DELTA DENTAL®

ANNUAL COMPLIANCE ATTESTATION

Because you are contracted with Delta Dental of Kentucky to provide administrative or health care service functions that relate to Delta Dental of Kentucky's Medicare Parts C and D contract(s), the Centers for Medicare and Medicaid Services (CMS) requires you to comply with various CMS program requirements. By completing this attestation, you certify that you and your organization are committed to ensuring compliance with CMS and Delta Dental of Kentucky requirements. As used in this Attestation, a Downstream Entity is an individual or entity with whom you or your organization contracts and who is involved in the benefits provided to Medicare Advantage Enrollees. You attest as follows (select all that apply):

Compliance Program

❑ My organization and I will maintain a compliance program appropriate for the size of my organization to ensure compliance with federal and state laws and regulations and Delta Dental of Kentucky policies and procedures.

OIG and GSA Exclusion Screening

❑ My organization and I review the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), the CMS Preclusion List, and General Services Administration (GSA) List for our employees, temporary employees, board members, volunteers and contractors involved in the administration and delivery of services to Medicare Advantage enrollees. Exclusion screenings from these sources are checked prior to initial hire or contracting, and monthly thereafter. Any individual found on such lists will immediately be removed from any work directly or indirectly related to Medicare Advantage programs.

Preclusion List

❑ Neither my organization nor I am on the CMS Medicare Preclusion List. If either my organization or I am ever placed on the CMS Medicare Preclusion List, we will promptly notify Delta Dental of Kentucky.

Reporting Mechanisms

❑ Internal employees were informed of their obligation and how to report any suspected noncompliance or potential Fraud, Waste, and Abuse (FWA) for internal review and investigation. The reporting mechanisms ensure confidentiality and allow for anonymity, as desired. Retaliation or intimidation against anyone who reports a concern in good faith is not allowed, and our organization reports any applicable incidents to Delta Dental of Kentucky as they occur.

Record Retention

❑ My organization and I agree to maintain records of compliance training, disciplinary standards, investigations, compliance program materials, and exclusion checking for all employees, including temporary employees and volunteers, board members and downstream entities, for a minimum of 10 years. Records maintained must include, but are not limited to: training materials and training logs, documentation of exclusion checks, and dissemination of compliance program policies.

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Compliance Information (applicable if you or your organization have any Downstream Entities)

❑ My organization and I attest that we have and will continue to obtain attestations from our downstream entities for which we have contracted to provide services for Medicare Advantage enrollees, and will upon Delta Dental of Kentucky request, obtain the same documentation requirements listed above from those entities.

❑ My organization and I perform ongoing oversight of our downstream entities and disclose issues identified to Delta Dental of Kentucky as soon as possible.

❑ Not applicable

Offshore Subcontractor Reporting

❑ My organization and I, including any of our downstream and related entities **(Check One)**

❑ Do or ❑ Do not engage in offshore operations of any administrative or health care services related to Medicare Advantage business. If you checked "Do," please contact us for an "Offshore Subcontractor Attestation" for completion and submission to Delta Dental of Kentucky.

Attestation Authorization

I certify that the information above is true and correct to the best of my knowledge, and the above compliance program requirements have been met. In addition, my organization and I will furnish evidence of completion of the above to Delta Dental of Kentucky upon request for monitoring and auditing purposes.

Organization/Practice Name	Email Address
Tax Identification Number	Phone Number
Physical Address	City, State, Zip Code
Name of Authorized Representative	Signature of Authorized Representative
Title of Authorized Representative	Date

A separate attestation must be completed for each location.

Please return the completed form to:

Email: medicareadvantage@deltadentalky.com

Mail: Delta Dental of Kentucky
Attention: Provider Relations
PO Box 242810
Louisville, KY 40224