Combined Evidence of Coverage and Disclosure Form

Delta Dental of California Healthy Families Program
Healthy Families Program Income Categories

Your monthly premium and copayments are determined by your income category. For more information about Income Categories A, B and C go to the HFP website address below and read about the HFP Income Categories.

Disclosure

This Combined Evidence of Coverage (EOC) and Disclosure Form (DF) booklet constitutes only a summary of the Dental Plan’s policies and coverage under the Healthy Families Program (HFP). The Health Plan contract and the HFP regulations (California Code of Regulations, Title 10, Chapter 5.8) issued by the California Managed Risk Medical Insurance Board (MRMIB), should be consulted to determine the exact terms and conditions of coverage. These regulations may be viewed on the Internet at http://www.mrmib.ca.gov.

Additionally, the HFP regulations require the Dental Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act’s regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act’s regulations shall be binding on the Dental Plan, even if it is not included in the Evidence of Coverage booklet or the Dental Plan contract.

Eligibility and Enrollment

Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another dental plan, annual requalification, premium payments, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is included in the Healthy Families Program Handbook that was mailed to you by the Healthy Families Program. If you have questions on these topics or would like another copy of the Handbook, please contact the Healthy Families Program at the following address or toll-free telephone number:

Healthy Families Program  
P.O. Box 138005  
Sacramento, CA 95813-8005  
800-880-5305

The hearing impaired should call the California Relay Service at 711(TDD/TTY).

Additional information about the Healthy Families Program is available at the Managed Risk Medical Insurance Board Website at www.mrmib.ca.gov or at Delta Dental of California’s State Government Programs Website at deltadentalins.com/gov.

Language Assistance Program Notice

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 877-580-1042. You may also be able to receive this document in Spanish, Chinese or Vietnamese.


重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。如需免費協助，請電 877-580-1042。您也能取得這份文件的西班牙文、中文或越南文譯本。

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Introduction

Welcome! About the Dental Plan

Welcome to the Delta Dental–Healthy Families Program (DD–HFP). Our goal is to provide you with high quality dental care and help you maintain good dental health. We encourage you not to wait until you have a problem to see your dentist–see your dentist on a regular basis. When you choose a network dentist from the list of participating dentists you can receive any necessary covered preventive or corrective dental care services at that location.

The DD–HFP provides healthcare coverage for children in families without access to affordable employer-based dependent coverage. Delta Dental is proud to be a participating dental plan in the Healthy Families Program.

Using this Booklet

This booklet, called the Combined Evidence of Coverage and Disclosure Form, or “EOC/DF”, contains detailed information about the DD–HFP benefits, how to obtain benefits, and the rights and responsibilities of DD–HFP Members. Please read this booklet carefully and keep it on hand for future reference. Individuals with special health care needs should refer to the “Accessing Care” section on page 9 for information on how to find a dentist to meet your needs.

Throughout this booklet, “you,” “your,” and “Member” refers to the child or children enrolled in the DD–HFP. “We,” “us,” and “our” always refers to Delta Dental of California (Delta Dental). “Your Provider” refers to a licensed dentist who is responsible for providing dental services to you.

Customer Service

Your introduction to the DD–HFP begins with Customer Service. This department can answer any questions you have about obtaining dental care and help you to:

- Choose a network dentist;
- Change to another network dentist;
- Schedule appointments with your dentist;
- Obtain dental health education material and information on health fairs and health education classes;
- Receive assistance and information on all your dental plan services;
- Get translation and interpretive services; and
- Receive assistance with filing grievances.

A representative is available by telephone Monday through Friday, 7:00 a.m. to 5:00 p.m. You can contact Customer Service by calling us toll-free at 877-580-1042. If you are hearing impaired, you may call our toll-free TDD/TTY number at 800-735-2922.

We want you to understand your dental program and its benefits, the services you can receive, the services that are not covered, and any limitations on covered services. We will send you bulletins and updates from time to time that will provide you with information on dentists, health education classes, program information, the grievance process, and the availability of
translator services. We will also assist you with information about non-dental services, such as transportation, if you are having difficulty in getting to your appointments.

This is your Combined Evidence of Coverage and Disclosure Form Booklet. It is only a summary of the Delta Dental–Healthy Families Program. The Delta Dental–Healthy Families Program contract has the exact terms and conditions of coverage. We will send you a copy of the contract upon request.

This booklet will help you understand how the program works and how you obtain dental care. Please read this booklet completely and carefully before calling your network dentist to schedule your first examination. Keep the booklet in a convenient place so you can refer to it again.

