Dominion Dental USA, Inc. and Subsidiaries

POLICY TITLE	**SUSPECTED CLAIM FRAUD, WASTE, AND/OR ABUSE**
POLICY NUMBER	**COMPLIANCE-003D**

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I. POLICY

This policy applies to Dominion Dental USA, Inc. and its subsidiaries, affiliates, and employees, collectively referred to as "Dominion."

This policy addresses the responsibilities of various Dominion personnel for reporting and investigating suspected Fraud, Waste, and/or Abuse, as well as the policy of Dominion regarding the recovery of overpayments, prosecution, and the release of information related to members, providers, and any other parties believed to be involved in such activities.

Provisions in each of Dominion's states of operation generally make it a criminal offense to knowingly present false, incomplete, or misleading information on insurance claims or applications for insurance, to conspire to present false, incomplete, or misleading information relating to a claim or application for insurance, to use another person's insurance identification card, or to allow another person to use one's identification card with the intent to present a fraudulent claim. The applicable laws criminalizing such actions include, but are not limited to: Virginia Code §18.2-178 and §52-36 et seq.; Maryland Insurance Article § 27-403 and §27-406; District of Columbia Code §22-3225.01 et seq.; Delaware Code Title 11, Chapter 5, §913 and §913A; Pennsylvania Act 219 of 1990; Oregon Revised Statutes §165.692 and §165.990; Revised Code of Washington §48.30.210 and §48.30.231; New Jersey Statutes Annotated §2C:21-4.6; and Georgia Code §33-1-9.

Many of these laws allow Dominion to file a civil action against such a person and to supply information to appropriate law enforcement entities, so that criminal charges may be filed against those persons who have fraudulently procured health insurance coverage or who have filed fraudulent claims.

In addition to state laws, the federal False Claims Act also makes it a civil liability to knowingly present a false or fraudulent claim, make use of a false record or statement material to a false of fraudulent claim, conspire to commit a violation of the Act, or knowingly make, use, or cause to be made or used, a false record or statement material to the payment of a claim.

In accordance with these principles, all provider agreements shall require that providers comply with federal and state statutes and regulations designed to prevent Fraud, Waste, and Abuse, including but not limited to those mentioned within this policy.

II. DEFINITIONS

Fraud

Any deliberate deception, misrepresentation, omission of fact or other misconduct by a member, a provider, or any other party, made with the intent to induce a representative of Dominion or other party to act in reliance on the false information provided or any attempt to use Dominion for the same purpose resulting in unauthorized and improper benefit, payment or gain to an individual or entity.

Examples of Fraud include, but are not limited to:

- Billing for services not rendered or supplies not provided
- Misrepresenting services rendered or supplies provided
- Applying for duplicate reimbursement with the intent to receive improper payment
- Making false or misleading entries or forging signatures on enrollment applications, claim forms, dental records and/or other documents required for the determination of eligibility and/or benefits; or false or misleading verbal statements in connection with the same
- Borrowing or using another person's insurance identification card or allowing another person to use one's insurance card for the purpose of obtaining treatment or submitting a claim when the user is not a member on the contract
- Altering a Dominion issued check or forging an endorsement on a check
- Knowingly endorsing a Dominion issued check for services that were not rendered or goods/supplies that were not provided
- Enrolling for healthcare coverage in a Plan for which the member and/or dependents are not eligible

Waste

Any inappropriate utilization and/or inefficient use of resources.

Examples of Waste include, but are not limited to:

- Deliberate performance of unwarranted/non-medically necessary services
- Billing for unnecessary dental services
- Excessive office visits

Abuse

Any receiving of payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and intentionally misrepresented facts to obtain payment.

Examples of Abuse include, but are not limited to:

- Providing care of an inferior quality
- Improper billings in relationship to established standards of billing practice

III. PROCEDURE

Dominion investigates all cases of suspected Fraud, Waste, and/or Abuse and pends or rejects claims when there is a basis to question the validity of the information on the claim, including the charges. Dominion pursues the recovery of any payments made as a result of Fraud, Waste, or Abuse. Dominion also reserves the right to release information related to Fraud, Waste, and/or Abuse on a case-by-case basis for appropriate purposes, subject to review by Legal and Compliance. Dominion reserves the right to pursue provider education and/or corrective action in lieu of payment recovery, when appropriate, or not prohibited by federal or state law or regulation.

