



How your Health Care Exchange (Marketplace) plan works

Providing transparency in coverage information and resources to help you make the most of your Health Care Exchange (Marketplace) plan.

Visiting a non-network dentist

Understand what Health Care Exchange (Marketplace) plan members need to know about visiting a dentist outside their network.

Receiving care with your plan

Delta Dental PPO™¹

As a Delta Dental PPO member, you have the freedom to visit any licensed dentist, but claims costs are likely lower when you visit a Delta Dental PPO dentist.

Our network dentists agree to:

- Accept Delta Dental's approved amounts as payment in full, with no balance billing to you (excludes deductibles, coinsurance, amounts over plan maximums and charges for non-covered services).
- File all claim forms on your behalf.
- Accept payment directly from Delta Dental.
- Charge only the deductible and coinsurance up front (unlike non-Delta Dental dentists who may charge the full amount at the time of visit).

If you receive care from a non-Delta Dental dentist:

- Out-of-network benefits apply.
- Non-Delta Dental dentists have no fee agreements with us. Claims costs are typically highest when you visit a non-Delta Dental dentist.
- You are responsible for paying the difference between the maximum plan allowance (what Delta Dental pays) and the dentist's submitted fee.

DeltaCare® USA¹

As a DeltaCare USA member, you are eligible for dental benefits when you receive covered services from your selected or assigned primary care dentist. You are responsible for charges for services from non-participating dentists.

Out-of-network financial liabilities

Delta Dental PPO

As a Delta Dental PPO member, you have access to emergency care 24 hours a day, seven days a week because you are free to visit any licensed dentist for care and receive benefits under the terms of your dental benefits contract. You can search Delta Dental's online dentist directory to locate a network dentist with 'after hours' office features. During business hours, you can call our Customer Care department's toll-free number for assistance in locating a Delta Dental PPO dentist.

If you receive care from a non-network dentist:

- Out-of-network benefits apply.
- Non-Delta Dental dentists have no fee agreements with us. Claims costs are typically highest when you visit a non-Delta Dental dentist.

You are responsible for paying the difference between the maximum contract allowance (what Delta Dental pays) and the dentist's submitted fee.

DeltaCare USA

If you experience an emergency while traveling outside your plan's service area, you have an out-of-area emergency benefit that allows you to receive palliative* dental treatment from a local dentist. Most DeltaCare USA plans limit this out-of-area benefit to a maximum allowance of \$100 for palliative emergency treatment. You may initially be required to pay for services upon treatment. To receive reimbursement, submit a copy of the itemized treatment form from the attending dentist to Delta Dental within 90 days of treatment. Depending on your plan benefits, copayments may apply.

*Palliative (emergency) treatment of dental pain — minor procedure

Balancing Billing

Delta Dental PPO

Network dentists agree to accept Delta Dental's contracted fees as payment in full for covered dental services and agree not to balance bill you beyond the patient's share (this includes deductibles, coinsurance, amounts in excess of plan maximums and for non-covered services) up to the dentist's submitted charge. Contracted dentists may not bill you for any difference between the accepted fee and the submitted fee.

In the event you are balance billed, you should notify Delta Dental. You will need to submit any receipts and bills from the dentist. Delta Dental will contact the dentist on your behalf and resolve the issue within 30 days.

DeltaCare USA

All network dentists contractually agree to accept set plan copayments as payment in full for covered dental services and agree not to seek additional fees. You are not required to pay more than the specified copayment for covered procedures.

Claims and payments

Understand how to submit claims and manage premium payments with a Health Care Exchange (Marketplace) plan.

Claim submission

Delta Dental PPO

Delta Dental dentists will handle all claims and paperwork for you. However, if you visit a non-Delta Dental dentist, you may need to file the claim yourself.

DeltaCare USA

We make it easy for you! When you visit your selected or assigned primary care DeltaCare USA dentist, there are no claim forms to submit. If you need to visit a specialist or receive emergency care, you may need to submit a claim form. Refer to your evidence/certificate of coverage.

