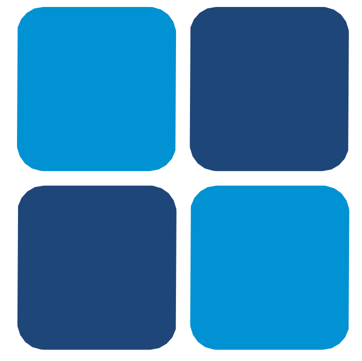

2021 Medicare Advantage Dental Manual

A Dental Administrative Guide

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

August 2021

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 and www.healthadvantage-hmo.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 theParticipating Provider Agreement are set forth in this section of the Dental Manual.

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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage. 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: 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 and Health Advantage Medicare Advantage in a timely manner of anymaterial changes in that information.

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Confidential Information	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").
	Confidential Information does not include information that: 1. Is based on documents in the Receiving Party's possession prior to disclosure of Information that was notacquired 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)	The determination of which Payors have primary and secondary responsibilities for paying for Covered Services in accordance with the rules set forth in the Member's Benefit Plan when that Member is eligible for Covered Services from more than one payor, including from a governmental or self-funded payor.
Copayment	A fixed-dollar amount that a Network Dentist must collect directly from a Member as a portion of the Maximum Allowable Charge forCovered Services.
Cost Sharing	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.
Covered Services	Necessary and Appropriate dental care services and supplies rendered to Members in accordance with the terms of the Member's Benefit Plan, the applicable Dental Manual and the Agreement.
Denied	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 hasagreed to pay for the service(s).
Downstream Entity	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.

Term	Definition
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 and Health Advantage Medicare Advantage, that provide administrative services or health care services toMedicare 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 and Health Advantage Medicare Advantage
	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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage maydeny 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 and Health Advantage Medicare Advantage, a Medicare Advantage Organization offering MedicareAdvantage 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 and Health Advantage Medicare Advantage 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: 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: 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage to participate in its Dental Network.
Provider Network	A group of Dentists who contract with Arkansas Blue Medicare and Health Advantage Medicare Advantage to renderCovered Services to Members.

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Pre-authorization	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. Preauthorization is subject to: • 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	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: • 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	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.
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 and Dental providers - Health Advantage (healthadvantage-hmo.com)

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

- ☐ Select My Patient's Benefits
- ☐ 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 at1-888-224-5213 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

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 www.arkansasbluecross.com/providers/resource-center/provider-forms and healthadvantage-hmo.com. 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 and Health Advantage Medicare Advantage 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 orsubject 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, restrictedor 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 publiclytraded 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 and Health Advantage Medicare Advantage when you begin or cease to accept new patients, or begin orcease 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
General location/contact information(telephone, fax, etc.)	Submit a provider information change form located on ourwebsite at www.arkansasbluecross.com and www.healthadvantage-hmo.com under the Providers tab; Fax request to (501) 208-8302 or email to DentalProviderRelations@uasblelife.com.
Employer Identification Number (EIN) orTaxpayer Identification Number (TIN)	Any changes to your (EIN) Employer Identification Numberor (TIN) Taxpayer Identification Number, submit a Provider information change form, W-9. Forms are located on our website at www.arkansasbluecross.com and www.healthadvantage-hmo.comunder the Providers/Resource tab. Submit with original signatures and fax (501) 208-8302 or email to DentalProviderRelations@uasblelife.com.
Associate dentist/orthodontist who has leftyour practice	Send a letter of termination on the Practice letterhead witha 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 yourpractice	Submit a credentialing application if the provider is not credentialed with Arkansas Blue Medicare and Health Advantage Medicare Advantage, 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 and www.healthadvantage-hmo.com.
Terminate participation in a networkRequires 90 day written notification	Send a letter of termination on your practice letterhead witha 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 existingEmployer Taxpayer identification number (TIN) on file.	Submit an Abbreviated Application. Forms are located on our website at www.arkansasbluecross.com and www.healthadvantage-hmo.com.
Terminate Arkansas Blue Medicare and Health Advantage Medicare Advantage Contract	Contact your Dental Network Manager.

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Provider Data Accuracy and Validation

Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage

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 and Health Advantage Medicare Advantage 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).

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    - 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 and Health Advantage Medicare Advantage Responsibilities

Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage's marketing program. Arkansas Blue Medicare and Health Advantage Medicare Advantage will also provide other programs that support, service and educate the Dentists and office staffs in conformity with Arkansas Blue Medicare and Health Advantage Medicare Advantage's programs then in effect.

Section 5: Working with Arkansas Blue Medicare and Health Advantage Medicare Advantage

What We Offer You

At Arkansas Blue Medicare and Health Advantage Medicare Advantage, 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 and Health Advantage Medicare Advantage network, which gives you:
  - Access to more than 73,000 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 and http://www.healthadvantage-hmo.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 and Health Advantage Medicare Advantage on Grievances and Appeals.
- File an appeal about an action or decision made by Arkansas Blue Medicare and Health Advantage Medicare Advantage.
- Be notified of any decision to deny services.
- Exercise these rights without adversely affecting how Arkansas Blue Medicare and Health Advantage Medicare Advantage treats you.

Section 6: Conditions of Participation in Our Network

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

General Conditions	• Dentist must complete a Provider Application with associated attachments. Found online at: http://www.arkansasbluecross.com/providers/resource-center/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.
Standards and Requirements	• 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. • 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 Heath 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage. • 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 policiesand 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 allother 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 and Health Advantage Medicare Advantage'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 and Health Advantage Medicare Advantage's obligations to CMS set forth inthe QHP Issuer Agreement. Dentist agrees that in no event, including, but not limited to non-payment by Arkansas Blue Medicare and Health Advantage Medicare Advantage, insolvency of Arkansas Blue Medicare and Health Advantage Medicare Advantage, 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 Health Advantage Medicare Advantage 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 Health Advantage Medicare Advantage 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 Health Advantage Medicare Advantage and shall provide such records and reports to Arkansas Blue Medicare and Health Advantage Medicare Advantage to enable Arkansas Blue Medicare and Health Advantage Medicare Advantage and Medicare Advantage Plan to meet their obligations to submit such information to CMS and to disclose certaininformation 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 bywritten 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 electronicsystems 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 and Health Advantage Medicare Advantage, 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 and Health Advantage Medicare Advantage 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, norits Affiliated Parties or Downstream Entities have been suspended orexcluded 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) andthe 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

Contractual Conditions	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 anyof 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 Medicare Advantage members. Arkansas Blue Medicare and Health Advantage Medicare Advantage reserves the right to require Dentist to demonstrate compliance with this provision upon reasonable request. • Dentist shall cooperate with Arkansas Blue Medicare and Health Advantage Medicare Advantage'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 and Health Advantage Medicare Advantage a copy of audit results and shall make all audit materials availableto Arkansas Blue Medicare and Health Advantage Medicare Advantage upon request. • Arkansas Blue Medicare and Health Advantage Medicare Advantage will monitor the performance of Dentist on an ongoing basis. Arkansas Blue Medicare and Health Advantage Medicare Advantage's monitoring activities include assessing Dentist and DownstreamEntities' compliance with applicable Medicare Advantage Program and QHP provisions,including the Required Terms. • Arkansas Blue Medicare and Health Advantage Medicare Advantage 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, orany Affiliated Party employed by Dentist, has been excluded from participation under Medicare as determined by CMS. • Notwithstanding any termination provision in the Agreement, in theevent Dentist materially breaches this Amendment, Arkansas Blue Medicare and Health Advantage Medicare Advantage 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) amaterial violation of Arkansas Blue Medicare and Health Advantage Medicare Advantage'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 and Health Advantage Medicare Advantage to safeguard our members' protected health information (PHI). Since the Privacy Rule applies to payors and providers, Arkansas Blue Medicare and Health Advantage Medicare Advantage shares with you the responsibility of protecting privacy. The HIPAA Privacy Rule allows for Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 USAble Mutual Company, d/b/a Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage Plan will review the credentials of Dentist and other medical professionals affiliated with Dentist or the Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage Plan's relevant written policies and procedures, including policies and procedures for the control of fraud, waste and abuse in the Arkansas Blue Medicare and Health Advantage 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.

8.3 Consistency with Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage Plan and Arkansas Blue Medicare and Health Advantage Medicare Advantage Plan's obligations to CMS set forth in the Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage Member or a person acting on behalf of an Arkansas Blue Medicare and Health Advantage Medicare Advantage Member for Covered Services provided pursuant to this Agreement. This Agreement does not prohibit Dentist from collecting Arkansas Blue Medicare and Health Advantage Medicare Advantage Member Cost Sharing, as specifically provided in the Plan Description, or fees for non-covered services as long as Arkansas Blue Medicare and Health Advantage Medicare Advantage Member has been informed in advance that services are not covered and that Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage Plan are required under applicable federal law and regulations to submit to CMS certain information regarding the benefits provided by Arkansas Blue Medicare and Health Advantage Medicare Advantage Plan and quality and performance indicators. Dentist acknowledges that PPP Arkansas and Arkansas Blue Medicare and Health Advantage Medicare Advantage Plan may be required under such laws and regulations to disclose certain information to Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage Plan to meet their obligations to submit such information to CMS and to disclose certain information to Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage 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. 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage 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, 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage 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.

