Transparency Claim Payment Policies & Other Information URL

A. OUT OF NETWORK LIABILITY AND BALANCE BILLING

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 (Select Plan)

Select Plan 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

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.

To file a claim, follow these steps:

1. Complete an ADA Claim Form. A separate claim form must be completed for each Member who received dental services. Members can also obtain an ADA Claim Form by contacting Customer Service.
2. Attach an itemized bill from the provider for the covered service.
3. Mail the completed claim form and itemized bill to the address below:

   Dominion National
   P.O. Box 211424
   Eagan, MN 55121

Members who need help submitting a 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

Subscribers Who Receive an Advance Premium Tax Credit (APTC)

Subscribers enrolled in a plan purchased on the *Health Insurance Marketplace* who receive an APTC are entitled to a three-month grace period when a premium payment is missed. A grace period is a time period when your plan will not terminate even though you did not pay your premium. During the first month of the grace period, Dominion National must continue to provide coverage (pay claims). During the second and third months of that grace period, any claims you incur may be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. 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 pended claims incurred in the second and third months may be denied.

No grace period applies to the first premium.

Subscribers Who Do Not Receive an APTC

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.

No grace period applies to the first premium.

D. RETROACTIVE DENIALS

A retroactive denial is the reversal of a previously paid claim. If the claim is retroactively 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 Prior Authorization for services.

E. RECOUPMENTS OF OVERPAYMENTS

If a Member overpays their premium bill and does not want to apply the overpaid amount to the next bill, the Member should call Customer Service at 1.800.613.2624 (TTY: 711) to request a refund. 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

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.[1] The Participating Provider 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

[1] Prior Authorization is not required for Ohio plans.

providers, specifying coverage. A decision on a request for Prior Authorization will typically be made within 10-15 business days of a request. The Prior Authorization is not a guarantee of coverage and is considered valid for 180 days. The Plan strongly advises the same to apply to non-Pediatric Services, but it is not required.

Failure to obtain a Prior Authorization as indicated above for Pediatric Services may result in a denial of overage for any such Pediatric Services.

G. EXPLANATION OF BENEFITS

The Explanation of Benefits (EOB) form is one of the most important communications that Members receive from Dominion National. Members receive an EOB after Dominion National processes a claim submitted by a Member or a Member's provider.

An EOB is not a bill. It explains how a Member's benefits were applied to that particular claim. An EOB explains costs and payments, what services were covered under the Member's dental plan, as well as any services that might not have been covered and why. An EOB includes:

- Dental services performed (description of procedures)
- Dentist fees
- Dominion National's payment
- Payment you may owe (such as deductibles, coinsurance and non-covered services)
- Claim Appeal Procedures

Each time a Member receives an EOB, the Member should review it closely and compare it to the receipt or statement from their provider.

H. COORDINATION OF BENEFITS

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.