**Cultural and Linguistic Services**

If you or your representative prefer to speak in any language other than English, call us toll-free at 877-580-1042 (TDD/TTY for the hearing impaired at 800-735-2922) to speak with a Delta Dental Customer Service Representative. Our Customer Service staff can help you find a Provider who speaks your language or who has office staff that speaks your language. If you cannot find a Provider that speaks your language you have the right to interpreter services at no charge. Delta Dental discourages the use of minors as interpreters except in extraordinary cases. You have the right not to use family members, friends, or minors as interpreters. You may request an interpreter during discussions of dental information such as diagnoses of dental conditions and proposed treatment options, and explanations of your plan of care or other discussions with Providers. You have the right to receive subscriber materials in alternative formats such as Braille, compact disc (CD), or audio cassette. You also have the right to receive this EOC, as well as other informational Member materials in the following languages: Spanish, Chinese, and Vietnamese. To request translated materials please call Customer Service toll-free at 877-580-1042. If you feel that your linguistic needs are not being met, you also have the right to file a grievance.

**Member Identification Card**

All Members of the DD–HFP are given a Member identification card. This card contains important information regarding your dental benefits. If you have not received or if you have lost your Member identification card, please call 877-580-1042 or TDD/TTY for the hearing impaired at 800-735-2922 and we will send you a new card. Please show your DD–HFP Member identification card to your Provider when you receive dental care.

Only the Member is authorized to obtain dental services using his or her Member identification card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your Member identification card, Delta Dental may not be able to keep you in our plan.
WELCOME TO THE HEALTHY FAMILIES PROGRAM

Dear New Member:

Delta Dental of California would like to welcome you into the Delta Dental family of dental healthcare services. We sincerely appreciate your choosing Delta Dental as your Healthy Families Program dental services provider and look forward to providing you with excellent service.

At the bottom of this letter is your Delta Dental–Healthy Families Program identification card. Under separate cover, you will soon receive your Combined Evidence of Coverage and Disclosure Form/Member Handbook and Provider Directory. The Member handbook explains all of the benefits, limitations and exclusions of the Healthy Families program. The Provider Directory lists the network dentists you can choose from as a Member in the Healthy Families Program.

To use your benefits simply call the dentist’s office to make an appointment. On the day of the appointment, remember to bring your ID card and any information about any past medical problems, or any medicine you may be currently taking. Also be sure to arrive on time and write down any follow-up instructions from the dentist, and be sure to make an appointment for your next visit.

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. If you have questions about the services you receive from a Plan Provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call Delta Dental’s Customer Service Department toll-free at 877-580-1042 or TDD/TTY for the hearing impaired at 800-735-2922.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 877-580-1042. You may also be able to receive this document in Spanish, Chinese or Vietnamese.


重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。如需免費協助，請電 877-580-1042。您也能取得這份文件的西班牙文、中文或越南文譯本。


Once again, welcome to Healthy Families and Delta Dental. We keep you smiling.

Customer Service Department
Delta Dental of California

Detach this identification card and keep it with you. Show this card to your dentist at each visit.

Front

Fold Here

Back

Healthy Families Program
Member Name:
Member ID:
Program Name:
Date of Birth:
Effective Date:

Delta Dental Customer Service: 877-580-1042
Delta Dental TDD/TTY: 800-735-2922 (for the hearing impaired)

Present this Healthy Families identification card to your dentist at each visit.

By using this card, the Member agrees to all terms under which it is issued and said terms as they are amended from time to time.

For questions regarding benefits and eligibility, please call Delta Dental’s Customer Service Department toll-free at 877-580-1042. The hearing impaired may call our toll-free TDD/TTY number at 800-735-2922.

Peel, then fold card on the dotted line and press toward outer edge.
Delta Dental’s Address and Telephone Number

Delta Dental of California
State Government Programs
P.O. Box 537010
Sacramento, CA 95853-7010
877-580-1042

For claims, eligibility, and benefit questions, call Delta Dental's Customer Service Department toll-free at the number above. Customer Service Representatives are available Monday through Friday, 7:00 a.m. to 5:00 p.m. to answer your questions in many languages.
Definitions

Certain words that you will see in this booklet have specific meaning. These definitions should make your dental program easier to understand.

Acute Condition - A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Applicant - A person over the age of eighteen (18) years who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. Applicant also means a person eighteen (18) years of age who is applying on his or her own behalf for coverage under the program.

Appropriately Qualified Dental Care Professional - A licensed Dental Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise related to a particular illness, disease, condition or conditions.

Authorization - The requirement that certain services be approved by Delta Dental or your primary care dentist before being provided in order to be a covered service.

Benefits (Covered Services) - Dental services and supplies that a Member is entitled to receive pursuant to the terms of this Agreement. A service is not a benefit, even if described as a covered service or benefit in this booklet if it is not medically necessary, or if it is not provided by a Delta Dental Provider with authorization as required.

Benefit Year - The twelve (12)-month period commencing October 1 of each year at 12:01 a.m.

