How to Obtain Dental Benefits
Your dental benefits are provided through Delta Dental of California. Your eligibility for dental benefits starts the same day as your medical benefits.

Make the best use of your dental benefits by:
- Getting regular checkups;
- Following your dentist’s advice about regular brushing and flossing;
- Using only network dentists; and
- Seeking treatment before you have a major problem.

To get dental services, please call one of the Delta Dental providers listed in the Dental Care Provider section of your Healthy Kids Provider Directory to make an appointment. Please make sure to let the office know when you call that you are a Central Coast Alliance for Health Healthy Kids Program member.

If you have a question or grievance about eligibility, covered services, the denial of dental services or claims, policies, procedures and operations of the dental program, or the quality of dental services performed by a network dentist, you may contact Delta Dental’s Customer Service toll free number at 1-877-580-1042, Monday through Friday, 7:15 a.m. to 5:00 p.m. For emergency situations, they are available 24 hours a day, seven days a week. The hearing impaired may contact Delta Dental’s Customer Service through their TDD number, 1-800-735-2922.

Choosing a Dentist
Your Healthy Kids Provider Directory lists the names of Delta Dental network dentists in Santa Cruz County. The directory also gives you information about office facilities including languages spoken in each office. If you have special health care needs, please contact Delta Dental’s Customer Service Department at 1-877-580-1042 for help in finding a dentist who can best meet your needs. You must go to a network dentist because only services provided by a network dentist are covered by Delta Dental. If you go to a dentist who is not a network dentist, you must pay for all of the cost of the treatment, except in the case of an emergency.

Scheduling Appointments
Call the dental provider you have chosen and schedule an appointment. Tell the dentist you are covered by Delta Dental under the Healthy Kids Program through Central Coast Alliance for Health and ask the dentist to confirm that he or she is a network dentist.

During your first appointment, please be sure to give your dentist the following information:
- Your Group Number (CC60)
- The name of your program (Central Coast Alliance for Health - Healthy Kids Program)
- Your member ID number (this can be found on your Alliance member ID card)
- Information about any other dental coverage you have

**Referrals to Specialists**
When you need dental services that cannot be done by your dentist, he or she will refer you to a dental Specialist who is also a network dentist. Your dentist and the Specialist will work together to take care of your dental needs. You will not be referred to a Specialist if your dentist can perform the needed services. Consultation with a Specialist requires a referral from your dentist. Your dentist will request this referral from Delta Dental. All treatment by a Specialist requires authorization from Delta Dental and if Delta Dental approves the treatment, Delta Dental will issue a notification letter to the Specialist. Delta Dental will provide notification to your dentist if any dental services or claims are denied, in whole or in part, stating the specific reason(s) for denial.

**Second Dental Opinions**
You have the right to request a second opinion. Second opinions are performed by a Delta Dental regional consultant, or another network dentist who conducts clinical examinations, prepares objective reports of dental conditions and evaluated treatment that is proposed or has been provided. A second opinion may be required prior to treatment when necessary to determine whether or not a treatment or service will be covered.

Authorizations for second opinions after treatment can be made if you have a grievance about the quality of care provided. You and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is authorized through a regional consultant, all charges will be paid by Delta Dental.

You may get a second opinion about treatment from a network dentist you choose, and claims for the examination or consultation may be submitted for payment. Such claims will be paid in accordance with the benefits of the program.

This is a summary of the Delta Dental policy on second opinions. You may request a copy of the formal policy by contacting Delta Dental’s Customer Service Department toll free at 1-877-580-1042. You will need to give them your Group Number (CC60) when you call.

**Emergency and Urgent Dental Care Services**
An emergency or urgently needed dental care service is a service required for, or, under the circumstances, reasonably believed to be required for treatment of severe pain, swelling or bleeding or the immediate diagnosis and treatment of unforeseen dental conditions which, if not immediately diagnosed and treated, would lead to serious deterioration in health, disability or death.
How to get Emergency or Urgent Dental Care Services
Prior approval from Delta Dental is not required for emergency or urgently needed dental services. You can get emergency dental services 24 hours a day, seven days a week. In case of an emergency, you should call your regular network dentist or any other network dentist. If you need additional help, call Delta Dental’s Customer Service Department toll free at 1-877-580-1042 and give them your Group Number which is CC60.

If you are outside of Santa Cruz County, you still have 24-hour emergency coverage. You can get emergency dental service from any licensed dentist without prior approval from Delta Dental. All emergency services by out-of-county dentists are paid at the allowable rate by Delta Dental for emergency treatment. The treating dentist should call 1-800-838-4337 for payment and benefits information.

