

BENEFIT SUMMARY CHART (MATRIX)

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Combined Evidence of Coverage/Disclosure Form and plan contract should be consulted for a detailed description of coverage benefits and limitations.

BENEFIT SUMMARY CHART	
DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
Diagnostic and Preventive Services including exams, x-rays, cleanings and fluoride treatments.	
VISITS - DIAGNOSTIC	
Examination, initial episode of treatment only	None
Examination, periodic	None
Office visit during regular office hours for treatment and observation of injuries to the teeth and supporting structures	None
Professional visit after regular office hours	None
Specialist consultation	None
Sealants, permanent first molars - members through age 18	None
Sealants, permanent second molars - members through age 18	None
Prophylaxis, members through age 12	None
Prophylaxis, members age 13 through 18	None
Prophylaxis, including topical application of fluoride - members age 5 and under	None
Prophylaxis, including topical application of fluoride - members age 6 through 18	None
Emergency treatment, palliative	None
Intraoral periapical, single, first film	None
Intraoral periapical, each additional film	None
Intraoral, complete series consisting of at least 14 periapical films plus bitewings	None
Intraoral, occlusal, each film	None
Extraoral, single, head or lateral jaw	None
Extraoral, each additional, head or lateral jaw	None
Bitewings, two films	None
Bitewings, four films	None
Bitewing, anterior, one film	None
Photograph or slide, first	None
Photograph or slide, each additional	None
Panographic-type film, single film	None

BENEFIT SUMMARY CHART

DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
Biopsy of oral tissue	None
Gross and microscopic histopathological report	None
Oral Surgery, Drugs, Endodontics and Periodontic Services including therapeutic drug injections, root canals, gum tissue surgery, deep root cleaning, extractions, sutures and treatment of post-surgical complications.	
ORAL SURGERY	
Removal of erupted tooth, uncomplicated, first tooth	None
Removal of erupted tooth, uncomplicated, each additional tooth	None
Removal of erupted tooth, surgical	None
Removal of root or root tip, completely covered by bone	5.00*+
Removal of root or root tip, not completely covered by bone	5.00*+
Postoperative visit, complications (e.g., osteitis)	None
Removal of impacted tooth - soft tissue	None
Removal of impacted tooth - partially bony	5.00+
Removal of impacted tooth - complete bony	5.00+
Alveoplasty per quadrant, edentulous (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Alveoplasty per quadrant, in conjunction with extractions (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Vestibuloplasty, submucosal resection, not to include grafts (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Alveoplasty with ridge extension, secondary epithelialization, per arch (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Removal of palatal exostosis, torus (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Removal of mandibular exostosis, torus, per quadrant (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Excision of hyperplastic tissue, per arch	None
Incision and drainage of abscess, intraoral	None
Incision and drainage of abscess, extraoral	None
Excision pericoronar gingiva, operculectomy	None
Sialolithotomy - intraoral	None

*The \$5.00 co-pay is per tooth or clasp.

+No co-payments will apply for documented American Indians or Alaska Natives.

BENEFIT SUMMARY CHART

DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
Sialolithotomy - extraoral	None
Closure of salivary fistula	None
Dilation of salivary duct	None
Reduction of tuberosity, unilateral (surgical procedure is a benefit only if necessary for allowed or modified prosthetic appliance)	None
Excision of benign tumor, up to 1.25 cm	None
Excision of benign tumor, larger than 1.25 cm	None
Reimplantation and/or stabilization of accidentally evulsed or displaced permanent tooth and/or alveolus	None
Transplantation of tooth or tooth bud (child only)	None
Removal of foreign body from bone (independent procedure)	None
Radical resection of bone for tumor with bone graft	None
Maxillary sinusotomy for removal of tooth fragment or foreign body	None
Oral-antral fistula closure	None
Excision of cyst, up to 1.25 cm	None
Excision of cyst, over 1.25 cm	None
Sequestrectomy	None
Condylectomy of mandible, unilateral	None
Meniscectomy of temporomandibular joint, unilateral	None
Excision of foreign body, soft tissue	None
Frenectomy, or frenotomy, separate procedure	None
Suture of soft tissue wound or injury	None
Injection of sclerosing agent into temporomandibular joint	None
Injection of trigeminal nerve branches for destruction	None
Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissue	None
Surgical exposure of impacted or unerupted tooth to aid eruption, partially bony	None
Surgical exposure of impacted or unerupted tooth to aid eruption, completely bony or ectopic eruption	None
Unlisted surgical service or procedure	None
DRUGS AND ANESTHESIA	
Injectable drugs	None
Relative analgesia (nitrous oxide), per visit	None
Conscious (oral) sedation	None
PERIODONTICS	
Emergency treatment (periodontal abscess, acute periodontitis, etc.)	None

