2022 Medicare Advantage Dental Manual

hmsa

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

Edition 01: 01-2022

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 via the **Plans, Manuals, and Training** page of our website at: **hmsadental.com**.

Your Dental Network Manager is available to assist you with any questions you haverelative 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, youcan 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 tocontinuing our mutually beneficial relationship with you and your staff.

Sincerely,

Edward A. Murphy
Executive Vice President
Life and Specialty Ventures, LLC

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Section 1: Definitions

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

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 HMSA 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 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 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 HMSA. The amount of any such expense is set forth in the applicable Dental Program.

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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 allmaterial respects throughout the term of the Agreement, and 2. The Dentist shall notify HMSA in a timely manner of any material changes in that information.
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 2. was not acquired directly 3. Or indirectly from the Disclosing Party; or 4. 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 5. 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 6. 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 for Covered 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 has agreed 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 MA Members under the terms of the Agreement.
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 MA Plan's subcontractors, including HMSA, that provide administrative services or health care services to MA 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 HMSA Dental. 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 HMSA's Responsible Payor that is more than 365 days (one year) from the date of service or the completion of a course of treatment. HMSA may deny Late Claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim.
Medicare Advantage Plan	HMSA, a Medicare Advantage Organization offering Medicare Advantage Programs through an MA Contract.
Medicare Advantage Organization	An insurance company or health maintenance organization that holds a contract with CMS and the MA Plan.
Medicare Advantage Program	An alternative to the traditional Medicare program authorized by Part Cof 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 HMSA has determined to be the maximum amount payable for a Covered Service rendered to a member as set forth inthe 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.
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.
Medicare Advantage Organization	An insurance company or health maintenance organization thatholds a contract with CMS and the MA Plan.

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Necessary and Appropriate	Dental services and supplies that are: 1. Rendered consistent with the prevention and treatment oforal disease or with the diagnosis and treatment of teeththat 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 andaging, including improving physical appearance that iswithin 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.

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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 HMSA for your participation in the HMSA Dental PPO which is made up of your standard contract and Medicare Advantage.
Participating Dentist	A duly licensed dentist who has contracted with HMSA to participate in its Dental PPO Network.
Provider Network	A group of Dentists who contract with HMSA to render covered Services to Members.
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 is rendered, • The Responsible Payor's allowed payment for such services,and • The terms of the Member's Benefit Plan at the time services rendered

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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 is rendered, • the Responsible Payor's allowed payment for such services,and • the terms of the Member's Benefit Plan at the time services are rendered
Responsible Payor	The Plan responsible for paying benefits for Covered Services rendered to a Member.
State	The State of Hawaii
Subscriber	A Member who is eligible and enrolled in a Benefit Plan as anindividual or as an employee or member of an Account.

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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……..…..…**(808) 948-6440**
Dental Provider Relations Team……..…**dentalproviderrelations@bshi.net**
Website……..…**hmsadental.com/providers**

Verify benefits online at: **https://www.mydentalcoverage.com/dentists.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

Note: When verifying eligibility using Online Provider portal, remove the first 3 numbers of the Member ID.

Customer Service:

You may contact our customer service department by phone at **(808) 948-6440 on Oahu** and **1 (800) 792-4672 Toll Free on the Neighbor islands** Monday through Friday from 8 a.m. to 5 p.m.

Claims mailing address:

Please submit your Medicare Advantage dental claims electronically using HMSA's Payor ID (HMSA1) or mail your dental claims to the following address:

HMSA Dental
P.O. Box 1187
Elk Grove Village, IL 60009-1187

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 or closing a plan panel. Forms are located on the **Update Your Status** page of our website at **hmsadental.com/providers.** For assistance with the forms, please contact us at **DentalProviderRelations@bshi.net**

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

HMSA requires written notification within established time periods as noted below:

Within seventy-two (72) hours if:

- You or your practice, or any of its officers or directors is indicted or convicted of a felony.
- You or your practice becomes the subject of an investigation by a state or federal government entity in which you have the potential to be subject to criminal charges or subject to any action for violation of Law.