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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage'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 PPO network but will be ineligible for the Medicare Advantage plans under this participation.

Section 9: Medicare Advantage Plans

Effective January 1, 2021 Arkansas Blue Medicare and Health Advantage Medicare Advantage 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
  - Health Advantage Classic HMO
  - Health Advantage Blue Premier HMO
- Medicare Advantage PPO
  - BlueMedicare Saver Choice PPO
  - BlueMedicare Value Choice PPO
  - BlueMedicare Premier Choice PPO
- Medicare Advantage PFFS
  - BlueMedicare Value PFFS
  - BlueMedicare Preferred PFFS

Providers who participate in Arkansas Blue Cross and Blue Shield PPO 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 and Health Advantage Medicare Advantage. 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.

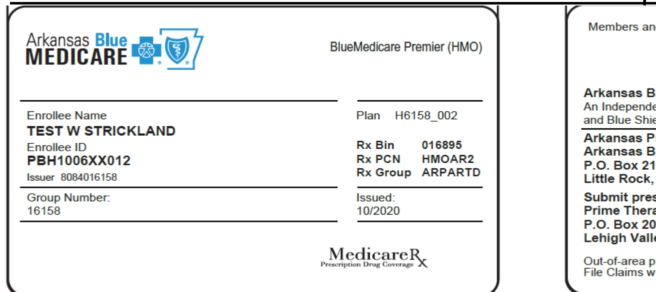
For Arkansas Blue Medicare and Health Advantage Medicare Advantage eligibility, benefits and claims information please visit our website at https://www.mydentalcoverage.com/shared/login.shtml to access online services on My Patient Benefits or contact customer service at 1-888-224-5213.

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

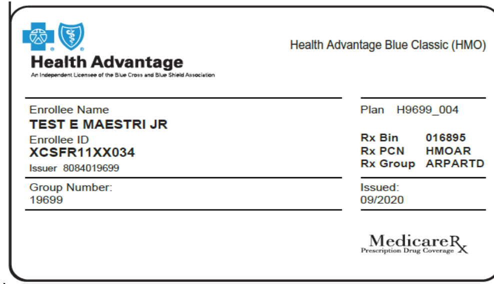
Dental Claims Administrator
P. O. Box 69436
Harrisburg, PA 17106-9436

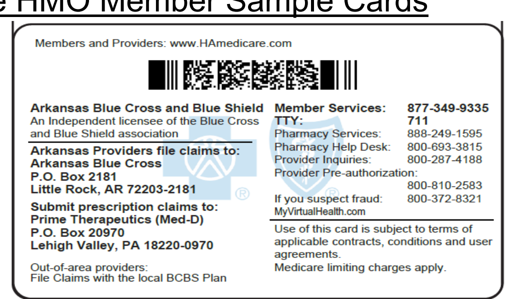
The diagrams below list the plan's covered procedures, copayments and limitations for the various Arkansas Blue Medicare and Health Advantage Medicare Advantage plans. Below are samples of ID Cards.

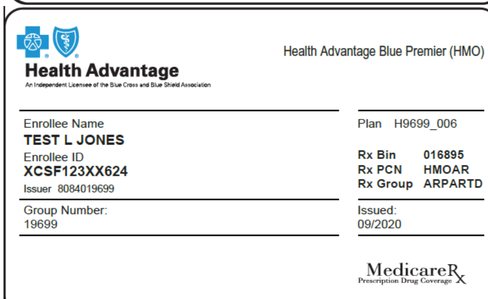
Arkansas Blue Medicare HMO Member Sample Card

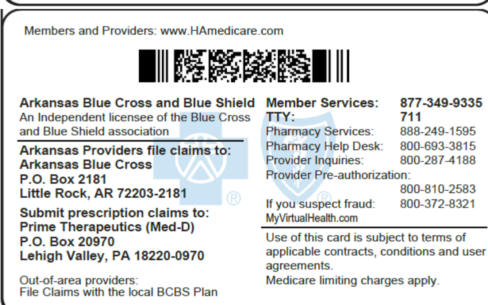


Health Advantage Medicare Advantage HMO Member Sample Cards

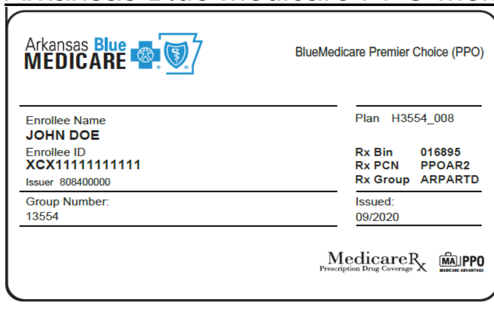


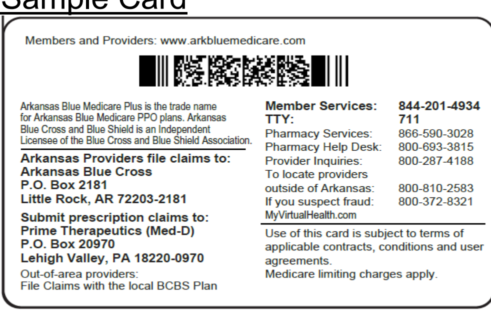




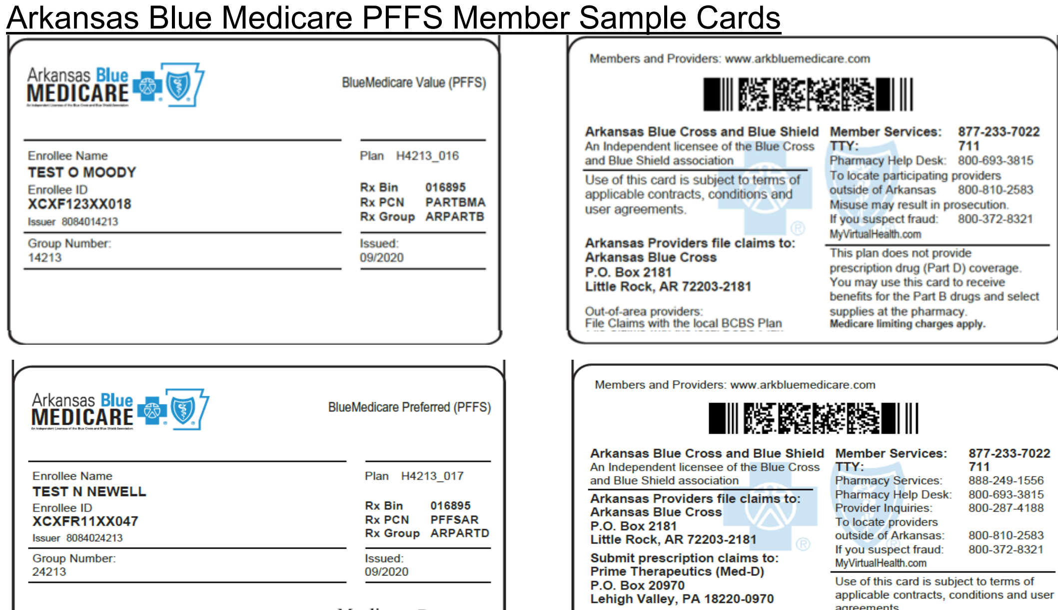


Arkansas Blue Medicare PPO Member Sample Card





Arkansas Blue Medicare PFFS Member Sample Cards



Medicare Advantage Plans

Health Advantage Classic HMO					
PROC CODE	**ADA TYPE**	**PROCEDURE DESCRIPTION**	**PROC CLASS**	**BENEFIT SPECIFICS 2021 Health Advantage Classic HMO- Plan 20**	**2021 COPAY AMOUNT**
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0150) - Max of 2)	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 cleanings per 12 consecutive months	$10
OTHER		**Medicare Covered Services**			**$40**
OTHER		**Optional Supplemental**			**No**
OTHER		**Dental Xtra**			**No**

Plan Number: H9699-004- HEALTH ADVANTAGE BLUE CLASSIC HMO

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Health Advantage Classic HMO

