

# Dental and Vision Benefits Member FAQs



## ID cards

### Q. Do I need an ID card?

- A. No, you don't need an ID card. However, if your policy includes one, you can access it in your [member account](#).

ID cards are provided with some plans as a convenient way to present your insurance information to the provider's office. Some plans don't issue cards. In place of an ID card, you may give your member ID or your group number, which includes your policy/division/certificate number.

### Q. What is my member ID number?

- A. In most cases, your member ID number is your social security number, or you may provide your name and date of birth. You can find your member ID on your benefit ID card.

For those with VSP or EyeMed vision network plans, please provide your member ID number in place of your social security number at your vision provider's office.

ID cards are not available on all plans and are not required to receive services.

### Q. How do I access my ID card?

- A. ID cards are not available on all plans. If your plan has an ID card, you can access it in your [member account](#) online.

### Q. How do I get a corrected ID card if there's an error on it?

- A. Benefits administrators submit member updates electronically. Contact your benefits administrator to update your information.

## Member account

### Q. What can I do in my member account?

- A. You have access to your dental and vision benefit information, ID cards, and network provider search in your [member account](#). For dental policies, you can view claims status and explanation of benefits in your account as well. Full account services are available when accessing the account online through a web browser. Learn more about the member account features available when accessing from a [web browser](#).

If you have a vision plan with benefits through a vision network, you can create a separate account through their website. View plan benefits, submitted claims and savings opportunities at [vsp.com](#) or [eyemed.com](#), depending on your plan.

### Q. How do I reset my password?

- A. To reset your password, click the 'Forgot password?' link on the password screen. A verification code will be sent to your email, or to your phone via SMS if you added a phone number during registration.

### Q. How do I unlock my account?

- A. If your account is locked after multiple failed login attempts, you can unlock it by clicking the 'Unlock account?' link on the sign-in screen. A verification code will be sent to your email, or to your phone via SMS if you added a phone number during registration.

### Q. How do I update my sign-in information?

- A. You can update your sign-in credentials anytime through the Profile Details page, accessible by clicking on your name in the top right corner of the screen when logged in.

For security reasons, updating your password or email will require signing back in after submitting the update form.

**Q. Who do I contact if I have issues accessing my member account?**

A. Call **800-497-7044, or 800-829-3177 in NY**, or email [reliancestandard@employeebenefitservice.com](mailto:reliancestandard@employeebenefitservice.com).

**Q. Where can I find details on my LASIK benefits?**

A. In most cases, LASIK, or laser vision correction, benefits are tied to a dental or vision plan. Some vision plans offer laser vision correction discounts with network limitations rather than a set benefit amount.

If your LASIK benefits are not tied to a network or are part of your dental or vision plan, view plan benefits and savings opportunities in your Reliance Matrix [member account](#).

If you have a vision plan with benefits through a vision network, view plan benefits and savings opportunities at [vsp.com](http://vsp.com) or [eyemed.com](http://eyemed.com), depending on your plan.

## Dental plan benefit information

**Q. How do I find a copy of my dental benefit information?**

A. Once enrolled, access your dental benefits at your convenience in your [member account](#) online.

**Q. How many exams, cleanings and X-rays are covered?**

A. The frequencies of covered procedures are determined by your policy. Access your benefit information, **contact us at 800-497-7044, or 800-829-3177 in NY**.

Each person has unique health needs. If your dental provider recommends additional cleanings or services not covered by your policy, those will be an out-of-pocket expense. Network provider discounts may apply to reduce your costs.

**Q. Is wisdom tooth removal (oral surgery) covered?**

A. Your dental plan may provide coverage for oral surgery. A pre-operative X-ray is required to review a surgical extraction because benefits are subject to consultant review. Refer to your certificate of coverage, which can be found in your [member account](#).

We recommend a pretreatment estimate for all dental work that you consider expensive. The estimate helps you know beforehand how much your plan can cover.

We also suggest submitting your oral surgery claim to your medical plan first as some medical plans have benefits for surgical extractions and general anesthesia or IV sedation.

