**Out-of-network liability and balance billing**

Out-of-network services are from dentists, facilities, and other health care professionals that have not contracted with your plan. A dental provider who is out of your plan network can set a higher cost for a service than providers who are in your dental plan network. Depending on the dental provider, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out of-network facility.

**Enrollee claim submission**

A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. Please contact customer service at (855) 425-4164 to determine the specific time limit for submitting your claim.

To file a claim, follow these steps:

1. Complete a claim form here
2. Attach an itemized bill from the provider for the covered service.
3. Make a copy for your records.
4. Mail your claim to the address below.
   California Dental Network
   P.O. Box 2190
   Laguna Hills, CA 92653
5. Alternatively, you can send the information by email to cdnclaims@caldental.net or by fax to (714) 242-7458

**Grace periods and claims pending**

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual dental plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. As an individual HMO plan in California, we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.

If you are enrolled in an individual dental plan offered on the Health Insurance Marketplace and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.

**Retroactive denials**

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you

might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible.

You can avoid retroactive denials by paying your premiums on time and in full and making sure you talk to your dental provider about whether the service performed is a covered benefit. You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

**Recoupment of overpayments**

If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.

**Medical necessity and prior authorization timeframes and enrollee responsibilities**

We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of dental specialist care requires prior authorization. If you need a service that we must first approve, your assigned primary care dentist will call us for the authorization. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll.

We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 5 days for non-urgent requests.

**Explanation of benefits (EOB)**

Each time we process a claim submitted by you or your dental provider, we explain how we processed it on an Explanation of Benefits (EOB) form.

The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.

**Coordination of benefits (COB)**

Coordination of benefits, or COB, is when you are covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about coordination of benefits can be found in your benefit booklet.