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 Health Advantage Classic HMO-Plan 15	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0120,D0140, D0150, D0160) max of 2)	$0
D0140	DIAGNOSTIC	Limited oral evaluation - problem focused	PREVENTIVE	One procedure per plan year	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0160	DIAGNOSTIC	Detailed and exensive problem focused exam	PREVENTIVE	One procedure per plan year	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0220	DIAGNOSTIC	Intraoral periapical - first radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0230	DIAGNOSTIC	Intraoral periapical - each additional radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0240	DIAGNOSTIC	Intraoral - occlusal radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 per 12 consecutive months (combined limit for D1110/D4910)	$0
D1206	PREVENTIVE	Topical application of fluoride varnish	PREVENTIVE	Two procedures per plan year	$0
D1208	PREVENTIVE	Topical application of fluoride - excluding varnish	PREVENTIVE		$0
D1310	PREVENTIVE	Nutritional Counseling	PREVENTIVE	One procedure per plan year	$0
D1354	RESTORATIVE	Application of medication to a tooth to stop or inhibit cavity formation	PREVENTIVE	Unlimited per plan year	$0
D2140	RESTORATIVE	Amalgam - one surface, primary or permanent	MAJOR	Two (2) restorations per twelve (12) month period	50%
D2150	RESTORATIVE	Amalgam - two surfaces, primary or permanent	MAJOR		50%
D2160	RESTORATIVE	Amalgam - three surfaces, primary or permanent	MAJOR		50%
D2161	RESTORATIVE	Amalgam - four or more surfaces, primary or permanent	MAJOR		50%
D2330	RESTORATIVE	Resin-based composite - one surface, anterior	MAJOR		50%
D2331	RESTORATIVE	Resin-based composite - two surfaces, anterior	MAJOR		50%
D2332	RESTORATIVE	Resin-based composite - three surfaces, anterior	MAJOR		50%
D2335	RESTORATIVE	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	MAJOR		50%
D2391	RESTORATIVE	Resin-based composite - one surface, posterior	MAJOR		50%
D2392	RESTORATIVE	Resin-based composite - two surfaces, posterior	MAJOR		50%
D2393	RESTORATIVE	Resin-based composite - three surfaces, posterior	MAJOR		50%
D2394	RESTORATIVE	Resin-based composite - four or more surfaces, posterior	MAJOR		50%
D2510	RESTORATIVE	Inlay - metallic - one surface	MAJOR		50%
D2520	RESTORATIVE	Inlay - metallic - two surfaces	MAJOR		50%

D2530	RESTORATIVE	Inlay - metallic - three or more surfaces	MAJOR		50%
D2542	RESTORATIVE	Onlay - metallic - two surfaces	MAJOR		50%
D2543	RESTORATIVE	Onlay - metallic - three surfaces	MAJOR		50%
D2544	RESTORATIVE	Onlay - metallic - four or more surfaces	MAJOR		50%
D2610	RESTORATIVE	Inlay - porcelain/ceramic - one surface	MAJOR		50%
D2620	RESTORATIVE	Inlay - porcelain/ceramic - two surfaces	MAJOR		50%
D2630	RESTORATIVE	Inlay - porcelain/ceramic - three or more surfaces	MAJOR		50%
D2642	RESTORATIVE	Onlay - porcelain/ceramic, two surface	MAJOR		50%
D2643	RESTORATIVE	Onlay - porcelain/ceramic - three surface	MAJOR		50%
D2644	RESTORATIVE	Onlay - porcelain/ceramic - four or more surfaces	MAJOR		50%
D2710	RESTORATIVE	Crown - resin-based composite (indirect)	MAJOR	One Crown per Year	50%
D2740	RESTORATIVE	Crown - porcelain/ceramic substrate	MAJOR		50%
D2750	RESTORATIVE	Crown - porcelain fused to high noble metal	MAJOR		50%
D2751	RESTORATIVE	Crown - porcelain fused to predominantly base metal	MAJOR		50%
D2752	RESTORATIVE	Crown - porcelain fused to noble metal	MAJOR		50%
D2790	RESTORATIVE	Crown - full cast high noble metal	MAJOR		50%
D2791	RESTORATIVE	Crown - full cast predominantly base metal	MAJOR		50%
D2792	RESTORATIVE	Crown - full cast noble metal	MAJOR		50%
D2794	RESTORATIVE	Crown - titanium	MAJOR		50%
D2910	RESTORATIVE	Re-cement inlay, onlay, or partial coverage restoration	MAJOR		50%
D2920	RESTORATIVE	Re-cement crown	MAJOR	Unlimited per plan year	50%
D2930	RESTORATIVE	Prefabricated stainless steel crown - primary tooth	MAJOR	Unlimited per plan year	50%
D2940	RESTORATIVE	Protective restoration	MAJOR	Unlimited per plan year	50%
D2949	RESTORATIVE	Small filling needed prior to fitting a tooth with a crown	MAJOR	One procedure per tooth every five plan years Performed together with a crown	50%
D2950	RESTORATIVE	Core build-up, including any pins when required	MAJOR		50%
D2951	RESTORATIVE	Pin retention - per tooth, in addition to restoration	MAJOR	One (1) per year	50%
D2952	RESTORATIVE	Post and core in addition to crown, indirectly fabricated	MAJOR	One (1) per year	50%
D2954	RESTORATIVE	Prefabricated post and core in addition to crown	MAJOR	One procedure per tooth every five plan years Has to be performed together with a crown. Tooth also has to have had root canal treatment	50%
D3110	ENDODONTIC	Pulp cap - direct (excluding final restoration)	MAJOR	Unlimited per plan year	50%
D3120	ENDODONTIC	Pulp-cap - Indirect (excluding final restoration)	MAJOR		50%
D3220	ENDODONTIC	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentincomental junction and application of medicament	MAJOR	One procedure per calendar year (limited to one from all covered codes)	50%
D3310	ENDODONTIC	Endodontic therapy, anterior tooth (excluding final restoration	MAJOR		50%
D3320	ENDODONTIC	Endodontic therapy, bicuspid tooth (excluding final restoration	MAJOR		50%
D3330	ENDODONTIC	Endodontic therapy, molar (excluding final restoration	MAJOR		50%
D3346	ENDODONTIC	Retreatment or previous root canal therapy - anterior	MAJOR		50%
D3347	ENDODONTIC	Retreatment or previous root canal therapy - bicuspid	MAJOR		50%
D3348	ENDODONTIC	Retreatment or previous root canal therapy -molar	MAJOR		50%

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D4341	PERIODONTICS	Periodontal scaling and root planning - four or more teeth per quadrant	MAJOR	One procedure per quadrant every two years, not to exceed four unique quadrants every two years	50%
D4342	PERIODONTICS	Periodontal scaling and root planning - one to three teeth per quadrant	MAJOR		50%
D4355	PERIODONTICS	Full mouth debridement to enable comprehensive evaluation and diagnosis	MAJOR	1 per 36 month period Not to be completed on the same day as D0150, D0160, or D0180	50%
D4381	PERIODONTICS	Medicine applied to gum space around a tooth (per tooth) for management of gum disease	MAJOR	Unlimited per plan year	50%
D4910	PROST,REMV	Periodontal maintenance	MAJOR	2 per 12 consecutive months (combined limit for D1110/D4910)	50%
D5110	PROST,REMV	Complete denture - maxillary	MAJOR	1 set of full or partial dentures every 5 years	50%
D5120	PROST,REMV	Complete denture - mandibular	MAJOR		50%
D5130	PROST,REMV	Immediate denture - maxillary	MAJOR		50%
D5140	PROST,REMV	Immediate denture - mandibular	MAJOR		50%
D5211	PROST,REMV	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	MAJOR		50%
D5212	PROST,REMV	Mandibular partial denture - resin base (inc. any conventional clasps, rests and teeth)	MAJOR		50%
D5213	PROST,REMV	Maxillary partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5214	PROST,REMV	Mandibular partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5221	PROST,REMV	Upper partial denture delivered at the time of extractions - resin base	MAJOR		50%
D5222	PROST,REMV	Lower partial denture delivered at the time of extractions - resin base	MAJOR		50%
D5225	PROST,REMV	Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)	MAJOR		50%
D5226	PROST,REMV	Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth	MAJOR		50%
D5410	PROST,REMV	Adjust complete denture - maxillary	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5411	PROST,REMV	Adjust complete denture - mandibular	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5421	PROST,REMV	Adjust partial denture - maxillary	MAJOR	Two procedures per denture per year of delivery of new partial denture Cannot be billed within 6 months of placement	50%
D5422	PROST,REMV	Adjust partial denture - mandibular	MAJOR		50%
D5511	PROST,REMV	Repair broken complete denture base, mandibular	MAJOR	2 per Calendar Year (Either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, OR D5660) Only 2 denture repairs per 1 calendar year with upto 5 total in 5 calendar years (Not Covered within 6 months of placement)	50%
D5512	PROST,REMV	Repair broken complete denture base, maxillary	MAJOR		50%
D5520	PROST,REMV	Replace missing or broken teeth - complete denture (each tooth)	MAJOR		50%
D5611	PROST,REMV	Repair resin denture base. Mandibular	MAJOR		50%
D5612	PROST,REMV	Repair resin denture base. Maxillary	MAJOR		50%
D5621	PROST,REMV	Repair cast framework. Maxillary	MAJOR		50%
D5622	PROST,REMV	Repair cast framework. Mandibular	MAJOR		50%
D5630	PROST,REMV	Repair or replace broken clasp	MAJOR		50%
D5640	PROST,REMV	Replace broken teeth - per tooth	MAJOR		50%
D5650	PROST,REMV	Add tooth to existing partial denture	MAJOR		50%
D5660	PROST,REMV	Add clasp to existing partial denture	MAJOR		50%