Within one (1) business day if:

- You are materially sanctioned by any state or federal government entity.
- Your eligibility to participate in the Medicare or Medicaid programs is limited, restricted,or otherwise terminated.
- You receive a notice of intent to file or actual filing of any professional liability action against you (or an entity in which you have an ownership interest, other than a publicly traded company) that involves a member.

Within five (5) business days if:

- You are required to pay damages in any malpractice action by way of judgment or settlement notification.
- There is any change in the nature or extent of Service rendered by you.

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- 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 HMSA 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 our website at **hmsadental.com** under the Providers tab; **Fax request to (808) 538-8996** or email to **DentalProviderRelations@bshi.net**
Employer Identification Number (EIN) or Taxpayer Identification Number (TIN)	Any changes to your (EIN) Employer Identification Number or (TIN) Taxpayer Identification Number, submit a Provider information change form, W-9, and a Participating provider Agreement for each provider. Forms are located on our website at **hmsadental.com** under the Providers tab. Submit with original signatures and mail to: **HMSA - Dental** **P O Box 1320** **Honolulu, HI 96807-1320**
Associate dentist/orthodontist who has left your practice	Send a letter of termination on the Practice letterhead with a provider's signature, including the dentist's name, practice address and TIN via **fax (808) 538-8996** or e-mail **DentalProviderRelations@bshi.net**
Add a new associate or dentist to your practice	Submit a credentialing application if the provider is not credentialed with HMSA, or submit an Abbreviated Application, W-9, and a Participating Provider Agreement for existing providers. Forms are located on our website at **hmsadental.com**
Terminate participation in a network Requires ninety (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 (808) 538-8996** or email to **DentalProviderRelations@bshi.net**
Add additional practice locations for existing Employer Taxpayer identification number (TIN) on file.	Submit an Abbreviated Application. Forms are located on our website at **hmsadental.com.**
Terminate HMSA Contract	Contact your **Dental Network Manager.**

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Provider Data Accuracy and Validation

HMSA 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

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Section 4: Your Relationship with HMSA

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 HMSA 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 (6) 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 plan's timely filing limit of twelve (12) months from the date-of-service, including any required documentation needed, including but not limited to:
    - Preoperative radiographic images that are current and dated
    - Labeled – left or right side – if duplicates
    - Mounted, if they are a full series
    - Of diagnostic quality
    - Labeled with the patient's name and ID number
    - Labeled with the dentist's name and address
- Provide services that meet criteria for medically necessary and care must be:
    - Rendered consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
    - Furnished in accordance with standards of good dental practice.
    - Provided in the most appropriate site and at the most appropriate level of services based upon the member's condition.
    - Not provided solely to improve a member's condition beyond normal variation in individual development and aging, including improving physical appearance that is

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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 HMSA 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.

HMSA's Responsibilities

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

Relationship between HMSA and LSV

Life and Specialty Ventures (LSV), LLC is a Delaware limited Liability Company. LSV is acting as a support company providing administrative services to independent licensees of the Blue Cross and Blue Shield Association (BCBSA), including HMSA. LSV is not licensed by BCBSA and is nota joint venture, agent, or representative of BCBSA. LSV is solely responsible forthe provision of administrative support services in accordance with the terms ofthe Agreement.

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Section 5: Working with HMSA

What We Offer You

At HMSA, 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 HMSA Dental PPO network, which gives you:

- Access to more than 8,300 insured 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 **hmsadental.com/find-a-dentist** to view your listing
- We are now using website, **hmsadental.com/providers** 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 “plans” listed under HMSA Akamai Advantage Dual Care Dental.

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 HMSA on Grievances and Appeals.
- File an appeal about an action or decision made by HMSA.
- Be notified of any decision to deny services.
- Exercise these rights without adversely affecting how HMSA treats you.

