Anthem BlueCross

Provider Reference Manual

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Section 1: General Information

About Anthem Blue Cross

Anthem Blue Cross (Anthem) and its affiliates offer a variety of dental plans for its members nationwide. These dental plans make available primary and specialty dental services. Our dental plans use dental networks that are created to provide you with choice regarding fees that are acceptable to you and create new opportunities to grow your dental practice.

Today's consumers of dental benefits desire more plan choices than at any time in the past. Having access to multiple dental PPO networks allows Anthem to market a greater variety of plans to our customers, increase choice for your patients and create opportunities for you.

What is a Dental Plan?

A dental plan is a product an employer group or an individual buys from a company who offers dental benefits, in order to offer their employees assistance or to have assistance with the payment of dental benefits.

Dental benefit plans are better characterized as financial assistance plans rather than as insurance. Unlike true insurance plans, which are designed to protect against major loss, dental benefit plans provide financial assistance to Members and their families to encourage regular visits to the dentist, which are essential to maintaining oral health. Most dental plans are structured to provide coverage that meets the basic needs of the general population.

Dental services are less costly and more predictable than medical care, dental plans typically feature a specific set of benefits and coverage parameters and are not always designed to address each individual's specific dental treatment needs.

Specific dental care needs vary for each individual and should be discussed with the patient. Depending on the Member's oral health circumstances the dental plan may or may not cover all of their treatment needs, and should not be the sole determinant of the dental treatment that they receive.

Anthem offers insured products where the insurance is underwritten by Anthem; administrative services to self-funded groups or unions who have an Anthem product; and services to provide Anthem products to health care exchanges.

How is the actual benefit plan determined?

The ***employer*** determines the combination and extent of dental benefits for their employee's dental program by purchasing the plan that fits their needs. If the dental benefits are purchased by an individual the person purchasing the plan makes the determination of which plan fits their needs. Anthem is responsible for administering the plan, making appropriate payments according to the plan benefits and maintaining the integrity of our dental networks. With regards to Affordable Healthcare Act plans, the Federal government and/or the state may determine benefits.

How does a Dental Network differ from a Dental Plan?

A Dental Network is:

A group of dentists who have agreed to provide dental services to a dental plan's Members at a specified reimbursement. Within a network there can be more than one plan for the employer group to select from.

A Dental Plan or Product is:

A dental plan is a product an employer group buys from a company who offers dental benefits, in order to offer their employees assistance with the payment of dental benefits.

Dental PPO (Preferred Provider Organization or Participating Provider Organization) plans are perhaps the most common type of dental insurance plans. Most dental PPO plans require the patient to pay Co-insurance and/or a deductible. Each one of those plans may have different amounts for the deductible, the yearly maximum, what procedures are covered and at what percentage.

See Section 2, Provider Networks and Plans, for the list of Anthem's networks and plans those networks serve.

Responsibilities of the Dentist

As a participating dentist you agree to recommend and provide dental services in the best interest of each individual patient's oral health needs. You are also obligated and strongly encouraged to:

- Identify which plan a patient is on and which network services that plan;
- Obtain a current copy of the patient's identification card at each dental visit;
- Submit claims for your Anthem patients timely and accurately;
    - **CA 2022 SB1242(B) Fraud Warning** "For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."
- Accept the allowed amount for covered services and direct payment from Anthem, Affiliates, self-funded groups (who may use Third Party Administrator for some administrative services), and National GRID program, as applicable to your Participating Agreement;
- Provide to an Anthem Blue Cross Member a written recommended treatment plan and cost associated with covered benefits and non-covered benefit options to ensure all parties are well informed of the treatment plan and agree prior to services being rendered;
- Submit diagnostic aids (such as x-rays) to the plan as necessary;
- Update Anthem's Provider Network Representative Services department with your most current dental practice information (i.e., adding new dentists to your practice, credentialing information, address changes, Tax Identification Number (TIN) changes, change in ownership, etc.) on a timely basis or as required by your Participating Agreement; and
- Provide quality dental services to covered Anthem Blue Cross Members in accordance with prevailing professional standards, and in a manner similar to and within the same availability in which you provide dental services to any other individual.

- Participate in, and abide by the Anthem Blue Cross Quality Assurance Program as set forth in Section 4 of this manual.

It is the sole responsibility of the dentist to confirm eligibility prior to treating Anthem Blue Cross covered members. A dental office is strongly encouraged to confirm if they are participating with the Member's dental plan so when recommending a treatment plan and cost of treatment it will reduce the risk of miscommunication and dissatisfaction between all parties

Responsibilities of an Anthem Member

Depending on a Member's oral health circumstance, the dental plan may or may not cover all of his or her treatment needs. The Member's coverage level is not to be the sole determinant of the dental treatment recommended or provided. Members are responsible for:

- Choosing a participating or non-participating dentist;
- Providing a current identification card at each dental visit;
- Discussing, understanding, and agreeing with treatment options and costs with their dentist prior totreatment; and
- Understanding their dental plan and be familiar with the dental benefits covered by their dental program. (Encourage Members to call Customer Service if they have questions about coverage.)

Responsibilities of Anthem or Affiliates or Self-Funded Groups (may use Third Party Administrators) or National Dental GRID program

Anthem or affiliates, self-funded groups (who may use Third Party Administrators) or National Dental GRID program are responsible for administering the dental plan, making appropriate payments according to the dental plan benefits and maintaining the integrity of our various dental networks. Anthem or affiliates, self-funded groups (who may use Third Party Administrators), or National Dental GRID program's obligations are to:

- Process submitted, "clean" dental claims correctly;
- Make payment directly to your office when the dentist is participating in the network that services a member's benefit plan; and
- Help the Member and dental office understand the different benefit plans.

How to Contact Anthem Blue Cross

Provider Network Representative Services

Call Provider Network Representative Services for questions regarding:

- All Anthem dentist or dental clinic/practice contracts
- Dentist or dental clinic/practice participation
- Fees
- Updating dentist and dental office information (address change, Tax ID number change, etc.)
- Escalated provider issues that cannot be resolved through Customer Service
- Provider Network Representative Services may also be contacted for questions related to GRID or GRID+

Provider Network Representative Services can be reached at **1-866-947-9398.**

Representatives are available Monday – Friday from 5:00am to 4:30pm PDT.

Updated dentist and dental office information may be emailed, faxed, or mailed to:

Email: DentalNetworkSubmit@Anthem.com

Fax: **1-877-283-1331**

Anthem Blue Cross Dental
Services
PO Box 1171
Minneapolis, MN 55440-9901

*For details regarding submitting changes, refer to Section 7: Administration and the section *Updating Dentist and Dental Office Information*

How to Contact Anthem Blue Cross, cont.

Customer Service

For product specific questions on subscriber eligibility, benefits, and claims call Customer Service at:

Prime and Complete Products/Networks

You may call **1-877-567-1804**. Please refer to the back of the Member's ID card.

Customer Service is available Monday – Friday from 8:00am to 5:00pm in your local time zone.

Anthem PPO Products

Prudent Buyer (also known as PPO Network)
PPO 100/200/300 (also known as Dental Blue Three-Tier Network)

You may call **1-800-627-0004.** Please refer to the back of the Member's ID card.