D5710	PROST,REMV	Rebase complete maxillary denture	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5711	PROST,REMV	Rebase complete mandibular denture	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5730	PROST,REMV	Reline complete maxillary denture (chair side)	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5731	PROST,REMV	Reline complete mandibular denture (chair side)	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5740	PROST,REMV	Reline maxillary partial denture (chair side)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5740 or D5760)	50%
D5741	PROST,REMV	Reline mandibular partial denture (chair side)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5741 or D5761)	50%
D5750	PROST,REMV	Reline complete maxillary denture (laboratory)	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5751	PROST,REMV	Reline complete mandibular denture (laboratory)	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5760	PROST,REMV	Reline maxillary partial denture (laboratory)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5740 or D5760)	50%
D5761	PROST,REMV	Reline mandibular partial denture (laboratory)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5741 or D5761)	50%
D5850	PROST,REMV	Tissue conditioning, maxillary	MAJOR	Two of each type of procedure per denture per plan year Cannot be billed within 6 months of delivery of the new denture.	50%
D5851	PROST,FIXED	Tissue conditioning, mandibular	MAJOR		50%
D6210	PROST,FIXED	Pontic - cast high noble metal	MAJOR	One procedure per tooth every five plan years Does not cover any part of an implant supported bridge.	50%
D6211	PROST,FIXED	Pontic - cast predominantly base metal	MAJOR		50%
D6212	PROST,FIXED	Pontic - cast noble metal	MAJOR		50%
D6214	PROST,FIXED	Pontic - titanium and titanium alloys	MAJOR		50%
D6240	PROST,FIXED	Pontic - porcelain fused to high noble metal	MAJOR		50%
D6241	PROST,FIXED	Pontic - porcelain fused to predominantly base metal	MAJOR		50%
D6242	PROST,FIXED	Pontic - porcelain fused to noble metal	MAJOR		50%
D6245	PROST,FIXED	Pontic - porcelain/ceramic	MAJOR		50%
D6740	PROST,FIXED	Crown - porcelain/ceramic	MAJOR	One procedure per tooth every five plan years Does not cover any part of an implant supported bridge.	50%
D6750	PROST,FIXED	Crown - porcelain fused to high noble metal	MAJOR		50%
D6751	PROST,FIXED	Crown - porcelain fused to predominantly base metal	MAJOR		50%
D6752	PROST,FIXED	Crown - porcelain fused to noble metal	MAJOR		50%
D6790	PROST,FIXED	Crown - full cast high noble metal	MAJOR		50%
D6791	PROST,FIXED	Crown - full cast predominantly base metal	MAJOR		50%
D6792	PROST,FIXED	Crown - full cast noble metal	MAJOR		50%
D6794	PROST,FIXED	Retainer crown - titanium and titanium alloys	MAJOR		50%
D6930	PROST,FIXED	Recement fixed partial denture	MAJOR	Unlimited per plan year Does not cover cementing a bridge on the day of initial bridge delivery	50%
D7111	ORAL, MAXIO SURGERY	Extraction, corneal remnants - deciduous tooth	MAJOR	Maximum 2 per year (limited to two from all covered codes - D7111-D7250)	50%
D7140	ORAL, MAXIO SURGERY	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	MAJOR		50%

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D7210	ORAL, MAXIO SURGERY	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	MAJOR		50%
D7220	ORAL, MAXIO SURGERY	Removal of impacted tooth - soft tissue	MAJOR		50%
D7230	ORAL, MAXIO SURGERY	Removal of impacted tooth - partially bony	MAJOR		50%
D7240	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony	MAJOR		50%
D7241	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony, with unusual surgical complications	MAJOR		50%
D7250	ORAL, MAXIO SURGERY	Surgical removal of residual roots (cutting procedure)	MAJOR		50%
D7310	ORAL, MAXIO SURGERY	Alveoloplasty, in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	MAJOR	Maximum 2 per year (limited to two from all covered codes D7310-D7511)	50%
D7311	ORAL, MAXIO SURGERY	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	MAJOR		50%
D7320	ORAL, MAXIO SURGERY	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant	MAJOR		50%
D7321	ORAL, MAXIO SURGERY	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	MAJOR		50%
D7510	ORAL, MAXIO SURGERY	Incision and drainage of abscess - intraoral soft tissue	MAJOR		50%
D7511	ORAL, MAXIO SURGERY	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	MAJOR		50%
D7880	ORAL, MAXIO SURGERY	Splint used to treat the TMJ	MAJOR	One procedure every three years	50%
D9110	ANESTHESIA	Palliative (emergency) treatment. of dental pain, minor procedure	MAJOR	Two procedures per calendar year-Not a covered benefit when reported with other definitive services on same treatment date.	50%
D9222	ANESTHESIA	Deep sedation/general anesthesia - first 15 min.	MAJOR	Covered when provided with covered surgical procedure. The number of 15 minute increments need to be reported. Contract limitation of 60 minutes per session.	50%
D9223	ANESTHESIA	Deep sedation/general anesthesia – each 15 minute increment	MAJOR		50%
D9230	ANESTHESIA	Nitrous oxide	MAJOR	No limit	50%
D9239	ANESTHESIA	Intravenous moderate (conscious) secdation/analgesia first 15 minutes	MAJOR	Covered when provided with covered surgical procedure. The number of 15 minute increments need to be reported. Contract limitation of 60 minutes per session.	50%
D9243	PROFESSIONAL CONSULTATION	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	MAJOR		50%
D9910	PROFESSIONAL VISITS	Application of desensitizing agent to a tooth or teeth	MAJOR	Unlimited per plan year	50%
D9943	PROFESSIONAL VISITS	Adjustment of occlusal guard	MAJOR	Two procedures per year	50%
D9944	PROFESSIONAL VISITS	top or bottom, full arch hard occulsal guard	MAJOR	One procedures every three plan years	50%
OTHER		**Medicare Covered Services**			**20% coinsurance**
OTHER		**Optional Supplemental**			**No**
OTHER		**Dental Xtra**			**Yes**

Plan Number: H9699-006- HEALTH ADVANTAGE BLUE CLASSIC HMO

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Classic BlueMedicare Premier

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 BlueMedicare Premier HMO Plan 13	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0120,D0140, D0150, D0160) max of 2)	$0
D0140	DIAGNOSTIC	Limited oral evaluation - problem focused	PREVENTIVE	One procedure per plan year	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0160	DIAGNOSTIC	Detailed and exensive problem focused exam	PREVENTIVE	One procedure per plan year	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0220	DIAGNOSTIC	Intraoral periapical - first radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0230	DIAGNOSTIC	Intraoral periapical - each additional radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0240	DIAGNOSTIC	Intraoral - occlusal radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 per 12 consecutive months (combined limit for D1110/D4910)	$0
D1206	PREVENTIVE	Topical application of fluoride varnish	PREVENTIVE	Two procedures per plan year	$0
D1208	PREVENTIVE	Topical application of fluoride - excluding varnish	PREVENTIVE		$0
D1310	PREVENTIVE	Nutritional Counseling	PREVENTIVE	One procedure per plan year	$0
D1354	PREVENTIVE	Application of medication to a tooth to stop or inhibit cavity formation	PREVENTIVE	Unlimited per plan year	$0
D2140	RESTORATIVE	Amalgam - one surface, primary or permanent	MAJOR	Six (6) restorations per twelve (12) month period	50%
D2150	RESTORATIVE	Amalgam - two surfaces, primary or permanent	MAJOR		50%
D2160	RESTORATIVE	Amalgam - three surfaces, primary or permanent	MAJOR		50%
D2161	RESTORATIVE	Amalgam - four or more surfaces, primary or permanent	MAJOR		50%
D2330	RESTORATIVE	Resin-based composite - one surface, anterior	MAJOR		50%
D2331	RESTORATIVE	Resin-based composite - two surfaces, anterior	MAJOR		50%
D2332	RESTORATIVE	Resin-based composite - three surfaces, anterior	MAJOR		50%
D2335	RESTORATIVE	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	MAJOR		50%
D2391	RESTORATIVE	Resin-based composite - one surface, posterior	MAJOR		50%
D2392	RESTORATIVE	Resin-based composite - two surfaces, posterior	MAJOR		50%
D2393	RESTORATIVE	Resin-based composite - three surfaces, posterior	MAJOR		50%
D2394	RESTORATIVE	Resin-based composite - four or more surfaces, posterior	MAJOR		50%
D2510	RESTORATIVE	Inlay - metallic - one surface	MAJOR		50%
D2520	RESTORATIVE	Inlay - metallic - two surfaces	MAJOR		50%
D2530	RESTORATIVE	Inlay - metallic - three or more surfaces	MAJOR		50%