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Section 6: Conditions of Participation in Our Network

To participate in the HMSA 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 • 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 a licensed in Hawaii. If Dentist practices in a state other than Hawaii, Dentist must comply with the license requirements ofthe 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 MA 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 inaccordance with all applicable local, state, and federal laws. Dentist, Dentist's sites, and all providers rendering services hereunder shallmeet applicable requirements and be properly certified under the Medicare programs, as set forth in in Title XVIII of the Social SecurityAct. 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 MA Plan will review the credentials of Dentist and other medical professionals affiliated with Dentist or the MA 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 provisionof and payment for Covered Services rendered to Members. Such records are to be maintained in accordance with customary industry record-keeping standards.

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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 HMSA 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, givenreasonable notice, during the Dentist's regular business hours. Neither HMSA 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 HMSA Participating Provider Agreement which apply to services renderedto MA Members and QHP Members and will, to the extent inconsistentwith any other terms of the Agreement, supersede such inconsistent terms solely as they relate to services rendered to MA Members and QHP Members. • If a party received Confidential Information from another party, the receiving party would 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 HMSA 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 andagrees that HMSA 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 of the disclosed information.
Contractual Conditions	• Dentist shall notify HMSA 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 individualprovider wishing to join an existing group practice shall notify HMSA.

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Contractual Conditions	• To the extent that services that otherwise meet the requirement of the HMSA Participating Provider Agreement are rendered by a dentist not located in Hawaii, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of HMSA. • 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 MA Plan's relevant written policies and procedures, including policiesand procedures for the control of fraud, waste, and abuse in the MA 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 HMSA's obligations to MA Plan and MAPlan's obligations to CMS set forth in the MA 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 HMSA's obligations to CMS set forth inthe QHP Issuer Agreement. Dentist agrees that in no event, including, but not limited to non-payment by HMSA, insolvency of HMSA, or breach of the Agreement or this Amendment, shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against an MA Member or a person acting on behalf of an MA Member for Covered Services provided pursuant to this Amendment. This Amendment does not prohibit collection of MA Member Cost Sharing, or fees for non-covered services as long as MA Member has been informed in advance that services are not covered, and that MA 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 toindividuals or entities receiving federal funds. • Dentist acknowledges that HMSA and MA Plan are required under applicable federal law and regulations to submit to CMS certain information regarding the benefits provided by MA Plan and quality and performance indicators. Dentist acknowledges that HMSA and MA Plan may be required under such laws and regulations to disclose certain information to MA Members and QHP Members in such form and manner requested by CMS.

Contractual Conditions	• Dentist shall maintain all records andreports reasonably requested by HMSA and shall provide such records and reports to HMSA to enable HMSA and MA Plan to meet their obligations to submit such information to CMS and to disclose certaininformation to MA 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: 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 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 HMSA, MA Plan, and HHS and the Comptroller General (or their designees) for the duration of the period in which theAgreement 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. HMSA retains the right to approve, suspend, or terminate any arrangement between Dentist and a selected Downstream Entity with respect to services provided under these Required Terms. • Excluded Persons. Dentist represents and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Dentist shall check appropriate databases regularly, but no less than monthly and upon hiring and subcontracting, to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare program or any other federal health care program. Databases include the U.S. Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals/Entities (http://exclusions.oig.hhs.gov) and the General Services Administration's System for Award Management (http://www.sam.gov/portal). Dentist shall notify HMSA immediately in writing if Dentist, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal program monitored as described in this Section. Dentist shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the delivery or administration of Covered Services to MA Members.