**Q. What is a missing tooth clause?**

A. A missing tooth clause explains any coverage limitations related to teeth missing or extracted prior to your effective date of coverage. The missing tooth clause can vary depending upon your plan, so be sure to check your certificate of coverage in your [member account](#) for details.

**Q. What are dental sealants?**

A. A sealant is a plastic material that is applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often.

Thorough brushing and flossing help remove food particles and plaque from smooth surfaces of teeth, but toothbrush bristles may not reach all the way into the depressions and grooves to extract food and plaque. Dental sealants act as a barrier, protecting the teeth against decay-causing bacteria.

**Q. When can I change or cancel my dental plan, including adding or removing dependents?**

A. Open enrollment is your opportunity to review your benefit coverage. If your benefits administrator offers a choice of plans, you may choose the plan that best fits your needs. You also can make changes when there is a qualifying event, such as marriage, divorce or legal separation, birth of a child, loss of employment, new employment, or death of an insured member. Contact your benefits administrator with questions on your dental plan options.

**Q. What is an elimination period?**

A. Some dental plans define a time period, called an elimination period, that begins on your effective date. This must be satisfied before benefits on certain procedures become available. Because elimination periods are sometimes called waiting periods, care should be taken not to confuse the two.

**Q. What is the late entrant limitation?**

A. If you enroll in a group dental plan more than 31 days after becoming eligible, you are considered a late entrant. There may be benefit limitations set by your benefits administrator and insurance carrier. Refer to your certificate of coverage in your [member account](#) for details.

**Q. Who is authorized to access my benefit information and claim status?**

A. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), we are required by law to maintain the privacy of our insured members' and their dependents' protected health information. If you are an insured member, the privacy law allows you to obtain benefit information and claim status on all individuals insured under your dental policy. If your spouse is on the policy, he or she is allowed to obtain information on dependents under the age of 18. If you'd like to authorize others to access benefit information, please click on the following link [Customer Care | Reliance Standard](#) to download the dental/vision "Authorization for Release of Protected Health Information" specific to your state of residence. Please also visit our [Reliance Matrix Legal and Privacy Notices website](#) for additional information.

**Q. Are teledentistry services covered?**

A. All services under our plans are covered when appropriately delivered through teledentistry services. They are subject to the same plan benefits and limitations as equivalent services that are not provided through teledentistry.

**Q. Where can I find definitions of dental terminology?**

A. There are many words you may not be familiar with related to your dental health and plan benefits. Browse our [glossary](#) to find definitions of many common terms.

**Q. Does my plan include LASIK benefits?**

A. Some dental plans provide coverage for laser vision correction. If LASIK benefits are part of your dental plan, they will be shown in your dental certificate of coverage in your [member account](#).

**Q. When can I start using my benefits?**

A. After your effective date, new hire or other applicable waiting periods, you may begin using your benefits. If you are unsure, [contact us](#) at **800-497-7044, or 800-829-3177 in NY**, to verify eligibility.

## Dental providers and dental appointments

**Q. Can I see any dentist or am I required to choose from network providers?**

A. You are always free to visit any dentist. You may benefit from lower out-of-pocket costs when you visit one of our [network providers](#).

To review your plan benefits and network information, access your dental benefit summary or certificate of coverage in your [member account](#). [Contact us](#) at **800-497-7044, or 800-829-3177 in NY**, if you have questions on how your dental provider choice may impact benefits.

**Q. How do I know if my dentist is part of the network?**

A. Search for your dental provider in the [provider directory](#).

**Q. How much will I have to pay at the time of my appointment?**

A. You may be responsible for your deductible and copayment or coinsurance. However, some dental offices will not collect these until after the claim as been processed by insurance. Contact your dental office to ask how their billing process works.

**Q. What do I bring to my appointment?**

A. If you have an ID card, you can take it with you. If you don't have an ID card, give the dental office your member ID number. Find your ID card and/or member ID number in your [member account](#) online.

