Dental Health Services

Qualified Dental Plans 2021 Transparency in Coverage Frequently Asked Questions

For your convenience, here is a list of answers to *frequently asked questions* from consumers about Dental Health Services' qualified dental plans in Oregon.

Prior to enrolling in one of Dental Health Services' SmartSmile-EC plans, we recommend reviewing the plan's *Evidence of Coverage and Schedule of Covered Services and Copayments.* You can find links to this information and more on Dental Health Services' Oregon Exchange landing page: https://www.dentalhealthservices.com/OR/.

Out-of-Network Liability and Balance Billing:

Services are covered when provided by your participating primary dentist, chosen from the Dental Health Services' Network of Quality Assured Dentists.

When services provided by an **out-of-network** dentist or specialist are not preauthorized, members are responsible for the entire bill for services.

Occasionally, it may be necessary for a member to have services provided by an **out-of-network** dentist or specialist:

- In a routine dental situation where no in-network dentists or specialists are available within a reasonable distance of a member (30 miles for general dentistry in urban and suburban areas and 60 miles in rural areas. 60 miles for specialty services in urban and suburban areas and 90 miles in rural areas). When services provided by an **out-of-network** dentist or specialist are pre-authorized, members will only be responsible for applicable copayments. The **out-of-network** dentist or specialist will submit a claim to Dental Health Services for payment.
    - In an emergency dental situation, the member may have services provided by an **out-of- network** dentist. Emergency services provided by an **out-of-network** dentist do not require pre-authorization by Dental Health Services.
- If a member receives services for the treatment of an emergency dental condition from an **out-of-network** dentist or specialist, an additional $50 may be charged above the applicable copayments, unless due to uncontrollable circumstances, the member is unable to go to a participating network dentist or specialist in a timely fashion without serious detriment to their health.

Please see the **Member Claims Submission** section of this document for details on how to submit an **out-of-network** emergency claim.

Balance billing is the practice of a provider billing a patient for the difference between what the patient's insurance chooses to reimburse them for a service and what the provider chooses to charge for the service**.** Because Dental Health Services' Network of Quality Assured Participating Dentists agrees to comply with your plan's Schedule of Covered Services and Copayments and Exclusions and Limitations of Benefits, members should never pay any additional charges for covered services. This means, **balance billing** is not allowed from a member's participating dentist.

Members should contact a Member Services Specialist at 855.495.0907 if any sort of **balance billing** is received.

Member Claims Submission:

Our qualified dental plans are designed so that **claim** forms are not required to be submitted by members when services are provided by one of Dental Health Services' Network of Quality Assured Participating Primary Dentists.

For pre-authorized, covered services provided by a participating specialist, the specialist will submit a **claim** for services provided to the member. The specialist will collect the member's applicable copayment(s) at the time of service.

For pre-authorized, covered services provided by an out-of-network specialist, the specialist will collect any applicable copayments from the member and then submit a **claim** directly to Dental Health Services for payment.

For emergency situations where services are handled by an out-of-network dentist or specialist, members are responsible for paying the entire bill at the time of service. To be reimbursed for any amount over the covered emergency services copayment, members must submit the itemized dental bill to Dental Health Services.

Dental Health Services only reimburses for the amount over the copayment, up to $150 for dental work performed to eliminate pain, swelling, or bleeding. Within 180 days of the occurrence, send the itemized bill with the member's name and member identification number to:

Dental Health Services
Claims Department
100 W. Harrison Street,
Suite S440, South Tower
Seattle, WA 98119

If the member does not submit this information within 180 days, Dental Health Services reserves the right to refuse payment.

Grace Periods and Claims Pending Policies During the Grace Period:

Benefits under your qualified dental plan depend on premium payments staying current.

HealthCare.gov grants non-subsidized individuals a one-month **grace period** beginning on the 1st of the month following a missed payment. If payment is not received after the one-month **grace period** permitted by HealthCare.gov, your dental plan coverage will be terminated on the last day of the month prior to the one-month **grace period**. Dental plan enrollees are generally considered to be non- subsidized.

