



**Dental Network
of America®**

Dental Administrative Guidelines



DNoA Preferred Network

Welcome

to the DNoA Preferred Network!

Dental Network of America, LLC (DNoA) would like to welcome you to the **DNoA Preferred Network**. DNoA is a wholly owned subsidiary of Health Care Service Corporation (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. These administrative guidelines provide you with an explanation of our policies and procedures for the administration of our dental programs and your role as a network dentist.



If you have any questions or need additional information regarding DNoA please contact (800) 972-7565 for assistance.



About DNOA

DNoA is a wholly-owned subsidiary of Health Care Service Corporation (HCSC), a mutual legal reserve company. DNoA has over 25 years experience in the dental benefits industry as a stand-alone dental Third Party Administrator. As one of the fastest growing dental networks in the country, DNoA continues to emphasize quality for participating dentists and the members we serve.



DNoA Programs

DNoA offers a full range of dental programs for our clients. DNoA also makes the network available to other clients who want to offer the benefits of a preferred network to their members.

Provider Relations

DNoA provides a full range of support services through our dedicated Dental Provider Relations Hotline. This toll-free number will put you in touch with our specially trained staff to handle your inquiries: 800-972-7565.

Inquiries regarding claims should be directed to our toll-free customer service department that can be found on the back of a member's ID card.



Preferred Network Program

DNoA's preferred network programs generally include member and family deductibles, coinsurance rates that vary by type of procedure, limitations and exclusions and annual maximums. Plan design features may encourage members to use participating dentists. These incentives may include lower deductibles, lower levels of coinsurance and lower out-of-pocket costs for the member.

As a preferred dentist, you have agreed to the Fee Schedule as payment in full for any service rendered to eligible members. The charge may not exceed the maximum fee on the Fee Schedule, regardless of whether or not the service is covered under the member's plan – with exceptions to state legislation limiting discounts on non-covered services.

You may NOT bill the member the balance between your usual fee and the maximum fee listed on your Fee Schedule.

Federal Government Programs

Federal DentalBlueSM – An optional dental program that supplements the Federal Employee Program coverage. Members purchasing Federal DentalBlueSM access this network, and your compensation will be limited to the Preferred Network Fee Schedule (which may be different from the FEP Maximum Allowable Charge Fee Schedule).

Discount Programs

Our network discount program and the dental plans using this network are not insurance. The dental plan offered by DNoA, its affiliates, or other clients makes no benefit payments on behalf of these members. Members accessing this network under the DNoA discount program receive financial savings by paying the contracted amounts in the established Fee Schedule. There are no claims to file, deductibles, waiting periods, annual maximums, or frequency limitations. Members are responsible for the entire cost of treatment. You should bill them directly as with other patients without insurance at a time you find mutually agreeable.

Other Preferred Network Programs

DNoA makes the network available to other insurers, third party payors and self-insured employers who process their own claims. Although these relationships vary in types of servicing provided by us to the specific plan and its members, ALL provide plan members with access to dental care from preferred dentists in accordance with your Fee Schedule. As a preferred dentist, you have agreed to the Fee Schedule as payment in full for any service rendered to eligible members.



How to Recognize a Member

Your contracted fees apply to members accessing the network. One way to recognize members is to examine the ID card they are issued. This card is not a guarantee of coverage but rather to identify their dental program.