Customer Service for all products is available Monday - Friday from 8:00am to 5:00pm in your local time zone.

Claims Address

Please refer to the back of the Member's ID card to verify the correct claims address.

Prime and Complete claims:

Anthem Dental Claims
PO Box 1115
Minneapolis, MN 55440-1115

Other Anthem PPO Claims:

Anthem Dental
PO Box 659444
San Antonio, TX 78265

Appeals/Written Correspondence Address

For Prime and Complete:

Anthem
Attn: Dental Claims Appeals & Grievances
PO Box 1122
Minneapolis, MN 55440-1122

Other Anthem PPO products:

Anthem Blue Cross
Attn: Appeals
PO Box 659471
San Antonio, TX 78265

Anthem Web Site – www.anthem.com/ca/dentalproviders

California Language Assistance Program

Effective January 1, 2009, all California health plans regulated by the Department of Managed Health Care and the California Department of Insurance are required to provide language assistance services to their limited English proficient (LEP) Members.

We appreciate the need for good communication between providers, patients, and the Plan, and offer the linguistic tools needed to satisfy the requirement.

Provider Responsibilities

Notification: Providers must notify Members of the availability of health plan interpreter services and strongly discourage the use of minors, friends and family who may act as interpreters.

> Plan has multilingual signage available for providers to post in areas likely to be seen by Members; this signage notifies Members of the availability of interpreter services that are provided by the Plan.

Documentation of Notification: If the Member chooses to use a friend, family member or minor as an interpreter after being notified of the availability of free interpreter services, the provider must document this choice in a prominent place in the Member's dental records. (We suggest following the protocol your office uses for HIPAA and/or Dental Materials Fact Sheet documentation.)

Plan Responsibilities

Telephone interpreters during working hours: Our Customer Service Representatives will facilitate a three way telephone connection to "Language Line" for telephonic interpretation in your office. Please use the following number to access this service: **1-800-627-0004.** This is at no cost to the Member or the dental office.

The Plan will also be providing written documents to the Members in their spoken language when requested. These languages include Spanish, Chinese, Korean, Vietnamese and Tagalog.

Get help in your language

Language Assistance Services

Anthem.

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721. (TTY/TDD: 711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

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Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는
언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오.
(TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы
также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по
номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa
pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa
libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc
thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi
ngay số 1-888-254-2721. (TTY/TDD: 711)

Section 2: Provider Networks and Plans/Products

Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete and Anthem Prudent Buyer Network are considered participating dentists to provider in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask members for their identification cards. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Anthem Prudent Buyer Network

The Anthem Prudent Buyer Network supports large group, small group and individual Anthem dental membership having purchased the Prudent Buyer Dental PPO plan.

Prudent Buyer large group and small group plans are claims based. The reimbursements to the dental offices are determined by percentages according to the members specific plan design.

Prudent Buyer individual plan is claims based reimbursing the dental offices according to a schedule of benefits. The schedule of benefits details what the insurance company will pay. The remainder, up to the maximum allowable amount, becomes the members' responsibility.

The Prudent Buyer network is comprised of General Dentists, Endodontists, Oral Surgeons, Periodontists, Orthodontists and Pedodontists.

Smile Net

Prudent Buyer Dentist Agreement includes the option to participate in the Smile Net Discount Dental Plan. The dentist must check the box on the signature page of the agreement in order to participate with Smile Net.

Smile Net does not require claim submission for reimbursement, nor does it have any plan restrictions, limitations or exclusions.

Payment for services rendered is received directly from the member based on the contracted Prudent Buyer allowed amounts per Exhibit A at the time of service.

The dentist is responsible for requesting Smile Net identification material prior to providing services.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the PPO 100/Prime/Complete level are also agreeing to participate in the PPO 200/Complete and PPO 300/Complete levels. Dentists choosing to participate in the PPO 200/Complete level are also agreeing to participate in the PPO 300/Complete level. Dentists choosing to participate in the PPO 300/Complete level are only participating in the PPO 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and is reimbursed based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Complete level and accept the 200/Complete fee schedule. The dentist must sign a separate agreement to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Complete allowed amount at time of service. Dentist agrees to accept the rates set forth in the Network Fee Schedule PPO 200/ Complete or 15% off Dentist usual charge for any procedure not listed on Network Fee Schedule PPO 200/Complete as payment in full for Discount Program Services provided to Discount Program Participants The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100, PPO 200, PPO 300, Prime and Complete Networks

- **Dental Prime** = In-Network if participating in PPO 100/Prime/Complete
- **Dental Complete** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID =** In-Network if participating in PPO 100/Prime/Complete as noted above
- **Dental GRID+** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY as noted above
- **Dental BLUE (DB) PPO 100, PPO 200, PPO 300** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY

Note – Dental Plans/Products can have numerous designs as an employer can select the benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 classic design)

GRID and GRID+

The National Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The National Dental GRID offers customers of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The National Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 200/Complete or PPO 300/Complete dentist.
    - PPO 200/Complete or PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Complete, PPO 300/Complete).

- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Complete, PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

A participating plan will issue their own member ID cards indicating the plan name on the front of the card.

A member's ID card will have either GRID or GRID+ on the back of their card.
The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Complete, PPO300/Complete, & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at 200/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Section 3: Dental Provider Portal

Availity Portal

Your online dental claims, eligibility and benefits website has changed! Based on your input, we launched a brand new dental provider website. All the functionality from our previous sites have been consolidated into a single web portal powered by Availity, along with enhancements to make doing business with Anthem even easier.

- Availity Gives You the Tools You Need
- You get one easy website for claims and attachments.
- You can check eligibility and benefits, manage claims, view remittances and complete secured administrative tasks online.
- It's easy to create an account with Availity if you don't already have one.
- Training is free online and available at your convenience—there's no need to schedule!

Introducing Patient Health History

- Availity now provides access to Patient Health History. This feature offers dental providers a more complete view of a patent's overall health. For members with Anthem dental benefits and an affiliated medical plan you can:
- View medications that may affect your patient's dental health
- Confirm medical information that may help you diagnose conditions that display specific symptoms in the mouth
- Receive care alerts that notify you of any gaps in patient care that we've identified
- Stay up-to-date about your patient's health when performing exams or procedures, helping to improve their overall care
- To learn more about how this tool works, visit www.viewmedicalhistory.com/dental or if you're ready to start using the Patient Health History button, visit www.availity.com to get started.

Section 4: Quality Assurance

Dentist Credentialing and Re-credentialing

The goal of Anthem is to establish long-term relationships with dentists who share our commitment to continuously improving the lives of our members.

Credentialing refers to the process of screening and continuous evaluation of new and existing dentist's abilities to meet specific participation requirements, while making fair approval decisions.

The credentialing and re-credentialing process provides assurances to employer groups, consumers, and regulators that our participating dentists meet minimum standards.