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D2542	RESTORATIVE	Onlay - metallic - two surfaces	MAJOR		50%
D2543	RESTORATIVE	Onlay - metallic - three surfaces	MAJOR		50%
D2544	RESTORATIVE	Onlay - metallic - four or more surfaces	MAJOR		50%
D2610	RESTORATIVE	Inlay - porcelain/ceramic - one surface	MAJOR		50%
D2620	RESTORATIVE	Inlay - porcelain/ceramic - two surfaces	MAJOR		50%
D2630	RESTORATIVE	Inlay - porcelain/ceramic - three or more surfaces	MAJOR		50%
D2642	RESTORATIVE	Onlay - porcelain/ceramic, two surface	MAJOR		50%
D2643	RESTORATIVE	Onlay - porcelain/ceramic - three surface	MAJOR		50%
D2644	RESTORATIVE	Onlay - porcelain/ceramic - four or more surfaces	MAJOR		50%
D2710	RESTORATIVE	Crown - resin-based composite (indirect)	MAJOR	Two Crowns per Year	50%
D2740	RESTORATIVE	Crown - porcelain/ceramic substrate	MAJOR		50%
D2750	RESTORATIVE	Crown - porcelain fused to high noble metal	MAJOR		50%
D2751	RESTORATIVE	Crown - porcelain fused to predominantly base metal	MAJOR		50%
D2752	RESTORATIVE	Crown - porcelain fused to noble metal	MAJOR		50%
D2790	RESTORATIVE	Crown - full cast high noble metal	MAJOR		50%
D2791	RESTORATIVE	Crown - full cast predominantly base metal	MAJOR		50%
D2792	RESTORATIVE	Crown - full cast noble metal	MAJOR		50%
D2794	RESTORATIVE	Crown - titanium	MAJOR		50%
D2910	RESTORATIVE	Re-cement inlay, onlay, or partial coverage restoration	MAJOR		50%
D2920	RESTORATIVE	Re-cement crown	MAJOR	Unlimited per plan year	50%
D2930	RESTORATIVE	Prefabricated stainless steel crown - primary tooth	MAJOR	Unlimited per plan year	50%
D2940	RESTORATIVE	Protective restoration	MAJOR	Unlimited per plan year	50%
D2949	RESTORATIVE	Small filling needed prior to fitting a tooth with a crown	MAJOR	One procedure per tooth every five plan years Performed together with a crown	50%
D2950	RESTORATIVE	Core build-up, including any pins when required	MAJOR		50%
D2951	RESTORATIVE	Pin retention - per tooth, in addition to restoration	MAJOR	One (1) per year	50%
D2952	RESTORATIVE	Post and core in addition to crown, indirectly fabricated	MAJOR	One (1) per year	50%
D2954	RESTORATIVE	Prefabricated post and core in addition to crown	MAJOR	One procedure per tooth every five plan years Has to be performed together with a crown. Tooth also has to have had root canal treatment	50%
D3110	ENDODONTIC	Pulp cap - direct (excluding final restoration)	MAJOR	Unlimited per plan year	50%
D3120	ENDODONTIC	Pulp-cap - Indirect (excluding final restoration)	MAJOR		50%
D3220	ENDODONTIC	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentincomental junction and application of medicament	MAJOR	Two procedure per calendar year (limited to two from all covered codes)	50%
D3310	ENDODONTIC	Endodontic therapy, anterior tooth (excluding final restoration	MAJOR		50%
D3320	ENDODONTIC	Endodontic therapy, bicuspid tooth (excluding final restoration	MAJOR		50%
D3330	ENDODONTIC	Endodontic therapy, molar (excluding final restoration	MAJOR		50%
D3346	ENDODONTIC	Retreatment or previous root canal therapy - anterior	MAJOR		50%
D3347	ENDODONTIC	Retreatment or previous root canal therapy - bicuspid	MAJOR		50%
D3348	ENDODONTIC	Retreatment or previous root canal therapy -molar	MAJOR		50%
D4341	PERIODONTICS	Periodontal scaling and root planning - four or more teeth per quadrant	MAJOR	One procedure per quadrant every two years, not to exceed four unique	50%

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D4342	PERIODONTICS	Periodontal scaling and root planning - one to three teeth per quadrant	MAJOR	quadrants every two years	50%
D4355	PERIODONTICS	Full mouth debridement to enable comprehensive evaluation and diagnosis	MAJOR	1 per 36 month period Not to be completed on the same day as D0150, D0160, or D0180	50%
D4381	PERIODONTICS	Medicine applied to gum space around a tooth (per tooth) for management of gum disease	MAJOR	Unlimited per plan year	50%
D4910	PERIODONTICS	Periodontal maintenance	MAJOR	2 per 12 consecutive months (combined limit for D1110/D4910)	50%
D5110	PROST,REMV	Complete denture - maxillary	MAJOR	1 set of full or partial dentures every 5 years	50%
D5120	PROST,REMV	Complete denture - mandibular	MAJOR		50%
D5130	PROST,REMV	Immediate denture - maxillary	MAJOR		50%
D5140	PROST,REMV	Immediate denture - mandibular	MAJOR		50%
D5211	PROST,REMV	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	MAJOR		50%
D5212	PROST,REMV	Mandibular partial denture - resin base (inc. any conventional clasps, rests and teeth)	MAJOR		50%
D5213	PROST,REMV	Maxillary partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5214	PROST,REMV	Mandibular partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5221	PROST,REMV	Upper partial denture delivered at the time of extractions - resin base	MAJOR		50%
D5222	PROST,REMV	Lower partial denture delivered at the time of extractions - resin base	MAJOR		50%
D5225	PROST,REMV	Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)	MAJOR		50%
D5226	PROST,REMV	Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth	MAJOR		50%
D5410	PROST,REMV	Adjust complete denture - maxillary	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5411	PROST,REMV	Adjust complete denture - mandibular	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5421	PROST,REMV	Adjust partial denture - maxillary	MAJOR	Two procedures per denture per year of delivery of new partial denture Cannot be billed within 6 months of placement	50%
D5422	PROST,REMV	Adjust partial denture - mandibular	MAJOR		50%
D5511	PROST,REMV	Repair broken complete denture base, mandibular	MAJOR	2 per Calendar Year (Either D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, OR D5660) Only 2 denture repairs per 1 calendar year with upto 5 total in 5 calendar years (Not Covered within 6 months of placement)	50%
D5512	PROST,REMV	Repair broken complete denture base, maxillary	MAJOR		50%
D5520	PROST,REMV	Replace missing or broken teeth - complete denture (each tooth)	MAJOR		50%
D5611	PROST,REMV	Repair resin denture base. Mandibular	MAJOR		50%
D5612	PROST,REMV	Repair resin denture base. Maxillary	MAJOR		50%
D5621	PROST,REMV	Repair cast framework. Maxillary	MAJOR		50%
D5622	PROST,REMV	Repair cast framework. Mandibular	MAJOR		50%
D5630	PROST,REMV	Repair or replace broken clasp	MAJOR		50%
D5640	PROST,REMV	Replace broken teeth - per tooth	MAJOR		50%
D5650	PROST,REMV	Add tooth to existing partial denture	MAJOR		50%
D5660	PROST,REMV	Add clasp to existing partial denture	MAJOR		50%
D5710	PROST,REMV	Rebase complete maxillary denture	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5711	PROST,REMV	Rebase complete mandibular denture	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%

