional liability or malpractice insurance changes, lapses or revocation
- Malpractice cases or an act of professional misconduct
- Transfer of ownership (TIN change)
- Change of practice name
- Relocation
- Adding dentists to your practice
- Additional offices
- Changes to telephone numbers, fax numbers, email addresses
- Any material or demographic changes to your practice
- Retirement/Death of Provider

Required Notification Time Limitations

Arkansas Blue Medicare requires written notification within established time periods as noted below:

- Within seventy-two (72) hours if:
 - You or your practice, or any of its officers or directors is indicted or convicted of a felony.
 - You or your practice becomes the subject of an investigation by a state or federal government entity in which you have the potential to be subject to criminal charges or subject to any action for violation of Law.
- Within one (1) business day if:
 - You are materially sanctioned by any state or federal government entity.
 - Your eligibility to participate in the Medicare or Medicaid programs is limited, restricted or otherwise terminated.
 - You receive a notice of intent to file or actual filing of any professional liability action against you (or an entity in which you have an ownership interest, other than a publicly traded company) that involves a Member.
- Within five (5) business days if:
 - You are required to pay damages in any malpractice action by way of judgment or settlement notification.
 - There is any change in the nature or extent of Service rendered by you.
 - Any other act, event, occurrence or the like that materially affects your ability to carry out your duties and obligations or otherwise perform under the Agreement.
 - You shall notify Arkansas Blue Medicare when you begin or cease to accept new patients, or begin or cease to provide Services at the location listed in the Agreement.
 - Within thirty (30) days of any change in your ownership or Affiliates or of a contemplated merger or acquisition of your practice(s).

| Type of Change | Method of Submission |
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| General location/contact information (telephone, fax, etc.) | Submit a provider information change form located on our website at www.arkansasbluecross.com under the Providers tab; Fax request to (501) 208-8302 or email to DentalProviderRelations@uasblelife.com . |
| Employer Identification Number (EIN) or Taxpayer Identification Number (TIN) | Any changes to your (EIN) Employer Identification Number or (TIN) Taxpayer Identification Number, submit a Provider information change form, W-9. Forms are located on our website at www.arkansasbluecross.com under the Providers/Resource tab. Submit with original signatures and fax (501) 208-8302 or email to DentalProviderRelations@uasblelife.com . |
| Associate dentist/orthodontist who has left your practice | Send a letter of termination on the Practice letterhead with a provider's signature, including the dentist's name, practice address and TIN via fax (501) 208-8302 or email to DentalProviderRelations@uasblelife.com . |
| Add a new associate or dentist to your practice | Submit a credentialing application if the provider is not credentialed with Arkansas Blue Medicare, or submit an Abbreviated Application, W-9 and a Participating Provider Agreement for existing providers. Forms are located on our website at www.arkansasbluecross.com . |
| Terminate participation in a network Requires 90 day written notification | Send a letter of termination on your practice letterhead with a provider's signature, include the Dentist name, practice address, TIN and network you are terming via fax (501) 208-8302 or email to DentalProviderRelations@uasblelife.com . |
| Add additional practice locations for existing Employer Taxpayer identification number (TIN) on file. | Submit an Abbreviated Application. Forms are located on our website at www.arkansasbluecross.com . |
| Terminate Arkansas Blue Medicare Contract | Contact your Dental Network Manager. |

Provider Data Accuracy and Validation

Arkansas Blue Medicare makes every effort to maintain the accuracy of the provider information used to promote the online directory. We are required by law to keep our provider directories current and up-to-date. Having accurate information helps our members locate participating providers, and it ensures fast and accurate claim processing. To help in this effort, we occasionally reach out to providers to verify that the information we have regarding provider name, zip code/distance, or county to validate provider name, practice address, phone number, office hours, and accepting patient status is accurate.

You may be contacted by phone, email, or in person for the following:

- Provider data audit
- Online Provider Directory verification
- Quarterly Website verification

Section 4: Your Relationship with Arkansas Blue Medicare

Dentist's Responsibilities

As a Participating Medicare Advantage Dentist, you are solely responsible for making treatment recommendations and decisions for your patients. You are also responsible for ensuring that all clean claims you submit are accurate, complete and in adherence to recognized standards of coding. A Participating dentist cannot bill patients for charges Arkansas Blue Medicare considers “unbundled” services that should be billed as one procedure, so there is no “cost shifting” to members. A Participating Medicare Advantage Dentist must meet the General Conditions, Standards, Requirements and Contractual Conditions detailed in section six of this manual.

As a Participating Medicare Advantage Dentist you also agree to the following:

- Uphold your Participation Agreement for Medicare Advantage Plans and standard dentist requirements, the Medicare Advantage rules, regulations and this manual.
- Provide a written explanation of cost to member prior to services being rendered, outlining any amount expected to be covered by the plan or any amount that is, copay, coinsurance, or non-covered amount.
- Collect prepayment for any portion of a covered service.
- Provide estimates and collection based on the allowed amount set forth in the Medicare Advantage Fee Schedule. (Non-covered services or services that exceed the maximum allowed plan dollar limit are eligible for balance billing).
- Respond to request to validate provider information which may include completing an Abbreviated Application.
- File claims within the plans timely filing limit of 180 days from the date-of-service, including any required documentation needed, including but not limited to:
 - Preoperative radiographic images 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
- Provide services that meet criteria for medically necessary and 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.
- Not rendered solely for Dentist's, Member's or a Third-party's convenience.
- Comply with all state and federal laws and regulations.
- Immediately notify Arkansas Blue Cross and Blue Shield if provider has opted out of Medicare or is placed on the OIG list, the GSA list, and/or the CMS Medicare Preclusion list.
- Submit complete and accurate information as requested for audits, re-credentialing, and provider data validation to ensure provider meets the Medicare Advantage Program requirements.
- If accepting new patients, you must accept all new Medicare Advantage patients and make appointments available regardless of payer source.
- Do not accept payment for services not eligible for reimbursement including:
 - Services rendered when provider status is excluded.
 - Administrative or management services not directly established for patient care or are otherwise payable by a Medicare Advantage plan.
 - Services paid by Medicare Advantage plan.