Along with signed participating provider agreements, each new dentist must provide the following credentialing elements:

- A completed Credentialing Application that includes answering disclosure questions, and confirmation of professional liability insurance including limits and expiration date.
  - ✓ Note: Some states require a state-specific or the CAQH credentialing application be used, please ensure you are using the correct application for the state you are practicing in.
- A copy of a current dental license for each state in which the dentist practices.
- A copy of a current DEA for each state in which the dentist practices, if the dentist holds such a registration.
- A copy of the specialty certificate (if applicable).
- Written verification of the dentist's National Provider Identifier (NPI) number (individual and/or clinic).
- A completed W9 form indicating the appropriate Tax Identification Number (TIN) or Social Security Number (SSN) used to submit claims.

Dentists are initially credentialed based on contract participation requirements. Dentists are re-credentialed on a regular basis depending on the re-credentialing requirements for the various contracts. In addition, verification with sources such as Medicare/Medicaid, Office of Inspector General, National Practitioner Data Bank (NPDB) and state dental boards are performed as part of the credentialing and re-credentialing process.

All information obtained as part of the credentialing or re-credentialing process is treated confidentially by Anthem.

A dentist is not considered a participating provider and added to a network until all participation and credentialing requirements are met.

Grievance Resolution

Anthem is committed to member satisfaction and quality care. Our commitment is demonstrated through a formal grievance resolution program that promptly addresses members' concerns regarding administration, quality of care and network specific issues.

A participating dental office should provide a level of patient care and open communication to facilitate the immediate internal resolution of a patient's concerns. Matters, which cannot be satisfactorily answered or concluded within the dental office, will be resolved through formal grievance procedures established by Anthem. Participating dentists shall comply and provide all necessary documentation to resolve patient grievances, complaints and/or inquiries. A participating dentist agrees to cooperate in the resolution of a quality of care grievance and comply with the requirements of any applicable state or federal law or regulation governing grievances. It is expected that a participating dentist will cooperate fully in Anthem's investigation of all grievances.

Anthem will make every reasonable effort to resolve grievances within 30 days of receipt or as required by state law or contract. If resolution cannot be made within 30 days of receipt members will be notified that additional time may be needed.

PROVIDER GRIEVANCE RESOLUTION

If you, as the treating dentist, disagrees with a claim or billing determination, or our request for reimbursement of an overpayment, or if you have a contract dispute, you may submit a provider dispute by mailing a written notice to us at: Grievances and Appeals, P.O. Box 659471, San Antonio, TX 78265. The written notice of dispute must include the provider's name, tax identification number, patient name, health plan identification number and a description of the dispute. Provider disputes must be received by the health plan no later than 365 days from the health plan's action that led to the dispute (or the most recent action, if there are multiple actions that led to the dispute).

All grievance correspondence includes the following paragraph:

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 627-0004 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR applications forms and instructions online."

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Member Grievance Form

You may use this form to submit a grievance. Please attach any information you have to support the request. Send the form and any supporting information to: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310. Or, you may call the toll-free phone number on your member ID card to ask customer service to fill out the form for you. We will send a response to your grievance within 30 calendar days from the date we receive it.

Member Name:	ID Number (see member ID card):
Group Number (see ID card):	Phone Number(s):
Address:	

If you are not the member, please provide the following information:

Your Name:	Relationship to Member (if applicable):
Your Phone Number(s):	
Your Address:	

Are you the member's authorized representative or legal guardian? Yes ☐ No ☐

Note: We must have written authorization to allow you to act on the member's behalf if you aren't their authorized representative or legal guardian.

Please explain your grievance. Include, if available, the following information:

- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision that you don't agree with; and
- The specific reason(s) why you don't agree with the decision.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

If your plan is regulated by the Department of Managed Health Care, please read the following information. If you don't know if your plan is regulated by the Department of Managed Health Care, please look at your benefits booklet. Customer service can also help you. To reach customer service, call the phone number on your member ID card.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** or at the TDD line **1-866-333-4823** for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If your plan is regulated by the California Department of Insurance, please read the following information. If you don't know if your plan is regulated by the California Department of Insurance, please look at your benefits booklet. Customer service can also help you. To reach customer service, call the phone number on your member ID card.

The California Department of Insurance is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** or at the TDD line 1-866-333-4823 for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. If you and your plan don't come to a solution that you are happy with, or you haven't been able to solve the problem through arbitration with your plan, you can contact the CDI:

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California Department of Insurance
Consumer Communications Bureau
300 Spring Street, South Tower
Los Angeles, CA 90013
Phone: 1-800-927-HELP (4357) or 1-213-897-8921
TDD number: 1-800-482-4TDD (4833)
http://www.insurance.ca.gov/

If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and the proposed treatment is denied because it is considered experimental or investigational, you may have the right to meet with us to discuss your case as part of the grievance process. Should you feel this applies to you and you would like to request a meeting, you may call customer service toll free at **1-800-365-0609** or 1-866-333-4823 for the hearing and speech and impaired. This right is in addition to any other dispute resolution options available to you as explained in this notice.

Signature:_____ Date: _____

For Use by Anthem Blue Cross/Anthem Blue Cross Life and Health Only

Representative Name:	Unit/Location:	Date:

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Participation in Anthem's Quality Assurance Program

Dentists who are participating in the Pediatric Dental Benefit under the Affordable Care Act (ACA) are required to comply with the California Code of Regulations, Title 28 and the Knox-Keene Act. This requires that dentists participate in and follow the guidelines of Anthem's Quality Assurance Program.

Anthem is required by regulation to demonstrate quality of care oversight of contracted dentists. Quality of Care oversight is performed through our Quality Assurance Program (QAP). Anthem has a multifaceted quality of care system, the primary goal of which is to ensure that the level of dental care provided to plan members meets professionally recognized standards of practice. Identification of less than satisfactory care is accomplished through the Quality Improvement Committee (QIC), on site review (which includes dental care record audits), accessibility data, grievance review and utilization management.

The California State Dental Director supervises the QAP and QIC for California, which consists of dentists from the general dental community, as well as specialty fields. The National Dental Director chairs the national QIC.

The objective of the QAP is to assure that issues are reviewed, problems identified, actions taken to improve care and that care is not withheld or delayed. Through monitoring and oversight, Anthem assures that members are not over or under treated, over or under diagnosed, or inappropriately charged for services rendered. Furthermore, Anthem prohibits dentists from switching patients from covered to uncovered services without prior appropriate disclosure to, and documented consent, from the member.

Section 5: Professional Review

The primary function of Professional Review is the evaluation of treatment for appropriateness of care and accuracy of coding for both Pre-estimate of Benefits and Claim for payment through pre and post-treatment review.

An initial benefit determination will be made within 30 days after receipt of your claim.

Helpful Hints for Claims Processing

If a claim does not pay, do not send in another claim until you've called Customer Service to determine what you need to do next. Sending multiple claims creates duplicates which delays the claims processing turnaround time.

Remember to check the member's ID card for the correct claims mailing address and, Customer Service number.

For prosthetics, please be sure to fill out the proper information on the claim form. This should include answering the question "Is this an initial placement?" and filling out the date of prior placement.

If a member has other insurance, remember to send the primary explanation of benefits as well as any secondary insurer information.

