Q&A: Continuous Orthodontic Coverage with your DeltaCare USA Plan

Welcome to your DeltaCare USA plan!
If you or an eligible member of your family has started orthodontic treatment under a previous plan sponsored by an employer/organization, you may be able to continue that coverage when you switch to a DeltaCare USA plan.

How does it work?
Through a provision called orthodontic treatment in progress, your DeltaCare USA plan allows you to continue treatment you started under your previous dental plan sponsored by an employer/organization. You have the convenience of visiting the same orthodontist and enjoying the same coverage and copayments as your previous plan. You pay the same amount that you would have paid under your previous coverage, as long as you remain eligible for coverage under your DeltaCare USA plan.

How do I qualify?
If you started orthodontic treatment under your previous dental plan, and if banding has taken place, you are eligible for continuous coverage under your DeltaCare USA plan and may continue to visit the same orthodontist.

If banding has not occurred, you are not eligible for continuous orthodontic coverage. In that case, orthodontic treatment must be provided by a DeltaCare USA network orthodontist in accordance with the copayments, limitations and exclusions defined in your DeltaCare USA plan.1

What if I am about to begin orthodontic treatment?
To begin orthodontic treatment, you must select a DeltaCare USA network orthodontist to receive your DeltaCare USA orthodontic benefits. Your copayments, limitations and exclusions are determined by your DeltaCare USA plan.1

How do I sign up for continuous orthodontic coverage?
Please have your treating orthodontist complete and submit the form below along with a claim form within 30 days of your plan effective date. We will coordinate benefits as necessary with your orthodontist.

Continuous Orthodontic Coverage Form (To be completed by the treating orthodontist)
If your patient’s previous orthodontic coverage was through an employer-sponsored dental plan and the patient meets all of the above conditions, please provide the following information:

Primary enrollee’s name: ____________________________
Primary enrollee’s ID #: ____________________________
Name of employer/organization: _____________________
Patient’s name: __________________________________
Previous dental plan carrier: __________________________

Previous dental plan end date: _______________________
Banding date of patient: ____________________________
Orthodontist’s name: ______________________________
Orthodontist’s address: _____________________________
Orthodontist’s phone number: _______________________

Previous plan’s total financial obligation: ________________________________________________________

In addition, please include the following required documents and information:

• Completed claim form, including the banding date.
• Explanation of Benefits showing how much the previous plan has paid to date and amount remaining.

Mail to: DeltaCare USA
Claims Department
P.O. Box 1810
Alpharetta, GA 30023

1 Upon enrollment in a DeltaCare USA plan, you will receive an Evidence/Certificate of Coverage (EOC/COC) booklet. Please review your EOC/COC for details about your plan. Retain this flyer and keep it with your EOC/COC.

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