SECOND AMENDMENT TO DENTEMAX PROVIDER SERVICE AGREEMENT FOR THE STATE OF NEW JERSEY

This Second Amendment ("Amendment") to the DenteMax Provider Service Agreement ("Agreement") is effective immediately unless the Provider objects thereto and such objections are received by DenteMax within 30 days pursuant to Article II, paragraph 4 of the Agreement. This Amendment only applies to dental plans that are subject to the applicable laws of the State of New Jersey and completely supersedes the applicable provisions of the Agreement to the contrary. This Amendment also applies to any providers or facilities subcontracting with Provider to provide covered services to Participants pursuant to the terms of the Agreement. The First Amendment to the Provider Service Agreement is amended as follows:

Section "IV. Compliance with the New Jersey Administrative Code" is amended to add the following:

1. Pursuant to N.J.A.C. 11:24B-5.2 (a) 1, the Provider Service Agreement and all amendments thereto are subject to prior approval by the New Jersey Department ("Department") of Banking and Insurance and may not be effectuated without such approval, except that the following types of amendments do not require prior approval by the Department:
   - Amendments that are of a clerical nature;
   - Amendments that alter numbers, by they dollar amounts, enrollments amounts or the like, without altering methodologies from which the numbers were derived; and
   - Amendments that involve the substitution of one set of variable text for another set of variable text, if both sets of variable text were previously approved by the Department for the provider agreement form.
2. Pursuant to N.J.S.A. 17B:27-44.2d(1)(a)-(e), DenteMax, through its agreements with Payors, requires Payors to remit payment for every insured claim submitted by a Covered Person or provider, no later than the 30th calendar day following receipt of the claim by the Payor, or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following the receipt if the claim is submitted by other than electronic means, if:
   a) the provider is eligible at the date of service;
   b) the person who received the health care service was covered on the date of service;
   c) the claim is for a supply covered under the health benefits plan;
   d) the claim is submitted with all the information requested by the Payor on the claim form or in other instructions that were distributed in advance to the provider or covered person in accordance with the provisions of section 4 of P.L. 2005, c. 352 (C.178B:30-51); and
   e) the Payor has no reason to believe that the claim has been submitted fraudulently.
3. Pursuant to N.J.A.C. 11:24B – 5.2(a) 14, Provider shall maintain malpractice insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate. Further, provider shall notify DenteMax within seven (7) calendar days of any changes in malpractice coverage.
4. Pursuant to N.J.A.C. 11:24B – 5.2(c) 6, Provider understands that up to 50% of the payment to the Provider may be denied if the service is not pre-certified or pre-authorized by the Provider prior to the provision of service.
5. Pursuant to N.J.S.A. 17B:27-44.2.d(9), DenteMax in its agreement with Payor, agrees that an overdue payment shall bear simple interest at the rate of 12% per annum. The interest shall be paid to the provider at the time the overdue payment is made. The amount of interest paid to a provider for an overdue claim shall be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a Payor that does not reserve the right to change the premium.
6. Pursuant to N.J.S.A. 17B:27-44.2.d.(10), DenteMax through its agreement with Payor, agrees that with the exception of claims that are submitted fraudulently or submitted by providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, Payor shall not seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. Further, Payor, at the time of the reimbursement request is submitted to the provider, shall provide written documentation that identifies the error made by the Payor in the processing or payment of the claim that justifies the reimbursement request. Payor shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:
   a) In judicial or quasi-judicial proceedings, including arbitration;
   b) In administrative proceedings;
   c) In which relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
   d) In which there is clear evidence of fraud by the provider and the Payor has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L. 1993, c. 362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L. 1998, c. 21 (C.17:33A-16).