Electronic Claims:

According to our Customer Service team, the primary reason that an electronic claim processes as a non-participating provider (not contracted) is due to omission of the individual NPI number in the treating section of the claim form (the clinic NPI is listed or no NPI is listed). To ensure accurate claims processing, please be sure you have obtained and notified Anthem's Professional Services of your individual NPI number and be sure to include it on all claim forms. Contact Professional Services at 866-947-9398.

Paper Claims:

The most common reasons that paper claims process as non-participating provider (not contracted), is due to missing or incomplete information, the treating provider's full license number and the treating location's address are not noted in the treating section of the claim form (the billing address is listed instead).

Claims Review Submission Guidelines – Anthem Dental PPO (Prudent Buyer) and PPO 100/200/300/Prime/Complete

For claims submission, one or more of the following procedures may be reviewed based on identified patterns of practice using historical claims data and/or review of procedures dictated by dental plans for accurate benefit administration.

These guidelines reference Legacy and Prime and Complete submission requirements and Anthem Clinical Policies where applicable.

Submission of Radiographic Image Requirements:
Patient identifier, Current (within 12 months), dated, mounted, properly labels and oriented diagnostic (sufficient contrast and density, no geometric distortion) radiographic images.

- All periapical radiographic images must show the entire tooth structures (crown and root including the apex).

Procedure Code	Description	Send with Claim/Pre-Determination
RESTORATIVE PROCEDURES		
D2390	Resin Crown	Dated pre-operative x-rays.
D2510 – D2664	Inlays/Onlays	Prior placement date, dated pre-operative x-rays including bitewings. Dated periodontal charting, if applicable.
D2710 – D2799	Crowns	Prior placement date, dated pre-operative x-rays including bitewings, if applicable. Date periodontal charting, if applicable.
D2710 – D2799	Crowns specific to third molars	Prior placement date, dated pre-operative x-rays including bitewings, if applicable. Date periodontal charting, if applicable.
D2930 – D2934	Crowns (Stainless Steel)	Dated pre-operative x-rays.
D2940	Protective Restoration	Dated pre-operative x-rays and chart notes.
D2950, 2951	Build-ups, pins	Dated pre-operative x-rays, and rationale for dental necessity, if applicable.
D2952 – D2957	Posts and core	Dated pre-operative x-rays, and rationale for dental necessity, if applicable.
D2960 – D2962	Veneers	Prior placement date, dated pre-operative x-rays, including bitewings, if applicable. Dated periodontal charting, if applicable.
D2980 – D2983	Crown Repair	Dated pre-operative x-rays.
ENDODONTIC PROCEDURES		
D3220 – D3240	Endodontic Therapy	Dated pre-operative x-rays.
D3310 – D3348	Endodontic Therapy	Dated pre and post-operative x-rays.
D3351 – D3353	Apexification/Recalcification	Dated pre-operative x-rays.
D3355 – D3357	Pulpal Regeneration	Dated pre-operative x-rays and chart notes.

Procedure Code	Description	Send with Claim/Pre-Determination
D3410 – D3450	Apicoectomy/Periradicular Surgery	Dated pre-operative x-rays.
D3470	Reimplantation	Dated pre-operative x-rays.
D3920	Hemisection	Dated pre-operative x-rays.
PERIODONTIC PROCEDURES		
D4210 – D4211	Gingivectomy	Dated Periodontal charting (pre and post root planing), pre-operative Full Mouth x-rays, progress or chart notes, narrative including dates of pre-operative root planing, intra-oral photographs, if applicable.
D4212	Gingivectomy/Gingivoplasty	Dated pre-operative x-rays and chart notes/narrative.
D4240 – D4245	Flap procedures	Dated Periodontal charting (pre and post root planing), pre-operative x-rays, progress or chart notes, narrative, including dates of pre-operative root planing.
D4249, D4268	Crown Lengthening	Dated Periodontal charting, Dated pre-operative x-rays, chart notes/narrative.
D4260 – D4261	Osseous Surgery	Dated Periodontal charting (pre and post root planing), pre-operative Full Mouth x-rays, progress or chart notes, narrative including dates of pre-operative root planing.
D4263 – D4264	Bone Grafts	Dated Periodontal charting, Dated pre-operative x-rays, progress or chart notes.
D4265 – D4267	Tissue Regeneration	Dated Periodontal charting, Dated pre-operative x-rays, progress or chart notes.
D4274	Distal Wedge Procedure	Dated Periodontal charting, Pre-operative x-rays, chart notes.
D4270 – D4285	Tissue Grafts	Dated Periodontal charting showing attachment levels, recession (in millimeters), and amount of attached keratinized gingiva (in millimeters); intraoral photographs.
D4341 – D4342	Scaling and Root Planing	Dated Periodontal charting, Dated pre-operative x-rays, progress or chart notes; for 4 quadrants the amount of time performed.
D4355	Full Mouth Debridement	Dated pre-operative x-rays and chart notes.
D4381	Local Delivery Antimicrobial Agent	Dated Periodontal charting; history of periodontal therapy.
D4910	Periodontal Maintenance	Dated Periodontal charting, if applicable. Chart notes/narrative regarding history of periodontal therapy.
REMOVABLE PROSTHODONTICS		
D5110 – D5140, D5211 – D5226, D5281	Complete and Partial Denture Placement	Prior placement date, dated pre-operative x-rays. Chart notes and dated periodontal charting, if applicable.
D5410 – D5761	Additional Denture Codes	Narrative for necessity.
D5982	Surgical Stent	Chart notes. Narrative for necessity.

Procedure Code	Description	Send with Claim/Pre-Determination
IMPLANT PROCEDURES		
D6010 – D6199, D3460	Implant Procedures	Dated pre-operative full mouth x-rays, dated periodontal charting.
D6190	Radiographic/surgical implant index	Narrative for necessity, progress or chart notes.
FIXED PROSTHODONTICS		
D6205 – D6794	Bridge procedures	Prior placement date, dated pre-operative full mouth x-rays, dated periodontal charting.
D6290 – D6999	Bridge repairs & Misc. Procedures	Dated pre-operative x-rays and chart notes/narrative.
ORAL AND MAXILLOFACIAL SURGERY PROCEDURES		
D7210 – D7251	Surgical Extraction	Pre-Determinations: Dated pre-operative x-rays, treatment notes detailing dental necessity. Claims: Dated pre-operative x-rays and detailed chart notes describing surgical procedure performed.
D7260 – D7283, D7287 – D7291	Other Oral Surgery Procedures	Dated pre-operative x-rays and chart notes.
D7270 – D7272	Reimplantation/Transplantation	Dated pre-operative x-rays.
D7285 – D7286	Biopsies	Pathology Report; x-rays if appropriate.
D7310 – D7321	Alveoloplasty	Dated pre-operative x-rays; narrative and progress notes.
D7410 – D7461	Surgical Excision (soft tissue)	Chart notes.
D7471 – D7490	Surgical Excision (hard tissue)	Dated pre-operative x-rays and chart notes.
D7510 – D7521	Incision and Drainage	Dated pre-operative x-rays and detailed chart notes describing surgical procedure performed and location.
D7530 – D7560	Surgical Incision	Dated pre-operative x-rays and chart notes.
D7810 – D7877	TMJ Surgery	No materials needed.
D7880 – D7881	Occlusal Device	Medical coverage information, narrative for necessity.
D7899	Unspecified TMD therapy by report	Diagnosis and detailed chart notes describing the therapy proposed/rendered.
D7920 – D7951, D7970 – D7996	Other surgical repairs	Dated pre-operative x-rays and chart notes.
D7953	Bone Graft	Dated pre-operative x-rays, progress or chart notes as applicable.
D7960 – D7963	Frenulectomy/Frenuloplasty	Chart notes.
ORTHODONTICS (MEDICALLY NECESSARY ORTHODONTIC CARE)		
D8030 – D8090	Medically Necessary Orthodontic Treatment	Completed HLD Index Form (found on our website), orthodontically trimmed study models with wax bites or ortho cadcam electric equivalent including all views, orthodontic treatment plan, when appropriate, surgical treatment plan and letter of medical necessity.