If you visit an out-of-network dentist, they may ask you to submit a claim for reimbursement. In most instances, you do not need to bring a claim form with you. You will need a statement of services from your dental provider to submit with your [claim form](#).

**Q. Can I request that my dentist be added to the network?**

A. If you would like your dental provider to consider joining the Ameritas network complete the [Nominate a Provider](#) form. Ameritas will reach out to the office and invite them to join the Ameritas network.

Please note: Inviting a dentist to join the Ameritas network does not guarantee they will become a participating provider.

**Q. Do I need a referral to see another dental provider?**

A. No. You are welcome to seek treatment from any dentist. If you have the PPO benefit, we suggest using an [Ameritas network provider](#) to help maximize your benefits and lower your out-of-pocket expenses.

**Q. Can I visit a dental provider in a foreign country?**

A. Yes, however we only honor assignment of benefits to providers in the United States. Since services provided outside the U.S. must be reimbursed directly to the member, foreign-based providers typically require payment in full before services are completed.

The [dental provider directory](#) includes a list of contracted dental providers in Mexico.

View more information about that service in your [member account](#).

**Q. What if I have a complaint about my network dental provider?**

A. [Contact us](#) at **800-497-7044, or 800-829-3177 in NY**, if you have concerns about the experience you had with a network provider.

## Claims, payments and benefit statements

**Q. How do I submit a claim?**

A. Network providers will submit the claim for you. Out-of-network claims can be submitted by you or your dental provider. Contact your provider's office and ask if they will submit claims for you.

If submitting a claim for an out-of-network visit, you may use any standard claim form, or [our claim form](#).

Mail completed claim forms to:

Group Claims  
PO Box 82510  
Lincoln, NE 68501-2510

**Q. Will benefit payments be sent to me or the provider?**

A. If services are performed in the United States, we will assign benefits according to how they are authorized on the [claim form](#). If services are performed outside the United States, benefits will automatically be assigned to the insured member.

If you visit a network provider, benefits are automatically issued directly to the provider based on their contractual agreement, and they submit the claim for you. For out-of-network visits, benefits can be assigned to the insured member or to the provider. **If you would like the benefits assigned to you, leave the authorization line blank on the claim form.**

[Contact us](#) at **800-497-7044, or 800-829-3177 in NY**, if you are being charged up front for the full amount of your services by a network provider.

**Q. Do I need to get a pretreatment estimate for a procedure?**

A. No. Although, we do recommend that a pretreatment estimate be submitted for all anticipated work that you consider to be expensive. Pretreatment estimates are the best way for you to determine your out-of-pocket costs based on your plan benefits.

**Q. How do I know how much a dental service might cost?**

A. After your coverage begins, you can view in-network charges in your [member account](#). Select a provider and expand their information card. Then select Dental Cost Estimator and search for a procedure.

You also may ask your dentist's office to submit a pretreatment estimate so you can see exactly how a proposed service would be covered and avoid any surprises. The pretreatment estimate is based on your plan benefits.

**Q. My dental claim was denied. What do I do?**

A. You can file an appeal for Reliance Matrix to review the benefit decision. Appeals may be submitted to the quality control department.

Quality Control  
PO Box 82657  
Lincoln, NE 68501-2657

We will review the submitted claim and your plan benefits. We may ask you or your provider for additional information. Find appeal information on your [member account](#).

**Q. Why does the deductible/copayment show again on my claim when it was already paid to the dental office?**

A. Your explanation of benefits (EOB) shows what your plan will pay on your claim. It is not a bill. If you have already paid your deductible to the dental office, that will be reflected in their billing statement to you. **Contact us at 800-497-7044, or 800-829-3177 in NY**, if you feel an error has been made on your EOB.

**Q. How much time do I have to submit a claim?**

A. We recommend that claims be submitted as soon as possible, as dental plans have a timely filing clause. Unless otherwise noted in your certificate of coverage, active insured members must submit claims within 90 days of the date of service. Claims submitted after 90 days will be denied due to failure to meet the timely filing requirements.