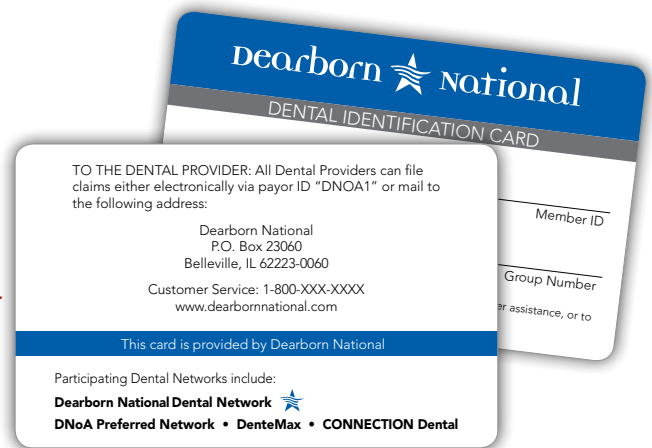
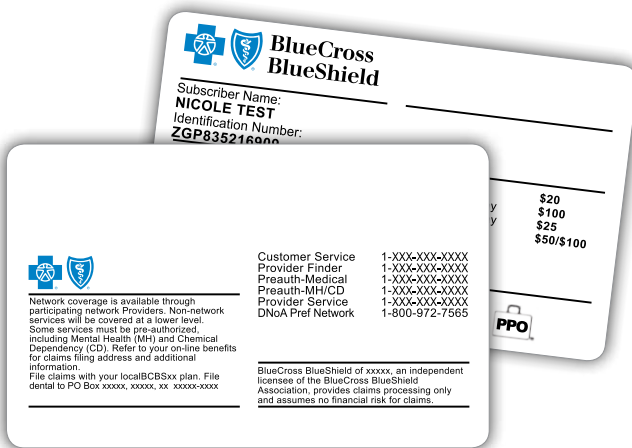
Members who participate in a DNoA Dental Program typically will present an ID card with the following network identifiers:

DNoA Preferred Network –

The national dental PPO network associated with Blue Cross and Blue Shield brands is fully administered by DNoA.

Dearborn National Dental Network –

The officially recognized national dental PPO network for Dearborn National clients that is fully administered by DNoA.



The network identifier is located on the back of the member's ID card. If you have questions regarding eligibility and benefits, or if you are unable to recognize the network identifier, please contact the toll-free customer service number also located on the back of the member's ID card.

Provider Services

DNoA has a fully staffed Dental only customer service team to assist you. Customer Advocates are available to answer questions regarding eligibility and claim status during normal business hours of 8:00am - 6:00pm, Monday - Friday (central time). Please call during these hours using the toll-free customer service number identified on the back of the member's ID card.

For the convenience of electronic claims submission and online claims administration DNoA partners with Securexchange/ANSLink, a 24/7 internet based service for providers. Securexchange/ANSLink is refreshed daily with a file feed from the DNoA system in real-time. There is no charge to the provider for using Securexchange/ANSLink with cost of service being covered by DNoA. Securexchange/ANSLink allows providers the opportunity to:

- Verify eligibility and high level benefits for DPPO plans
- Electronically submit DPPO claims
- Electronic claim status if original claim was submitted through Securexchange/ANSLink

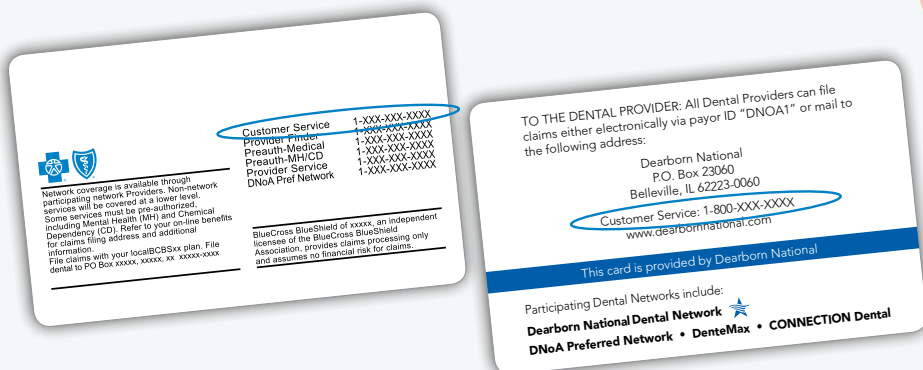


Not a current Securexchange/ANSLink user?

Participating network dentists can access Securexchange/ANSLink free of charge. All claims transaction fees through Securexchange/ANSLink are covered by DNoA.

Contact Securexchange/ANSLink to get started and save:
www.anslink.net or (888) 466-9656.

For Member Eligibility and plan information call the number located on the back of the member's ID card.



Filing Claims

Claims can be filed electronically to reduce your administrative costs, improve accuracy and expedite payment. We accept electronic claims from all major vendors and clearinghouses that agree to forward claims to Availity, our centralized clearinghouse. We have contractual agreements with:

- **Securexchange/ANSLink** – www.anslink.net or (888) 466-9656
- **Availity** – www.THINEDI.com, or (972) 776-5480

When submitting electronic claims, please be sure to use your National Provider Identifier (NPI). **An NPI is required for all electronic transactions.**

NPI numbers are required for any claims submitted for the Federal Employee Plan (FEP) program.