Procedure Code	Description	Send with Claim/Pre-Determination
ADJUNCTIVE SERVICES		
D9120	Fixed partial denture sectioning	Dated pre-operative x-rays and chart notes.
D9223	Deep sedation/General Anesthesia	On the same claim form, submit procedures performed on the same date of services that the sedation/general anesthesia was performed. If the procedures were provided by another practitioner, include these procedures in the "Remarks" (Section 35) of the claims form. Complete anesthesia record indicating start and stop times of anesthesia.
D9243	IV Conscious Sedation	On the same claim form, submit procedures performed on the same date of services that the sedation/general anesthesia was performed. If the procedures were provided by another practitioner, include these procedures in the "Remarks" (Section 35) of the claims form. Complete anesthesia record indicating start and stop times of anesthesia.
D9610, D9630	Other Drugs/Medications	Narrative and progress notes.
D9920 – D9930	Behavior Management	Chart notes.
D9940	Occlusal Guards	Chart notes.
D9951 – D9952	Occlusal Adjustments	Chart notes.

Appeal Process

In the event a claim is denied in whole or in part, a patient and dentist shall have the right to a full and fair review. Dentists may submit an appeal on their own behalf or on behalf of a patient if the patient has authorized the submission of an appeal.

An appeal may be submitted in writing or by contacting Customer Service. Requests must be submitted within 365 days from the claim denial date. A written appeal must include the patient's name, patient's identification number, group number, claim number and dentist's name as shown on the Explanation of Benefits (EOB). Appeals must be mailed to the address shown on the EOB.

Written comments, documents, or other information should be submitted in support of an appeal. Appealed claims must include all additional information from the treating dentist that could describe the services, underlying conditions and unique circumstances of the treatment serving as the basis for the appeal. If new information is not provided, the initial denial will remain in effect. Appropriate diagnostic information and the original Anthem pre estimate of EOB should accompany the appeal.

For Dental Prime and Dental Complete Products/Networks Only:

Acknowledgement of receipt of an appeal will be issued within 3 business days of receipt. A benefit determination will be made within 30 business days following receipt of an appeal. In some cases, the timeframe to review an appeal may be extended.

The dental consultant who made the original decision will not conduct the appeal review. A second dental consultant will review the appeal without deference to the initial decision. All benefit determinations are based on a preset schedule of dental services eligible under the patient's plan. Claims are not reviewed to determine dental necessity or appropriateness. Dental professionals who have appropriate training and experience will be consulted in all cases where professional judgment is required to determine if a procedure is a covered service under the patient's Anthem plan schedule-of-benefits.

Section 6: Compliance Program

Compliance with the Participating Dentist Agreement and our network requirements is necessary for the proper administration and servicing of Anthem's networks and the various dental programs they service.

Examples of Non-Compliance

Some examples of non-compliance include, but are not limited to:

- Misrepresentation of dates of dental service, services performed, or fees charged on a claim form.
- Misrepresentation of usual, customary, and reasonable charged fees.
- Waiver of applicable contract co-payments or deductibles.
- Other types of activities involving claim forms or fee data which result in inaccurate information being submitted.
- Any other type of activity that amounts to insurance fraud.
- Any type of misconduct as determined by applicable state, county, or local dental society or other licensing authorities, which results in the loss or suspension of a license to practice dentistry.
- More than one formal disciplinary action of the same or similar type by a State Board of Dentistry or licensing authority, or a criminal conviction for sexual misconduct of any type, fraud, or any other felony or gross misdemeanor.
- Balance billing and not accepting agreed upon participating fees.

Compliance Investigation Procedures

When non-compliance has been identified, all relevant documents and information may be examined by the appropriate staff of the Compliance areas within Anthem and a complete investigation of the matter may be conducted.

If non-compliance is verified, the participating dentist will be notified in writing of the facts and Anthem's requested corrective action. The requested corrective action may include but is not limited to payment of subscriber or patient refunds, payment of refunds to Anthem, and written dentist certification that requested action items have been corrected. Follow-up provider audits may be performed to verify compliance with requested action/s and to monitor future compliance.

Whenever it is determined that a dentist must refund Anthem or another payer as a result of the dentist's non-compliance or as a result of duplicate or erroneous claim payment, Anthem may, upon prior written notice to the participating dentist, deduct from any future payments due the participating dentist the amounts as reasonably determined to be due and owing as a refund of payments incorrectly made to or claimed by the participating dentist. When this occurs, Anthem will notify the dentist of the amounts credited by individual patient accounts. The dentist must reflect the payments as credits on the patient's account.

Non-compliance with the Participating Dentist Agreement and network participation requirements is grounds for termination of participation and notification, when required, to appropriate regulatory entities, including but not limited to, the State Board of Dentistry and the NPDB.

Fraud and Abuse

All participating dentist's claim submissions are subject to review and/or audit for possible fraud, waste and abuse (FWA). Prevention and detection of FWA is in accordance with applicable State and Federal law.

Anthem Dental recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse, and is committed to protecting and preserving the integrity and availability of health care resources for our recipients, clients, and business partners. Anthem Dental accordingly maintains a comprehensive program to combat fraud, abuse, and waste in the healthcare industry.

These responsibilities are delegated to Anthem's fraud, waste and abuse department whose mission is to combat fraud, waste and abuse in addition to investigating misrepresentation of services against various Anthem commercial and government plans. These responsibilities ensure the integrity of publicly-funded programs.

Right to Audit

The Dentist Provider shall keep and make available for examination and audit at Anthem Dental's request all clinical records and all substantiating documents supporting dental treatment including, but not limited to: all past and current radiographic images, all past and current chart or treatment records, all past and current laboratory prescriptions and invoices, all past and current treatment plans, office schedules and all financial records. An internal office audit may be necessitated dependent upon the findings of the audit. If an internal audit is requested, it must be accomplished during normal business hours and satisfied within 45 days of the request by Anthem Dental. The Dentist Provider will be informed of the results of the audit.