BENEFIT SUMMARY CHART

DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
Subgingival curettage and root planing, per quadrant	None
Occlusal adjustment (limited), per quadrant (minor spot grinding)	None
Gingivectomy or gingivoplasty, per quadrant	None
Osseous and mucogingival surgery, per quadrant	5.00+
Gingivectomy or gingivoplasty treatment, per tooth (fewer than six teeth)	None
Endodontics	
Direct Pulp Cap	None
Therapeutic pulpotomy excluding final restoration (deciduous tooth - child only)	None
Vital pulpotomy	None
Recalcification, includes temporary restoration, per tooth	None
Anterior root canal therapy	5.00+
Bicuspid root canal therapy	5.00*+
Molar root canal therapy	5.00*+
Apicoectomy – surgical procedure in conjunction with root canal filling	5.00*+
Apicoectomy (separate surgical procedure), per tooth	5.00*+
Apexification/apexogenesis (therapeutic apical closure), per treatment (child only)	None
Basic and restorative Services including sealants and space maintainers, metal fillings, composite and plastic fillings, and prefabricated crowns.	
SPACE MAINTAINERS	
Fixed, unilateral band type (including band)	None
Removable, plastic with two stainless steel round wire clasps or rests	None
Each additional clasp or rest	None
Fixed, unilateral stainless steel crown type (including crown)	None
Fixed, bilateral, lingual or palatal bar type	None
Fixed or removable appliance to control harmful habit	None
RESTORATIVE DENTISTRY/AMALGAM RESTORATIONS	
One surface, primary tooth (child only)	None
Two surfaces, primary tooth (child only)	None
Three surfaces, primary tooth (child only)	None
Four or more surfaces, primary tooth (maximum) (child only)	None
One surface, permanent tooth	None
Two surfaces, permanent tooth	None
Three surfaces, permanent tooth	None

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BENEFIT SUMMARY CHART	
DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
Four or more surfaces, permanent tooth (maximum)	None
COMPOSITE AND PLASTIC RESTORATIONS	
Composite or plastic restoration	None
Composite or plastic restorations, two or more in a single tooth (maximum)	None
Pin retention (per pin), maximum three pins per tooth	None
CROWNS	
Crown, plastic (laboratory processed)	None
Crown, plastic with metal	None
Crown porcelain, members ages 12 through 18	5.00+
Crown porcelain fused to metal, members ages 12 through 18	5.00+
Crown, cast, full (members ages 12 through 18)	5.00+
Crown, cast, three quarters	5.00+
Crown, stainless steel (primary; child only)	None
Crown, stainless steel (permanent)	None
Cast metal dowel post (benefit only with endodontically treated teeth)	None
Prosthetics including bridges, recementations, removable prosthetics (dentures), and crown, bridge and denture repairs	
PROSTHETICS	
Fixed bridge pontic, cast metal	5.00+
Fixed bridge pontic, slotted facing	5.00+
Fixed bridge pontic, slotted pontic	5.00+
Fixed bridge pontic, porcelain fused to metal	5.00+
Fixed bridge pontic, plastic processed to metal	None
RECEMENTATION	
Recement inlay, facing, pontic	None
Recement crown	None
Recement bridge	None
REPAIRS, CROWN AND BRIDGE	
Repair fixed bridge	None
Replace broken tru-pontic	None
Replace broken facing, post intact	None
Replace broken facing, post backing broken	None