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D5730	PROST,REMV	Reline complete maxillary denture (chair side)	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5731	PROST,REMV	Reline complete mandibular denture (chair side)	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5740	PROST,REMV	Reline maxillary partial denture (chair side)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5740 or D5760)	50%
D5741	PROST,REMV	Reline mandibular partial denture (chair side)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5741 or D5761)	50%
D5750	PROST,REMV	Reline complete maxillary denture (laboratory)	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5751	PROST,REMV	Reline complete mandibular denture (laboratory)	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5760	PROST,REMV	Reline maxillary partial denture (laboratory)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5740 or D5760)	50%
D5761	PROST,REMV	Reline mandibular partial denture (laboratory)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5741 or D5761)	50%
D5850	PROST,REMV	Tissue conditioning, maxillary	MAJOR	Two of each type of procedure per denture per plan year Cannot be billed within 6 months of delivery of the new denture.	50%
D5851	PROST,REMV	Tissue conditioning, mandibular	MAJOR		50%
D6210	PROST,FIXED	Pontic - cast high noble metal	MAJOR	One procedure per tooth every five plan years Does not cover any part of an implant supported bridge.	50%
D6211	PROST,FIXED	Pontic - cast predominantly base metal	MAJOR		50%
D6212	PROST,FIXED	Pontic - cast noble metal	MAJOR		50%
D6214	PROST,FIXED	Pontic - titanium and titanium alloys	MAJOR		50%
D6240	PROST,FIXED	Pontic - porcelain fused to high noble metal	MAJOR		50%
D6241	PROST,FIXED	Pontic - porcelain fused to predominantly base metal	MAJOR		50%
D6242	PROST,FIXED	Pontic - porcelain fused to noble metal	MAJOR		50%
D6245	PROST,FIXED	Pontic - porcelain/ceramic	MAJOR		50%
D6740	PROST,FIXED	Crown - porcelain/ceramic	MAJOR	One procedure per tooth every five plan years Does not cover any part of an implant supported bridge.	50%
D6750	PROST,FIXED	Crown - porcelain fused to high noble metal	MAJOR		50%
D6751	PROST,FIXED	Crown - porcelain fused to predominantly base metal	MAJOR		50%
D6752	PROST,FIXED	Crown - porcelain fused to noble metal	MAJOR		50%
D6790	PROST,FIXED	Crown - full cast high noble metal	MAJOR		50%
D6791	PROST,FIXED	Crown - full cast predominantly base metal	MAJOR		50%
D6792	PROST,FIXED	Crown - full cast noble metal	MAJOR		50%
D6794	PROST,FIXED	Retainer crown - titanium and titanium alloys	MAJOR		50%
D6930	PROST,FIXED	Recement fixed partial denture	MAJOR	Unlimited per plan year Does not cover cementing a bridge on the day of initial bridge delivery	50%
D7111	ORAL, MAXIO SURGERY	Extraction, corneal remnants - deciduous tooth	MAJOR	Maximum 6 per year (limited to six from all covered codes - D7111-D7250)	50%
D7140	ORAL, MAXIO SURGERY	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	MAJOR		50%
D7210	ORAL, MAXIO SURGERY	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	MAJOR		50%
D7220	ORAL, MAXIO SURGERY	Removal of impacted tooth - soft tissue	MAJOR		50%
D7230	ORAL, MAXIO SURGERY	Removal of impacted tooth - partially bony	MAJOR		50%
D7240	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony	MAJOR		50%
D7241	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony, with unusual surgical	MAJOR		50%

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		complications			
D7250	ORAL, MAXIO SURGERY	Surgical removal of residual roots (cutting procedure)	MAJOR		50%
D7310	ORAL, MAXIO SURGERY	Alveoloplasty, in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	MAJOR	Maximum 2 per year (limited to two from all covered codes D7310-D7511)	50%
D7311	ORAL, MAXIO SURGERY	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	MAJOR		50%
D7320	ORAL, MAXIO SURGERY	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant	MAJOR		50%
D7321	ORAL, MAXIO SURGERY	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	MAJOR		50%
D7510	ORAL, MAXIO SURGERY	Incision and drainage of abscess - intraoral soft tissue	MAJOR		50%
D7511	ORAL, MAXIO SURGERY	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	MAJOR		50%
D7880	ORAL, MAXIO SURGERY	Splint used to treat the TMJ	MAJOR	One procedure every three years	50%
D9110	ADJUNCTIVE	Palliative (emergency) treatment. of dental pain, minor procedure	MAJOR	Two procedures per calendar year-Not a covered benefit when reported with other definitive services on same treatment date.	50%
D9222	ANESTHESIA	Deep sedation/general anesthesia - first 15 min.	MAJOR	Covered when provided with covered surgical procedure. The number of 15 minute increments need to be reported. Contract limitation of 60 minutes per session.	50%
D9223	ANESTHESIA	Deep sedation/general anesthesia – each 15 minute increment	MAJOR		50%
D9230	ANESTHESIA	Nitrous oxide	MAJOR	No limit	50%
D9239	ANESTHESIA	Intravenous moderate (conscious) secdation/analgesia first 15 minutes	MAJOR	Covered when provided with covered surgical procedure. The number of 15 minute increments need to be reported. Contract limitation of 60 minutes per session.	50%
D9243	ANESTHESIA	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	MAJOR		50%
D9910	PROFESSIONAL VISITS	Application of desensitizing agent to a tooth or teeth	MAJOR	Unlimited per plan year	50%
D9943	PROFESSIONAL VISITS	Adjustment of occlusal guard	MAJOR	Two procedures per year	50%
D9944	PROFESSIONAL VISITS	top or bottom, full arch hard occulsal guard	MAJOR	One procedures every three plan years	50%
OTHER		**Medicare Covered Services**			**20% coinsurance**
OTHER		**Optional Supplemental**			**No**
OTHER		**Dental Xtra**			**Yes**

Plan Number: H6158-001- BLUEMEDICARE HMO
Plan Number: H6158-002- BLUEMEDICARE HMO

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BlueMedicare Value					
PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 BlueMedicare Value PFFS Plan 20	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0150) - Max of 2)	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 cleanings per 12 consecutive months	$10
OTHER		Medicare Covered Services			$45
OTHER		Optional Supplemental			No
OTHER		Dental Xtra			No

Plan Number: H4213-016- BLUEMEDICARE PFFS

BlueMedicare Preferred					
PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 BlueMedicare Preferred PFFS Plan 20	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0150) - Max of 2)	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 cleanings per 12 consecutive months	$10
OTHER		Medicare Covered Services			$45
OTHER		Optional Supplemental			No
OTHER		Dental Xtra			No

Plan Number: H4213-017- BLUEMEDICARE PFFS

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BlueMedicare Saver Choice PPO

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 BlueMedicare Saver Choice PPO Plan 19	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0150) - Max of 2)	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 cleanings per 12 consecutive months	$0
D5410	PROST,REMV	Adjust complete denture - maxillary	PREVENTIVE	Two (2) per benefit period	$20
D5411	PROST,REMV	Adjust complete denture - mandibular	PREVENTIVE		$20
D5421	PROST,REMV	Adjust partial denture - maxillary	PREVENTIVE		$20
D5422	PROST,REMV	Adjust partial denture - mandibular	PREVENTIVE		$20
D7140	ORAL, MAXIO SURGERY	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	PREVENTIVE	up to 2 per year (for an erupted tooth OR exposed tooth) includes local anesthetic, suturing and routine postoperative care	$20
OTHER		**Medicare Covered Services**			**$45**
OTHER		**Optional Supplemental**			**No**
OTHER		**Dental Xtra**			**Yes**

Plan Number: H3554-001- BLUEMEDICARE PPO
Plan Number: H3554-002- BLUEMEDICARE PPO

BlueMedicare Value Choice PPO

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 BlueMedicare Value Choice PPO Plan 17	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0150) - Max of 2)	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0220	DIAGNOSTIC	Intraoral periapical - first radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0230	DIAGNOSTIC	Intraoral periapical - each additional radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0240	DIAGNOSTIC	Intraoral - occlusal radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0

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D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE	codes constitute a set of bitewings.	$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 per 12 consecutive months (combined limit for D1110/D4910)	$0
D2140	RESTORATIVE	Amalgam - one surface, primary or permanent	BASIC	One (1) restoration per surface per tooth per twelve (12) month period	30%
D2150	RESTORATIVE	Amalgam - two surfaces, primary or permanent	BASIC		30%
D2160	RESTORATIVE	Amalgam - three surfaces, primary or permanent	BASIC		30%
D2161	RESTORATIVE	Amalgam - four or more surfaces, primary or permanent	BASIC		30%
D2330	RESTORATIVE	Resin-based composite - one surface, anterior	BASIC		30%
D2331	RESTORATIVE	Resin-based composite - two surfaces, anterior	BASIC		30%
D2332	RESTORATIVE	Resin-based composite - three surfaces, anterior	BASIC		30%
D2335	RESTORATIVE	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	BASIC		30%
D2391	RESTORATIVE	Resin-based composite - one surface, posterior	BASIC		30%
D2392	RESTORATIVE	Resin-based composite - two surfaces, posterior	BASIC		30%
D2393	RESTORATIVE	Resin-based composite - three surfaces, posterior	BASIC		30%
D2394	RESTORATIVE	Resin-based composite - four or more surfaces, posterior	BASIC		30%
D4341	PERIODONTICS	Periodontal scaling and root planning - four or more teeth per quadrant	MAJOR	One procedure per quadrant every two years, not to exceed four unique quadrants every two years	50%
D4342	PERIODONTICS	Periodontal scaling and root planning - one to three teeth per quadrant	MAJOR		50%
D4355	PERIODONTICS	Full mouth debridement to enable comprehensive evaluation and diagnosis	BASIC	1 per 36 month period Not to be completed on the same day as D0150, D0160, or D0180	30%
D4910	PROST,REMV	Periodontal maintenance	MAJOR	2 per 12 consecutive months (combined limit for D1110/D4910)	50%
D5110	PROST,REMV	Complete denture - maxillary	MAJOR	1 set of full or partial dentures every 5 years	50%
D5120	PROST,REMV	Complete denture - mandibular	MAJOR		50%
D5130	PROST,REMV	Immediate denture - maxillary	MAJOR		50%
D5140	PROST,REMV	Immediate denture - mandibular	MAJOR		50%
D5211	PROST,REMV	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	MAJOR		50%
D5212	PROST,REMV	Mandibular partial denture - resin base (inc. any conventional clasps, rests and teeth)	MAJOR		50%
D5213	PROST,REMV	Maxillary partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5214	PROST,REMV	Mandibular partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5410	PROST,REMV	Adjust complete denture - maxillary	BASIC	Two (2) per benefit period	30%
D5411	PROST,REMV	Adjust complete denture - mandibular	BASIC		30%
D5421	PROST,REMV	Adjust partial denture - maxillary	BASIC		30%
D5422	PROST,REMV	Adjust partial denture - mandibular	BASIC		30%
D5611	PROST,REMV	Repair resin denture base. Mandibular	BASIC	As needed/No frequency limit	30%
D5612	PROST,REMV	Repair resin denture base. Maxillary	BASIC	As needed/No frequency limit	30%