Dependent upon the audit findings, the Dentist Provider may be placed into a Pre-Payment Review Program (PPR). In the event the Dentist Provider is placed into the PPR program, all relevant clinical documentation will be requested to determine justification of the dental service prior to payment. When the Dentist Provider is placed into the PPR program, removal from the program occurs at Anthem Dental's discretion. All relevant documentation includes, but is not limited to, all clinical and financial documentation that substantiates dental treatment. Failure to comply with the program may lead to network termination.

Definitions

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property owned by, or under the custody or control of, any health care benefit program. Fraud is the intentional deception or misrepresentation of facts resulting in unauthorized benefits, payments,or gains to an individual or entity.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are dentally or medically unnecessary and payable by a commercial program, Medicaid or any other governmental agency program or health plan sponsor. Abuse is the receipt of payment for items or services when there is no legal entitlement to that payment, and the recipient of said payment has not knowingly and intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by negligent actions but rather the misuse of resource.

Section 7: Administration

HIPAA Information

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. The goals of this federal law (and its related regulations) included protecting confidential patient data and reducing the cost of health care by standardizing electronic transactions. The HIPAA regulations that may impact dental providers cover the following topics:

- Electronic Transactions
- Patient Privacy (Protected Health Information (PHI)
- Security of Patient Data
- National Identifiers
- Provider responsibility in the event of misrouted PHI

IMPORTANT: Only those providers who transmit a HIPAA-governed electronic transaction (that is, electronic claims submission) are subject to its regulations regarding electronic transactions.

HIPAA Regulations

The Privacy Rule permits a covered entity to use and disclose PHI for treatment, payment, or health care operations. For treatment purposes, the Rule generally allows PHI to be shared without restriction. The definition of "treatment" incorporates the necessary interaction of more than one entity. In particular, the definition of "treatment" includes the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another. As a result, covered entities are permitted to disclose PHI for treatment purposes regardless of to whom the disclosure is made, as well as to disclose PHI for the treatment activities of another health care provider.

Electronic Data Interchange (EDI)

HIPAA dictates uniform standards for certain health care EDI transactions. If providers conduct any of the specified transactions electronically (electronic claims submission, for example), they must do so in the standard format, or verify that their clearinghouse is doing so.

Privacy

The Privacy regulation requires written policies and procedures (and training of all staff members) so that access to patient data is restricted and storage of patient data is safeguarded appropriately. Affected providers must also make available a Notice of Privacy Practices to every patient and appoint a Privacy Officer for their organization. Business Associate agreements, however, are not required between providers and claims payers.

Security

HIPAA mandates uniform standards to protect confidential health information in electronic form. All providers who submit electronic claims must comply by implementing technical, administrative and physical safeguards. Technical safeguards pertain to computer and electronic data security, and physical safeguards pertain to building and room security. Administrative safeguards require written policies and procedures governing data security.

National Provider Identifier (NPI)

In order to uniquely identify every provider, HIPAA requires that every U.S. health care provider who bills for services obtain an NPI. This number becomes the primary means for provider identification and is required on all electronic transactions nationwide.

On January 23, 2004, the federal government issued a Health Insurance Portability and Accountability Act (HIPAA) regulation. It is the National Provider Identifier (NPI) regulation, which establishes one unique identifier for each health care provider and eliminates the multiple identifiers currently in use.

The NPI regulation offers several advantages, including:

- One unique provider identifier for all health plans and payers to utilize
- A permanent provider identifier that will not change in the event of practice relocation
- An easier process for health plans to track claims payment and avoid duplication

The NPI is a random ten-digit number (nine digits plus a check digit to detect keying errors). It never expires. It contains no inherent information about the provider, such as state of residence or license number. NPI numbers are administered by the Centers for Medicare and Medicaid Services (CMS), which has contracted with the National Plan and Provider Enumeration System (NPPES). The federal government is also responsible for assisting providers in completing the application and resolving problems associated with an NPI.

The broad definition of health care "provider" in the NPI regulation encompasses all who provide health care services:

- Individuals – such as physicians, dentists, and pharmacists
- Organizations – such as hospitals and clinics

Although dental assistants and hygienists are "providers" and are thus eligible to obtain an NPI, they are only required to do so if they submit claims for their services.

All providers are eligible to receive an NPI. However, only "Covered Entities" are required to obtain an NPI. A dental provider is a "Covered Entity" if he or she transmits electronic transactions governed by HIPAA, primarily **electronic claims**.

Providers who submit only paper claims may not be required to submit an NPI on their claims. However, Anthem strongly encourages the use of the NPI to ensure claims processing accuracy as some states have started to require the NPI on paper claims in addition to electronic claims. The most current ADA claim form includes a place to provide an NPI.

The NPI **does not replace** numbers used for purposes other than general identification, such as:

- Social Security Number
- DEA number
- Taxpayer ID number
- Taxonomy number
- State license number

There is no cost to apply for an NPI. Paper applications are available. Call NPPES to have an application sent. Call 1-800-465-3203 or TTY 1-800-692-2326.

Providers must communicate (to NPPES) any changes to the information collected during the application process within 30 calendar days of the change. Even if a provider changes location or specialty field, the NPI itself will never change.

Other health and dental plans will distribute communications regarding the use of NPI. But the same NPI is used when submitting claims to any payer. Providers need to notify all payers as to their NPI numbers.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. Providers and Facilities must contact Customer Service or call the number listed on the documentation received to report receipt of misrouted PHI.

HIPAA 5010

HIPAA 5010 standard is a federal directive mandated by the Health Insurance Portability and Accountability Act (HIPAA). This standard seeks to enhance the consistency and usage of transactions handled through Electronic Data Interchange (EDI). The implementation of the X12 version 5010 standard transactions brings better automation to your electronic submissions.

Your Practice Management vendor should be aware of these upcoming changes. Your office should also be receiving communication or updates from your Practice Management vendor.

Launch of dedicated 5010 webpage on EDI website

Recently, a webpage was launched to help keep you and our electronic trading partners informed about our 5010 activities, timelines, and current updates. Here's what you'll find on the webpage:

- News and updates about our ongoing progress, as we work to comply with the new HIPAA 5010 requirements
- Frequently asked questions from the provider community along with detailed responses
- Online registration – Capability to sign up to receive e-mail alert messages and important updates regarding HIPAA 5010
- Online functionality to contact us via e-mail with prompt responses to your e-mails

To access our HIPAA 5010 web page, simply visit www.anthem.com/edi, and select your state. On the EDI page, select the Communication tab and select 5010.

We encourage you to visit the webpage often and sign up to receive e-mail alert messages. If you plan to have your electronic vendor or clearinghouse to implement HIPAA 5010 changes on your behalf, we suggest that you urge them to register for e-mail alert messages as well.

Resources

The Federal Government's HIPAA Web Site

http://www.hhs.gov/ocr/privacy/index.html

NPI Application Help

https://nppes.cms.hhs.gov/NPPES/Help.do?topic=

Updating Dentist and Dental Office Information

As a participating dentist, it is important for you to inform Anthem of any changes to your practice. This information is vital for accurate claims processing and payment. Changes must be submitted via fax, email, or mail. Update requests (provider change forms (see below), or letter) will be reviewed to ensure all necessary documentation is present and complete. A Provider Network Representative Services representative will contact you if additional clarification is required.