Contractual Conditions	HMSA reserves the right to require Dentist to demonstrate compliance with this provision upon reasonable request. • Dentist shall cooperate with HMSA's or MA 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 HMSA a copy of audit results and shall make all audit materials available to HMSA upon request. • HMSA will monitor the performance of Dentist on an ongoing basis. HMSA's monitoring activities include assessing Dentist and Downstream Entities' compliance with applicable MA Program and QHP provisions, including the Required Terms. • HMSA shall immediately cease making all payments to Dentist for Covered Services provided to MA Members and QHP Members by excluded persons as described in Section 8 as of the date Dentist, or any Affiliated Party employed by Dentist, has been excluded from participation under Medicare as determined by CMS. • Notwithstanding any termination provision in the Agreement, in the event Dentist materially breaches this Amendment, HMSA may terminate this Amendment and the Agreement immediately. For purposes of these Required Terms, a material breach will have occurred upon the following events including, but not limited to (a) a material violation of HMSA's or MA 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 HMSA to safeguard our members' protected health information (PHI). Since the Privacy Rule applies to payors and providers, HMSA shares with you the responsibility of protecting privacy.

The HIPAA Privacy Rule allows for HMSA to share PHI with other parties without 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 HMSA/LSV 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.

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

Section 8: Medicare Advantage Program and QHP Requirements

a. **Maintenance and Provision of Certain Information.** Provider acknowledges that HMSA and MA Plan are required under applicable federal law and regulations to submit to CMS certain information regarding the benefits provided by MA Plan and quality and performance indicators. Provider acknowledges that HMSA and MA Plan may be required under such laws and regulations to disclose certain information to MA Members and QHP Members in such form a manner requested by CMS. Provider shall maintain all records and reports reasonably requested by HMSA and shall provide such records and reports to HMSA to enable HMSA and MA Plan to meet their obligations to submit such information to CMS and to disclose certain information to MA Members and QHP Members as required by applicable law and regulations.

b. **Offshore Operations.** Provider shall not disclose any of MA Members' or QHP 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 MA Plan's or HMSA's protected health information by any Downstream Entity for any function, activity, or purpose to be performed outside of the United States, without HMSA's prior written approval.

c. **Cease Payment Upon Exclusion**. HMSA shall immediately cease making all payments to Provider for Covered Services provided to MA Members and QHP Members by excluded persons as described in Section 8 as of the date Provider, or any Affiliated Party employed by Provider has been excluded from participation under Medicare.

d. **Contracts with Downstream Entities.** If Provider contracts with a Downstream Entity to fulfill Provider's obligations hereunder, Provider shall require the Downstream Entity by written agreement, and shall require such Downstream Entities to include in their contracts with other Downstream entities, to comply with all provisions of these Required Terms and which expressly requires each Downstream Entity to: (a) comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F.R. Parts 155 and 156 and 42 C.F.R. Part 422, to the extent relevant, in performing or assisting in the performance of services; and (b) grant access to its books, contracts, computers, or other 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 HMSA, MA 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. HMSA retains the right to approve, suspend, or terminate any arrangement between Provider and a selected Downstream Entity with respect to services provided under these Required Terms.

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

e. Excluded Persons. Provider 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)). Provider 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). Provider shall notify HMSA immediately in writing if Provider, 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. Provider shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the delivery or administration of Covered Services to MA Members. HMSA reserves the right to require Provider to demonstrate compliance with this provision upon reasonable request.

f. Fraud, Waste and Abuse Prevention. Policies and Procedures. Provider shall adopt and follow, and Provider shall require its Downstream Entities to adopt and follow policies and procedures that reflect a commitment to detecting, preventing, and correcting fraud, waste, and abuse in the administration of the MA Program and QHPs. Provider shall implement this Section 14.6(a) within a reasonable time period, but not later than 12 months. HMSA reserves the right to require Provider to demonstrate compliance with this provision upon reasonable request. Such policies and procedures shall include but are not limited to policies and procedures regarding:

i. Provider's code of conduct.
ii. Ensuring that Provider's managers, officers, and directors who are responsible for the administration or delivery of MA Program and QHP benefits are free of conflicts of interest in the delivery and administration of such benefits.
iii. Delivery of annual general and specialized Medicare compliance training for all persons involved in the administration or delivery of MA Program benefits.
    - General compliance training shall include subjects such as Provider's compliance responsibilities, code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues.