Arkansas Blue Medicare Responsibilities

Arkansas Blue Medicare reserves the authority to make eligibility and coverage determinations and to make claims-processing decisions that may include re-bundling or down-coding. Arkansas Blue Medicare will exercise best efforts to adjudicate and pay each Clean Claim for Dental Benefits directly to the Dentist within 30 days of receipt or in accordance with applicable federal or state prompt payment laws. Arkansas Blue Medicare will market and promote its Dental Programs, and provide a list of Participating Dentists to members, employer groups and other Participating Dentists, in conformity with Arkansas Blue Medicare's marketing program. Arkansas Blue Medicare will also provide other programs that support, service and educate the Dentists and office staffs in conformity with Arkansas Blue Medicare's programs then in effect.

Section 5: Working with Arkansas Blue Medicare

What We Offer You

At Arkansas Blue Medicare, we are committed to helping you provide the best care to your Medicare Advantage patients, our members. We have established a reputation based upon trust and excellent customer service, the same qualities you deliver to your patients. We offer:

- Fast, reliable and accurate electronic claims processing, with payments issued directly to the Participating Dentist
- Dedicated Dental Network Managers
- Website access to self-service tools and collateral materials
- Competitive reimbursement rates driven by the market
- The Arkansas Blue Medicare network, which gives you:
 - Access to more than 20,000 members
 - A listing in our online Provider Directory, which members can use to search for you by location or specialty. You may access the directory at <https://secure.arkansasbluecross.com/healthcare-providers/#/ChooseNetwork> to view your listing.

We are now using our website, www.arkansasbluecross.com, for all communication with our participating dental providers. Fee schedules, updates and announcements are now available to you at your convenience 24/7 by selecting “Dental Provider” listed under Providers tab.

Provider Rights

As a Participating Provider you have the right to:

- Recommend treatment that may be non-covered services or non-covered under the Medicare Advantage plan.
 - You must provide a written explanation of cost to the member prior to services being rendered, outlining any amount expected to be covered by the plan or any amount that is, copay, coinsurance, or non-covered amount.
- Provide factual information to a member when a complaint has been filed against you by the member.
- Receive information from Arkansas Blue Medicare on Grievances and Appeals.
- File an appeal about an action or decision made by Arkansas Blue Medicare.
- Be notified of any decision to deny services.
- Exercise these rights without adversely affecting how Arkansas Blue Medicare treats you.

Section 6: Conditions of Participation in Our Network

To participate in the Arkansas Blue Medicare Dental network, each dentist must meet the General Conditions, Standards, and Requirements and Contractual Conditions described below.

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| <p>General Conditions</p> | <ul style="list-style-type: none"> • Dentist must complete a Provider Application with associated attachments. Found online at: https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms • Submit a W-9 or a tax coupon or letter from the Department of Treasury(IRS) CP 575C. • Submit a Type 1 NPI number. |
| <p>Standards and Requirements</p> | <ul style="list-style-type: none"> • Dentist must be licensed in Arkansas. If Dentist practices in a state other than Arkansas, Dentist must comply with the license requirements of the state where Dentist is located and where services are rendered to members. • Dentist warrants that Dentist, and all health care practitioners, including employees, contractors and agents of Dentist, who render Covered Services to Medicare Advantage members and QHP members, shall be at all times during the term hereof, properly licensed by the state in which such services are rendered, certified, qualified and in good standing in accordance with all applicable local, state, and federal laws. Dentist, Dentist’s sites, and all providers rendering services hereunder shall meet applicable requirements and be properly certified under the Medicare programs, as set forth in in Title XVIII of the Social Security Act. Upon request, Dentist shall provide satisfactory documentary evidence of such licensure, certification, and qualifications of Dentist, Dentist’s sites, and other health care providers rendering services at Dentist’s sites. Either the Medicare Advantage Plan will review the credentials of Dentist and other medical professionals affiliated with Dentist or the Medicare Advantage Plan will review and approve the credentialing process and will audit the credentialing process on an ongoing basis. • Dentist 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 Dentist. • DEA (Drug Enforcement Administration) and CDS (Controlled Dangerous Substances) eligible dentist who do not have an active DEA certificate will provide a DEA waiver indicating the reason for the waiver and provide a designated practitioner to write on their behalf. The alternate prescriber may be an individual or a practice but must be identified by name and NPI. • Dentist 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. • Dentist 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. |

Standards and Requirements

- Dentist must maintain dental, financial, and administrative records concerning the provision of services to members for at least ten (10) years from the date those services were rendered.
- Dentist must provide a written explanation of cost to member prior to services being rendered, outlining any amount expected to be covered by the plan or any amount that is, copay, coinsurance, or non-covered amount.
- Dentist must agree that Arkansas Blue Medicare or its authorized designees, regulators, or accreditation agencies; have the right to inspect and make copies of records directly related to the provision of services to members, given reasonable notice, during the Dentist's regular business hours. Neither Arkansas Blue Medicare nor its designees shall be required to pay for copies of records necessary to complete or evaluate claim or encounter data. You agree to obtain any releases required by Applicable Laws to provide access to Member's records.
- Dentist must comply with the Required Terms of the Amendment to the Arkansas Blue Medicare Participating Provider Agreement which apply to services rendered to Medicare Advantage members and QHP members and will, to the extent inconsistent with any other terms of the Agreement, supersede such inconsistent terms solely as they relate to services rendered to Medicare Advantage members and QHP members.
- If a party received Confidential Information from another party, the receiving party will not disclose the Confidential Information to third parties, in whole or in part, except with prior written consent of the disclosing party, as required by Applicable Laws or as permitted by the Arkansas Blue Cross and Blue Shield Participating Provider Agreement. The receiving party and its representatives shall utilize Confidential Information disclosed pursuant to the Agreement as is reasonably necessary to accomplish the objectives of the Agreement and in accordance with Applicable Laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and its implementing regulations and the Health Information Technology for Economic and Clinical Health Act and its implementing regulation. The receiving party and its representative shall not utilize Confidential Information for any other purpose including, without limitation, using that confidential Information for its own benefit or for the benefit of third parties, except with the prior written consent of the disclosing party. The Dentist acknowledges and agrees that Arkansas Blue Medicare may disclose Confidential Information received from or on behalf of the Dentist, including fee, claims and encounter information, to affiliates, reciprocity plans, regulators, accreditation agencies, Administrators and auditors after informing those third parties of the confidential nature.

