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Get paid faster! Enroll in direct deposit and Delta Dental will send claim payments electronically to your designated bank or financial institution. With this free service, payments often can be in your account within 48 hours.

There are many great reasons to sign up for direct deposit and Delta Dental will be happy to help you get started. Enrolling is easier than ever. Simply log into the Dental Office Toolkit at www.deltadentalnc.com and follow the direct deposit link. If you’re not currently a Dental Office Toolkit user, just complete a short registration to set up your account.

Delta Dental patients for prophylaxis or periodontal maintenance services that are disallowed.

Policy change for prophylaxis (D1110, D1120), periodontal maintenance (D4910) or full mouth debridement (D4355) completed within 30 days of periodontal scaling and root planing (D4341, D4342) performed by the same dentist or dental office

The following processing policy change will become effective March 1, 2014, as part of our continuing process to provide consistency across our national Delta Dental plans and maintain uniform coverage for our members:

- Prophylaxis codes D1110, D1120 or periodontal maintenance code D4910 will be disallowed when completed with 30 days of periodontal scaling and root planing codes D441 or D4342 that were performed in three or more quadrants of the mouth by the same dentist or dental office. Participating dentists may not charge Delta Dental patients for full mouth debridement services that are disallowed.

- Prophylaxis codes D1110, D1120 or periodontal maintenance code D4910 will be allowed when the preceding periodontal scaling and root planing was performed in only one or two quadrants of the mouth.

- Full mouth debridement code D4355 will be disallowed when completed within 30 days of periodontal scaling and root planing done in any area of the mouth. Participating dentists may not charge Delta Dental patients for full mouth debridement services that are disallowed.

Field deposit account activation typically takes seven days to be reflected in your account. You can check your progress by calling Delta Dental’s customer service at (919) 424-1048 or 1-800-392-6376.

For general network information including participation and dentist contracting, please contact North Carolina Professional Services representatives

Emily Bowling at (919) 424-1048 or Traci Harris at (919) 863-0181.
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1. What is ACA?
The Affordable Care Act. It is also known as Health Care Reform, the Patient Protection and Affordable Care Act and Obamacare. The measure was signed into law in 2010.

2. What is EHB?
Essential Health Benefits (EHB). Under the ACA, only policies in the small group and individual markets are required to cover EHBs. There are 10 benefit categories that must be included in EHB-compliant plans.

3. What are the 10 EHB categories?
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services including oral and vision care

4. A patient notices that their children’s benefits have changed. Why did they change?
ACA requires that pediatric dental plans match the state’s benchmark plan and be offered at either an 85 percent or 70 percent actuarial value (high and low). Matching the state’s benchmark only refers to the scope of covered services and associated limitations. Patient cost-sharing levels may vary from plan to plan and carrier to carrier.

5. Why are children’s benefits different than their parents?
The ACA’s dental plan requirements are only for people under age 19. Adults are able to keep their existing dental plan.

6. Why do different members of the same family have different benefit levels?
Dental benefits are based on age and plan. Individuals 19 and over maintain standard benefit levels. To eliminate any confusion, it is vital that enrollees and dental offices check benefits on an individual level, not at a family level.

7. What if a patient has a procedure that is not part of an EHB-compliant plan, but is part of “standard” coverage?
Regardless of the patient’s age, coverage will revert to the standard plan.

8. What if a patient has a procedure that is covered as both a “standard” benefit and an EHB benefit in a plan?
There is no coordination of benefits (COB) between the standard and EHB benefits. Only one set of benefits will cover the procedure. Having both EHB and non-EHB benefits does not mean the patient will receive complete coverage.

9. How long is a patient covered in an EHB-compliant plan once they turn 19?
Small group: To the end of the calendar year of the 19th birthday.
Individuals: To the end of the policy year after the 19th birthday.

10. How does the out-of-pocket maximum work?
Certain costs paid by your patient for in-network EHB-covered services apply to the out-of-pocket maximum. All in-network, EHB services covered in an EHB-compliant plan are paid at 100 percent after the out-of-pocket maximum has been reached.

11. What is included in the out-of-pocket maximum?
Deductibles, coinsurance and copayments for in-network, EHB-covered services are applied to the out-of-pocket maximum in an EHB-compliant plan.

12. Is the out-of-pocket maximum different for a policy covering one individual under 19 or two or more individuals under 19?
Yes. The out-of-pocket limit for pediatric dental essential health benefits is $700 for families with one covered member under the pediatric age limit and $1,400 for families with two or more covered members under the pediatric age limit.

To read the remainder of the ACA, please visit www.deltadentalnc.com/ddcacafaq.
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