- Specialized compliance training shall include prevention of fraud, waste, and abuse ("FWA"), FWA laws and regulations, recognizing and reporting FWA, consequences and penalties of FWA, available FWA resources, and areas requiring specialized knowledge of applicable MA Program procedures and requirements in order for Provider to perform or provide services under the Agreement.

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

v. Monitoring and auditing of Provider's performance of its obligations under these Required terms.

- Cooperation with Compliance Activities. Provider shall cooperate with HMSA's or MA Plan's compliance program, including, but not limited to inquiries, preliminary and subsequent investigations, and implementation of corrective action. Provider 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 Provider performs pursuant to the Agreement, Provider shall provide HMSA a copy of audit results and shall make all audit materials available to HMSA upon request.
- Fraud and Abuse Statutes. Provider 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-7b(b)), and the Anti-Influencing statute (42 U.S.C. S 1320a-7a(a)(5))

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 HMSA 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 HMSA'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 ninety (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 HMSA Dental PPO Plan but will be ineligible for the Medicare Advantage plans under this participation.

Section 9: Medicare Advantage (MA) Plans

HMSA Akamai Advantage Dual Care (PPO-SNP) is a Dual Eligible Special Needs Plan (D- SNP) offered to members who have both Medicare and Medicaid benefits (also referred to as Dual Eligible members). This medical plan is administered by HMSA and includes limited dental benefits such as Dental Exams, Cleanings, X-Rays, Amalgams, Composite Restorations, Root Canal Therapy, Periodontal Scaling/Root Planing and Denture Adjustment/Repair.

If you are a participating dentist in HMSA's MA network, you are considered in-network for members of the HMSA Akamai Advantage Dual Care Plan. You will be reimbursed at your current HMSA contracted MA fee schedule.

Providers who participate in HMSA's Dental MA network will have access to members with a Medicare Advantage plan. This plan covers a limited number of services, but those procedures that are covered have a $0 member copayment in-network, with the balance of the allowable charge payable by HMSA. Any 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 services not covered by the plan, please notify the members before services are rendered.

Please be sure to verify eligibility and benefits for all members before rendering services.

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

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

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

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

HMSA Dental Claims
P.O. Box 1187
Elk Grove Village, IL 60009-1187

Covered services embedded in member's HMSA Akamai Advantage Dual Care Plan

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	2022 BENEFIT FREQUENCY & LIMITATIONS
0120	DIAGNOSTIC	Clinical oral examination, periodic	Two per calendar year, combined frequency with 0140 and 0150
0140	DIAGNOSTIC	Oral exam problem focused	One per calendar year, combined frequency with 0120 and 0150
0150	DIAGNOSTIC	Comprehensive exam	One per lifetime, combined frequency with 0120 and 0140
0270	DIAGNOSTIC	Radiographs, bitewing - single film	One set per calendar year (any of these codes 0270, 0272, 0273, 0274, 0277 constitute a set, except when done within 12 months of 0210 or 0330)
0272	DIAGNOSTIC	Radiographs, bitewing - two films	See details listed for Code D0270
0273	DIAGNOSTIC	Radiographs, bitewing - three films	See details listed for Code D0270
0274	DIAGNOSTIC	Radiographs, bitewing - four films	See details listed for Code D0270
0277	DIAGNOSTIC	Radiographs, bitewing - four films	See details listed for Code D0270
0210	DIAGNOSTIC	Intraoral – complete series of x- rays	One set per five years, (any of these codes 0210 or 0330 constitute a set)
0330	DIAGNOSTIC	Radiographs, panoramic film	See details listed for Code D0330
1110	PREVENTIVE	Prophylaxis - adult	Two per calendar year
2140	RESTORATIVE	Amalgam – 1 surface, primary or permanent	One per surface per tooth per calendar year
2150	RESTORATIVE	Amalgam – 2 surfaces, primary or permanent	One per surface per tooth per calendar year
2160	RESTORATIVE	Amalgam – 3 surfaces, primary or permanent	One per surface per tooth per calendar year
2161	RESTORATIVE	Amalgam – 4 surfaces, primary or permanent	One per surface per tooth per calendar year
2330	RESTORATIVE	Resin based composite – 1 surface, anterior	One per surface per tooth per calendar year
2331	RESTORATIVE	Resin based composite – 2 surfaces, anterior	One per surface per tooth per calendar year
2332	RESTORATIVE	Resin based composite – 3 surfaces, anterior	One per surface per tooth per calendar year