Instructions for follow-up care after an emergency or urgently needed dental service will be provided by the treating dentist. Follow the directions provided by the treating dentist on follow-up care or call your regular network dentist for more information.

Payment Responsibilities
Delta Dental pays network dentists directly. Delta Dental’s agreement with its network dentists makes sure that you will not be responsible to the dentist for any money for a covered service other than copayments. There are no copayments required for diagnostic, preventive services.

In addition to the copayments for certain services, you must pay for any non-covered or optional benefits that you choose to have done.

Non-Covered or Optional Services: Often there are several choices, or different approaches, that a dentist may take to treat dental needs. This program is designed to cover dental treatment using the most affordable method possible, while also delivering quality dental care for members. If you ask for a treatment that costs more than the most affordable option, you must pay for the charges in excess of the covered dental benefit.

Your Dental Benefits
Delta Dental covers several categories of benefits when those services are provided by a network dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

Diagnostic and Preventive Benefits

- **Diagnostic**

  **Cost to Member:** No copayment

  **Description:** Comprehensive and periodic oral examination, x-rays, palliative emergency office visits, and consultation by a specialist.
**Exclusions:** Dental x-rays are limited as follows:
- 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.
- Full mouth x-rays in conjunction with a periodic exam are limited to once every 24 consecutive months.
- Panoramic film x-rays are limited to once every 24 months.

**Preventive**

**Cost to Member:** No copayment

**Description:** Prophylaxis (cleaning), fluoride treatment, dental sealants, and oral hygiene instruction.

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

**Space Maintainers**

**Cost to Member:** No copayment

**Description:** Covered benefits include space maintainers, including removable acrylic and fixed band type.

**Restorative, Oral Surgery, Endodontic and Periodontic Benefits**

**Restorative**

**Cost to Member:** No copayment

**Description:** 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 and may be included in the fee for final restoration.

**Exclusions:** Restorations are limited as follows:
- If the tooth can be adequately restored with amalgam, composite resin, acrylic, synthetic or plastic restorations materials, any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are considered optional.
• 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.

- **Oral Surgery**

**Cost to Member:**

Removal of impacted teeth:

- No copayment for soft tissue impaction
- $5 copayment per tooth for bony impaction

Root Recovery:

- $5 copayment per root

**Description:** 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 mandibular torus, frenectomy, incision and drainage of abscesses, root recovery (separate procedure) and post operative services including exams, suture removal and treatment of complications.

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

- **Endodontic**

**Cost to Member:** $5 copayment for root canal therapy (per root)

$5 copayment for apicoectomy

**Description:** Direct pulp capping, therapeutic and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy, apicoectomy and vitality tests.

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

Retreatment of root canals is a covered benefit only when 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 Treatment**

**Cost to Member:** $5 copayment per quadrant for osseus or muco-gingival surgery
Emergency treatment, including treatment for periodontitis abscess and acute periodontitis; periodontal scaling and root planning, and subgingival curettage, gingivectomy and osseous or mucogingival surgery.

Exclusions: Periodontal scaling and root planning, and subgingival curettage is limited to four quadrant treatments in any 12 consecutive months.

Crowns and Fixed Bridges

- **Crowns**

  **Cost to Member:** $5 copayment for each porcelain crown; porcelain fused to metal crown; full metal crown; and ¾ crown. (Plus the cost of precious metals).

  **Description:** 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.

  **Exclusions:** Crowns are limited as follows:
  - Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional.
  - 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**

  **Cost to Member:** $5 copayment on each pontic

  **Description:** Fixed bridges which are case, porcelain baked with metal, or plastic processed to gold. Benefit includes:
  - Recementation of crowns, bridges, inlays and onlays
  - Cast post and core, including cast retention under crown
  - Repair or replacement of crowns, abutments or pontics

  **Exclusions:** Fixed bridges are limited as follows:
Fixed bridges will be used only when a partial denture cannot satisfactorily restore the case. If fixed bridges are used when a partial denture could satisfactorily restore the case, it is considered optional treatment.

A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient’s oral health and general dental condition permits.

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.

Fixed bridges are optional when provided in connection with a partial denture on the same arch.

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.

Removable Prosthetic Benefits

- **Dentures**

  **Cost to Member:** $5 copayment for the following services:
  - Complete maxillary denture
  - Complete mandibular denture
  - Partial acrylic upper or lower denture with clasps
  - Partial upper or lower denture with chrome cobalt alloy, lingual or palatal bar, clasps and acrylic saddles
  - Reline – laboratory processed per arch
  - Dental duplication
  - Removable unilateral partial denture

  **Description:** 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.

  **Exclusions:** Dentures (full maxillary, full mandibular, partial upper, partial lower), teeth, clasps, denture repair, adjustment and duplication, tissue reconditioning (two per denture) and stress breakers are limited as follows:
- Partial dentures will not be replaced within 36 consecutive months, unless:
  - It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  - The denture is unsatisfactory and cannot be made satisfactory.

