WESTERN DENTAL SERVICES
POLICIES & PROCEDURES

POLICY: Timely Claims Payment

Western Dental Services, Inc. (the "Plan") provides reimbursement to providers for dental treatment in a timely manner, not to exceed 30 working days from the date of receipt of the request for payment provided the claim is submitted within 90 days of the date of service for contracted providers and 180 days of the date of service for non-contracted providers. Western Dental will provide a clear, accurate and written description for the reason for the non-payment of a claim (pended or denied) and provides a mechanism for providers to appeal claims decisions through its Provider Dispute Resolution Process.

PROCEDURES:

Submission of Claims

Contracting providers must submit claims within 90 days from the date of service. Non-contracting providers must submit claims within 180 days from the date of service.

Restorative, pedodontic, oral surgery and endodontic claims must include applicable pre and post operative x-rays as outlined in your Provider Guide. Periodontal claims must include applicable pre and post operative x-rays and periodontal charting as outlined in your Provider Guide.

Claims should be submitted by mail to:

Western Dental Services
Plan Claims Department
P.O. Box 14227
Orange, CA 92863

Claims may be delivered by courier or fax to:
Western Dental Services
Plan Claims Department
530 S. Main St, 6th Floor
Orange, CA 92868
Fax: 714-571-3647

To confirm receipt of a claim or for claim inquires please call the Claims Department at 1-800-417-4444 extension 3670.

Disclosure of Fee Schedule and Other Information Electronically

Initially upon contracting all provider offices are given a Provider Guide that includes all applicable fee schedules and plan information. Fee schedules and payment policies and rules can be provided electronically upon written request by the provider.

Acknowledgment of Claims

The Plan will identify and acknowledge the receipt of each claim, and will disclose the recorded date of receipt to the provider within 15 working days from the date the Plan receives the claim.

Time for Reimbursement

The Plan will process all complete claims within 30 working days of the date of receipt. A complete claim is defined as a claim that contains all of the reasonably relevant information and documentation (claim form, radiographs, and clinical notations) necessary to determine the Plan's liability for the claim.

Amount of Reimbursement

For contracted providers, the Plan will pay claims in accordance with the terms of the provider's written contract with the Plan. For non-contracted providers, the Plan will pay the reasonable and customary value of the services rendered, based on statistically credible information that is updated at least annually and takes into consideration the provider's training, qualifications and length of time in practice, the nature of the services provided, the fees usually charged by the provider, the prevailing provider rates charged in the general geographic area in which the services were rendered, other relevant aspects of the economics of the provider's practice, and any unusual circumstances in the case.

Denying, Adjusting or Contesting Claims

For each claim that is denied, adjusted or contested, the Plan will provide a clear written explanation of the specific reasons for the Plan's action within the Time for Reimbursement stated above.

The Plan will deny a claim, or a portion of a claim, for an ineligible person, for excluded procedures, for procedures where there is no coverage, or when it is submitted after the allowable time period.

Incomplete Claims

The Plan may contest a claim that does not contain all of the reasonably relevant information necessary to accurately review the claim. The Plan will provide the provider with a clear and accurate written explanation of why additional information is needed. The provider shall provide the information within 10 working days from the date of the request. The Plan will have 15 days to request any additional information necessary to make the claim complete. The Plan

will have 30 working days from the date of receipt of the additional information from the provider to reconsider the claim.

Overpayment of Claims

If the Plan determines it has overpaid a claim, the Plan will send the provider a written request for reimbursement within 365 days from the date of payment. The Plan will identify the claim, patient name, date of service, and will provide a clear explanation of the basis upon which the Plan believes the amount paid was in excess of the amount due.

A Provider may contest the Plan's notice of overpayment of claim, in writing, within 30 working days, through the Provider Dispute Resolution Process.

If the provider does not contest the notice of overpayment, the provider shall reimburse the Plan within 30 working days from the receipt of the notice of overpayment. The Plan may offset the amount stated in the uncontested notice of overpayment against the provider's current claims submission if provider has entered into a contract that allows for such offset. The Plan will provide a detailed written explanation identifying the specific overpayment(s) pertaining to the offset against the current claims.

Payment of Late Claims

If a complete claim has not been contested or denied within 30 working days from the date of receipt of the claim, the Plan will pay interest at the rate of 15% per annum for the period of time that the payment is late. Late payments on a complete claim for emergency services and care which is neither contested nor denied will include the greater of $15 for each 12 month period or portion thereof on a non-prorated basis or interest at the rate of 15 percent annum for the period of time that the payment is late.

Interest shall automatically be included with the claims payment. In the event that interest is not automatically included, the Plan pays a $10.00 penalty for that late claim. If the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, the Plan may pay the interest on that claim along with interest on other such claims within 10 calendar days of the close of the calendar month in which the claim was paid. The Plan will include a statement identifying the specific claims for which the interest is paid and will set forth a method for calculating interest on each claim and will document the specific interest payment made for each claim.

Amendments to this Policy

The Plan shall provide 45 days prior written notice before instituting any changes, amendments, or modifications to this policy.

Receipt of Claims by Providers

If a provider erroneously received a claim that should be paid by the Plan, the provider must forward the claim to the Plan within 10 working days of the receipt of the claim.

Provider Disputes

Provider may file disputes regarding this Timely Claims Payment Policy and Procedure through the Provider Dispute Resolution Process, as described in this Manual.

Second Dental Opinions

A Member or Participating Provider may request a second opinion consultation by writing or calling the Plan's Member Services Department by telephone at (800) 805-8000 or in writing at P.O. Box 14227, Orange, CA 92863. Decisions and notifications regarding requests for second opinion consultations will be rendered within the following time limits: For routine second opinion requests, the decision to approve or deny requests for second opinion consultations will be made within 5 business days of the Plan's receipt of the request. For urgent requests, the second opinion will be authorized or denied within 72 hours of the Plan's receipt of the request. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within 2 business days.

A second opinion consultation may be authorized for surgical procedures, unclear or complex and confusing clinical indications, conflicting test results, the Participating Provider's inability to diagnose the Member's condition, a treatment plan in progress but not improving the Member's condition within an appropriate time period, or the Member's serious concerns about a particular diagnosis or plan of care. A written Explanation of Benefits will be issued to the Member and the Member's Participating Provider, including the name and location of the second opinion provider if the second provider if the second opinion is approved. Upon approval, the Plan will refer the Member's Participating Provider who is under contract with the Plan. Should there be no available Participating Provider in the appropriate geographical area, the Plan will refer the Member to a non-participating Provider for a second opinion consultation. A Plan representative will assist an appointment. The second opinion provider will submit the claim for payment to the Plan. The Member is only responsible for the applicable copayment as set forth in the Schedule of Benefits. The Plan will pay any cost in excess of the applicable copayment and will contact the provider rendering the second opinion to advise of Western Dental's payment in excess of the Copayment.

The second opinion provider will provide the Member and the Member's Participating Provider with a written narrative report of the results of the Member's consultation. All treatment must be performed by the Member's Participating Provider for the Member to received Covered Services under the Benefit Plan. This shall not limit the Member's right to transfer to another Participating Provider in order to receive Covered Services under the Benefit Plan.