Don't have an NPI number? You can apply using one of the following options:

- **Online application:** <http://nppes.cms.hhs.gov>
- **E-mail:** customerservice@npienumerator.com
- **Mail application:** NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059
- **Telephone:** 800-465-3203
800-692-2326 (NPI TTY)

We strongly recommend electronic submission of attachments and x-rays. To enroll in our e-attachment program and submit x-rays electronically, please visit the web site at www.nea-fast.com or call National Electronic Attachments (NEA) at (800) 782-5150.

Paper claims can be submitted to us on the current, standard ADA claim form to the claim address on the member's ID card.

We support the recommendation that original documentation should never leave your office. We encourage you to submit copied radiographs or send your dental claim and radiographs electronically.



Coordination of Benefits

A patient under this program may also be covered under another insurance plan necessitating benefits to be coordinated between carriers. In order to coordinate benefits, the office needs to determine which plan is primary and which is secondary. The primary plan is the plan that pays first and without consideration of the other plan's benefits. The secondary plan is the plan that pays second, and takes into account the primary plan's benefits so that total payment to a provider does not exceed 100% of the allowable fee or the office charge, whichever is less. If the primary carrier pays more than the allowance of the secondary carrier, the member has no further obligation. If the primary carrier pays less than the allowance of the secondary carrier, the secondary carrier may pay the difference up to the allowance providing the member no further obligation. If the Dentist is contracted with the primary and/or secondary insurance plan, reimbursement is based on the contracted maximum allowed fee or the office charge, whichever is less.

Lab Fees:

All Lab Fees associated with treatment are included in the PPO allowed fee. You may not bill the member Lab Fees as a separate fee.

Member's responsibility:

Our members are only responsible for the predetermined co-insurance amount and any related deductible at the time of service. Participating providers agree to file all claims for our members, and participating providers agree to accept assignment of benefits.

Special Note:

Radiographs submitted with a paper claim will NOT be returned to the provider office unless accompanied by a self-addressed envelope.

No Specialist Referrals Needed

Members will obtain their maximum level of benefit if they receive treatment from a network specialist and are not required to receive a referral.

The member or you may call Customer Service at the toll-free number identified on the back of the ID Card for contracting network specialists in their immediate area, or you may visit the website provider finder feature at www.dnoa.com. Be sure to choose the applicable dental program directory option.



Dental Claim Review

As a component of the claim adjudication process, specific dental procedures are identified for submission to our Professional Review Unit. In order to provide a professional opinion, our clinical staff relies on various forms of supporting documentation to accompany the claim or predetermination of benefits, eg. radiographs, charting, patient notes, etc.

Submissions without supporting documentation will not be adjudicated until the required information is received. Please DO NOT send original documents.

Grievance and Appeals

The Grievance Procedure provides network doctors with a formal process for expressing dissatisfaction concerning determination of benefits, authorization of services and claim denials.

All complaints will be resolved and outcomes communicated in a timely matter, dependent upon the urgency of the situation and the requirements of specific state laws.

If a grievance cannot be resolved due to insufficient information necessary for a full investigation, a decision will be rendered based upon available information. If additional information is later received, the grievance will be reopened.

If a dentist disagrees with the decision regarding his/her grievance, they can submit a written request to appeal the original decision. Upon receipt of an appeal the case will be forwarded to the Benefit Policy and Appeals Committee for further consideration.

In order for the Claim Review or Grievance and Appeals process to work effectively, it is imperative that all requested information (records, X-rays etc.) be submitted in a timely matter. Lack of complete documentation can delay the process and adversely affect the final decision.

Provider Relations

Questions regarding network participation, contracts, fee schedules and applications for new locations and/or associates should be directed to:

Dental Network of America
Attn: Network Management
701 E. 22nd Street
Lombard, IL 60148
(800) 972-7565

Important: If a change occurs in the license status of any dentist participating in the program, written notification of such change is required, e.g., suspension or revocation. Any change in your malpractice coverage must also be reported.



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