Frequently Asked Questions

Why are dental benefits important?

Dental benefits are the single largest factor in determining whether a person sees a dentist regularly, and regular dental care is the best way to prevent oral disease. Three out of four Americans have some form of gum disease, and many lack dental coverage that encourages necessary care. Regular dental exams can also detect the first signs of severe medical conditions, including diabetes, oral cancer and hardening of the arteries, making treatment easier and more effective.

Can members access their AWA Dental plan information online?

Yes, AWA membership includes access to our secure Member Portal – **myhealthmembers.com**. On the portal, members will find phone numbers, web links and information regarding the AWA Dental plan included in their AWA membership. They will also be able to view, download and print their member guide, which contains information about their AWA Dental plan, as well as their AWA resources. If members have questions about their materials, please call Member Services at **(214) 436-8881**.

Will members receive a separate dental ID card?

Yes, members will receive a packet from Reliance Standard containing their Dental ID card.

When can members begin using their dental and other benefits?

Members can begin using their benefits on their membership's effective date for Type 1 and Type 2 procedures. There is a 12-month waiting period for Type 3 procedures. A waiting period is a period of time a person must be enrolled in a plan before qualifying for benefits.

Can members go to any dentist?

Members are free to see the dentist of their choice and there are no restrictions on changing primary dentists. However, in-network providers are dentists who have agreed to offer discounts on services provided. Out-of-network dentists have not agreed to discounts, and members may have more out-of-pocket expenses.

Does the dental plan design change based on whether members go to an in-network or an out-of-network dentist?

No, the coinsurance, deductible and maximum are the same, regardless of whether members visit an in-network dentist or an out-of-network dentist. But if members do visit an in-network dentist, the amount they pay for a procedure will almost always be lower. Visiting an in-network dentist can result in an average savings of 25%. If members visit an out-of-network dentist, the dental procedure charges are reimbursed up to the PPO contracted fee amount in the zip code where the dental work was received. If the out-of-network dentist charges are above the PPO contracted fee, members are responsible for any remaining dollar amount.

How large is the PPO network and how do members look up participating dentists?

With more than 249,000 provider access points nationwide, the Dental Participating Provider Organization (PPO) Network is one of the largest in the country, and continually growing. To locate participating dentists, visit **https://dentalnetworkpartners.ameritas.com/** and select the "Classic (PPO)" network" or call Reliance Standard Customer Relations at **(800) 497-7044**.

Do the dental plans have an annual maximum?

Yes. The annual maximum benefit allowance for the AWA Dental plans varies by plan. AWA Dental 1000 has a $1,000 annual maximum and AWA Dental 1500 has a $1,500 annual maximum. An annual maximum is the maximum dollar amount a dental plan will pay toward the cost of dental care incurred by an insured member in a calendar year.

What is an annual deductible?

An annual deductible is a specified amount of eligible expenses that must be incurred and paid by the insured member prior to any benefits being paid. Ineligible or non-covered expenses do not count toward satisfaction of a deductible. The AWA Dental plans have a $50 calendar year deductible per insured member with a family maximum of $150.

How many cleanings may members have in a calendar year?

The plan includes two cleanings or periodontal maintenance, whichever is appropriate, per calendar year. This matches the covered examinations per calendar year. For those who benefit from additional cleanings, in-network providers continue to honor their contracted fee for procedures, reducing the out-of-pocket expense.

Do members have coverage outside of the state they live in?

Yes, if members are traveling or have a covered dependent living in a different state, they will still have coverage.

How much time do members have to submit a claim?

Members or their providers must submit claims within 90 days from their initial date of service. Claims submitted after 90 days will be denied due to failure to meet the timely filing requirements. PPO providers are required to file the claim for the patient. Non-PPO providers have no specific requirements regarding filing of claims.

How will members identify the monthly drafts from their account?

All drafts will have "**PHS-HEALTH-BILL**" listed as the originator of the drafts.