



Health Care Exchange (Marketplace) transparency in coverage report

Learn about out-of-network care, claim processing, plan authorizations and more for your Health Care Exchange dental plan.

Visiting a non-network dentist

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

Balance billing

Balance billing occurs when a dentist does not participate in our network. Because they have not agreed to Delta Dental's contracted fees, out-of-network dentists may charge more for services and may bill a member for the difference between what the plan allows and what they charge.

Out-of-network financial liabilities

When you receive care from a dentist who does not participate in your plan's network, out-of-network benefits apply. These providers are not subject to contracted fee agreements and may bill you for the difference between the plan allowance and their submitted fee (balance billing).

Delta Dental PPO

You may receive care from any licensed dentist. You are responsible for any amounts above the maximum contract allowance, in addition to applicable deductibles, coinsurance and non-covered services. Emergency care is covered, including services received from out-of-network providers.

DeltaCare USA

Out-of-network services are generally not covered, except for out-of-area emergency care. Emergency services are limited to palliative treatment, as defined by your plan. You may be required to pay for services at the time of treatment. To request reimbursement, submit an itemized bill within the applicable timeframe.

Claims and payments

A claim is a request for payment of covered dental services. In most cases, claims are submitted by your provider. If you receive services from a non-network provider, you may need to submit a claim.

How to submit a claim:

1. Download the **PPO claim form** or **DHMO claim form**
2. Complete a claim form
3. Attach an itemized bill
4. Submit by mail or other accepted method

Delta Dental PPO

Network providers submit claims on your behalf. If you receive care from a non-network provider, the provider may submit the claim as a courtesy, or you may submit it directly.

Claims must be submitted within the applicable filing period under your plan.

DeltaCare USA

Claim forms are not required for services performed by your assigned general dentist.

For specialty or out-of-area emergency services:

- The provider may submit the claim on your behalf, or you may need to submit a claim for reimbursement
- When required, submit a completed claim form with an itemized bill within the applicable filing period.

Time limit for submitting claims

Claims must be submitted within the required filing period following the date of service.

Delta Dental PPO

Claims must be submitted within 12 months of the date of service. Claims submitted after this period may be denied.

DeltaCare USA

Filing time limits vary by service type:

- Out-of-area emergency claims must be submitted within 90 days of treatment.
- Other applicable claims must be submitted within the plan's required filing period.

Retroactive denial of claims

A retroactive denial is the reversal of a claim that 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

Grace periods for Health Care Exchange (Marketplace) plans

Delta Dental does not terminate coverage immediately for non-payment. For most individual dental insurance plans, you'll receive a 30-day grace period, but no claims will be processed during this time until your premium is paid in full.

If you receive an Advance Premium Tax Credit (APTC) and have paid at least one full month's premium during the year, your grace period will extend to three months. We will process claims during the first month of the grace period but any claims made during the second and third month will be placed on hold.

If you pay your full outstanding premium before the end of the three-month grace period, we will pay all properly submitted claims from the last two months.

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 any claims submitted during the second and third months will not be paid. Your provider can bill you for those services.

How to obtain a premium overpayment

If you believe you need to obtain a premium refund due to an overpayment, please call the member service number on the back of your ID card.

Pre-authorization

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

How pre-authorization works

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 pre-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 practicing 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-authorizations 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 Coordination of Benefits (COB).

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.
- **Amount applied to deductible:** How much of your deductible you have fulfilled with the given procedure(s).
- **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?

Coordination of Benefits (COB) applies when you are covered under more than one dental plan. It determines which plan pays first (primary) and ensures that total payments do not exceed the cost of covered services.

Delta Dental PPO

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

If you have coverage under more than one plan, one plan will pay as the primary carrier and the other as secondary. The primary plan pays first, and the secondary plan may cover a portion of the remaining costs, based on plan provisions.

If applicable, COB information must be included when submitting a claim. Claims submitted without this information may be denied.

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.

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.