D5621	PROST,REMV	Repair cast framework. Maxillary	BASIC	As needed/No frequency limit	30%
D5622	PROST,REMV	Repair cast framework. Mandibular	BASIC	As needed/No frequency limit	30%
D5630	PROST,REMV	Repair or replace broken clasp	BASIC	As needed/No frequency limit	30%
D5730	PROST,REMV	Reline complete maxillary denture (chair side)	MAJOR	One (1) in a thirty-six (36) month period	50%
D5731	PROST,REMV	Reline complete mandibular denture (chair side)	MAJOR		50%
D5740	PROST,REMV	Reline maxillary partial denture (chair side)	MAJOR		50%
D5741	PROST,REMV	Reline mandibular partial denture (chair side)	MAJOR		50%
D5750	PROST,REMV	Reline complete maxillary denture (laboratory)	MAJOR		50%
D5751	PROST,REMV	Reline complete mandibular denture (laboratory)	MAJOR		50%
D5760	PROST,REMV	Reline maxillary partial denture (laboratory)	MAJOR		50%
D5761	PROST,REMV	Reline mandibular partial denture (laboratory)	MAJOR		50%
D7140	ORAL, MAXIO SURGERY	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	MAJOR	Maximum 1 per year (limited to two from all covered codes - D7140-D7250)	50%
D7210	ORAL, MAXIO SURGERY	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	MAJOR		50%
D7220	ORAL, MAXIO SURGERY	Removal of impacted tooth - soft tissue	MAJOR		50%
D7230	ORAL, MAXIO SURGERY	Removal of impacted tooth - partially bony	MAJOR		50%
D7240	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony	MAJOR		50%
D7241	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony, with unusual surgical complications	MAJOR		50%
D7250	ORAL, MAXIO SURGERY	Surgical removal of residual roots (cutting procedure)	MAJOR		50%
D7510	ORAL, MAXIO SURGERY	Incision and drainage of abscess - intraoral soft tissue	MAJOR	Maximum 1 per year	50%
D9910	PROFESSIONAL VISITS	Application of desensitizing agent to a tooth or teeth	BASIC	Maximum 1 per year	30%
OTHER		**Medicare Covered Services**			**$45**
OTHER		**Optional Supplemental**			**No**
OTHER		**Dental Xtra**			**Yes**

Plan Number: H3554-003- BLUEMEDICARE PPO
Plan Number: H3554-004- BLUEMEDICARE PPO
Plan Number: H3554-005- BLUEMEDICARE PPO
Plan Number: H3554-006- BLUEMEDICARE PPO

BlueMedicare Premier Choice PPO

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	PROC CLASS	BENEFIT SPECIFICS 2021 BlueMedicare Premier Choice PPO Plan 14	2021 COPAY AMOUNT
D0120	DIAGNOSTIC	Periodic oral evaluation	PREVENTIVE	2 evaluations per 12 consecutive months (Combined with (D0150) - Max of 2)	$0
D0150	DIAGNOSTIC	Comprehensive oral evaluation - new or established patient	PREVENTIVE	1 per lifetime per dentist	$0
D0210	DIAGNOSTIC	Intraoral - complete series of radiographic images	PREVENTIVE	One set every three years	$0
D0220	DIAGNOSTIC	Intraoral periapical - first radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0230	DIAGNOSTIC	Intraoral periapical - each additional radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0240	DIAGNOSTIC	Intraoral - occlusal radiographic image	PREVENTIVE	As needed but are included in the 1 set per year limit	$0
D0270	DIAGNOSTIC	Bitewing - single radiographic image	PREVENTIVE	One set per year - Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings.	$0
D0272	DIAGNOSTIC	Bitewings - two radiographic images	PREVENTIVE		$0
D0273	DIAGNOSTIC	Bitewings - three radiographic images	PREVENTIVE		$0
D0274	DIAGNOSTIC	Bitewings - four radiographic images	PREVENTIVE		$0
D0277	DIAGNOSTIC	Vertical bitewings - 7-8 radiographic images	PREVENTIVE		$0
D0330	DIAGNOSTIC	Panoramic radiographic image	PREVENTIVE	One set every three years	$0
D1110	PREVENTIVE	Prophylaxis - adult	PREVENTIVE	2 per 12 consecutive months (combined limit for D1110/D4910)	$0
D2140	RESTORATIVE	Amalgam - one surface, primary or permanent	BASIC	Two (2) restorations per twelve (12) month period	20%
D2150	RESTORATIVE	Amalgam - two surfaces, primary or permanent	BASIC		20%
D2160	RESTORATIVE	Amalgam - three surfaces, primary or permanent	BASIC		20%
D2161	RESTORATIVE	Amalgam - four or more surfaces, primary or permanent	BASIC		20%
D2330	RESTORATIVE	Resin-based composite - one surface, anterior	BASIC		20%
D2331	RESTORATIVE	Resin-based composite - two surfaces, anterior	BASIC		20%
D2332	RESTORATIVE	Resin-based composite - three surfaces, anterior	BASIC		20%
D2335	RESTORATIVE	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	BASIC		20%
D2391	RESTORATIVE	Resin-based composite - one surface, posterior	BASIC		20%
D2392	RESTORATIVE	Resin-based composite - two surfaces, posterior	BASIC		20%
D2393	RESTORATIVE	Resin-based composite - three surfaces, posterior	BASIC		20%
D2394	RESTORATIVE	Resin-based composite - four or more surfaces, posterior	BASIC		20%
D2710	RESTORATIVE	Crown - resin-based composite (indirect)	MAJOR	One crown per year	50%
D2740	RESTORATIVE	Crown - porcelain/ceramic substrate	MAJOR		50%
D2750	RESTORATIVE	Crown - porcelain fused to high noble metal	MAJOR		50%
D2751	RESTORATIVE	Crown - porcelain fused to predominantly base metal	MAJOR		50%
D2752	RESTORATIVE	Crown - porcelain fused to noble metal	MAJOR		50%
D2790	RESTORATIVE	Crown - full cast high noble metal	MAJOR		50%
D2791	RESTORATIVE	Crown - full cast predominantly base metal	MAJOR		50%
D2792	RESTORATIVE	Crown - full cast noble metal	MAJOR		50%
D2794	RESTORATIVE	Crown - titanium	MAJOR		50%