**Q. How are orthodontic benefits paid?**

A. Under many group plans, benefits are released in a maximum of 8 quarterly payments with the first payment being released 3 months after the banding date. Quarterly payments will automatically be released thereafter. However, this may vary by plan.

For specifics on your plan's orthodontic benefits, see your certificate of coverage in your [member account](#).

## Children

**Q. How long is a child considered an eligible dependent?**

A. Child eligibility depends upon age and student status at the time of services. Refer to your certificate of coverage in your [member account](#) for details.

**Q. What information do you need for my student-dependent?**

A. **Contact us at 800-497-7044, or 800-829-3177 in NY**, for the most current information.

**Q. What age do I start taking my child to the dentist?**

A. The American Academy of Pediatric Dentistry (AAPD) recommends that a child go to the dentist by age 1 or within six months of their first tooth coming in.

**Q. What age should my child have their wisdom teeth removed?**

A. Wisdom teeth are the upper and lower third molars, located at the very back of the mouth. They are called wisdom teeth because usually they come in between ages 17 and 21 when a person is old enough to have gained some wisdom.

It is not always necessary to have wisdom teeth removed. If they are impacting or crowding the teeth, your dentist will likely recommend removing them.

**Q. What age should I take my kids to the orthodontist?**

A. Many orthodontists say kids should see an orthodontist once their permanent teeth start coming in, around age 7. At this age, issues such as uneven bite and overcrowding will become apparent. Starting the process early doesn't mean a child will get braces right away.

Your child's dentist can detect issues and may recommend your child visit an orthodontist for a consultation.

## Vision plan benefit information

**Q. Can I get frames and contacts in the same year?**

A. VSP network plans: Benefits can be applied to contacts OR glasses (frames and/or lenses) during the benefit year. If you use your lens benefits to purchase contacts, you will not receive an allowance for frames during the same benefit year.

EyeMed network plans: If you use your lens benefits to purchase contacts, you are still able to use your frame allowance toward new glasses during the same benefit year. In this case, the eyeglass lenses to go in your new frames would be an out-of-pocket expense.

No-network plans: Benefits vary. If your plan provides a flat amount, benefits may be applied to any covered vision expenses up to the benefit dollar amount. Other plans may specify benefits for either contacts or glasses (frames and/or lenses) per benefit year.

You are eligible for new frames based on your plan's frame frequency (if applicable) — either every 12 or 24 months.

**Q. If my Reliance Matrix vision plan has VSP network benefits, how do I access my benefit information?**

- A. View your benefit information and claims history through a VSP account at [vsp.com](https://www.vsp.com) or the VSP Vision Care app. A provider search is available on their website.

VSP offers online options for purchasing vision materials with in-network benefits. Network providers submit the claim for you. For claim status and out-of-network forms, go to your VSP member account.

Contact VSP for benefit, claims or network questions: **800-877-7195**.

**Q. If my Reliance Matrix vision plan has EyeMed network benefits, how do I access and use my benefits?**

- A. View your benefit information and claims history through an EyeMed account at [eyemed.com](https://www.eyemed.com) or the EyeMed Members app. A provider search is available on their website.

EyeMed offers online options for purchasing vision materials with in-network benefits. Network providers submit the claim for you. For claim status and out-of-network forms, go to your EyeMed member account.

Contact EyeMed for benefit, claims or network questions: **866-289-0614**

**Q. If I have a Reliance Matrix vision plan with no network, how do I access and use my benefits?**

- A. View your benefit information in your Reliance Matrix [member account](#). You can see your plan details and annual maximum reimbursement amount.

When you are ready, schedule an appointment with any vision provider. Since there is no network, you can take advantage of special pricing offers.

Pay your provider and request an itemized receipt. Claims can be submitted through your member account or by mail.

**Q. What services and materials are covered in a vision plan?**

- A. Most vision plans provide coverage for an annual eye exam and vision correction materials such as glasses and contact lenses. Benefits vary on eyeglass lens options, such as ultra-violet coating, scratch-resistant coating and tinting.