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BENEFIT SUMMARY CHART

DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
REMOVABLE PROSTHODONTICS	
Complete maxillary denture (includes immediate denture)	5.00+
Complete mandibular denture (includes immediate denture)	5.00+
Partial upper and lower denture with two assembled wrought chrome cobalt clasps or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base, includes unilateral partial	5.00+
Partial upper or lower denture with cast chrome cobalt skeleton, two cast clasps, and necessary teeth, includes unilateral partial	5.00+
Clasps, third and each additional clasp for procedure 703	None
Stress breakers, extra	None
Partial upper or lower stayplate, acrylic-base fee, teeth and clasps extra	5.00+
Partial upper or lower denture, all acrylic with two assembled chrome cobalt wrought clasps having two clasp arms, but no rests, and necessary teeth	5.00+
Clasp, third and each additional for procedure 708	None
Clasp, third and each additional for procedure 702	None
Clasp or teeth, each for procedure 706	None
Denture adjustment, per visit (no documentation required)	None
Reline – office, cold cure, per arch	None
Reline – laboratory processed, per arch	5.00+
Tissue conditioning, limit two per denture	None
Denture duplication (“jump”, “reconstruction”) denture base including necessary tooth replacement, per denture	5.00+
REPAIRS AND DENTURES	
Repair broken denture base only (complete or partial)	None
Repair broken denture and replace one broken denture tooth	None
Each additional denture tooth replaced on 751 repair (maximum two)	None
Replace one broken denture tooth only (complete or partial)	None
Each additional denture tooth replaced on 753 repair (maximum two)	None
Adding first tooth to partial denture to replace newly extracted natural tooth	None
Each additional natural tooth replaced on 755 repair (maximum two)	None
Add a new, or replace a broken, chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 702 partial denture	None

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BENEFIT SUMMARY CHART	
DESCRIPTION OF SERVICE AND PROCEDURES	CO-PAY
Each additional new or replacement clasp for repair 757 (maximum two)	None
Add a new, or replace a broken, chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 708 partial denture	None
Each additional new or replacement clasp for repair 759 (maximum two)	None
Re-attaching clasp on partial denture, clasp intact, each (maximum two)	None
Add a new, or replace a broken, cast chrome cobalt clasp with two clasp arms and rest to an existing 703 partial denture	None
Each additional new or replacement clasp for repair 762 (maximum two)	None
Other Miscellaneous Services	
EMERGENCY SERVICES	None
UNLISTED PROCEDURES	
Fees to be determined by report	None

DESCRIPTION OF YOUR BENEFITS

This section lists the dental services covered by Delta Dental – Healthy Families. Delta will provide coverage for all listed dental services when they are provided by network dentists and when they are necessary for your dental health consistent with professionally recognized standards of practice, subject to the limitations listed here and in the “EXCLUSIONS” and “LIMITATIONS” section beginning on page 29.

You are covered for pre-existing conditions. There is no post-enrollment waiting period required of members.

1. DIAGNOSTIC AND PREVENTIVE BENEFITS

DIAGNOSTIC — initial and periodic oral examinations, x-rays, palliative emergency office visits, and consultation by a specialist.

PREVENTIVE — prophylaxis (cleaning), fluoride treatment, dental sealants, preventive dental education and oral hygiene instruction.

SPACE MAINTAINERS — covered benefits include space maintainers, including removable acrylic and fixed band type.

LIMITATIONS:

- X-rays are limited as follows:
 - 1) Bitewing x-rays are limited to one set of four films in any six consecutive month period. However, isolated bitewing or periapical films are allowed on an emergency or episodic basis.
 - 2) Full mouth x-rays in conjunction with a periodic exam are limited to once every 24 consecutive months.
 - 3) Panoramic film x-rays are limited to once every 24 consecutive months.

Prophylaxis services (cleanings) are limited to two in a 12-month period.
Dental sealant treatments are limited to permanent first and second molars only.

