Transparency Claim Payment Policies & Other Information URL

a. Out of network liability and balance billing

CMS Requirements

Description of the data element:
Balance billing occurs when an out-of-network provider bills an enrollee for charges – other than copayments, coinsurance, or any amounts that may remain on a deductible.

Issuers will provide the following:

- Information regarding whether an enrollee may have financial liability for out-of-network services.
- Any exceptions to out-of-network liability, such as for emergency services.
- Information regarding whether an enrollee may be balance-billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing.

Proposed:

Out of Network Dental Services (PPO)

If a PPO Member obtains dental services from a Non-Participating Provider, the Member may be required to pay for the service at the time the service is rendered. Although Non-Participating Providers may file claims on behalf of the Member, they are not required to do so. Therefore, Members who obtain dental services from Non-Participating Providers must be prepared to pay for the service and submit their claim to Dominion National for reimbursement. Unless otherwise required by law, all payments are made directly to the Subscriber. It is the Subscriber's responsibility to pay the Non-Participating Provider, if payment has not already been made.

Out of Network Dental Services (DHMO-Select Plan)

Select Plan (DHMO) Members may obtain the full range of covered services only from Participating Providers. Services by Non-Participating providers are covered only in emergency situations

Out-of-Network Emergency Services

When Emergency Services are provided by Non-Participating Providers, members may be responsible for the difference between the provider's charge for that service and the amount Dominion National paid for that service.

Balance Billing (PPO)

Non-Participating providers are not obligated to accept Dominion National's payment as payment in full. Members may be responsible for the difference between the provider's charge for that service and the amount Dominion National paid for that service. This difference between the provider's charge for a service and the Plan Allowance is called the **balance billing charge**.

b. Enrollee claim submission

CMS Requirement

Description of the data element:
An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.
Issuers will provide the following:

- General information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.
- A time limit to submit a claim, if applicable. Links to any applicable forms. The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number.

Proposed:

A Participating Provider will submit a claim for Benefits directly to Dominion National.

Non-Participating Providers may file claims on behalf of the Member, but they are not required to do so. Members who obtain dental services from Non-Participating Providers must be prepared to pay for the service and submit their claim to Dominion National for reimbursement.

If it is necessary for Members to submit a dental claim to Dominion National, they should be sure to request an itemized bill from their Provider. The itemized bill should be submitted to Dominion National with a completed Claim Form.

Members can obtain a copy of the Claim Form by contacting Customer Service or visiting the Member link at https://www.dominionnational.com/claims-payment-policies. The Member's claim will be processed more quickly when this Claim Form is used. A separate claim form must be completed for each Member who received dental services.

Members can submit their claims, which include a completed Claim Form and an itemized bill to Dominion National, PO Box 1126, Elk Grove Village, IL 60009.

Members who need help submitting a dental claim can contact Customer Service at 1.800.613.2624 (TTY: 711).

All claims must be submitted within twelve (12) months from the date of service with the exception of claims from certain State and Federal agencies.

c. Grace periods and claims pending

CMS Requirement

Description of the data element:
A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Issuers will provide the following:

- An explanation of what a grace period is.

- An explanation of what claims pending is.
- An explanation that it will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

Proposed:

Subscribers eligible for premium subsidies

Subscribers eligible for premium subsidies on plans purchased on the federally facilitated marketplace are entitled to a three-month grace period when a premium payment is missed. During the first month of the grace period, Dominion National must continue to provide coverage (pay claims). In addition, Dominion National notifies the affected providers on the possibility that claims may be denied during the second and third months of the grace period if the premium is not paid.

If the premium is paid in full by the end of the three month grace period, any pended claims will be processed in accordance with the terms of your contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

Subscribers who are not eligible for premium subsidies

Subscribers have a 31-day grace period when a premium payment is missed. If the Subscriber does not make payment during the grace period, the Contract will be cancelled effective on the last day of the grace period and Dominion National will have no liability for services which are incurred after the grace period.

d. Retroactive denials

CMS Requirement

Retroactive denials
Description of the data element:
A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

Issuers will provide the following:
- An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
- Ways to prevent retroactive denials when possible, for example paying premiums on time.

Proposed:

A retroactive denial is the reversal of a previously paid claim. If the claim is denied, the Member becomes responsible for payment.

Retroactive denial of claims can be avoided by paying premiums on time, using Participating Providers for services, and obtaining Preauthorization for services.

e. Recoupments of overpayments

CMS Requirement

Description of the data element:
Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.

Issuers will provide the following:

- Instructions to enrollees on obtaining a refund of premium overpayment.

Proposed:

If a Member overpays his premium bill and does not want to hold the overpaid amount to use toward the next bill, the Member should call Customer Service to request a refund to be issued. If a Member paid by credit card the overpayment will be refunded onto the member's credit card. All other refunds will be issued by check.

f. Medical necessity and prior authorization timeframes and enrollee responsibilities

CMS Requirement

Description of the data element:
Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.
Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

Issuers will provide the following:

- An explanation that some services may require prior authorization and/or be subject to review for medical necessity.
- Any ramifications should the enrollee not follow proper prior authorization procedures.
- A time frame for the prior authorization requests.

Proposed:

MEDICAL/DENTAL NECESSITY means care and services that are provided by a properly licensed dentist within the standards of generally accepted dental practice.

PRIOR AUTHORIZATION is required for treatment that is expected to exceed $300 for Pediatric Services. The Plan strongly advises the same to apply to non-Pediatric Services, but it is not required. The participating dentist (or orthodontist as applicable) is required to submit a treatment plan prior to initiating Pediatric Services. The proposed services will be reviewed and a prior authorization will be issued to the subscriber or treating dentists (or orthodontist), specifying coverage. The prior authorization is not a guarantee of coverage and is considered valid for 180 days.

g. Drug Exception timeframes and enrollee responsibilities

CMS Requirement – Does this apply to dental?

Description of the data element:
Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).

Issuers will provide the following:

- An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.
- The time frame for a decision based on a standard review or expedited review due to exigent circumstances.
- How to complete the application.

Proposed

Not Applicable to Dental.

h. Explanation of benefits

CMS Requirement

Description of the data element:
An EOB is a statement an issuer sends the enrollee to explain what medical treatments and/or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

Issuers will provide the following:

- An explanation of what an EOB is.
- Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).
- How a consumer should read and understand the EOB.

Proposed:

After a visit to your dental provider, a member may receive an Explanation of Benefits (EOB) detailing the services received, how much they cost and how much your plan paid. Cost-sharing includes copayment, deductible and coinsurance.

An EOB is not an invoice. Your dental provider will provide a bill for any amount you may owe.

i. Coordination of Benefits

CMS Requirement

Description of the data element:
Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.

Issuers will provide the following:

- An explanation of what COB is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

Proposed:

Coordination of Benefits applies when a person has dental coverage under more than one Plan.

Coordination of Benefit rules set the order in which each Plan pays a claim for benefits.

- The Plan that pays first is the “Primary Plan.” The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- The Plan that pays after the Primary Plan is the “Secondary Plan.” The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.