7. Pursuant to N.J.S.A., DenteMax through its agreement with Payor, agrees that a Payor who seeks reimbursement pursuant to paragraph 6 (b) above, shall not collect or attempt to collect:
    a) The funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the provider;
    b) The funds for the reimbursement if the provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the provider and until the provider's rights to appeal has been exhausted or the monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee. The Payor may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the provider after the 45th calendar day following the submission of the reimbursement request to the provider or after the provider's right to appeal have been exhausted if the Payor submits an explanation in writing to the provider in sufficient detail so that the provider can reconcile each covered person's bill.
8. The agreement and all amendments thereto are governed by New Jersey law. Any provision in the Provider Service Agreement or any amendments thereto that conflict with state or federal law are effectively amended to conform with the requirements of the State or Federal law.
9. Provider is paid by the carrier or payor pursuant to the established DenteMax fee schedule. Provider may not accept financial incentives in any form for the withholding of covered services. The Provider may appeal a decision denying the provider additional compensation to which the provider believes he/she is entitled under the terms of the provider agreement.
10. Provider understands that the Provider's activities and records relevant to the provision of services may be monitored from time to time either by DenteMax or a Payor, or another contracted entity acting on behalf of the Payor in order for DenteMax or the Payor to perform quality assurance and continuous quality improvement functions.
11. Provider understands that he/she is responsible for complying with the quality management program established by the carrier or payor. The quality management program of the Payor, though managed on a day-to-day basis by the Payor, is adopted by DenteMax. Provider may file a complaint with the Payor regarding the quality assurance program, and upon request obtain information from payor regarding how provider feedback regarding payor's operations is elicited.
12. Provider understands that he/she is responsible for complying with the utilization management program established by the carrier or Payor. The utilization management program of the Payor, though managed on a day-to-day basis by the payor, is adopted by DenteMax. Provider may file a complaint with the Payor regarding any utilization management decision and shall have the right to receive the name and telephone number of the individual who made the decision to deny a service. Provider has the right to request from the Payor information regarding utilization management protocols and parameters placed on the use of one or more protocols. Provider may also review and provide comment on protocols for the Provider's practice area. When applicable, Provider has the right to rely on the written or oral authorization of a service if made by the Payor, and services may not be retroactively denied as not medically necessary except in cases where there was material representation of the facts to the payor; or fraud.
13. Provider has a right to appeal a utilization management decision on behalf of a covered person, including the right to receive a written notice of the utilization management determination. The utilization management program outlined by the Payor will stipulate whether the provider must obtain consent of the covered person in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth at N.J.A.C. 11:24-8 and 11:24A-3.5, or whether failure to obtain consent of the covered person results in review of the appeal using a separate complaint or provider grievance process. In the event that an appeal instituted by a provider on behalf of a covered person will be entertained as a member utilization management appeal without the covered person's consent, the appeal will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained. In any event, nothing shall prohibit the provider from submitting an appeal on behalf of a covered person when the covered person may be financially liable for the cost of the services.
14. Paragraph II.4 of the DenteMax Provider Service Agreement stipulates that DenteMax has the right to amend this agreement by providing written notice and that failure to object within thirty days constitutes acceptance of the change. Provider understands that he/she is not required to abide by the amended terms of the contract during either a notice of termination period or a continuity of care period in the event that the provider elects to terminate the contract rather than accept the amendment.
15. Paragraph 9 of the First Amendment Applicable to Plans in New Jersey is amended to reflect the internal payment appeal and binding state sponsored arbitration mechanisms at N.J.S.A. 17B:27-44.2e as follows:

    e.(1) Payor shall establish an internal appeal mechanism to resolve any dispute raised by a provider regardless of whether the provider is under contract with the payor regarding compliance with the requirements of this section or compliance with the requirements of sections 4 through 7 of P.L. 2005, c. 352 (C.17B:30-51 through C.17B:30-54). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals

Program established pursuant to section 11 of P.L. 1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The Payor shall conduct the appeal at no cost to the provider.

A provider may initiate an appeal on or before the 90th calendar day following receipt by the provider or the Payor's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The Payor shall conduct a review of the appeal and notify the provider of its determination on or before the 30th calendar day following the receipt of the appeal form. If the provider is not notified of the Payor's determination of the appeal within 30 days, the provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If the Payor issues a determination in favor of the provider, the Payor shall comply with the provision of this section and pay the amount of the money in dispute, if applicable, with accrued interest at the rate of 12% per annum, on or before the 30th calendar day following the notification of the Payor's determination on the appeal. Interest shall begin to accrue on the day the appeal was received by the Payor.

If the Payor issues a determination against the provider, the Payor shall notify the provider of its findings on or before the 30th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration as provided by paragraph (2) of this subsection.

The Payor shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

e.2. Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that a provider may aggregate his own disputed claim amounts for he purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

e.3. The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by state or federal laws.

e.4. The arbitrator's determination shall be:

a) Signed by the arbitrator;
b) Issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the termination is based, and;
c) Issued on or before the 30th calendar day following the receipt of the required documentation.

e.5 If the arbitrator determines that a Payor has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the Payor to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a Payor has withheld or denied payment on the basis of information submitted by the provider and the Payor requested, but did not receive, this information from the provider when the claim was initially processed pursuant to subsection d of this section or reviewed under internal appeal pursuant to paragraph (1) of this subsection, the Payor shall not be required to pay any accrued interest.

e.6 If the arbitrator determines that a provider has engaged in a pattern and practice of improper billing and a refund is due to the Payor, the arbitrator may award the Payor a refund, including interest accrued at the rate of 12% per annum. Interest shall begin to accrue on the day the appeal was received by the Payor for resolution through the internal appeals process established pursuant to paragraph (1) of this subsection.

e.7 The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

16. Paragraph 4 of the First Amendment to to Dentemax Provider Service Agreement Applicable to Plans in New Jersey is amended to re-codify N.J.A.C. 8:38 to N.J.A.C. 11:24.

Dated: September 9, 2009

DenteMax
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