2. RESTORATIVE, ORAL SURGERY, ENDODONTIC AND PERIODONTIC BENEFITS

RESTORATIVE — amalgam, composite resin, acrylic, synthetic or plastic restorations (fillings) for treatment of cavities (decay). Related pin and pin build up in conjunction with a restoration. Sedative bases and sedative fillings are also included as benefits.

ORAL SURGERY — extractions, surgical removal of impacted teeth, biopsy of oral tissues, and other surgical procedures, such as: alveolectomies, excision of cysts and neoplasms, treatment of palatal and mandibular torus, frenectomy, incision and drainage of abscesses, root recovery (separate procedure) and post-operative services including exams, suture removal and treatment of complications.

ENDODONTIC — direct pulp capping, pulpotomy and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy, apicoectomy and vitality tests.

PERIODONTIC — emergency treatment, including treatment for periodontitis abscess and acute periodontitis; periodontal scaling and root planing, and subgingival curettage; gingivectomy and osseous or muco-gingival surgery.

LIMITATIONS:

Restorations are limited as follows:

- 1) If the tooth can be adequately restored with amalgam, composite resin, acrylic, synthetic or plastic restoration materials, any other restoration such as a crown or jacket is considered optional.

Composite resin or acrylic restorations in posterior teeth are considered optional.

Only micro filled resin restorations which are non-cosmetic are allowed.

Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Root canal therapy, including culture of canal, is limited as follows:

Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontal scaling and root planing, and subgingival curettage are limited to five quadrant treatments in any 12 consecutive months.

3. CROWN AND FIXED BRIDGE BENEFITS

CROWNS — including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel as necessary to treat cavities that cannot be directly restored with amalgam, composite resin, acrylic, synthetic, or plastic fillings. Related dowel pins and pin build-up are also included.

FIXED BRIDGES — which are cast, porcelain baked with metal, or plastic processed to gold are covered benefits.

RECEMENTATION of crowns, bridges, inlays, and onlays is a covered benefit.

CAST POST AND CORE, including cast retention under crown is a covered benefit.

REPAIR OR REPLACEMENT of crowns, abutments or pontics is a covered benefit.

LIMITATIONS:

Crowns are limited as follows:

- 1) Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional.

Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

Fixed bridges are limited as follows:

- 1) Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- 2) A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- 3) Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- 4) Fixed bridges are optional when provided in connection with a partial denture on the same arch.

- 5) Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

Five units of crown or bridgework per arch are allowed. The sixth unit is considered full mouth reconstruction and is an optional treatment.

4. REMOVABLE PROSTHETIC BENEFITS

DENTURES — Covered benefits include construction or repair of partial dentures and complete dentures when provided to replace missing, natural teeth.

Benefits also include office or laboratory relines or rebases; denture repair; denture adjustments; tissue conditioning; stayplates; and denture duplication. Implants are considered an optional benefit.

LIMITATIONS:

Dentures (full maxillary, full mandibular, partial upper, partial lower), teeth, clasps, denture repair, adjustment and duplication, tissue conditioning (two per denture) and stress breakers are limited as follows:

- 1) Partial dentures will not be replaced within 36 consecutive months, unless:
 - a. it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
 - b. the denture is unsatisfactory and cannot be made satisfactory.
 - c. there has been an extensive loss of remaining teeth, or a change in supporting tissue.
- 2) The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the applicant will be responsible for all additional charges.
- 3) A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the same dental arch. Other treatments of such cases are considered optional.

- 4) Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- 5) The covered dental benefit for complete denture(s) will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

Office or laboratory relines or rebases are limited to one per arch in any 12 consecutive months.

Stayplates are a benefit only when used as anterior space maintainers for children.

If implants are utilized, an allowance will be made for the cost of a standard full or partial denture toward the cost of implants and appliances constructed thereon. The member must pay any difference in cost plus any applicable co-payment. Surgical removal of implants is not covered.