How to submit a claim form

If you do need to file a claim form, download the claim form for your Delta Dental plan:

1. Download the claim form for your Delta Dental plan:
 - **Delta Dental PPO (DPO) Claim Form**
 - **DeltaCare USA Claim Form**
2. Complete the patient and subscriber information on the claim form.
3. Obtain the following information from the provider (note that a Statement of Treatment provided by your dentist may not include all the information we need):
 - Dentist's name, address and phone number
 - Dentist's National Provider Identifier (NPI)
 - Tax identification number (TIN)
 - State license number
 - Specialty code
 - Description of each service that the dentist performed, along with the procedure code and provider's fee
4. Make a copy for your records.
5. Mail the original copies to the address printed on the form. On the Delta Dental PPO (DPO) form, choose your Delta Dental member company from the interactive drop-down list at the beginning of the form to display the address.

We usually process claims within two weeks unless additional information is required from you or the dentist.

Time limit for submitting claims

Delta Dental PPO

The standard filing is 12 months from the date of service. Our agreement with contracted dentists is that we may deny payment of a dental claim submitted more than 12 months after the date the service was provided.

DeltaCare USA

DeltaCare USA is a prepaid plan that does not use claim forms for general services. Contracted dentists are paid on a capitation basis. When you receive specialty care from an approved network dentist, the network dentist handles the paperwork.

To receive reimbursement for out-of-area emergency care, you simply submit a copy of the itemized treatment form from the attending dentist to Delta Dental within 90 days of treatment. Depending on your plan benefits, copayments may apply. The deadline for submitting a specialty care or out-of-area emergency claim is 365 days, except in California where it is 410 days.

Retroactive denial of claims

A retroactive denial is the reversal of a claim that Delta Dental has already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment.

Retroactive denials may occur, for example, when a claim was paid during the second or third month of a grace period or when a claim was paid for a service for which you were not eligible.

To help avoid a retroactive denial:

- Pay your premiums on time and in full
- Talk to your provider about whether the service performed is a covered benefit
- Obtain your dental services from an in-network provider

What is the grace period for Health Care Exchange (Marketplace) plans?

Delta Dental does not terminate coverage immediately for non-payment. We allow a grace period of 90 days if you receive an Advance Premium Tax Credit (APTC) and have paid at least one full month's premium during the year. If you do not receive an APTC and have paid one month's premium, the grace period is 30 days.

Claims do not go into a pending status.

A pending claim is a claim that has been submitted but not yet paid or denied.

How claims are paid during the grace period

You are required to pay your premium by the scheduled due date. If you do not, your coverage could be canceled.

For most individual dental insurance plans, if you do not pay your premium on time, you'll 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 the grace period will be placed on hold. 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, Delta Dental will pay all claims for covered services you received during the grace period that are submitted properly.

For Health Care Exchange (Marketplace) plans with an advance premium tax credit

If you're enrolled in an individual dental insurance plan offered on the Health Care Exchange (Marketplace) and you receive an advance premium tax credit (APTC), you'll get a three-month grace period and Delta Dental will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of the grace period, any claims you incur will be placed on hold.

If you pay your full outstanding premium before the end of the three-month grace period, Delta Dental will pay all claims for covered services that are submitted properly for the second and third months of the grace period.

If you do not pay all of your outstanding premium by the end of the three-month grace period, your coverage will be terminated and Delta Dental will not pay for any on-hold claims submitted for you during the second and third months of the grace period. Your provider may bill you for those services.

How to obtain a refund

Individual plan:

If you believe you have overpaid your premium, please call or write to us directly — for contact details, see the Contact Delta Dental section. We look forward to clarifying any billing inquiries. If we identify that a refund is due, we will issue a refund within 30 days.

Group plan:

If you believe you have overpaid your premium, please contact your local Health Care Exchange (Marketplace) to research and remedy any overpayments.