Provider Change Forms:

- *Online Provider Maintenance Form* (refer to CA SB 137: Online Provider Maintenance Form in section 8) – A form you fill out online and submit right from our website for any of the changes listed below! We have also provided a step by step guide on how to complete the *Online Provider Maintenance Form*, which is located on our website.

- *Standardized Provider Maintenance Form* - A fillable PDF form, available on our website, or by contacting Provider Network Representative Services to email, or fax it to you. We have forms for all of types of changes listed below. You will fill out and submit a *General Office Information Form*with each change (only one *General office Information Form* is needed if submitting multiple changes). This may be submitted to us via fax, email or mail.
  Please Note: Both Provider Maintenance Form options can be found on our website, located at https://www.anthem.com/ca/provider/dental/

Please notify Anthem via fax, email or mail when any of the following changes/updates occur to your practice:
NOTE: As a general guideline, effective date for changes cannot be guaranteed. Please contact Provider Network Representative Services for confirmation of an effective date.

Address Change (Change practice address, or phone/fax number)

When a change of address is anticipated, the dental office needs to notify Anthem prior to the effective date of changes*. The update request should indicate:

- Office name
- Old address
- New address
- Tax identification number (TIN)
- Names of all providers the change applies to
- Effective date of the change*
- Any other information that will change such as phone number, fax number, office hours, emergency number, billing address, correspondence address, contact name, or languages spoken by office staff.

Add a New Location(s)

When an additional office location(s) is being established, Anthem needs to be notified prior to the effective date of the office opening. The update request should indicate:

- Office name
- TIN
- Physical address
- Billing address
- Correspondence address
- Names, license numbers, and employment status (owner, partner, or associate) of all dentists that will be participating at the new office

NOTE: If the office was purchased from another dentist, if another dentist will continue working at the location as a separate business, or if the location was previously a dental office, please review the information under "ownership changes," and contact Provider Network Representative Services to discuss your change further.

Tax Identification Number (TIN)/IRS Name Change

If the business entity name and/or TIN change, the dentist must notify Anthem prior to the effective date of the change. The update request should indicate:

- Previous office name (if applicable)
- New office name (if applicable)
- Previous TIN
- New TIN
- Office address(es) this change applies to
- Names, license numbers, and employment status (owner, partner, or associate) of all providers that this change applies to

NOTE: A new W9 form is also required. If you do not have a W-9 form, contact the Provider Network Representative Services department to request this form be sent to your office.

Change of Ownership

If you are adding a new location that was purchased from another dentist, or if the location was previously a dental office and operated under a different TIN, Anthem must be notified prior to the effective date of the change. Ownership change requirements may vary in each individual scenario, however in most cases the update request from the current or new owner should indicate:

- Previous owner's name
- Previous business name
- New owner's name
- New business name
- Previous TIN
- New TIN
- Office address(es) this applies to

- Names, license numbers, and employment status (owner, partner, or associate) of all dentists this change applies to
    - New dentists practicing under the new ownership may need to be credentialed before being considered participating dentists. Provider Network Representative Services will contact you if this is necessary for any dentists mentioned in the letter.

NOTE:

- **A new W9 form is also required**. If you do not have a W-9 form, contact the Provider Network Representative Services department to request this form be sent to your office.
- New network agreements may also be required. Please contact Provider Network Representative Servicesbefore submitting documentation to verify if this is a requirement in your specific situation.

Adding New Dentist(s) – New or existing location

When a new dentist joins the office and needs to be listed as a participating dentist, Anthem needs to be notified prior to the date the dentist begins practicing at the office. The update request should indicate:

- New dentist's full name, employment status at the office (owner, partner, or associate), license number, and individual NPI number
- Confirmation if he or she should be contracted with the same networks as the existing dentists.
- Office address
- TIN the dentist is to be listed under

NOTE: Adding a new dentist to your office may require additional paperwork, such as signing a network agreement, credentialing application, completing a W-9, or providing credentialing documents. Contact the Provider Network Representative Services department for assistance in obtaining the correct information foryour office.

Remove a Provider from a Location - Dentist(s) leaves a practice, retires, no longer practices due to medical or other reasons, or is deceased

When an existing dentist at the practice either retires, is no longer working at the practice, or passes away, Anthem needs to be notified. Updating Anthem with this information will avoid unnecessary mailings to your office, as well as keep the directories accurate. The update request should indicate:

- Dentist's full name
- Dentist's license number(s) and state(s) licensure
- Office address(es) this applies to
- Tax identification number(s) (TIN[s]) this applies to
- Reason for this request (no longer at this location, retired, or deceased)

How to Complete a W-9 Form

A Tax Identification Number (TIN) is registered with the Internal Revenue Service (IRS) under the name of the person or the corporation of the dental practice. This name can be known as:

- The Business Entity
- Legal Name
- IRS Name

There can be only one IRS name per TIN, even if multiple dentists are working under the same TIN. All information listed on the W-9 form must match what has been filed with the IRS. Information listed on claims must match what is listed on the W-9 form.

If the W-9 form does not match what was filed with the IRS, there may be issues with your 1099 at the end of the year.

If the information submitted on claims does not match the W-9 form there may be claim issues. (e.g. claims may process as non-participating and the payments may go to the member rather than the dental office.)

NOTE: Calling Anthem with a change or showing an office change on a claim will NOT result in the updating of the dentist's information. Separate written notice is required.

Updated dentist and dental office information may be faxed or mailed to:

Fax:
1-877-283-1331

Mail To:
Anthem Blue Cross
PO Box 1171
Minneapolis, MN 55440-9901

Professional Services can be contacted by providers from any state at 1-866-947-9398.

How Anthem Communicates

Anthem has important information available online that assists our providers in obtaining information regarding contract updates, Health Care Reform, claims filing and more!

- **Fee Adjustment Notifications** – If there is a change to an existing fee schedule, Anthem Blue Cross provides notification of that occurrence.

- **Annual CDT Updates** –CDT Dental Procedure Codes are the source for dentists to code and document services accurately for claims submissions and dental records. CDT codes are updated with new procedure codes, revised procedure codes and deleted procedure codes on an annual basis.

- **Healthcare Reform Updates** – Anthem Blue Cross provides information on changes with the Affordable Care Act (ACA) that may affect a dental practice.

- **Contract Provision Amendments and Updates** – Anthem Blue Cross provides updates as they occur.

- **Dental Dispatch** – This newsletter is one of Anthem Blue Cross' communication resources available to dental providers to keep them informed about all of the updates above and more.
    - The Spring/Summer version is electronic and is posted to the website (website information listed below)
    - The Fall/Winter version is mailed to participating providers, but is also posted to the website (website information listed below)

Where can you find this information?

Please visit our dental provider resources page at **www.anthem.com/ca/dentalproviders**

Section 8: Administrative Guidelines and Network Bulletins

About Administrative Guidelines/Network Bulletins

The following outlines specific requirements/administrative guidelines/polices that a Participating Dentist is required to comply with in accordance with the Anthem Blue Cross Participating Dentist Agreement, Section 2. Provision of Dental Care, part ii) "Dentist agrees to comply with all Administrative Guidelines, Network Bulletins, Dentist Provider Manual, and all related materials."