Additional codes on next page

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

PROC CODE	ADA TYPE	PROCEDURE DESCRIPTION	2022 BENEFIT FREQUENCY & LIMITATIONS
2335	RESTORATIVE	Resin based composite – 4 surfaces, anterior	One per surface per tooth per calendar year
2391	RESTORATIVE	Resin based composite – 1 surface, posterior	One per surface per tooth per calendar year
2392	RESTORATIVE	Resin based composite – 2 surfaces, posterior	One per surface per tooth per calendar year
2393	RESTORATIVE	Resin based composite – 3 surfaces, posterior	One per surface per tooth per calendar year
2394	RESTORATIVE	Resin based composite – 4 surfaces, posterior	One per surface per tooth per calendar year
3310	ENDODONTICS	Endodontic Therapy – anterior tooth	One per tooth per calendar year
3320	ENDODONTICS	Endodontic Therapy – bicuspid tooth	One per tooth per calendar year
3330	ENDODONTICS	Endodontic Therapy – posterior tooth	One per tooth per calendar year
4341	PERIODONTICS	Periodontal Scaling and root planing	One per quadrant per calendar year
5410	PROST, REMV	Denture adjustment complete upper	Two per calendar year
5411	PROST, REMV	Denture adjustment complete lower	Two per calendar year
5421	PROST, REMV	Denture adjustment partial upper	Two per calendar year
5422	PROST, REMV	Denture adjustment partial lower	Two per calendar year
5511	PROST, REMV	Repair broken complete denture base, mandibular	One per arch per calendar year

PROCEDURE CODES NOT LISTED IN TABLE ABOVE ARE NOT COVERED FOR THIS PLAN

Key Highlights

- All services payable at 100% for Par providers and 50% for non-Par providers
- This maximum applies to in-and out-of-network preventive and additional comprehensive dental services.
- HMSA Akamai Advantage Dual Care has offered Oral Health for Total Health enhanced dental benefits since January 1, 2019.

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

Section 10: 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 HMSA'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

HMSA has a Dental Advisory Committee that provides valuable guidance and counsel to HMSA regarding various dental issues related to operations and programs. HMSA 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 HMSA 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)

- Enter an X in the appropriate box to indicate if this claim is a pre- treatment estimate or a claim for actual services rendered.
- Predetermination/Preauthorization Number is not required.

Insurance Company/Dental Benefit Plan Information (block 3)

HMSA Dental Claims
P.O. Box 1187
Elk Grove Village, IL 60009-1187

Other Coverage (blocks 4-11)
refers to the possible existence of other medical or dental insurance policies, relevant for coordination of benefits.

Policyholder/Subscriber Information (blocks 12-17)
documents information about the insured person (subscriber), who may or may not be the patient.

Patient Information (blocks 18-23)
refers to the patient receiving services or treatment.

Record of Services provided (blocks 24-35)
regards the treatment performed or proposed. For a predetermination of benefits, complete this area in the same way as for an actual service, but omit the date of service. Ten lines are available for reporting.

Authorizations (blocks 36 and 37)
where the patient or subscriber signs to provide consent for treatment and authorization for direct payment.

Ancillary Claim/Treatment Information (blocks 38-47)
asks for additional information regarding the claim and the member's prior dental history. Some of these questions may be left blank if the service is not orthodontic or prosthetic.