Contractual Conditions

- Dentist shall notify Arkansas Blue Cross and Blue Shield of Dentist intent to terminate, or alter Dentist participation in writing, no less than ninety (90) days prior to your requested date of change or termination. Furthermore, any individual provider wishing to join an existing group practice shall notify Arkansas Blue Cross and Blue Shield.
- To the extent that services that otherwise meet the requirement of the Arkansas Blue Cross and Blue Shield Participating Provider Agreement are rendered by a dentist not located in Arkansas, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of Arkansas Blue Medicare.
- Dentist shall comply and shall contractually obligate its Downstream Entities to comply with all applicable laws and regulations including, but not limited to, the provisions of 45 C.F.R. Parts 155 and 156 and Medicare Advantage Plan's relevant written policies and procedures, including policies and procedures for the control of fraud, waste and abuse in the Medicare Advantage Programs. 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.
- Dentist shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with Arkansas Blue Medicare's obligations to Medicare Advantage Plan and Medicare Advantage Plan's obligations to CMS set forth in the Medicare Advantage Contract. Additionally, you shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with Arkansas Blue Medicare's obligations to CMS set forth in the QHP Issuer Agreement. Dentist agrees that in no event, including, but not limited to non-payment by Arkansas Blue Medicare, insolvency of Arkansas Blue Medicare, or breach of the Agreement or this Amendment, shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against an Medicare Advantage Member or a person acting on behalf of an Medicare Advantage Member for Covered Services provided pursuant to this Amendment. This Amendment does not prohibit collection of Medicare Advantage Member Cost Sharing, or fees for non-covered services as long as Medicare Advantage Member has been informed in advance that services are not covered and that Medicare Advantage Member is financially responsible for any non-covered services. Dentist further agrees that this provision will survive termination of the Agreement and this Amendment. Payments to Dentists may be, in whole or in part, from federal funds and Dentist is subject to all laws applicable to individuals or entities receiving federal funds.

Contractual Conditions

- Dentist acknowledges that Arkansas Blue Medicare and Medicare Advantage Plan are required under applicable federal law and regulations to submit to CMS certain information regarding the benefits provided by Medicare Advantage Plan and quality and performance indicators. Dentist acknowledges that Arkansas Blue Medicare and Medicare Advantage Plan may be required under such laws and regulations to disclose certain information to Medicare Advantage and QHP members in such form and manner requested by members CMS. Dentist shall maintain all records and reports reasonably requested by Arkansas Blue Medicare and shall provide such records and reports to Arkansas Blue Medicare to enable Arkansas Blue Medicare and Medicare Advantage Plan to meet their obligations to submit such information to CMS and to disclose certain information to Medicare Advantage members and QHP members as required by applicable law and regulations.
- If Dentist contracts with a Downstream Entity to fulfill Dentist's obligations hereunder, Dentist shall require the Downstream Entity by written agreement, and shall require such Downstream Entities to include in their contracts with other Downstream entities, to comply with all provisions of these Required Terms and which expressly requires each Downstream Entity to: (a) comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156 and 42 C.F.R. Part 422, to the extent relevant, in performing or assisting in the performance of services; and (b) grant access to its books, contracts, computers, or other electronics systems relating to such Downstream Entity's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 and 42 C.F.R. Part 422 to Arkansas Blue Medicare, Medicare Advantage Plan, and HHS and the Comptroller General (or their designees) for the duration of the period in which the Agreement is effective, and for a minimum of ten (10) years from the date the Agreement terminates or the date of completion of an audit by CMS, whichever is later. Arkansas Blue Medicare retains the right to approve, suspend, or terminate any arrangement between Dentist and a selected Downstream Entity with respect to services provided under these Required Terms.

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 monthly 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://exclusions.oig.hhs.gov>) and the General Services Administration's System for Award Management (<http://www.sam.gov/portal>). Dentist shall notify Arkansas Blue Cross and Blue Shield 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

**Contractual
Conditions**

work directly or indirectly related to the delivery or administration of Covered Services to Medicare Advantage members. Arkansas Blue Medicare reserves the right to require Dentist to demonstrate compliance with this provision upon reasonable request.

- Dentist shall cooperate with Arkansas Blue Medicare’s or Medicare Advantage Plan’s compliance program, including, but not limited to inquiries, preliminary and subsequent investigations, and implementation of corrective action. 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 Agreement or this Amendment, Dentist shall provide Arkansas Blue Medicare a copy of audit results and shall make all audit materials available to Arkansas Blue Medicare upon request.
- Arkansas Blue Medicare will monitor the performance of Dentist on an ongoing basis. Arkansas Blue Medicare’s monitoring activities include assessing Dentist and Downstream Entities’ compliance with applicable Medicare Advantage Program and QHP provisions, including the Required Terms.
- Arkansas Blue Medicare shall immediately cease making all payments to Dentist for Covered Services provided to Medicare Advantage members by excluded persons as described in Section 8 as of the date Dentist, or any Affiliated Party employed by Dentist, has been excluded from participation under Medicare as determined by CMS.
- Notwithstanding any termination provision in the Agreement, in the event Dentist materially breaches this Amendment, Arkansas Blue Medicare may terminate this Amendment and the Agreement immediately. For purposes of these Required Terms, a material breach will have occurred upon the following events including, but not limited to (a) a material violation of Arkansas Blue Medicare’s or Medicare Advantage Plan’s policies and procedures, or
- (b) a determination by CMS that Dentist has not satisfactorily performed its obligations under the Agreement or this Amendment.

Section 7: 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 Arkansas Blue Medicare to safeguard our members' protected health information (PHI). Since the Privacy Rule applies to payors and providers, Arkansas Blue Medicare shares with you the responsibility of protecting privacy. The HIPAA Privacy Rule allows for Arkansas Blue Medicare to share PHI with other parties without member's 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 healthcare 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 US Able Mutual Company, d/b/a Arkansas Blue Medicare 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 assess and handle their records to support treatment, payment and healthcare operations.

