Dental Allowance FAQs – November 18, 2019

What is a dental allowance?

A: A dental allowance is a set amount that you are given each year that you can use for dental services, such as fillings, extractions, cleanings, and other procedures as needed. The allowance is only available for non-Medicare covered preventive dental services and non-Medicare covered comprehensive dental services. The allowance will not cover cosmetic procedures.

How do I use my dental allowance benefit?

A: You will have a designated amount of benefit to use towards dental services. You may use and receive services against this amount during the calendar year period. Once the benefit is used up in a calendar year, you will not have any more services that you can be reimbursed for.

What dentist can I use?

A: You can use any licensed dentist that you choose. Providers on the exclusion and preclusion list are excluded. Link to these dentists below.

Exclusion is updated monthly: https://oig.hhs.gov/excusions/exclusions list.asp (contains all medical & dental – would need to filter for dental only)

How does my dentist bill you?

A: The dentist would bill us just as they do traditional dental insurance. They can call customer service to receive instructions on how to bill the claim and limits that you have. The provider will bill Cigna Medicare for the cost of dental services and this amount will be applied to the yearly allowance.

How do I know what my limit is?

A: Your dental allowance limit is listed in your evidence of coverage document. If you do not have your evidence of coverage, you may call customer service for a full explanation of your benefit.

How can I find out how much I have used and what is left?

A: You would call the customer service number on the back of your card. They will be able to assist you and tell you what claims have been paid through that day and what is remaining for use on your allowance.

Can you help me find a dentist?

A: You may see any dentist of your choosing. Since this is an allowance, we do not mandate participating dentists, therefore, do not have a list to choose from.

Are some dentist more expensive than others and how do I know what they charge?

A: All dentists have different rates for their services and can give you those amounts. You can call the dentist and ask for a pretreatment estimate and that will tell you the amount for your services. Think of

this as a “quote” for future work. Therefore, you can determine the best use of your allowance and manage your services.

What markets/plans will offer the dental allowance?

A: The will be offered on all PPO products with the exception of the Texas PPO plans. So, it will be available in Alabama, Georgia, Illinois, MAPA (PA and DE), North Carolina and Tennessee.

It will also be offered on all HMO plans in Alabama (Alabama, North Florida and Southern Mississippi), Florida (Daytona, Orlando, and Tampa), Georgia, North Carolina, South Carolina and Tennessee (Arkansas, Georgia, Tennessee).

Will a Cigna Medicare Advantage customer receive the Cigna negotiated rates for services?

A: No. The provider will bill Cigna Dental Health billed charges and this is the amount that will be deducted from the customer’s allowance. There is no fee schedule or Usual and Customary Charges (UCC). And since there are no fee schedules or no UCC, there is no balance billing.

What if a dentist requires payment up front?

A: The structure of the benefit is designed so that the customer does not have to pay up front, provided they still have monies in their allowance. If a dentist requires payment up front or will not file a claim, the provider should contact Cigna Medicare. This will be included in the provider outreach in Q4 2019 to educate and inform them of the dental allowance. There is not a direct member reimbursement process for 2020. There is not a process in place, nor was it in scope. We want to continue to reinforce the benefit value, which is a provider reimbursement model where the member does not pay up front.

What if the service exceeds the amount of the customer’s allowance?

A: The customer will be required to pay for any remaining monies that are over the allowance amount. To help prevent issues, both the customer and the provider will be able to check the remaining allowance amount by calling customer service. The customer can also get a pre-estimate from the provider to determine if they want to move forward with a particular service if there are no dollars left in the allowance.

What customer service number should providers and customers use?

A: A new customer service number will be used for customers and providers and will be listed on the back of the ID card. It is **866-213-7295.**

Are braces considered a cosmetic procedure?

A: No, they are not a cosmetic procedure.

What are the top 10 services that the plan covers that are not covered by Medicare?

A: Note, Original Medicare does not cover any preventive or comprehensive dental services. The allowance will cover both preventive and comprehensive services up to the customer’s allowance amount.

Typical services include cleaning and exam, x-rays, filling and repair of cavities, root canals, extractions and crowns. The dental allowance can also be applied towards detures.

Are night guards covered?

A: The allowance will cover night guards.

What is considered cosmetic services?

A: Examples of cosmetic services include: teeth whitening, enamel shaping, or crowns/veneers done solely for cosmetic reasons.

When will the allowance be available to the customer?

A: The total amount of the allowance will be available on the effective date of the plan. For example, a 1/1/20 effective date – the entire allowance amount will be available.

Can the plan transportation benefit be used for dental visits?

A: Yes, if the plan includes a transportation benefit, it can be used for dental visits.

Are x-rays included in the dental allowance?

A: Yes, x-rays are included in the dental allowance.

Will the customer receive an EOB?

A: The customer receives an EOB, but it does not include the allowance amount.

What should a customer do if a provider will not submit a claim directly to Cigna?

A: The ideal situation is for the provider to bill Cigna directly. If this is not feasible we suggest that the provider contact Cigna Medicare. If after all discussions, the provider still requires payment up front, there is an opportunity for the customer to submit a DMR (Direct Member Reimbursement). If a customer chooses to submit a claim for the dental allowance benefit, they would submit an ADA Dental Claim form and an itemized receipt (if available). The claim form includes instructions on filling out the form. To submit, there are two options:

- Providers can submit electronically through their EDI database
- Submit form to PO Box 188037, Chattanooga, TN 37422-8045

It is important to note box #37 indicates who payment should be made too, the customer should sign if payment is to be made directly to the provider and left blank if payment goes to the customer. The amount a customer is requesting, will be deducted from their current dental allowance benefit.

ADA claim forms are available at cigna.com, can be e-mailed/mailed, and can be found in C-Kit under RES8585.