DentaTrust
Underwritten by DCP, Inc.

Important Transparency in Coverage Information

As part of the Affordable Care Act ("ACA"), please see the following transparency in coverage information for individuals enrolled in dental plans purchased through healthcare.gov.

Unless otherwise noted, the information provided below applies to 2018 Individual On-Exchange plans and Small Group On-Exchange plans. This information is only a guide and this information does not modify any of the terms of your Subscriber Policy. For specific information on your plan, please review your specific policy and schedule of benefits.

Balance Billing

Balance billing occurs when a participating dentist bills you for charges (other than charges that result from co-payments, coinsurance or deductibles) after we have paid your claim. Participating dentists within our network have agreed to accept our contracted fee as full payment and have agreed not to bill you above their contracted fee. When you see a dentist within our network of dentists, balance billing is not permitted.

Out-of-Network Liability

If the amount billed by a dentist, who is not within our network of dentists, is more than the payment amount allowed under your contract, you are responsible for paying the dentist the percentage amount listed in your subscriber certificate, plus the difference between the payment we allow for the service and the payment charged by the dentist. Please understand that a dentist that is outside of the network of dentists is under no obligation to limit the amount charged and you are responsible for the amount charged by the dentist.

Claims Submission

A participating provider will submit claims to us on your behalf. If you seek services from a dentist outside of our network of dentists, you will need to submit your own claim for services within 12 months of receiving the service to:

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906
Payer ID: CX014
To obtain a claim form, please click HERE. Please fill out and submit the claim form and any supporting documentation to the address listed above.

Grace Period

A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force.

If you are receiving advance payments of the premium tax credit under the ACA, and you have previously paid at least one full month's premium during the benefit year, the grace period is extended to three (3) consecutive months. We may pend claims made during the second and third months of the extended three (3) month grace period. If your premium is not paid by the end of the grace period, coverage will be terminated as of the end of the first month of the grace period and claims pended during the second and third months of the grace period will be denied.

Claims Pending

A claim is pending when it has been submitted to us and is under process by the claims department.

Retroactive Claims Denials

As outlined in your Subscriber Certificate, we will pay for claims submitted for covered services if you are eligible for coverage at the time the services were rendered.

If for any reason your coverage is retroactively terminated, we may retroactively deny your claims. If a retroactive coverage termination occurs, we may retract any payments made to your dentist and the dentist may seek to recoup the payment for the services from you.

You can prevent retroactive denials by paying your premium on time, providing us with the correct information, ensuring you are covered when the services are rendered, and contacting us with any questions you may have about your eligibility.

Premium 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

The Essential Health Benefits requirement for pediatric oral care services (for children as defined in your subscriber policy) may limit certain covered services, including orthodontia, to those that are medically necessary. In the case of orthodontia, this means that only orthodontic treatment that is assessed as being reasonable, necessary and/or appropriate, based on evidence-based clinical standards of care may be considered an Essential Health Benefit. Medically necessary orthodontia was not specifically defined by federal law or regulation and coverage may vary by state. Please refer to your Subscriber Certificate and Schedule of Benefits for a description of covered, medically necessary orthodontia. Please note that medical necessity review turn-around times may vary by state, as follows:

Ohio, Pennsylvania, Texas and Georgia Plans

Routine prior authorization requests will be processed within 5 business days of receiving complete information from your dentist, and we will respond to prior authorization requests within 30 calendar days

Arizona and Illinois Plans

Routine prior authorization requests will be processed within 10 business days of receiving complete information from your dentist, and we will respond to prior authorization requests within 30 calendar days

Virginia and Tennessee Plans

Routine prior authorization requests will be processed within 2 business days of receiving complete information from your dentist, and we will respond to prior authorization requests within 30 calendar days

Missouri Plans

Routine prior authorization requests will be processed within 36 hours (including 1 business day) of receiving complete information from your dentist, and we will respond to prior authorization requests within 30 calendar days

Michigan and Wisconsin Plans

Routine prior authorization requests will be processed within 14 calendar days of receiving complete information from your dentist, and we will respond to prior authorization requests within 30 calendar days.

Failure to follow proper prior authorization procedures may result in claims being denied.

Explanation of Benefits (EOB)

Each time we process a claim for you under this Policy, a written notice will be sent to you explaining your benefits for that claim. This notice will tell you how we paid the claim or the reasons it was denied. The notice is called an Explanation of Benefits or "EOB." The EOB is not a bill. It simply 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 applies when you have coverage under more than one dental policy. It determines which plan will pay benefits first. Please see your Subscriber Policy for more information related to Coordination of Benefits.