5. OTHER DENTAL BENEFITS

Other dental benefits include:

1. Local anesthetics
2. Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.
3. Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.
4. Coordination of benefits with member's health plan in the event hospitalization or out-patient surgery setting is medically appropriate for dental services.

LINKAGES TO OTHER PROGRAMS (SPECIAL PROGRAMS FOR YOUR CHILDREN)

As part of the services provided through the Healthy Families Program (HFP), children needing specialized medical care may be eligible for the California Children's Services (CCS) Program.

CCS is a California medical program that treats children with certain physically handicapping conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. All children enrolled in the HFP are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the local county CCS office.

If a Health Family Program (HFP) member's Primary Care Physician (PCP) suspects or identifies a possible CCS eligible condition, **he/she must refer the member to the local county CCS program**. The CCS program (local or the CCS Regional Office) will determine if the member's condition is eligible for CCS services.

If determined to be eligible for CCS services, a HFP member continues to stay enrolled in the HFP. He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS paneled dentists and/or CCS approved specialty centers. These CCS paneled dentists and specialty centers are highly trained to treat CCS eligible conditions. Delta will continue to provide primary care and prevention services that are not related to the CCS eligible condition, as described in this document, and will also work with the CCS program to coordinate care provided by both the CCS program and the plan.

If a child is determined not eligible for CCS Program services the child will continue to receive all medically necessary services from Delta.

CCS services must be received from CCS paneled dentists, Payment for CCS eligible services obtained from non-CCS paneled dentists will be the responsibility of the parents or guardians.

Although all children enrolled in the HFP are determined to be financially eligible for the CCS Program, the CCS office must verify residential status for each child in the CCS Program. If your child is referred to the CCS Program, you will be asked to complete a short application to verify residential status and ensure coordination of your child's care after the referral has been made.

Additional information about the CCS Program can be obtained by calling Delta's Customer Service Department at (877) 580-1042. The hearing impaired may contact us through our TDD number at (800) 735-2922.

EXCLUSIONS

A wide variety of dental care expenses are covered, but there are some services for which benefits are not provided. It is important for you to know what these services are before you visit your network dentist.

Delta does not pay for:

- a. Services which are not necessary for dental health consistent with professionally recognized standards of practice.
- b. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits.
- c. Cosmetic dental care.
- d. Orthodontic Treatment. Orthodontic treatment is not a benefit of this dental plan. However, orthodontic treatment may be provided by the California Children's Services (CCS) program if the member meets the eligibility requirements for medically necessary orthodontia coverage under the CCS program.
- e. Experimental procedures.
- f. Services which were provided without cost to the member by State government or an agency thereof, or any municipality, county or other subdivision.
- g. Hospital charges of any kind.
- h. Major surgery for fractures and dislocations.
- i. Loss or theft of dentures or bridgework.
- j. Dental treatment that is started after termination of coverage. For continuation of treatment started prior to the date the member became eligible for benefits, please refer to the section entitled "Continuity of Care on page 13.
- k. Any service that is not specifically listed as a covered benefit.
- l. Malignancies.

- m. Dispensing of drugs not normally supplied in a dental office.
- n. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the member. For example, a member is hospitalized or needs to have treatment performed in a surgery center, any facility charges and/or associated charges must be paid by the member. Delta will only pay for covered dental services performed in these situations.
- o. The cost of precious metals used in any form of dental benefits.
- p. The removal of implants.
- q. Services eligible for reimbursement by, or covered under any other insurance, healthcare service plan, or dental plan. Delta shall provide the services at the time of need, and the member or applicant shall cooperate to ensure that Delta is reimbursed for such benefits.

LIMITATIONS

The following procedures **may** be covered if the member meets the eligibility requirements for medically necessary treatment:

General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or unless it is given by a dentist for covered oral surgery procedures.

Orthodontic treatment may be a benefit of this dental plan provided by the California Children's Services (CCS) program if the member meets the eligibility requirements for medically necessary orthodontia coverage under the CCS program. Please refer to the section entitled "Linkages to Other Programs (Special Programs for your Children)" on page 28.