Section 8: Medicare Advantage Program and QHP Requirements

8.1 Licensure and Certification. Dentist warrants that Dentist, and all health care practitioners, including employees, contractors and agents of Dentist, who render Covered Services to Arkansas Blue Medicare Members, shall be at all times during the term hereof, properly licensed by the state in which such services are rendered, certified, qualified and in good standing in accord with all applicable local, state, and federal laws. Dentist, Dentist's sites, and all providers rendering services hereunder shall meet applicable requirements and be properly certified under the Medicare programs, as set forth in Title XVIII of the Social Security Act. Upon request, Dentist shall provide satisfactory documentary evidence of such licensure, certification, and qualifications of Dentist, Dentist's sites, and other health care providers rendering services at Dentist's sites. Either the Arkansas Blue Medicare Plan will review the credentials of Dentist and other medical professionals affiliated with Dentist or the Arkansas Blue Medicare Plan will review and approve the credentialing process and will audit the credentialing process on an ongoing basis.

8.2 Compliance with Laws, Policies, and Procedures. Dentist shall comply and shall contractually obligate its Downstream Entities to comply with all applicable laws and regulations including, but not limited to, the provisions of 45 C.F.R. Parts 155 and 156 and Arkansas Blue Medicare Plan's relevant written policies and procedures, including policies and procedures for the control of fraud, waste and abuse in the Arkansas Blue Medicare Programs. 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.

8.3 Consistency with Arkansas Blue Medicare Contract Issuer Agreement. Dentist shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with PPP Arkansas's obligations to Arkansas Blue Medicare Plan and Arkansas Blue Medicare Plan's obligations to CMS set forth in the Arkansas Blue Medicare Contract.

8.4 Hold Harmless. Dentist agrees that in no event, including, but not limited to non-payment by PPP Arkansas, insolvency of PPP Arkansas, or breach of the Agreement shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against an Arkansas Blue Medicare Member or a person acting on behalf of an Arkansas Blue Medicare Member for Covered Services provided pursuant to this Agreement. This Agreement does not prohibit Dentist from collecting Arkansas Blue Medicare Member Cost Sharing, as specifically provided in the Plan Description, or fees for non-covered services as long as Arkansas Blue Medicare Member has been informed in advance that services are not covered and that Arkansas Blue Medicare Member is financially responsible for any non-covered services. This provision will survive termination of the Agreement, regardless of the reason for termination,

a. including insolvency of the PPP Arkansas, and shall supersede any oral or written agreement between Dentist and an Arkansas Blue Medicare Member.

8.5 Payments from Federal Fund. Payments to Dentist under this Agreement may be, in whole or in part, from federal funds, and as such, Dentist is subject to all laws applicable to individuals or entities receiving federal funds.

8.6 Maintenance and Provision of Certain Information. Dentist acknowledges that PPP Arkansas and Arkansas Blue Medicare Plan are required under applicable federal law and regulations to submit to CMS certain information regarding the benefits provided by Arkansas Blue Medicare Plan and quality

and performance indicators. Dentist acknowledges that PPP Arkansas and Arkansas Blue Medicare Plan may be required under such laws and regulations to disclose certain information to Arkansas Blue Medicare Members in such form and manner requested by CMS. Dentist shall maintain all records and reports reasonably requested by PPP Arkansas and shall provide such records and reports to PPP Arkansas to enable PPP Arkansas and Arkansas Blue Medicare Plan to meet their obligations to submit such information to CMS and to disclose certain information to Arkansas Blue Medicare Members and QHP Members as required by applicable law and regulations.

8.7 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, and shall require such Downstream Entities to include in their contracts with other Downstream entities, to comply with all provisions of these Required Terms and which expressly requires each Downstream Entity to: (a) comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156 and 42

a. C.F.R. Part 422, to the extent relevant, in performing or assisting in the performance of services; and (b) grant access to its books, contracts, computers, or other electronic systems relating to such Downstream Entity's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 and 42 C.F.R. Part 422 to PPP Arkansas, Arkansas Blue Medicare Plan, and HHS and the Comptroller General (or their designees) for the duration of the period in which the Agreement is effective, and for a minimum of ten (10) years from the date the Agreement terminates or the date of completion of an audit by CMS, whichever is later. PPP Arkansas retains the right to approve, suspend, or terminate any arrangement between Dentist and a selected Downstream Entity with respect to services provided under these Required Terms.

8.8 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 monthly 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://exclusions.oig.hhs.gov>) and the General Services Administration's System for Award Management (<http://www.sam.gov/portal>). Dentist shall notify PPP Arkansas 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.

a. 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 Arkansas Blue Medicare Members. PPP Arkansas reserves the right to require Dentist to demonstrate compliance with this provision upon reasonable request.

8.9 Fraud, Waste and Abuse Prevention.

a. Policies and Procedures. Dentist shall adopt and follow and Dentist shall require its

1. Downstream Entities to adopt and follow policies and procedures that reflect a commitment to detecting, preventing, and correcting fraud, waste, and abuse in the administration of the Arkansas Blue Medicare Program. Dentist shall implement this Section 12(a) within a reasonable time period. PPP Arkansas reserves 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:
2. Dentist's code of conduct.

3. Ensuring that Dentist's managers, officers, and directors who are responsible for the administration or delivery of Arkansas Blue Medicare Program benefits are free of conflicts of interest in the delivery and administration of such benefits.
4. Delivery of annual general and specialized Medicare compliance training for all persons involved in the administration or delivery of Arkansas Blue Medicare Program 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 Arkansas Blue Medicare Program procedures and requirements in order for Dentist to perform or provide services under the Agreement).
5. Prompt reporting of compliance concerns and suspected or actual misconduct in the administration or delivery of Arkansas Blue Medicare Program benefits to PPP Arkansas, including nonretaliation 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 this Agreement.
6. Monitoring and auditing of Dentist's performance of its obligations under these Required Terms.

b. Cooperation with Compliance Activities. Dentist shall cooperate with PPP Arkansas's or Arkansas Blue Medicare Plan's compliance program, including, but not limited to inquiries, preliminary and subsequent investigations, and implementation of corrective action. 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 Agreement, Dentist shall provide PPP Arkansas a copy of audit results and shall make all audit materials available to PPP Arkansas upon request.

c. Fraud and Abuse Statutes. Dentist shall comply with federal statutes and regulations designed to prevent FWA, 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-7 b (b)), and the Anti-Influencing statute (42 U.S.C. § 1320a- 7a(a)(5)).

