

Subscriber Frequently Asked Questions

Does Delta Dental of South Dakota offer an individual plan?

Yes, Delta Dental offers three individual/family plans. Please visit our Individual and Family plan section of the website to find our traditional individual/family plan or the Health Care Reform section.

Does Delta Dental offer a toll-free number if I have a question?

Delta Dental's toll free number is 1-877-841-1478. Call this number with questions regarding your benefits, eligibility, Explanation of Benefits statement, etc.

How can I get a Delta Dental benefits handbook?

To obtain a benefits handbook, please contact your employer.

What do I do if I've lost my ID card?

Go to the Subscribers section of the website. Under "Your Delta Dental Benefits at a Glance" click ID card. You will be asked to sign on to our secure site to get your ID Card. You can also call 1-877-841-1478 and ask for a replacement card.

What is a Delta Dental of South Dakota participating dentist?

A Delta Dental of South Dakota participating dentist signed an agreement with Delta Dental and agrees to abide by certain guidelines, such as not charging Delta Dental subscribers more than the pre-approved fees. Delta Dental of South Dakota participating dentists submit claims directly to Delta Dental of South Dakota for their patients.

What is "balance billing," and how do you prevent a dentist from billing the patient any amount in excess of the "Amount Allowed"?

Participating dentists agree to accept payment based on the contract amount allowed or submitted amount, whichever is less. If the amount allowed for a particular covered service is lower than the dentist's submitted amount, he or she agrees not to charge the difference to the subscriber.

For example: Dr. X charges \$50.00 for a particular covered service. Delta Dental's contract amount allowed is \$40.00. When Dr. X performs the service on a Delta Dental patient, his office then files a claim. Delta Dental sends him a check for \$40.00 (less any co-insurance or deductible as per the group's contract), and the service is considered paid in full. Per his contract agreement, Dr. X may not "balance bill" the patient for the remaining \$10.00.

How do I confirm if my dentist is a participating dentist with Delta Dental of South Dakota?

Information about your dentist's membership with Delta Dental can be found on our online dentist search at www.deltadentalsd.com. A call to your dentist can also confirm his or her participation.

Do I have to go to a particular dentist?

You can go to any dentist you choose but you receive maximum out-of-pocket savings when you go to a Delta Dental participating dentist (roughly 98% of South Dakota dentists participate with Delta Dental).

What happens if I visit an out-of-state dentist?

If the dentist you see is outside South Dakota, yet participates with that state's Delta Dental, benefits will be based that state's approved fees.

Do I need a referral to have a procedure done by a specialist?

You do not need a referral from Delta Dental, but some specialists require referrals from a general dentist before providing treatment. You may also want to have the specialist submit a "Predetermination of Benefits," to determine any potential out-of-pocket costs. Exams and consultations by specialists may not be covered by your plan so check your benefits.

Does Delta Dental require claim forms? Where should claims be sent?

Delta Dental of South Dakota does not require special claims forms. However, most dental offices (and all Delta Dental participating dentist offices) have standardized claim forms. If your dental office does not have claim forms, you can download a claim form from our web site. Claims can be sent to:

Delta Dental of South Dakota

PO Box 1157

Pierre, SD 57501

How will I know when my claim is processed?

When Delta Dental has processed your claim, you will receive an Explanation of Benefits (EOB) that describes the services your dentist submitted and the benefits that your plan provided.

Can I find out what my treatment will cost before I have it?

Yes, for services of \$500 or more, your dentist should submit a Predetermination of Benefits, of your proposed treatment plan to Delta Dental. We will process it and send your dentist an Explanation of Benefits that shows what would be covered and how much you would have to pay. Please keep in mind that although a pre-treatment estimate may state Delta Dental will pay a certain amount for a procedure, it is not a guarantee of payment, as circumstances may change (e.g.: your annual maximum could be met before the proposed treatment date). For services that your dental plan does not cover at 100%, having a pre-treatment estimate lets you know what your out-of-pocket costs will be.

Is there a frequency limitation on any of the procedures I receive?

Some procedures do have a time frequency on how often they can be covered by your plan. Most dentists are aware of procedure frequencies. This is another reason to have your treatment pre-determined.

What is an annual maximum and deductible?

The annual maximum benefit is the maximum benefit each member is eligible to receive for certain covered services in a coverage year. A deductible is the dollar amount you pay for covered services in a coverage year before benefits are available. The family deductible is reached from deductible amounts paid on behalf of any combination of members.

Why did Delta Dental pay less for white fillings on my back teeth?

Tooth colored or composite fillings are considered to be cosmetic. Dental amalgam or silver fillings, are less expensive and clinically equivalent to composite fillings. Because of this, your plan reimburses your dentist for the least costly clinically equivalent fillings (amalgam) on back (posterior) molars.

How often will my dental plan pay for me to have my teeth cleaned?

How frequently your dental plan will pay for you to have your teeth cleaned depends on the benefits that were purchased by your employer. To find out about your benefits check your benefits handbook provided by your employer or go online to the subscriber connection.

I just got married. How do I add my new spouse to my plan?

Delta Dental receives the information about covered family members from your employer. Please review and follow the procedures at your company to add, delete, or change information about covered family members, particularly those procedures that pertain to the time limit on making changes.

What happens if I am covered by two dental plans? Does this mean I now get four cleanings a year instead of two?

Having two dental plans (called "dual coverage") does not "double" your coverage. However, it may mean that you will pay lower out-of-pocket costs. One plan will be considered primary (the one that usually covers you as an employee), and the other will be secondary (the one that typically covers you as a dependent). If you have children covered, the primary is usually the plan that covers the parent whose birthday falls first in the calendar year (month and day, not year). For example, if your spouse's birthday is March 13 and your birthday is June 27, your spouse's is the primary plan for the children.

When a person has coverage through two carriers, benefits are coordinated by the two carriers so the person gets the maximum benefit from both plans, but not to exceed 100% of the total charge. Claims should first be submitted to the primary plan for payment. If the charges are not paid in full by the primary plan, the claim should then be submitted to the secondary plan for possible additional payment on the charges. Some dental plans may have a non-duplication of benefits rule. This means the secondary plan would pay only if the primary plan paid less than the secondary plan would have paid had it been the primary plan. In this case, the total benefit would be limited to the payment made by the primary plan. You are responsible for paying the remainder.

Can I continue my dental coverage after I leave my job?

You may be eligible for COBRA continuation coverage through your employer. You should contact your human resources department for this information. There are various conditions that will determine COBRA eligibility. Your employer gives COBRA information (including eligibility and length of continuance) to us. If COBRA coverage is not available to you, you can enroll in one of our individual/family plans.

To what age are dependent children covered?

Coverage depends on the benefits your employer has chosen for their plan. Usually, dependent children are covered to the age of 19, but their coverage could extend longer if they are unmarried and they are a FULL TIME STUDENT. The dependent must be enrolled in an accredited college or university to be eligible for coverage. Remember, eligibility must be verified for each semester. Please check your benefit handbook or contact your human resources department to determine age limits.

I am divorced. If my former spouse and I both have dental coverage, whose insurance covers the children first?

It usually depends on who has financial responsibility for the children. If the parents have joint custody, then the parent with the birthday earliest in the calendar year has primary coverage.

If I am divorced and have physical custody of my children, does my former spouse's insurance still cover our children?

If your former spouse has dental coverage that includes dependents, the children have coverage regardless of whether or not they reside with you or your spouse.