- 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 it is not necessary to satisfactorily restore the arch, the patient/applicant will be responsible for all additional charges.

- 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.

- 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.

- 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 patient/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 and to replace extracted anterior teeth for adults during a healing period.

**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 his/her licensure;
3. Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and
4. Coordination of benefits with the Alliance in the event hospitalization or out-patient surgery setting is medically appropriate for dental services.

There are no copayments for these benefits.
**Orthodontic Benefits**
Orthodontic treatment is not a benefit under this dental plan. However, orthodontic treatment will be provided by the California Children’s Services (CCS) program if the member meets CCS eligibility requirements and requirements for medically necessary orthodontia coverage.

**Other Excluded Dental Services**
The following dental services are excluded:

- Services that are not medically necessary to the member’s dental health
- Optional cosmetic dental care (dental treatments aimed at improving the appearance of the teeth)
- Experimental procedures
- Conventional or surgical orthodontics or orthognathics
- Dental conditions arising out of and due to a member’s employment for which worker’s compensation is payable.
- Services which were provided without cost to the member by state government or an agency thereof, or any municipality, county or other subdivisions
- Major surgery for fractures and dislocations
- Loss or theft of dentures or bridgework
- Dental expenses incurred in connection with any dental procedures started after termination of coverage
- Any service that is not specifically listed as a covered benefit
- Malignancies
- Dispensing of drugs not normally supplied in a dental office
- The cost of precious metals used in any form of dental covered services (included in the copay)
- The insertion or removal of implants
- Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, dental plan or worker’s compensation. Delta Dental shall provide the services at the time of need, and the member or applicant shall cooperate to assure that reimbursement is obtained for such services.

**Grievances About Dental Services**
If you have questions about the services you get from a network dentist, first talk to your dentist. If you continue to have concerns or have a grievance, call Delta Dental’s Customer Service Department at 1-877-580-1042, Monday through Friday from 7:15 a.m. to 5:00 p.m.

The Delta Dental Customer Service Representative will try to resolve the problem immediately, however, sometimes more than one day is needed to investigate and gather information. If necessary, the representative will contact you to request any information needed to investigate the problem. Resolution of your grievance will then be resolved within 30 days from the date the grievance was received.
To file a grievance, do one of the following:

- Call a Delta Dental Customer Service Representative at 1-877-580-1042 and ask to file a grievance. The Customer Service Representative will explain the grievance process to you. You can file a grievance with the Customer Service Representative by telephone.

- Visit your network dentist’s office and request a grievance form in person. The dental office staff may help you fill out the form, but we strongly encourage you to contact a Delta Dental Customer Service Representative to make sure that the form is accurately filled out and submitted to Delta Dental.

Write to Delta Dental or mail in a grievance form. If you file a grievance in writing with Delta Dental, include the group name (Central Coast Alliance for Health - Healthy Kids) and the group number (CC60), the member’s name, the member’s Alliance identification number and your telephone number on everything you send to Delta Dental. You should also include a copy of the treatment form (you can get this from your dentist) and any other relevant information. Delta Dental’s address and telephone number are:

Delta Dental of California – CCAH Healthy Kids
P.O. Box 537010
Sacramento, CA 95853-7010
1-877-580-1042

Delta Dental will acknowledge receipt of your grievance form or letter within five (5) calendar days from the date they receive it. They will resolve your grievance within thirty (30) days. You will get a letter from them letting you know how they propose to resolve your grievance.

If your grievance involves a serious and imminent threat to the member’s health, please call Delta Dental’s Customer Service Department and state that you want to file an urgent grievance. Your grievance will be resolved or you will be given the pending status within three (3) calendar days from receipt of the grievance.

If appropriate for your grievance, an arrangement can be made for you to be examined by another dentist in your area. If the dentist recommends that the work be replaced or corrected, Delta Dental will coordinate with the original dentist to either have the service replaced or corrected at no additional charge to you. In certain cases, you may be allowed to choose another network dentist to receive your benefits.

Members who have a grievance involving services received from Delta Dental may also contact the Alliance’s Member Services Department at 1-800-700-3874 ext. 4396.

**Appeals**

If you have a grievance involving dental services, you should first contact Delta Dental toll free at 1-877-580-1042 and use their grievance process. However, if you have an urgent grievance, or within 30 days after filing your grievance you need help and your grievance has not been satisfactorily resolved, you have the option to contact the
Department of Managed Health Care as described in Part 11 of this Evidence of Coverage. You may also use the Alliance’s grievance process as described in Part 11.