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

Billing Dentist or Dental Entity (blocks 48-52A)
provides information on the dentist or group/corporation responsible for billing and receiving payment, which may or may not be the treating dentist. Block 49 is specific to reporting the associated National Provider Identifier (NPI).

Treating Dentist and Treatment Location Information (blocks 53-58)
asks for information specific to the provider. Block 54 asks for the treating dentist's NPI.

To obtain an NPI, visit the Centers for Medicare & Medicaid Services' National Plan and Provider Enumeration System (NPPES) website at nppes.cms.hhs.gov/NPPES/Welcome.do. You must submit all claims with your NPI information. See Section 10 of this manual for details.

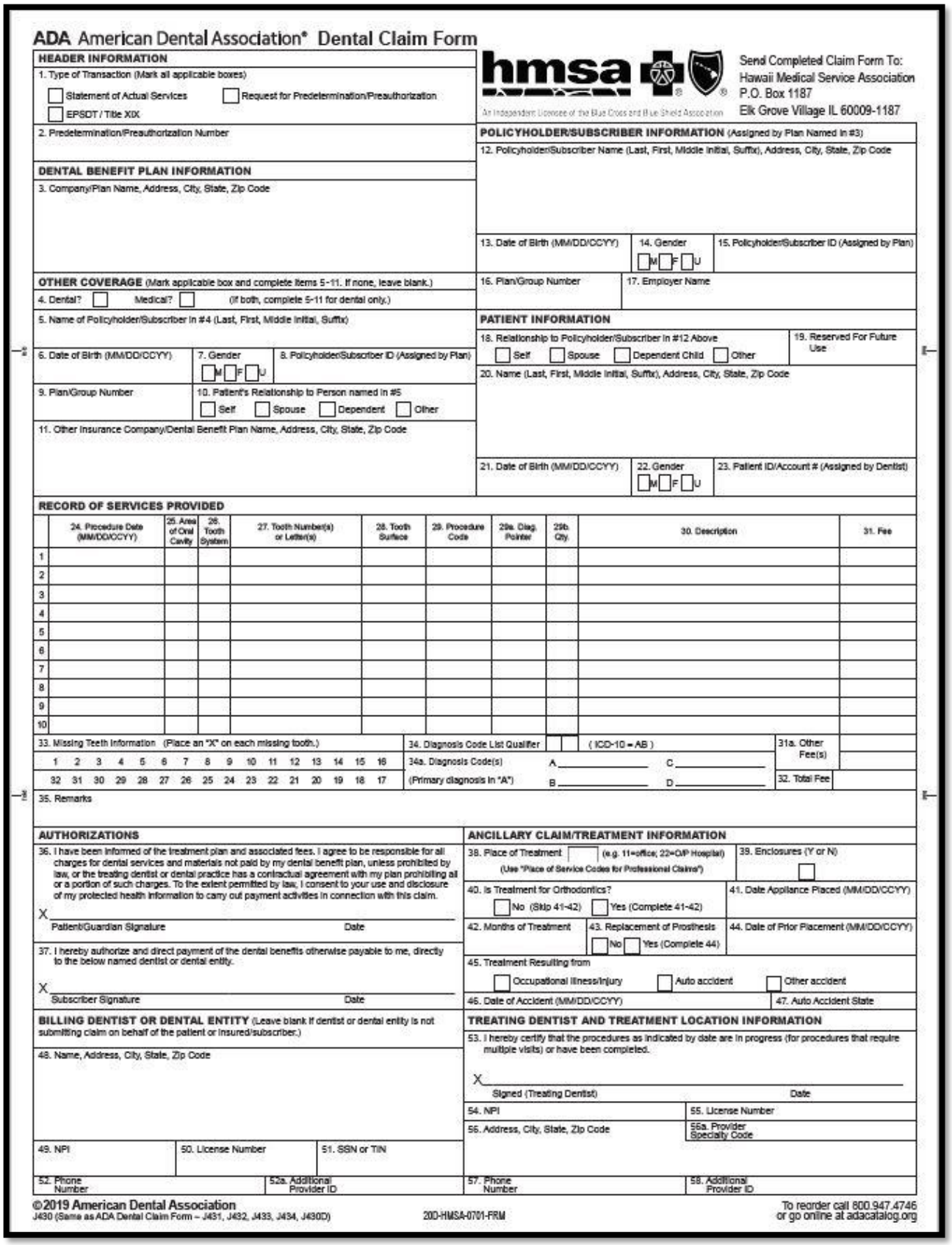
Billing with a National Provider Number (NPI)

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.