REPORTING AND INVESTIGATING

Note: A member, provider, or other party is not guilty of Fraud until convicted in a court of law. In order to minimize Dominion's potential legal liability and to maintain appropriate evidence for possible prosecution, all Dominion employees must use extreme caution when taking any action or communicating any information (i.e., both verbally and in writing) related to enrollment, claims or the like, where Fraud is suspected.

This includes not referring to a member, provider, or other party as having performed fraudulent acts. Activities related to suspected Fraud cases are coordinated and/or approved as addressed in this policy.

RESPONSIBILITIES OF DOMINION PERSONNEL

In accordance with the Code of Conduct, all employees of Dominion are responsible for reporting suspected cases of member, provider, or other party Fraud, Waste and/or Abuse to their immediate supervisor, department manager, or the Compliance department. Additional responsibilities for employees are explained below.

Claims Department

- Claims processing and auditing personnel are responsible for reporting claims that appear altered, or excessive, or otherwise appear to meet the definition of Fraud, Waste, and/or Abuse and referring all pre-payment claim exceptions to their supervisor or manager.

- Claims management personnel are responsible for reviewing cases reported by claims personnel and reporting legitimate cases to the Compliance department for logging.
- Claims processing personnel, under the oversight of claims management personnel, are responsible for pursuing the reimbursement of overpayments on cases referred to the Claims department.
- Claims management personnel are responsible for developing and implementing new procedures, system edits, and other techniques to facilitate the identification of suspected Fraud, Waste, and/or Abuse.
- Claims management personnel are responsible for conducting in-depth training on detecting Fraud, Waste, and Abuse to claims processing personnel.

Compliance Department

Compliance department is responsible for:

- Providing general information company-wide on Fraud, Waste, and Abuse and assisting with in-depth training as deemed appropriate.
- Receiving and logging all referred cases, both internally and externally, including referrals submitted through the Compliance Hotline, involving suspected Fraud, Waste, and/or Abuse.
- Coordinating the examination of all referred cases, both internally and externally, involving suspected Fraud, Waste, and/or Abuse.
- Coordinating all provider investigations with the Dental Director, Associate Director of Network Development, Associate Vice President of Operations, and Credentialing Manager prior to initiating any contact with the subject provider.
- Referring cases involving quality of care issues to the Cost of Care and Quality Assurance Committees.
- Investigating or contributing to the investigation by others of cases of suspected Fraud, Waste, and/or Abuse involving the Medicare Advantage program, as well as State healthcare programs.
- Reporting cases of suspected Fraud, Waste, and/or Abuse to alliance partners, as required by applicable contractual agreements and regulations. Compliance will consult the FWA Reporting Survey maintained by Legal and Regulatory and comply with any requirements regarding the timeliness, content, and method of reporting.
- Referring cases involving Medicare-related matters to CMS and/or other enforcement agencies, as appropriate.
- Requesting provider and member claim flags, subject to the approval of Legal.

- Communicating results of internal investigations to Capital BlueCross Legal (for Commercial account matters) and/or Capital BlueCross Compliance (for Medicare-related matters) for further investigation as may be necessary. Dominion's Legal and Compliance departments will coordinate with Capital BlueCross' Legal department and Chief Compliance Officer for matters that require further evaluation and/or disclosure to regulatory bodies.
- Working collaboratively with the Special Investigations Unit (Capital BlueCross) if the case was received and referred by them through the BlueCross Dental Program.
- Maintaining documentation on case investigation results as dictated by federal and/or state regulations. (*Example, 10 years for Medicare)*

Customer Service Department

Service Team Associates are responsible for documenting in DataDental under the Member or Provider Notes any allegations of Fraud, Waste, and/or Abuse received from a caller.

Service Team Associates must refer to the Compliance department, by e-mail or use of the toll-free Compliance Hotline, all allegations received, as well as potential Fraud, Waste, and/or Abuse identified during the normal course of Customer Service business. Referrals include, but are not limited to, allegations related to plans and products offered on and off the Federally-facilitated Marketplace (FFM) that are reported by a caller.

Credentialing Department

Credentialing Manager is responsible for:

- Upon notice by the Compliance department of a case involving suspected Fraud, Waste, and/or Abuse by a network provider, performing a review of internally logged complaints and querying the National Practitioner Data Bank (NPDB) and State Dental Board databases for reports of malpractice claims, adverse licensing actions, and carrier terminations.
- Presenting cases of suspected Fraud, Waste, and/or Abuse involving network providers to the Quality Assurance Committee for recommended actions.

