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| **FAQs** **Delta Dental - Preferred Provider Organization (PPO) Plan** |  |

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| Delta Dental - Preferred Provider Organization (PPO) Plan |
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| https://secure.benergy.com/images/spacer.gif | **What is a dental preferred provider organization (dental PPO) plan, and how does it work?**

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|   | A dental preferred provider organization (dental PPO) plan works for you in two ways: through a panel or network of participating dentists, or through dentists you select that are not in the network. Each time you or a covered family member needs dental care, you choose whether to see an in-network or an out-of-network dentist.In-network dentists are listed in your plan's provider directory. When you use an in-network dentist, also called obtaining dental services in-network, your costs tend to be lower, because the dentists and the network have negotiated to have the dentists accept certain fees for certain services. |

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| https://secure.benergy.com/images/spacer.gif | **With a dental PPO plan, do I name a primary dentist?**

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|   | The dental PPO plan does not require you to name a primary care dentist or coordinate your care through a particular dentist. However, you are free to choose a primary dentist, whether or not that dentist participates in the network. |

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| https://secure.benergy.com/images/spacer.gif | **What are the advantages of obtaining my care from in-network dentists?**

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|   | There are several advantages when you go in-network. Generally:* You don't need to pay a deductible, or your deductible is lower than when you go out-of-network.
* You don't need to submit claim forms and wait to be reimbursed by your plan.
* With some plans, you pay a smaller percentage of coinsurance when you go in-network. With other plans, you only pay a copayment (fixed dollar amount) at the time you receive covered services. With these plans, after you pay your copayment, you owe no more payments for the covered services.
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| https://secure.benergy.com/images/spacer.gif | **How does the dental PPO plan work when I go out-of-network?**

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|   | Generally, you may use any covered dentist you choose. However, your cost will generally be higher and you have certain added responsibilities. For example:* Each year, you must pay part of your eligible out-of-network expenses before the plan begins to pay benefits. This amount is called the deductible.
* After you satisfy the deductible, the plan will reimburse you for a percentage of your eligible expenses and you will pay the balance. The percentage you pay is called your coinsurance percentage, and may be higher than for in-network services.
* You must complete claim forms and file claims with the dental plan to receive payment of benefits.
* The plan will not cover any charges above the allowable amount.
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| https://secure.benergy.com/images/spacer.gif | **When do I need to file a claim form?**

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|   | You may not need to file a claim form when you see in-network providers.When you do need to file a claim form, as you need to do in most cases when you go out-of-network, your dentist may handle your expense in one of two ways. Most dentists require you to pay the bill right away. In this case, get a receipt and file it with a claim form to be reimbursed. If the expense is covered, you will be reimbursed for part of the bill. To file a claim, follow the instructions on the claim form. If you have more than one health or dental insurance plan and have received an Explanation of Benefits (EOB) form from another plan, be sure to include a copy with your claim.Sometimes dentists are willing to wait for payment. In this case, you or your dentist will file the receipt and completed claim form with your dental health care company. The dental health care company will pay the dentist for the part of your expense the plan will cover. The dentist will then bill you for the part the plan did not pay. |

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| **What happens if I need dental care while I'm traveling?**

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|   | If you need dental care while traveling, call member services for your dental plan at the number on your ID card. Member services can refer you to an in-network dentist.In a dental emergency such as an accident in which you lose teeth or extreme dental pain, contact member services if you are able and the dental plan can help you decide where to go for care. However, even if you are unable to contact member services, get the care you need. Even if you need to go out-of-network, your plan may cover emergency care at in-network benefit levels as long as you follow the plan rules. |

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| **What is a deductible?**

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|   | A deductible may only apply, or may be higher, when you obtain care out-of-network. A deductible is the part of eligible expenses you must pay before the plan begins to pay a percentage of your eligible expenses. |

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| **Are there expenses that don't count toward my deductible?**

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|   | Yes. Some of your expenses will not count toward your deductible. For example, amounts your dentist charges above the plan’s allowable amount for a given service will not count toward your deductible. |

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| **What is coinsurance?**

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|   | Coinsurance may only apply to out-of-network care. After you satisfy the deductible, the plan will reimburse you for a percentage of your eligible expenses for out-of-network care and you will pay the balance. The percentage you pay is called your coinsurance percentage. |

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| **What is predetermination of benefits?**

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|   | Predetermination of benefits is the process by which a dental care company reviews the proposed treatment and tells you and your dentist how benefits may be paid.It's a good idea to obtain a predetermination of benefits before expensive services are performed. Have your dentist complete a form showing the proposed treatment and submit it to your dental care company. The dental care company will send your dentist an explanation of what benefits would be covered and what you would have to pay out of your pocket. You can then discuss your treatment options with your dentist. |

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| **What are covered services?**

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|   | Covered services are services covered by the plan. No dental plan covers everything. If you obtain services that are not covered services, you pay the full cost for those services. |

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| **What is an out-of-pocket maximum?**

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|   | An out-of-pocket maximum is the most you would have to pay out of your own pocket for eligible expenses. Not all plans have an out-of-pocket maximum. Check your Benefits Overview for details. With a plan that has an out-of-pocket maximum, once you reach the out-of-pocket maximum for a given year, the plan would pay all eligible expenses for covered services until any lifetime maximum benefit is reached.Not all expenses count toward an out-of-pocket maximum. Expenses for services that are not covered under the plan and amounts over any allowable amount limit would not count toward your out-of-pocket maximum. |

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