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

Sample Dental Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

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

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

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

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

Send Completed Claim Form To:
Hawaii Medical Service Association
P.O. Box 1187
Elk Grove Village IL 60009-1187

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

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

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

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

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

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

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

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

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

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

52. Phone Number | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

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

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

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

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

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

57. Phone Number | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D) 20D-HMSA-0701-FRM
To reorder call 800.947.4746 or go online at adacatalog.org

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

Reimbursements

Medicare Advantage Participating providers

HMSA will always reimburse claim payments for covered members directly to the participating provider. If an unassigned claim is submitted on behalf of the member, we will still pay the claim directly to the participating dentist. 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 HMSA in cases when medical necessity could not be established.

Medicare Advantage Non-Participating providers

Members with plans under the MA network should be directed to MA providers for services. No payments will be made for services rendered by Non-Participating providers. Please verify the member's eligibility and benefits prior to rendering services. Non-participating providers should notify the member of participation status prior to services being rendered.

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 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

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

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

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

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

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

Section 12: Coordination of Benefits (COB)

Determining the Primary Payor

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

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

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

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

2. When two or more dental plans cover the same child as a dependent of different parents:

   a. The dental 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 is 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:

    - Indemnity
    - Excess insurance
    - Specified illness or accident
    - Medicare supplement

Determining Your Patient's Liability in a COB Situation

1. If the HMSA Plan is the Secondary Plan in accordance with the order of benefits determination rules outlined above; the benefits of the Plan will be reduced when the sum of:
    a. The benefits that would be payable for the allowable expense under the HMSA Plan in the absence of this COB provision; and
    b. The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether a claim is made, exceeds those Allowable Expenses in a claim determination period. In that case, the benefits of the HMSA plan will be reduced so that its benefits and the benefits payable under the other plans do not total more than those Allowable Expenses.

2. When the benefits of the HMSA Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the HMSA 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 HMSA Plans).
- Always calculate your patient's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary payor's EOB may not correctly reflect the patient's balance and that your patient's liability may be affected by contracts that you hold with the primary carrier.
- If the provider receives payment more than 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, 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 ora 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 discrepancythat 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

1. **Hawaii Medical Service Association (HMSA)** 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:

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

   The request may also be **faxed to (888) 667-8388.**

2. If the inquiry is regarding Quality of Care or Quality of Service, it must be in writing and is handled by the Quality Assurance Area of HMSA'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:

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

   The request may also be **faxed to (888) 667-8388.**

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

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

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

Section 15: Termination

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

Types of Termination and Effective Dates

a. *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 HMSA, that address is:

HMSA Dental
P.O. Box 1320
Honolulu, HI 96807-1320

The effective date of the termination will be as of 12:01am on the first day of the month following the ninety (90)-day notice period. During this ninety (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 HMSA. The parties may also terminate the Agreement at any time by written mutual consent.

b. *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.

c. *With cause:* may occur if you do not consent to any change(s) to the Agreement made by HMSA. The "Agreement" consists of the Agreement, Dental Manual, MA Manual, and any Amendments to the Agreement. HMSA 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, HMSA has the right to either: (1) notify you that it has elected to not amend the Agreement, or (2) terminate the Agreement upon ninety (90) days written notification. Changes to administrative policies, procedures, rules and regulations, conditions of participation, or the Maximum Allowable Charges (fee schedule) do not require an amendment to the Agreement.

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