Provider Relations Department

Provider Relations department is responsible for contacting the Compliance department with suspected cases of Fraud, Waste, and/or Abuse involving a participating provider (professional or facility).

Provider Relations may also be elicited to help coordinate the investigation, and follow-up actions, including on-site visits for suspected cases of Fraud, Waste, and/or Abuse involving a participating facility provider.

Dental Director

The Dental Director will refer suspected issues of Fraud, Waste, and/or Abuse to the Compliance department.

The Compliance department may request the Dental Director or a professional consultant to review a suspected Fraud, Waste, and/or Abuse case when a determination is needed regarding the appropriateness of a service(s) or medical necessity.

Quality and Appeals Department

The Quality and Appeals department will refer potential issues of Fraud, Waste, and/or Abuse that are identified as part of an appeal, grievance, quality of care, or quality of service review to the Compliance department.

The Compliance department will refer potential issues of quality of care or quality of service that are identified as part of a Fraud, Waste, and/or Abuse investigation to the Quality and Appeals department.

Legal

Legal is responsible for reviewing and advising on actions referred to it by Compliance in order to assure that the investigative actions taken are legally appropriate.

PRIVACY

Most, if not all, claims information constitutes Protected Health Information, subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy rule and corporate policy HR-735, Privacy of Member Information. In cases involving the investigation of suspected Fraud, Waste, and/or Abuse, Dominion is permitted to use and disclose relevant information as appropriate, and as permitted or required under law, on a case-by-case basis. Release of information to any party or person must be done in compliance with corporate policy and all applicable laws, including, but not limited to the HIPAA Privacy Rule. Release of such information must be coordinated with the Privacy Officer.

RECOVERY OF OVERPAYMENTS

Dominion has established no minimum dollar threshold that must be met before pursuing reimbursement for payments made for claims involving Fraud, Waste, and/or Abuse.

CONTRACT CANCELLATION

Dominion reserves the right to terminate the contract of any individual account member involved in claim Fraud, Waste, and/or Abuse, subject to the approval of Legal.

PROVIDER AGREEMENT TERMINATION

Dominion reserves the right to terminate a provider agreement for any provider involved in claim Fraud, Waste, and/or Abuse, subject to the approval of Legal. If a provider who is being terminated is associated with a group practice, the Provider Relations department will work with the group practice to assure that this provider is excluded from providing services to the

members of Dominion. Dominion also reserves the right to terminate a group agreement for any group involved in claim Fraud, Waste, and/or Abuse, subject to the approval of Legal.

Termination of provider agreements (either facility or professional provider agreements) must be coordinated with Legal, the Dental Director, and the Associate Director of Network Development prior to taking action.

COMMUNICATION OF INFORMATION

Dominion may communicate cases involving member and provider Fraud, Waste, and/or Abuse when considered appropriate as described below.

GROUP NOTIFICATION

Cases of proven Fraud and/or confirmed Waste and/or Abuse involving group members are communicated by the Compliance department to the Sales department who may share this with the group, on a case-by-case basis, after review and approval by Legal.

CORPORATE COMMUNICATIONS

The Compliance department, in consultation with Legal, may forward information regarding providers and members convicted of Fraud to the Marketing department, in order to prepare for any potential contacts from the media about the conviction.

OTHER COMMUNICATIONS

If a provider agreement is terminated based on the provider's involvement in claim Fraud, Waste, and/or Abuse, the Credentialing Manager will report the information to the National Practitioner Data Bank and State Dental Board after review by Legal.

EXCHANGE OF INFORMATION

Case information may be released to a federal, state, or local law enforcement agency for investigation or prosecution in accordance with legal requirements, only after review and approval by Legal, or if otherwise required by law.

IV. RELATED INFORMATION

Refer all questions regarding the administration of this policy to Compliance.

Refer to the following policies and procedures for additional information:

- Dominion Code of Conduct
- HR-735, Privacy of Member Information
- CC-107, Auditing and Monitoring (Contact Compliance for information on this policy.)
- CC-117, External Reporting of Fraud, Waste and Abuse and/or Other Potential Misconduct (Contact Compliance for information on this policy.)

- Desktop procedures for Fraud, Waste, and/or Abuse workflow with Dominion's alliance partners

This policy is subject to revision to reflect any changes in federal or state law, regulation or agency guidance, and/or changes in internal business operations and procedures.