8.10 Inspection, Evaluation, Audit, and Document Retention.

a. Access to Records. Dentist shall permit, PPP Arkansas, Arkansas Blue Medicare Plan, HHS, and the Comptroller General, or their designees, to inspect, collect, evaluate, and audit any books, contracts, records, including dental records, and documentation of the Dentist and Downstream Entities that pertain to any aspect of Covered 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 the Records to PPP Arkansas or to Arkansas Blue Medicare Plan,

1. HHS, the Comptroller General, or their designees, unless otherwise mutually agreed by the
2. Parties. Dentist may not make the access described in this paragraph contingent upon a
3. confidentiality statement or agreement. The above-described rights to inspect, collect evaluate, and audit will extend through the period during which Dentist is required to maintain the Records established in paragraph b below.

b. Retention Period. Dentist shall maintain the Records for ten (10) years from the longer of (i) the termination or expiration of the Agreement or (ii) completion of final audit by CMS, unless otherwise required by law.

8.11 Offshore Operations. Dentist shall not disclose any of Arkansas Blue Medicare Members' health or enrollment information, including any dental records or other protected health information (as defined in 45 C.F.R. § 160.103) or allow the creation, receipt or use of any of Arkansas Blue Medicare Plan's or PPP Arkansas's protected health information by any Downstream Entity for any function, activity or purpose to be performed outside of the United States, without PPP Arkansas's prior written approval.

8.12 Monitoring. PPP Arkansas will monitor the performance of Dentist on an ongoing basis. PPP Arkansas's monitoring activities include assessing Dentist and Downstream Entities' compliance with applicable Arkansas Blue Medicare Program provisions, including the Required Terms.

8.13 Cease Payment Upon Exclusion. PPP Arkansas shall immediately cease making all payments to Dentist for Covered Services provided to Arkansas Blue Medicare Members by excluded persons as described in Section 8 as of the date Dentist, or any Affiliated Party employed by Dentist has been excluded from participation under Medicare as determined by CMS.

8.14 Termination for Material Breach. Notwithstanding any termination provision in the Agreement, in the event Dentist materially breaches this Agreement, PPP Arkansas may terminate this Agreement immediately. For purposes of these Required Terms, a material breach will have occurred upon the following events including, but not limited to (a) a material violation of PPP Arkansas's or Arkansas Blue Medicare Plan's policies and procedures, or (b) a determination by CMS that Dentist has not satisfactorily performed its obligations under the Agreement.

Access to Care

Provider is to make accessibility, within the usual and customary range of Provider's facilities and personnel, to provide dental and any related health care services to Medicare Advantage members on at least an equal basis and of at least the same high quality as that provided to all other patients of Provider. Provider agrees to provide Covered Services to Medicare Advantage members in accordance with the professional standards of care with which services are provided to all patients of Provider, but, in any event, not less than the standard of care recognized and prevailing for the same or similar services in the Provider's applicable practice area or specialty. Provider hereby warrants and represents to Arkansas Blue Medicare that Provider shall not provide or attempt to provide any dental or health care services for which Provider is not qualified, licensed and accredited or for which Provider has not been credentialed in accordance with Arkansas Blue Medicare's credentialing policies and procedures. Provider further agrees not to bill or allow any person or entity to bill any Payor for services of any assistant or persons working for or under the direct or indirect supervision of Provider unless such individuals (a) are properly licensed to perform the services; and (b) meet the definition of a "Provider" in the Member's applicable Health Plan so as to be eligible for reimbursement under the Health Plan; and (c) perform all services in accordance with applicable law and regulations. Provider agrees that in providing services to Medicare Advantage members, Provider shall not discriminate on the basis of race, color, national origin, ancestry, sex, age, religion, marital status, sexual orientation, disability, health status or source of payment.

Marketing Medicare Advantage

As a participating Medicare Advantage provider you are prohibited from engaging in marketing of Medicare Advantage Plans except as set forth:

- 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 members 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.

Medicare Opt Out

Providers who are Medicare opt out are excluded from participating in any Medicare Advantage network. If you opt out you will have 90 days to change your status, after that you will remain opt out status for two years. Once you become an opt out provider you are no longer eligible to be reimbursed for services provided under Medicare Advantage. If you opt out of Medicare you are still an eligible provider under the Arkansas Blue Cross and Blue Shield PPP network but will be ineligible for the Medicare Advantage plans under this participation.

Section 9: Medicare Advantage Plans

Effective January 1, 2023 Arkansas Blue Medicare will be offering the following plans for its Medicare Advantage members to choose from during the open enrollment period.

- Medicare Advantage HMO
 - BlueMedicare Premier HMO
 - BlueMedicare Independence HMO
 - BlueMedicare Classic Plus HMO
- Medicare Advantage PPO
 - BlueMedicare Saver Choice PPO
 - BlueMedicare Freedom Giveback PPO
 - BlueMedicare Premier Choice PPO
- Medicare Advantage PFFS
 - BlueMedicare Value PFFS
 - BlueMedicare Preferred PFFS

Providers who participate in Arkansas Medicare Advantage dental network may have access to members with these Medicare Advantage plans.

These Medicare Advantage plans cover a limited number of dental services, but those procedures that are covered have a \$0 member copayment in network, with the balance of the allowable charge payable by Arkansas Blue Medicare. Select plans have 30%-50% member copayment. Any dental service not covered by the member's plan may be billed at your usual and customary charge. This does not include procedures that would otherwise be covered but are denied due to frequency limitations having been met. **For dental services not covered by the plan, please notify the members in writing before services are rendered.**

Please be sure to verify eligibility and benefits for all Medicare Advantage members before rendering services, frequencies and limitations vary plan to plan. The diagram below is an **example** of covered procedures, copayments and limitations on one of the various Arkansas Blue Medicare plans.




