Delta Dental of Wyoming's Transparency in Coverage

Out of Network liability and balance billing

Out-of-network services are from dentists that have not contracted with Delta Dental of Wyoming. A dentist who is out of the Premier network can set a higher cost for a service than dentists who are in the Premier network. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover.

Enrollee Claims Submission

A claim is a request to Delta Dental of Wyoming for payment of dental services. Usually, dentists file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. There are time limits on how long you have to submit claims. Claims must be submitted within 12 months of your date of service.

To file a claim, follow these steps:

1. Complete a claim form [Include link to Claim Form].
2. Attach an itemized bill from the provider for the covered service.
3. Make a copy for your records.
4. Mail your claim to the address below.

   Delta Dental of Wyoming
   6705 Faith Drive
   Cheyenne, WY 82009

Grace Periods and Claims Pending

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. If you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly.

Retroactive Denials

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid for a service for which you were not eligible. You can avoid retroactive denials by

paying your premiums on time and in full and making sure you talk to your provider about whether the service performed is a covered benefit.

Recoupment of overpayments

If you believe you have paid too much for your premium and should receive a refund, please call our customer service number at 800-735-3379.

Medical/Dental Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

We recommend that any services over $250 be approved before you obtain them. This is called prior authorization. For example, any kind of crown, build up or oral surgery should have prior authorization. If you need a service that we should first approve, your in-network dentist will submit the prior authorization and information about your services to us for review. If you don't get prior authorization, you may have to pay up to the full amount of the charges. We typically decide on requests for prior authorization for medical services within 10 days of receiving the request.

Explanation of Benefits (EOB)

Each time we process a claim submitted by you or your dentist, we explain how we processed it on an Explanation of Benefits (EOB) form. The EOB is not a bill. It 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

Coordination of benefits (COB) is required when you are covered under one or more additional group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about COB can be found in your benefit booklet.