All contact lenses containing a prescription, including disposables, are reimbursable up to your set annual benefit dollar amount.

**Q. Is LASIK or PRK covered?**

- A. Some vision plans offer laser vision correction discounts with network limitations.

If your vision plan offers benefits through a vision network, view plan benefits and savings opportunities at [vsp.com](https://www.vsp.com) or [eyemed.com](https://www.eyemed.com), depending on your plan. If your vision plan does not include a network, view plan benefits and savings opportunities in your Reliance Matrix [member account](#).

**Q. What are medically necessary contact lenses?**

- A. Medically necessary contact lenses are for people who are not able to wear glasses to correct their vision. Usually because the contact acts as a brace to correct or retain the shape of the eye. For those who choose contacts over glasses, the elective contact benefit applies.

**Q. What information do you need for my student-dependent?**

- A. **Contact us at 800-497-7044, or 800-829-3177 in NY**, for the most current information.

## Using my benefits

**Q. Do I need an ID card?**

- A. Policies with the VSP network: ID cards are not required to receive services. You can provide your name and date of birth or member ID. In fact, VSP does not issue an ID card unless the plan includes VSP affiliates.

Policies with the EyeMed network: ID cards are not required to receive services. You can provide your name and date of birth or member ID.

Policies with no network: Most vision policies without a network do not issue an ID card. If your benefits include discounts through a vision network, you may be issued an ID card.

**Q. Can I see any vision provider?**

- A. Yes. You have the freedom to choose any vision provider. If you visit an out-of-network provider, you pay your provider the full balance and submit a claim with your itemized receipt for reimbursement. Greater benefits are available with network providers, if applicable, and they submit the claim for you.

**Q How do I find an in-network provider?**

- A. Reliance Matrix offers benefits with VSP and EyeMed network providers. Review your plan benefits to determine which network, if any, is included in your vision plan. Search network providers at [vsp.com](http://vsp.com) or [eyemed.com](http://eyemed.com), depending on your plan benefits.

**Q. How often do I need an eye exam?**

- A. Unless otherwise directed by your doctor, it is recommended to see your vision provider once a year.

**Q. Can I use FSA or HSA funds after my vision benefit is applied?**

- A. Yes. A Flexible Spending Account (FSA) or Health Savings Account (HSA) can be used to pay for out-of-pocket vision expenses.

**Q. Can I apply my vision benefits when I purchase glasses or contacts online?**

- A. Yes. If you have a plan with a vision network, each network offers online options with in-network benefits. Visit [vsp.com](http://vsp.com) or [eyemed.com](http://eyemed.com), depending on your plan benefits.

If your plan does not include a network, you can purchase from any online retailer and be reimbursed the same as if you visited a physical location.

## Submitting a claim

**Q. How do I submit a vision claim?**

- A. If your vision benefits do not include the VSP or EyeMed network, submit the [claim form](#) and receipt in your [member account](#). You can also choose to mail your claim to:

Group Claims  
PO Box 82510  
Lincoln, NE 68501-2510

If your vision benefits include the VSP or EyeMed network, you only need to submit claims for out-of-network visits. This can be done at either [vsp.com](http://vsp.com) or [eyemed.com](http://eyemed.com), depending on your plan's network.

**Q. How much time do I have to submit a claim?**

- A. We recommend that claims be submitted as soon as possible. Unless otherwise noted in your certificate of coverage, active insured members must submit claims within 90 days for no-network vision plans, or 12 months from the date of service for policies with the VSP or EyeMed networks. Network providers will submit claims for you.

**Q. When can I change or cancel my vision plan, including adding or removing dependents?**

- A. Open enrollment is your opportunity to review your benefit coverage. If your benefits administrator offers a choice of plans, you may choose the plan that best fits your needs. You also can make changes when there is a qualifying event, such as marriage, divorce or legal separation, birth of a child, loss of employment, new employment, or death of an insured member. Contact your benefits administrator with questions on your vision plan options.



For more information visit [reliancematrix.com](http://reliancematrix.com)