For Arkansas Blue Medicare eligibility, benefits and claims information please visit our website at <https://www.mydentalcoverage.com/shared/login.shtml> to access online services on MyDentalCoverage or contact customer service at 1-888-224-5213.




Claims can be files electronically using payor ID TLY26 or mail claims to the address listed below.




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

Below are samples of ID Cards.




Arkansas Blue Medicare HMO Member Sample Cards


| | | | |
|---|--------------------|---|--|
|  | | BlueMedicare Classic Plus (HMO) | |
| Enrollee Name Sam Sample | Plan H9699-007 | Rx Bin 004336 | |
| Enrollee ID MCMAB102xxxx | Rx PCN MEDDADV | Rx Group RX17AD | |
| Group Number: 29699 | Issued: 01/2024 | | |
|  | |  | |




| | | | |
|---|--------------------|--|--|
|  | | BlueMedicare Independence (HMO) | |
| Enrollee Name Sam Sample | Plan H6158-003 | Rx Bin 004336 | |
| Enrollee ID MCMAB102xxxx | Rx PCN MEDDADV | Rx Group RX17AC | |
| Group Number: 36158 | Issued: 01/2024 | | |
|  | |  | |

| | | | |
|---|--------------------|---|--|
|  | | BlueMedicare Premier (HMO) | |
| Enrollee Name Sam Sample | Plan H6158-001 | Rx Bin 004336 | |
| Enrollee ID MCMAB102xxxx | Rx PCN MEDDADV | Rx Group RX17AC | |
| Group Number: 16158 | Issued: 01/2024 | | |
|  | |  | |




Arkansas Blue Medicare PPO Member Sample Card




| | | | |
|---|--------------------|---|--|
|  | | BlueMedicare Saver Choice (PPO) | |
| Enrollee Name Sam Sample | Plan H3554-002 | Rx Bin 004336 | |
| Enrollee ID MCMAB102xxxx | Rx PCN MEDDADV | Rx Group RX17AA | |
| Group Number: 23554 | Issued: 01/2024 | | |
|  | |  | |

| | | | |
|---|--------------------|--|--|
|  | | BlueMedicare Freedom Giveback (PPO) | |
| Enrollee Name Sam Sample | Plan H3554-011 | | |
| Enrollee ID MCMAB102xxxx | | | |
| Group Number: 113554 | Issued: 01/2024 | | |
|  | |  | |

| | | | |
|---|--------------------|---|--|
|  | | BlueMedicare Premier Choice (PPO) | |
| Enrollee Name Sam Sample | Plan H3554-007 | Rx Bin 004336 | |
| Enrollee ID MCMAB102xxxx | Rx PCN MEDDADV | Rx Group RX17AA | |
| Group Number: 73554 | Issued: 01/2024 | | |
|  | |  | |

Arkansas Blue Medicare PFFS Member Sample Cards

| | | | |
|---|--------------------|--|--|
|  | | BlueMedicare Value (PFFS) | |
| Enrollee Name Sam Sample | Plan H4213-016 | | |
| Enrollee ID MCMAB102xxxx | | | |
| Group Number: 14213 | Issued: 01/2024 | | |
|  | |  | |

| | | | |
|---|--------------------|--|--|
|  | | BlueMedicare Preferred (PFFS) | |
| Enrollee Name Sam Sample | Plan H4213-017 | Rx Bin 004336 | |
| Enrollee ID MCMAB102xxxx | Rx PCN MEDDADV | Rx Group RX17AB | |
| Group Number: 24213 | Issued: 01/2024 | | |
|  | |  | |

Sample Medicare Advantage Plan

| BlueMedicare | | Copayment/ Coinsurance | |
|----------------------------------|--|---------------------------|--|
| CDT CODE | DESCRIPTION | In-Network Member Pays | Comment |
| CLINICAL ORAL EVALUATIONS | | | |
| D0120 | Periodic oral evaluation | \$0 | Two evaluations per 12 consecutive months (Combined with (D0150) - Max of 2) |
| D0150 | Comprehensive oral evaluation - new or established patient | \$0 | One per lifetime per dentist |
| DIAGNOSTIC IMAGING | | | |

| | | | |
|-----------------------------|---|-----|--|
| D0210 | Intraoral - complete series of radiographic images | \$0 | One set every 36 consecutive months, either D0210 or D0330 |
| D0220 | Intraoral periapical - first radiographic image | \$0 | As needed but are included in the 1 set per year limit |
| D0230 | Intraoral periapical - each additional radiographic image | \$0 | As needed but are included in the 1 set per year limit |
| D0240 | Intraoral - occlusal radiographic image | \$0 | As needed but are included in the 1 set per year limit |
| D0270 | Bitewing - single radiographic image | \$0 | One set per 12 consecutive months - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings. |
| D0272 | Bitewings - two radiographic images | \$0 | |
| D0273 | Bitewings - three radiographic images | \$0 | |
| D0274 | Bitewings - four radiographic images | \$0 | |
| D0277 | Vertical bitewings - 7-8 radiographic images | \$0 | |
| D0330 | Panoramic radiographic image | \$0 | One set every 36 consecutive months, either D0210 or D0330 |
| DENTAL PROPHYLAXIS | | | |
| D1110 | Prophylaxis - adult | \$0 | Two per 12 consecutive months (combined limit for D1110/D4910) |
| RESTORATIVE SERVICES | | | |
| D2140 | Amalgam - one surface, primary or permanent | 50% | One (1) restoration per surface per tooth per twelve (12) month period |
| D2150 | Amalgam - two surfaces, primary or permanent | 50% | |
| D2160 | Amalgam - three surfaces, primary or permanent | 50% | |
| D2161 | Amalgam - four or more surfaces, primary or permanent | 50% | |
| D2330 | Resin-based composite - one surface, anterior | 50% | |
| D2331 | Resin-based composite - two surfaces, anterior | 50% | |
| D2332 | Resin-based composite - three surfaces, anterior | 50% | |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | 50% | |
| D2391 | Resin-based composite - one surface, posterior | 50% | |
| D2392 | Resin-based composite - two surfaces, posterior | 50% | |
| D2393 | Resin-based composite - three surfaces, posterior | 50% | |
| D2394 | Resin-based composite - four or more surfaces, posterior | 50% | |
| PERIODONTICS | | | |
| D4341 | Periodontal scaling and root planning -four or more teeth per quadrant | 50% | One procedure per quadrant every 24 consecutive months, not to exceed four unique quadrants every 24 consecutive months |
| D4342 | Periodontal scaling and root planning - one to three teeth per quadrant | 50% | |