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D2910	RESTORATIVE	Re-cement inlay, onlay, or partial coverage restoration	MAJOR		50%
D2920	RESTORATIVE	Re-cement crown	BASIC	Unlimited per plan year	20%
D2930	RESTORATIVE	Prefabricated stainless steel crown - primary tooth	BASIC	Unlimited per plan year	20%
D2940	RESTORATIVE	Protective restoration	BASIC	Unlimited per plan year	20%
D2950	RESTORATIVE	Core build-up, including any pins when required	BASIC	One (1) per year	20%
D2951	RESTORATIVE	Pin retention - per tooth, in addition to restoration	BASIC	One (1) per year	20%
D2952	RESTORATIVE	Post and core in addition to crown, indirectly fabricated	MAJOR	One (1) per year	50%
D3220	ENDODONTIC	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentincomental junction and application of medicament	BASIC	One procedure per calendar year (limited to one from all covered codes)	20%
D3310	ENDODONTIC	Endodontic therapy, anterior tooth (excluding final restoration	BASIC		20%
D3320	ENDODONTIC	Endodontic therapy, bicuspid tooth (excluding final restoration	BASIC		20%
D3330	ENDODONTIC	Endodontic therapy, molar (excluding final restoration	BASIC		20%
D3346	ENDODONTIC	Retreatment or previous root canal therapy - anterior	BASIC		20%
D3347	ENDODONTIC	Retreatment or previous root canal therapy - bicuspid	BASIC		20%
D3348	ENDODONTIC	Retreatment or previous root canal therapy -molar	BASIC		20%
D4341	PERIODONTICS	Periodontal scaling and root planning - four or more teeth per quadrant	MAJOR	One procedure per quadrant every two years, not to exceed four unique quadrants every two years	50%
D4342	PERIODONTICS	Periodontal scaling and root planning - one to three teeth per quadrant	MAJOR		50%
D4355	PERIODONTICS	Full mouth debridement to enable comprehensive evaluation and diagnosis	MAJOR	1 per 36 month period Not to be completed on the same day as D0150, D0160, or D0180	50%
D4910	PROST,REMV	Periodontal maintenance	MAJOR	2 per 12 consecutive months (combined limit for D1110/D4910)	50%
D5110	PROST,REMV	Complete denture - maxillary	MAJOR	1 set of full or partial dentures every 5 years	50%
D5120	PROST,REMV	Complete denture - mandibular	MAJOR		50%
D5130	PROST,REMV	Immediate denture - maxillary	MAJOR		50%
D5140	PROST,REMV	Immediate denture - mandibular	MAJOR		50%
D5211	PROST,REMV	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	MAJOR		50%
D5212	PROST,REMV	Mandibular partial denture - resin base (inc. any conventional clasps, rests and teeth)	MAJOR		50%
D5213	PROST,REMV	Maxillary partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5214	PROST,REMV	Mandibular partial denture - cast metal framework with resin denture bases (including and conventional clasps, rests and teeth)	MAJOR		50%
D5410	PROST,REMV	Adjust complete denture - maxillary	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5411	PROST,REMV	Adjust complete denture - mandibular	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5520	PROST,REMV	Replace missing or broken teeth - complete denture (each tooth)	MAJOR	2 per Calendar Year (Either D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, OR D5660) Only 2 denture repairs per 1 calendar year with upto 5 total in 5 calendar years (Not Covered within 6 months of placement)	50%
D5611	PROST,REMV	Repair resin denture base. Mandibular	MAJOR		50%
D5612	PROST,REMV	Repair resin denture base. Maxillary	MAJOR		50%
D5621	PROST,REMV	Repair cast framework. Maxillary	MAJOR		50%
D5622	PROST,REMV	Repair cast framework. Mandibular	MAJOR		50%
D5630	PROST,REMV	Repair or replace broken clasp	MAJOR		50%

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D5640	PROST,REMV	Replace broken teeth - per tooth	MAJOR		50%
D5650	PROST,REMV	Add tooth to existing partial denture	MAJOR		50%
D5660	PROST,REMV	Add clasp to existing partial denture	MAJOR		50%
D5710	PROST,REMV	Rebase complete maxillary denture	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5711	PROST,REMV	Rebase complete mandibular denture	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5730	PROST,REMV	Reline complete maxillary denture (chair side)	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5731	PROST,REMV	Reline complete mandibular denture (chair side)	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5740	PROST,REMV	Reline maxillary partial denture (chair side)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5740 or D5760)	50%
D5741	PROST,REMV	Reline mandibular partial denture (chair side)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5741 or D5761)	50%
D5750	PROST,REMV	Reline complete maxillary denture (laboratory)	MAJOR	1 per calendar year (either D5410, D5710, D5730 OR D5750)	50%
D5751	PROST,REMV	Reline complete mandibular denture (laboratory)	MAJOR	1 per calendar year (Either D5411, D5711, D5731, OR D5751)	50%
D5760	PROST,REMV	Reline maxillary partial denture (laboratory)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5740 or D5760)	50%
D5761	PROST,REMV	Reline mandibular partial denture (laboratory)	MAJOR	1 per calendar year, (Not covered within 6 months of placement) Either D5741 or D5761)	50%
D7140	ORAL, MAXIO SURGERY	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	MAJOR	Maximum 2 per year (limited to two from all covered codes - D7140-D7250)	50%
D7210	ORAL, MAXIO SURGERY	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	MAJOR		50%
D7220	ORAL, MAXIO SURGERY	Removal of impacted tooth - soft tissue	MAJOR		50%
D7230	ORAL, MAXIO SURGERY	Removal of impacted tooth - partially bony	MAJOR		50%
D7240	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony	MAJOR		50%
D7241	ORAL, MAXIO SURGERY	Removal of impacted tooth - completely bony, with unusual surgical complications	MAJOR		50%
D7250	ORAL, MAXIO SURGERY	Surgical removal of residual roots (cutting procedure)	MAJOR		50%
D7510	ORAL, MAXIO SURGERY	Incision and drainage of abscess - intraoral soft tissue	MAJOR	Maximum 1 per year	50%
D9910	PROFESSIONAL VISITS	Application of desensitizing agent to a tooth or teeth	BASIC	Maximum 1 per year	20%
OTHER		**Medicare Covered Services**			**$45**
OTHER		**Optional Supplemental**			**No**
OTHER		**Dental Xtra**			**Yes**

Plan Number: H3554-007- BLUEMEDICARE PPO
Plan Number: H3554-008- BLUEMEDICARE PPO
Plan Number: H3554-009- BLUEMEDICARE PPO
Plan Number: H3554-010- BLUEMEDICARE PPO

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 and Health Advantage Medicare Advantage'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 and Health Advantage Medicare Advantage has a Dental Advisory Committee that provides valuable guidance and counsel to Arkansas Blue Medicare and Health Advantage Medicare Advantage regarding various dental issues related to operations and programs. Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage:
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.

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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.

Sample Claim Form

Dental Claim Form

Arkansas Blue MEDICARE

Send Completed Claim Form To:
Dental Claims Administrator
P.O. Box 69436
Harrisburg, PA 17106-9436

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

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

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

RECORD OF SERVICES PROVIDED

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

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X ______________________________
Patient / Guardian signature Date

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

X ______________________________
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐

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

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

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

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

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

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

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X ______________________________
Signed (Treating Dentist) Date

54. NPI | 55. License Number

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

57. Phone Number ( ) – | 58. Additional Provider ID

Dental Claim Form

Health Advantage

Send Completed Claim Form To:
Dental Claims Administrator
P.O. Box 69436
Harrisburg, PA 17106-9436

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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

6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

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

13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS

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

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

RECORD OF SERVICES PROVIDED

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

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X ______________________________
Patient / Guardian signature Date

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

X ______________________________
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

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

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

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

52. Phone Number ( ) –
52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X ______________________________
Signed (Treating Dentist) Date

54. NPI
55. License Number

56. Address, City, State, Zip Code
56A. Provider Specialty Code

57. Phone Number ( ) –
58. Additional Provider ID

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Reimbursements

Medicare Advantage Participating providers

Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage in cases when medical necessity could not be established.

Medicare Advantage Non-Participating providers

Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage 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	Member's Co-insurance
D2150	Basic	80%	$100	$100 x 20% = $20

The member's Co-insurance is based on a percentage of your Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 or Health Advantage Medicare Advantage HMO 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 or Health Advantage Medicare Advantage HMO 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

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For questions about these materials, please contact your Provider Network Manager.

Expenses in a claim determination period. In that case, the benefits of the Arkansas Blue Medicare or Health Advantage Medicare Advantage HMO 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 or Health Advantage Medicare Advantage HMO 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 or Health Advantage Medicare Advantage HMO 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 or Health Advantage Medicare Advantage HMO Plans).
- Always calculate your patient's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary payor's EOB may not correctly reflect the patient's balance and that your patient's liability may be affected by contracts that you hold with the primary carrier.
- 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 and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage 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 andis handled by the Quality Assurance Area of Arkansas Blue Medicare and Health Advantage Medicare Advantage'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 and Health Advantage Medicare Advantage 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 theState where the Group is located.

If there is no State Appeal or Grievance process: Our Dental Claims Administrator will follow the Arkansas Blue Medicare and Health Advantage Medicare Advantage Appeals process. All Arkansas Blue Medicare and Health Advantage Medicare Advantage Appeals and Grievances resulting in a financial orclinical 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 and Health Advantage Medicare Advantage, 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 and Health Advantage Medicare Advantage. 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 and Health Advantage Medicare Advantage. The “Agreement” consists of the Agreement, Dental Manual, MA Manual and any Amendments to the Agreement. Arkansas Blue Medicare and Health Advantage Medicare Advantage 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 and Health Advantage Medicare Advantage has the right to either: (1) notify you thatit 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 and Health Advantage Medicare Advantage may terminate your Participating Provider Agreement immediately, upon written notice, if you fail to satisfy the requirements set forth in the Conditions of Participation.