Pre-authorization

Know what kinds of services require pre-authorization (or prior authorization) with a Health Care Exchange (Marketplace) plan and how should they be handled.

How does pre-authorization work?

Delta Dental PPO

Pediatric plans that cover medically necessary orthodontic services require pre-authorization before treatment is started.

DeltaCare USA

If you require treatment from a specialist who meets DeltaCare USA specialty care referral guidelines, your primary care dentist will provide you with a completed referral form to take to the participating DeltaCare USA specialist.

Most services not performed by your primary care dentist must be authorized by us in order to be covered. We provide participating DeltaCare USA dentists with a list of procedures that do not require pre-authorization. It is required for procedures not included on the list. Pediatric plans that cover medically necessary orthodontic services also require pre-authorization before treatment is started.

How prior authorization works

Your dentist will submit a request for pre-authorization to Delta Dental, along with all necessary x-rays and records for the recommended specialty procedures. Once we receive the request for pre-authorization:

- A claims processor will verify the accuracy of the information and forward it for review.
- Either a dental auditor or dental consultant will review the request based on the level of clinical complexity involved. Dental procedures requiring professional judgment are reviewed by one of our in-house dental consultants to determine benefits. Dental consultants are licensed dentists employed by Delta Dental.
- Once the dental auditor or dental consultant approves the request, we send an approval to your dentist.
- In the event of a dental emergency, we will give your dentist a specialist referral authorization over the telephone. The specialist is then advised of the approved procedure(s) and given instructions for claim submittal.
- When we receive the resulting claim, a claims processor verifies the accuracy of the information and enters the claim in the system for payment. Claims that have not been pre-authorized are denied.

If an oral surgeon, endodontist, periodontist or pediatric dentist is not available in your area, you are free to choose a qualified out-of-network specialist.

Because the DeltaCare USA plan features specific copayments for most covered procedures, you will be aware of your financial responsibility in advance of any procedures being performed.

If pre-authorization is not obtained

Delta Dental PPO

Claims for medically necessary pediatric orthodontic services will be denied.

DeltaCare USA

Most services not performed by your primary care dentist must be authorized by us in order to be covered. We provide participating DeltaCare USA dentists with a list of procedures that do not require pre-authorization; procedures not included on the list require it. For example, medically necessary pediatric orthodontic services must be pre-authorized.

Time frame for pre-authorization requests

Delta Dental PPO

The amount of time it takes to receive your pre-authorization varies, depending on your dentist and treatment plan. Pre-authorization are completed by Delta Dental within three days on average; however, the process can take up to two to three weeks. This timeframe may vary based on state-specific laws.

DeltaCare USA

Pre-authorization requests are processed by Delta Dental within three days on average; however, processing can take up to two to three weeks. This timeframe may vary based on state-specific laws.

Explanation of Benefits

Find out what you need to know about your Explanation of Benefits (EOB) and when it was sent?

What's an Explanation of Benefits (EOB) and when is it sent?

An EOB is a statement created after a dental visit. It lists the treatments and/or services you received, the amount the plan pays and your financial responsibility as outlined under your plan.

Delta Dental PPO

After a claim is processed, we will send you and the treating dentist an EOB statement that explains the services provided, costs of the treatment and any fees you owe your dentist. Your claims information is automatically available via Online Services. For added convenience, sign up for "Online with Email Alerts" under "My Profile" to go paperless and receive an email when a new statement is available.

DeltaCare USA

In general, you will not receive a claim statement or EOB after your dental visit. Since you've already paid your set copayment at the time of your visit, there should be no surprises.

However, when you visit a specialist or receive out-of-area emergency care and submit a claim form, you and the treating dentist will receive an EOB. The EOB explains the services provided, costs of the treatment and any fees you owe your dentist.

What's in my EOB?

Here's what you see on your EOB.