| | | | |
|---------------------------------------|--|-------------|---|
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | 50% | One per 36 month period Not to be completed on the same day as D0150 |
| D4910 | Periodontal maintenance | \$0 | Two per 12 consecutive months (combined limit for D1110/D4910) |
| PROSTHODONTICS, REMOVABLE | | | |
| D5410 | Adjust complete denture - maxillary | \$20 | Two (2) per benefit period |
| D5411 | Adjust complete denture - mandibular | \$20 | |
| D5421 | Adjust partial denture - maxillary | \$20 | |
| D5422 | Adjust partial denture - mandibular | \$20 | |
| D5611 | Repair resin denture base. Mandibular | 50% | Two per 12 consecutive month (either D5611, D5612, D5621, D5622, D5630). Only 2 denture repairs per 12 consecutive month with up to 5 total in 60 consecutive months (not covered within 6 months of placement) - |
| D5612 | Repair resin denture base. Maxillary | 50% | |
| D5621 | Repair cast framework. Maxillary | 50% | |
| D5622 | Repair cast framework. Mandibular | 50% | |
| D5630 | Repair or replace broken clasp | 50% | |
| D5730 | Reline complete maxillary denture (chair side) | 50% | |
| D5731 | Reline complete mandibular denture (chair side) | 50% | One Upper and One Lower in a thirty-six (36) consecutive month period |
| D5740 | Reline maxillary partial denture (chair side) | 50% | |
| D5741 | Reline mandibular partial denture (chair side) | 50% | |
| D5750 | Reline complete maxillary denture (laboratory) | 50% | |
| D5751 | Reline complete mandibular denture (laboratory) | 50% | One Upper and One Lower in a thirty-six (36) consecutive month period |
| D5760 | Reline maxillary partial denture (laboratory) | 50% | |
| D5761 | Reline mandibular partial denture (laboratory) | 50% | |
| ORAL AND MAXILLOFACIAL SURGERY | | | |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | \$20 | up to two per 12 consecutive months (for an erupted tooth OR exposed tooth) includes local anesthetic, suturing and routine postoperative care |
| OTHER | Medicare Covered Services | \$40 | |
| OTHER | Optional Supplemental | No | |
| OTHER | Dental Xtra | Yes | |

Dental Xtra

The oral health of your patients can have a big impact on their overall health, especially if they've been diagnosed with certain medical conditions. For members with medical and dental plans with Arkansas Blue Cross, we're able to review their medical claims to identify and automatically enroll those with qualifying health conditions (listed in the grid below) that benefit from additional dental care. We conduct outreach and education to make sure our members are aware of the positive impacts preventive and/ or periodontal dental services have on their total well-being.

Your Partnership with Arkansas Blue Cross

Our Dental Xtra program allows us to combine expertise in all disciplines of comprehensive care. By partnering with Arkansas Blue Cross, you can help your patients who have medical conditions that might benefit the most from preventive dental care. Through Dental Xtra, you can:

- Help your patients achieve better overall health
- Easily identify patients eligible to enroll, or already enrolled, in the program, so they can take advantage of enhanced dental benefits
- Increase your revenue by providing additional services

Effective 1/1/2023 periodontal scaling and root planing will be covered at 100% when enrolled in the program, regardless of standard benefit coverage (for applicable conditions only).

D4355 full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit will be covered once every 24 months at 100% when enrolled in the program (applicable to all [covered conditions](#)).

Enhanced dental benefits at no additional cost

We've made it easier financially for your patients to take advantage of the program:

- Services do not count toward the annual maximum when seen by a participating provider
- There are no deductibles, copayments or coinsurance, and waiting periods do not apply
- The benefits are worth more than \$1,000 for each enrolled member – additional revenue for your practice

How do my patients enroll?

Members who have medical and dental plans through Arkansas Blue Cross and a qualifying medical condition are auto-enrolled in the program. Members who have only a dental policy with Arkansas Blue Cross or are pregnant must self-enroll. If your patient qualifies and needs to self-enroll, they can do so at <https://www.arkansasbluecross.com/members/dental-xtra/enroll>. Once you have identified members who are enrolled, we encourage setting up their four prophylaxis recalls

For more information about the impact oral health has on the qualifying conditions, please visit:

<https://www.arkansasbluecross.com/members/dental-xtra>

Section 10: General Policies and Procedures

Quality and 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 Arkansas Blue Medicare's Quality Assurance and Utilization Management programs that may include, an on-site review of facilities, on-site 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.

Information Needed to Review a Procedure

Please refer to the 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. The narrative must be legible.

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

- Preoperative radiographic images 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

Advisory Committee

Arkansas Blue Medicare has a Dental Advisory Committee that provides valuable guidance and counsel to Arkansas Blue Medicare regarding various dental issues related to operations and programs. Arkansas Blue Medicare will consider recommendations for new committee members from individual dentists and dental organizations in the community.

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. Fraud Waste and Abuse evaluation by Arkansas Blue Medicare may occur in either prepayment or post payment review.

Section 11: Completing a dental claim form

How to submit a Clean Claim

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 pre-treatment estimate or a claim for actual services rendered.
- 2: Predetermination/Preauthorization Number is not required.

Insurance Company/Dental Benefit Plan Information (block 3)

*For Arkansas Blue Medicare:
Dental Claims Administrator
P.O. Box 69436
Harrisburg, PA 17106-9436*

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) where the patient or subscriber signs to provide consent for treatment and authorization for direct payment.

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.

Please be sure to check the appropriate blocks if treatment is rendered as the result of an accident.