Referrals To In and Out of Network Providers

As an Anthem contracted Participating Dentist, in the event that you refer an Anthem member patient to an out of network dental provider for non-emergent dental services, you are required to inform that member patient of the out of network status of that dental provider. It is recommended Participating Dentist document in writing, of member patient being informed of out of network status referral. Contracted Participating Dentists may rely on the Anthem on-line provider directory in fulfilling this requirement.

Cost of Care

Participating Dentists agree to inform and document the presentation and acceptance or rejection of prescribed dental treatment, treatment options and fees associated with the informed choices. The document must be retained as a permanent part of the Anthem patients' records.

State and Federal Laws

Participating Dentist will comply with and ensure that its employees comply with all state and federal laws, rules and regulations.

California AB954 - Network Leasing Requirements

Contract Amendment – Effective 1/1/2020 - Your Dental Provider Agreements will contain the following language:

In accordance with state law, Anthem Dental is informing Dentist that we do lease our ("Networks(s)"). This contract grants third-party access to the provider network. The provider network contracting entity has entered into an agreement with other dental plans or third parties that allows the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity. The list of all third parties with access to this provider network can be found at (https://www.anthem.com/ca/provider/dental/). You have the right to choose not to participate in third-party access. To exercise your right to not participate in the third-party access, submit your written or electronic request to Anthem Dental. Dentist agrees to notify each Covered Person who seeks Dentist's services that he/she is not participating in third party access, which may affect Covered Person's coverage and cost share.

California SB137 – Health Care Coverage: Provider Directories

Please be aware, as required by the State of California, Anthem and our affiliates must follow regulated procedures that are outlined in SB137 to maintain accurate provider directories. Our responsibility is to provide accurate dental directories to our members.

Our responsibility will be reaching out to you and your office to verify critical data elements about your practice and each dentist contracted at your practice once every six months effective immediately. If no response is received within 45 business days from the date on the verification form, then we will have to remove the identified dentist from our directories within 10 business days until this information can be verified and could lead to delay in compensation.

We will make several contacts to remind you to respond to our verification form in order to avoid being removed from our dental directories. For every contracted dentist listed in your practice you will receive a verification form unless the dentist was credentialed within the last six months. This verification will not replace our current re credentialing requirements.

Your responsibility is to respond to Anthem within 45 business days and the verification form must be completed entirely and signed and dated by an authorized signee. The verification form requires you to verify information about you and your practice. Note that you will receive a verification form for every dentist contracted at your office and we will require a response for each form.

California SB137 – Online Provider Maintenance Form

We are excited to announce our **ONLINE PROVIDER MAINTENANCE** FORM, which is available as of June 3, 2016 on our website https://www.anthem.com/ca/provider/dental/. Your office will now have the ability make updates to your practice utilizing out Provider Maintenance Form and submit right from our website! Below is a list of updates you will be able to submit via Online Provider

- Updates to your practice (phone, fax, e-mail address, office etc.)
- Update Tax ID, IRS Name/DBA
- Add/removing dentist to your practice
- Update physical/billing/correspondence address
- Update NPI (Individual/Corporate)
- Changes in Ownership

We have also provided a step by step guide on how to complete the Online Provider Maintenance form, which is also located on our website.

Call our Professional Services Team at **866-947-9398** for any questions or assistance on completing the Online Provider Maintenance Form.

Quality Assurance Timely Access to Care Regulations

As an Anthem contracted Participating Dentist, you agreed to abide with the provisions of the Plan Quality Assurance Program including the approved accessibility standards. The Plan's access standards are as follows:

Emergency Visit	within 72 hours
Initial Visit (exam, x-rays and diagnosis)	within 36 business days
Routine Dental Visit	within 36 business days
Preventive/Hygiene Visit	within 40 business days
Urgent Exam	within 72 hours
Wait Time in Reception Area	not to exceed 45 minutes

Providers are expected to reschedule a patient/member's appointment in a manner that is appropriate to the patient/member dental care needs.

Emergency appointments need to be available as necessitated by the patient/member dental condition. This requires that the dentist be on call 24 hours a day 7 days a week to assess the patient/member needs and determine when the patient/member should be seen. This availability requires the Anthem contracted Participating Dentist to use an answering service, telephone answering machine that is monitored for emergency telephone calls or other means of contacting the Anthem contracted Participating Dentist.

Healthcare Reform/Covered California

Pediatric Dental Essential Health Benefits

As of January 1, 2014, all health benefits plans must, by law, cover 10 Essential Health Benefits (EHBs) to be considered a Qualified Health Plan (QHP) under the Affordable Care Act (ACA). EHB's are included in all of Anthem's new individual and small group health benefit plans. Pediatric Dental EHBs provide important dental coverage for children to keep their teeth and gums healthy.

Pediatric Dental EHBs for children cover preventive care, fillings, and other services like medically necessary orthodontia. Pediatric Dental EHBs for children have no annual maximum when children are seen by in-network dentists. There will be a member out-of-pocket maximum when members see in-network dentists. This change is required as part of the Affordable Care Act.

Please note, there is no Adult EHB dental coverage. Adult dental coverage, if a member has such coverage, is offered in a traditional dental plan.

Conflict of Interest

Covered California requires a Participating Dentist to be free from any conflicts of interest. Please be informed that all Dentists licensed in the State of California are required to be compliant with all sections of the DENTAL PRACTICE ACT, including Section 654.2. Abiding by this section of the DENTAL PRACTICE ACT insures Participating Dentist is in compliance with Covered California conflict of interest requirement. A conflict of interest is a situation where professional judgment concerning a patient's welfare tends to be influenced by a secondary interest (such as personal obligations or personal/financial interests) that would make it difficult for professionals to fulfill their duties fairly.

Non-Discrimination

Exchanges, such as Covered California, require Participating Dentist and Participating Dentist employees, to comply with their contractual requirements and all Federal and/or State nondiscrimination laws that are applicable to the workplace. Participating Dentist, as well as its agents and employees, shall not, unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity or use of family and medical care leave. Participating Dentist, as well as their agents and employees, shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Participating Dentist, as well as its agents and employees, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2, CCR Section 8103, et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Participating Dentist shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

Cooperation with Blue Cross and The Exchange

Participating Dentist agrees to cooperate with Blue Cross to the extent necessary and as applicable to promote compliance with requirements of the Exchange. In the event of a change in Participating Dentists or a change in Qualified Health or Dental Plan for any Exchange member, Participating Dentist agrees to cooperate with the Exchange and Blue Cross for the orderly transfer of Exchange members as necessary and as required under applicable laws, rules, and regulations, including those relating to continuation of care.

Continuity of Care

Except when termination occurs due to a loss of license, Dentist, upon termination, of their Agreement or the loss of a Covered Person's eligibility, will continue to provide Covered Services to Covered Persons if a multi-step procedure is already in progress, to the extent that it is a requirement of applicable state law or regulations. Dentist must accept terms of payment under their Agreement for only that service until such service is completed. Includes, but is not limited to, multi-staged type treatments (i.e. crowns, bridges, dentures, root canals).