- **Submitted fee:** How much the procedure would cost if you didn't have insurance.
- **Accepted fee:** The total owed to the dentist, including your share and the amount paid by insurance.
- **Maximum contract allowance:** The total on which Delta Dental bases its portion of the fee. Note: If you go to an out-of-network dentist, this amount may be lower than the accepted fee.
- **Amount applied to deductible:** How much of your deductible you have fulfilled with the given procedure(s). Note: Not all plans include a deductible (a fixed dollar amount you are required to pay before your coverage applies). A deductible may also be waived for diagnostic and preventive services.
- **Paid by another plan:** The amount covered by a secondary plan (for example, through your spouse or second job).
- **Contract benefit level:** The percent of the maximum contract allowance that's paid by your dental plan.
- **Delta Dental pays:** The amount your dentist is paid through your dental plan.
- **Patient pays:** How much you owe the dentist is what's left over from the accepted fee after your insurance covers its portion(s).

How does Coordination of Benefits (COB) work with a Health Care Exchange (Marketplace) plan?

When you're covered under two dental plans (for example, through your spouse or second job), one plan is considered your primary carrier. This carrier will pay a larger portion of your benefits, leaving a smaller amount to your secondary carrier depending on your coverage. Review your Evidence of Coverage for specific details about your plan.

Delta Dental PPO

Delta Dental doesn't coordinate coverage with other policies for individual plans.

If you have a group plan, tell your dentist that you have another dental plan. The dentist will add COB information to the claim form. We will use that information to share the cost of treatment with your other carrier and update our claims system.

Claims submitted with missing COB information are denied, and you and the dentist will be notified and asked to resubmit with the necessary information.

DeltaCare USA

Delta Dental doesn't coordinate coverage with other policies for individual plans.

If you have a group plan, no COB occurs when services are provided by your primary care general dentist. But if you visit a specialist, be sure to let this dentist know you are covered under another plan. The specialist will include COB information on the claim form. We will process the claim based on this information and update our claims processing system.

COB is calculated by subtracting the payment made by the other carrier from the dentist's contracted rate.

Your explanation of benefits, explained!

Need more information? Check out our video [Explanation of Benefits](#).

Contact us

Reach your specific Delta Dental customer service office by mail or telephone.

Delta Dental PPO

Residents	Mailing address	Customer service
California residents	Delta Dental of California PO Box 997330 Sacramento, CA 95899-7330	888-282-8978; Monday through Friday between 8:00 a.m. and 9:00 p.m. PT
Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah residents	Delta Dental Insurance Company PO Box 1809 Alpharetta, GA 30023-1809	888-857-0314; Monday through Friday between 8:00 a.m. and 9:00 p.m. ET
Delaware, Maryland, New York, Pennsylvania, Washington, D.C. and West Virginia residents	Delta Dental P.O. Box 2105 Mechanicsburg, PA 17055	888-857-0314; Monday through Friday between 8:00 a.m. and 9:00 p.m. ET

DeltaCare USA

Residents	Mailing address	Customer service
California residents	Delta Dental Insurance Company P.O. Box 1803 Alpharetta, GA 30023-1803	888-282-8528; Monday through Friday between 8:00 a.m. and 6:00 p.m. PT
Maryland, Nevada, Pennsylvania, Texas, Utah residents	Delta Dental Insurance Company P.O. Box 1803 Alpharetta, GA 30023-1803	888-857-0337; Monday through Friday between 8:00 a.m. - 9:00 p.m. ET

¹ Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York; DE - Delta Dental of Delaware; WV - Delta Dental of West Virginia. In Texas, Delta Dental Insurance Company provides a Dental Provider Organization (DPO) plan.

² DeltaCare USA is underwritten in these states by these entities: CA - Delta Dental of California; DC, FL - Delta Dental Insurance Company; MD, TX - Alpha Dental Programs, Inc.; NV - Alpha Dental of Nevada, Inc.; UT - Alpha Dental of Utah, Inc.; NY - Delta Dental of New York; PA - Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. The plan is a dental HMO in CA and TX.