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).*

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 <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. You must submit all claims with your NPI information. See Section 10 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.

Reimbursements

Medicare Advantage Participating providers

Arkansas Blue Medicare 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. Please verify the member's eligibility and benefits prior to rendering services. Medicare Advantage only pays for treatment that is medically necessary. Post-payment review may result in refund to Arkansas Blue Medicare in cases when medical necessity could not be established.

Medicare Advantage Non-Participating providers

Arkansas Blue Medicare will always reimburse claim payments for covered members directly to the members if seen by non-participating providers. Please verify the member's eligibility and benefits prior to rendering services. Blue Medicare PPO plans offer out of network benefits that may be at a higher copay, coinsurance or out of pocket expense for the member. Blue Medicare HMO plans do not allow out of network benefits. Non-participating providers should notify the member of participation status prior to services being rendered.

Medicare Opt Out providers

Arkansas Blue Cross will not provide reimbursement for any service provided by a participating or non-participating provider if they are opt out of Medicare.

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. Prior to rendering Non-Covered Service(s) you need to inform the Member and obtain the Member's written acknowledgment that he or she has been informed of the nature of the service, why it is not a covered benefit and that the Member is personally and financially liable for payment of the Non-Covered Service(s). Amounts due for the Non-Covered Service(s) may then be billed to the Member at the Dentist's usual and customary charge(s).

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 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 | Allowed Amount | Member's Co-insurance |
|----------------|--------------|------------------------|----------------|----------------------------|
| D2150 | Basic | 80% | \$100 | $\$100 \times 20\% = \20 |

The member's Co-insurance is based on a percentage of your Arkansas Blue Medicare 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.

Section 12: Coordination of Benefits (COB)

Determining the Primary Payor

The first of the following rules applicable shall be used by Arkansas Blue Medicare 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 benefits of the plan of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the dental plan of the parent whose birthday, excluding the year of birth, falls later in the year; but
 - 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 this 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.

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

payor 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 also 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:

1. Indemnity
2. Excess insurance
3. Specified illness or accident
4. Medicare supplement

Determining Your Patient's Liability in a COB Situation

- 1) If the Arkansas Blue Medicare Plans are 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 Arkansas Blue Medicare Plans 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 or not a claim is made, exceeds those Allowable Expenses in a claim determination period. In that case, the benefits of the Arkansas Blue Medicare plans 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 Arkansas Blue Medicare Plans are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Arkansas Blue Medicare Plan.

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.
- Submit the primary payor's Explanation of Benefits (EOB) to the secondary payor (even if both payors are Arkansas Blue Medicare).
- 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.
- If the provider receives payment in excess of actual charges and has collected a copayment, deductible or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the copayment, deductible or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

Section 13: Member Enrollee Rights

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

- To be treated with respect, dignity and privacy.
- To receive care – Regardless of race, color, nationality, ethnicity, disability, health status, sexual orientation, religion, age, genetic information.
- To obtain accurate, easy to understand information used to make educated decisions.
- To file a complaint or Grievance about a dentist or the care received.
- To file an Appeal about an action or decision made.
- To have Online Provider Directory for access to care.
- To take part in all decisions about their dental care. This may include refusing treatment.
- To obtain a second opinion from another dentist regarding treatment.
- To be treated fairly by us, Participating Dentists and other dentists.
- Have dental records kept private.
- Access to a copy of dental records.
- To understand 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 a spoken translation at no cost for all non-English languages, not only those identified as prevalent.
- To have their privacy protected in accordance with the privacy requirements in federal law.
- To receive detailed information on emergency and after-hours coverage.
- To understand what constitutes an emergency medical condition, Emergency Dental Care, and post-Stabilization Services.
- To Understand Emergency Dental Care does not require prior approval.
- The process and procedures for obtaining Emergency Dental Care.

Section 14: Appeals and Grievances

A member, a provider, a third party representative acting on behalf of the member or a provider acting on behalf of the member, may file an Appeal or Grievance if they are dissatisfied with their service or there is a benefit or service eligibility discrepancy that resulted in a denial, reduction of payment or termination of or failure to make payment (in whole or in part). If a third party representative is filing an Appeal on behalf of a member, HIPAA Authorization is required.

Process

Arkansas Blue Medicare receives an inquiry request regarding an Appeal or Grievance via a phone call. The Customer Service Representative will ask the caller to put their request in writing and forward to:

**Arkansas Blue Medicare Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437**

If the inquiry is regarding **Quality of Care or Quality of Service**, it must be in writing and is handled by the Quality Assurance Area of Arkansas Blue Medicare's Dental Administrator. (Refer to Grievance Processing – Quality of Care & Quality of Service document). A Customer Service Representative will ask the caller to put their request in writing and forward to:

**Arkansas Blue Medicare Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437**

Our Dental Claims Administrator will determine if a group has a specific Appeal or Grievance process. If so, the group's Appeal or Grievance process is followed.

If there is not a group specific Appeal or Grievance process, our Dental Claims Administrator will determine if there is a State Appeal or Grievance process that needs to be followed. The Appeal or Grievance process will be followed based upon the State where the Group is located.

If there is no State Appeal or Grievance process: Our Dental Claims Administrator will follow the Arkansas Blue Medicare Appeals process. All Arkansas Blue Medicare Appeals and Grievances resulting in a financial or clinical adverse determination will be forwarded to the LSV Dental Director for final determination.

Section 15: Termination

The initial term of the Dental Network Participation Agreement is one year from the effective date. The Agreement shall automatically renew at the end of the initial term and continue in effect until terminated in accordance with such Agreement.

Types of Termination and Effective Dates

- 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 onfile. For Arkansas Blue Medicare, that address is:

Dental Provider Relations
P. O. Box 1650
Little Rock, AR 72203

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

- 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 Arkansas Blue Medicare. The "Agreement" consists of the Agreement, Dental Manual, MA Manual and any Amendments to the Agreement. Arkansas Blue Medicare 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, Arkansas Blue Medicare 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.

Arkansas Blue Medicare may terminate your Participating Provider Agreement immediately, upon written notice, if you fail to satisfy the requirements set forth in the Conditions of Participation.