Frequently Asked Dental Benefits Questions

Delta Dental of Minnesota

Delta Dental of Minnesota, in partnership with Target, is pleased to offer Target team members two national dental networks through Delta Dental: Delta Dental PPO℠ and Delta Dental Premier®. Both networks offer significant cost savings and greater access to quality dental providers and convenient claims processing/benefit payment.

Q1. Can I see any dentist?

A. As a part of the dental plan, you have access to two network choices: Delta Dental PPO and Delta Dental Premier. Delta Dental PPO provides you the most discounted service value within a smaller network of providers; the Delta Dental Premier provides you with a slightly lesser discount value and a broader selection of providers. While you are welcome to see any dentist you choose, there may be a difference in the payment amount if your dentist does not participate in the Delta Dental PPO and Delta Dental Premier networks. This payment difference could mean you pay more. To avoid any misunderstanding of benefit payment amounts, ask your dentist if he or she participates in the Delta Dental networks prior to receiving dental care. To find a participating dentist, log on to DeltaDentalMN.org/tgt

Q2. Can I change provider at any time?

A. Yes, you are free to go to the dentist of your choice. Remember you may pay more if you use a provider not in the Delta Dental networks.

Q3. Do I need my ID card when I get care?

A. You will receive an ID card when initially enrolling in the dental plan. It is helpful to show your ID card at each dental visit, but is not required. If you do not have your ID card, make sure your dental office has the following information from your card: team member name, group number, member ID, claims address and customer service phone number.

Q4. How is dental work that is in progress handled?

A. Under the Delta Dental plan, payment of a claim is based on the service completion date for work that started prior to the team member's effective date on root canals and major restorative services (crowns, bridges and dentures).

Q5. Are pre-treatment estimates required?

A. Pre-treatment estimates are not required, but are strongly recommended if your dental treatment involves extensive treatment, such as dental implants, crowns, periodontics, dentures, bridges, orthodontia or complex oral surgery. The treatment plan should be submitted to Delta Dental before treatment begins. The treatment plan will provide you with an estimate of your portion of the cost and coverage provided under the plan. However, a pre-treatment estimate does not guarantee coverage. Your actual benefits will be based on treatment received, current eligibility, remaining annual maximum and plan provisions in effect at the time treatment is completed. Note: a treatment plan need not be submitted for emergency treatment, oral examinations, X-Rays or cleaning of teeth (prophylaxis).

Q6. Do I need a referral to see a specialist?

A. No, if you need to see a specialist for service your dentist does not provide, your dentist can help you find a specialist to treat your condition. You may also select one yourself. Again, you may pay more if your visit an out-of-network provider.

See more on next page

Q7. How are orthodontic services covered if they are currently in progress?

A. If a covered person is currently receiving orthodontic treatment (i.e. bands are in place) and is enrolled under the Enhanced Dental plan, the provider needs to supply Delta Dental with the following information:

- Treatment type (procedure number)
- Total fee for treatment
- Number of months treatment will take place
- Provider signature
- Claim form completed by provider or team member

The benefit amount to be paid will be pro-rated based on the number of months of active treatment remaining and the eligibility status of the covered person. You may not receive the full benefit.

NEW - Effective April 1, 2018: Under the Enhanced Dental Plan (#50803), covered Target team members may be eligible to receive up to a $500 increase in orthodontic lifetime maximum benefit per person.

To qualify:

- The patient must still be in active orthodontic treatment (bands are in place) as of the benefit change on April 1, 2018 (not applicable for retention phase).
- Typically, original treatment length has not been extended.*

To apply for the increase:

- The claim will be reviewed and the increase paid based on the treatment plan and eligible dollars that qualify.
- To have your claim reviewed for the additional benefit, your orthodontist will need to submit a written request on a voucher or resubmit the original claim in writing indicating "Increase in benefit, please review."

*If your original treatment length has been extended, contact the Customer Service Number on the back of your ID card to discuss your specific circumstances.

Q8. How are orthodontic services covered if orthodontic care has not been provided?

A. For new orthodontic treatment cases beginning after a team member's effective date under the Enhanced Dental plan, the provider needs to supply Delta Dental with the same information listed above. Orthodontia payments are made over the course of treatment. The covered person must be enrolled in the plan in order to receive ongoing orthodontic payments. Benefit payments are made in three equal amounts: (1) when the appliances are inserted and at six month intervals thereafter (six months after appliance placement and 12 months after appliance placement) for the duration of the treatment plan, as long as the person remains covered or until the lifetime maximum benefits are exhausted. Final payment will not be made if you or your dependent(s) is no longer eligible.

Q9. How does Coordination of Benefits work when dental coverage is provided by two or more dental plans?

A. Coordination of Benefits (COB) applies to the payment of dental care benefits when a team member is covered by two or more dental plans. Delta Dental coordinates the insurance benefits between the two plans: the primary plan, which pays your claim first, and the secondary plan, which pays the claim next. If Target is the secondary plan, it will pay the difference between the amount the Target plan allows and the amount already paid by the primary plan. For example, if the Target plan would have paid $300 as the amount allowed, and your primary plan paid $300, then the Target plan will not pay an additional benefit.

Delta Dental will coordinate benefits up to the allowed amount for participating dentists and up to the billed amount for non-participating dentists. Please consult your dental plan's Summary Plan Description (SPD) for additional information on how COB works.

See more on next page

Q10. Where will benefit payments be sent?

A. If you receive dental services from an in-network dental provider, claim payments will be sent directly to your dentist. You will receive an Explanation of Benefits (EOB) detailing the plan payment.

If you receive services from an out-of-network dental provider, claim payment(s) will be sent directly to you. It is your responsibility to forward the payment to your out-of-network dentist.

Q11. Who do I contact if I have additional questions?

A. For more details about your Target dental plan, please review your Summary Plan Description (SPD) and the Medical Dental Common Administration document, which is available to Target team members on TargetPayAndBenefits.com or by calling the Target Benefits Center at 800-828-5850. Representatives are available to assist you from 9 am to 7 pm CST.

You can also contact Delta Dental of Minnesota for more information, especially if you are visiting an out-of-network dentist, need a claim form mailed to you, or to obtain additional ID cards at 800-493-0513 or locally at 651-994-5100.