A **grace period** can only be applied if a member becomes current on their past month's premium payments. Consecutive or rolling **grace periods** are not permitted.

Any previously initiated services then "in progress" must be completed within 30 days from the last appointment date occurring prior to the termination date. The member will remain liable for the scheduled copayment, if any. If a member's coverage is terminated, the member will be required to pay the participating dentist's usual fees for continuing the prescribed treatment.

Dental Health Services will pay all appropriate claims for services rendered to the member during the first month of the **grace period** and may pend or postpone the payment of claims for services rendered to the member in the second and third months of the **grace period**.

Retroactive Denials:

In the majority of instances, claims for your treatment will be submitted to Dental Health Services by your participating dentist or specialist or if necessary, out-of-network dentist or specialist. In very few cases, claims may be denied retroactively, even after a member has received services from their selected dentist or specialist.

Members can prevent **retroactive denials** by paying premiums in a timely fashion and ensuring that services provided by a dentist or specialist are pre-authorized by Dental Health Services before undergoing treatment.

Medical Necessity and Pre-Authorization Timeframes and Member Responsibilities:

Pre-authorization is a process through which Dental Health Services reviews and approves a request to access a covered benefit prior to treatment beginning. **Pre-authorization** may be required for some services covered by your Dental Health Services plan. If **pre-authorization** is not properly obtained, you may have to pay up to the full amount of the charges for services provided.

In most cases, **pre-authorization** will be obtained by your participating primary dentist or specialist. Dental Health Services will respond to **pre-authorization** requests to you and your dentist within 15 days of receipt of the request. Please consult with your participating primary dentist regarding any services requiring **pre-authorization.**

Qualified dental plans include coverage of **medically necessary** orthodontia for pediatric aged (0 – 18 years old) members. **Medical necessity** is used to describe care or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms that is reasonable, and meets appropriate evidence-based, clinical standards of care. Please consult your plan's Schedule of Covered Services and Copayments for direction on which orthodontic services require a review for **medical necessity** prior to receiving treatment**.**

Pre-authorization for **medically necessary** orthodontia services will be requested from Dental Health Services by the member's participating orthodontist. The **pre-authorization** timeline for **medical necessity** approval is 15 days from receipt of Dental Health Services Orthodontic Form for **Medical Necessity** and supporting materials. If an extension is necessary, the member and treating Orthodontist will be notified of a 15-day extension, within 5 days of receipt of the initial **pre-authorization**.

P**re-authorization** is not required for non-medically necessary orthodontia benefits covered by Dental Health Services' qualified dental plans. Please review the Schedule of Covered Services and Copayments to determine if your orthodontia services require **pre-authorization** before treatment begins.

Information on Explanations of Benefits:

Dental Health Services does not provide an **explanation of benefits** to members. Members can access their utilization and claims records 24-hours-a-day through a secure, privacy-protected log-in at www.dentalhealthservices.com. Members can view detailed explanations of dental services provided, including payments made to the dentist or specialist and the member's financial responsibility.

Coordination of Benefits:

Dental Health Services' plans do not facilitate the **coordination of benefits** with other coverage plans. During **coordination of benefits** facilitated by either the member or other medical or dental plan, Dental Health Services' plans will always be defined as the primary dental plan.

Recoupment of Premium Overpayment:

Dental Health Services strives to invoice its members accurately and timely. If you believe you are due a refund for premium paid or have a concern with the amount you have been invoiced, please contact your Member Services Specialist at 855-495-0907.

Contact Us:

We hope this document is helpful. If you have any questions about this information, please contact us for more information:

During business hours, please contact your Member Services Specialist at: 855-495-0907
membercare@dentalhealthservices.com.

You can also connect with us 24-hours a day at dentalhealthservices.com/OR/