Category A, B or C - How much you pay for the monthly premium and co-payments is determined by your income category. The income categories are determined based on the current Federal Poverty Income Guidelines as follows:

- Income Category A = 100%-150% of the Federal Poverty Income Guideline
- Income Category B = 151%-200% of the Federal Poverty Income Guideline
- Income Category C = 201%-250% of the Federal Poverty Income Guideline

Complaint – A complaint is also called a grievance or an appeal. Examples of a complaint can be when:

- You can’t get a service, treatment, or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Co-payment - A fee, which the Plan provider may collect directly from a Member for a particular covered benefit at the time the service is rendered.
Coordination of Benefits - The method by which this program and one or more other dental plans or insurance policies will determine their respective reimbursements when a Member and the dental service(s) provided to the Member are covered by each program.

Dental Plan - Delta Dental of California (Delta Dental).

Effective Date - The date your eligibility begins.

Emergency Care - An emergency is a dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member’s dental health in serious jeopardy; or
- Causing serious impairment to the Member’s dental functions; or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.

Evidence of Coverage (EOC) and Disclosure Form (DF) - This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Exclusion - Any dental treatment or service for which the program offers no coverage.

Experimental or Investigational Service - Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or the safety and efficacy of which have not been determined for use in the treatment of a particular dental condition for which it is recommended or prescribed.

Federal Poverty Income Guideline - The federal poverty income guideline is set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for certain programs such as HFP or Medi-Cal. The poverty guidelines are sometimes referred to as the “Federal Poverty Level” (FPL).

Grievance - A written or oral expression of dissatisfaction regarding the plan and/or a Provider including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a Member or the Member’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Healthy Families - The state program administered by MRMIB to provide medical, dental, and vision coverage to children who meet the eligibility and income requirements and contribute a monthly family contribution.

Limitations - A description of the number or type of services, if medically appropriate, allowed as a benefit under the program.

Managed Risk Medical Insurance Board (MRMIB) - The State agency with the authority to administer the Healthy Families Program.

Medically Necessary - Those dental treatments or supplies which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the dental condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits, and alternatives.
**Member** - A person who is enrolled in the Delta Dental–Healthy Families Program and receives dental care from a plan Provider.

**Member Identification Card** - The identification card provided to Members by Delta Dental that includes the Member number and important telephone numbers.

**Non-Covered Service** - A dental procedure or service that you choose to have performed even though it is not a covered benefit.

**Non-Participating Provider** - A Provider who has not contracted with Delta Dental to provide services to Members.

**Optional Benefit** - A dental benefit that you choose to have upgraded. For example, when a filling would correct the tooth but you choose to have a full crown instead.

**Participating Provider** - A dentist or dental facility licensed to provide covered services who or which at the time care is rendered to a Member, has a contract in effect with Delta Dental to provide covered services to its Members.

**Program** - Healthy Families Program (HFP).

**Program Name** - The name that identifies the Healthy Families Program. Your Program Name is HF.

**Provider Directory** - The directory of all the Providers contracted with Delta Dental to provide services to its Members.

**Serious Chronic Condition** - A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

**Urgent Care** - Dental care needed to prevent serious deterioration of a Member’s health resulting from unforeseen illness or injury for which treatment cannot be delayed.
Member Rights and Responsibilities

As a DD–HFP Member, You Have the Right To:

- Be treated with respect and dignity.
- Choose your primary care provider from our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your dental care needs, including appropriate or medically necessary treatment options for your condition(s), regardless of cost or regardless of whether the treatment is covered by the plan.
- Have your dental records kept confidential. This means that we will not share your dental care information without your written approval or unless it is permitted by law.
- Voice your concerns about Delta Dental, or about dental services you received, to Delta Dental.
- Receive information about Delta Dental, our services and our Providers.
- Make recommendations about your rights and responsibilities.
- See your dental records.
- Get services from Providers outside of our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- Receive Member materials translated into your language.
- File a complaint if your linguistic needs are not met.

Your Responsibilities Are To:

- Give your Providers and Delta Dental correct information.
- Understand your dental problem(s) and participate in developing treatment goals, as much as possible, with your Provider.
- Always present your Member Identification Card when getting services.
- Ask questions about any dental condition and make certain that the explanations and instructions are understandable.
- Make and keep dental appointments. You should inform your Provider at least twenty-four (24) hours in advance when an appointment must be cancelled.
- Help Delta Dental maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health care coverage.
- Notify Delta Dental as soon as possible if a Provider bills you inappropriately or if you have a complaint.
- Treat all Delta Dental personnel and Providers respectfully and courteously.
Accessing Care

Physical Access

Delta Dental has made every effort to ensure that our offices and the offices and facilities of Delta Dental Providers are accessible to the disabled. If you are not able to locate an accessible Provider, please call us toll-free at 877-580-1042 and we will help you find an alternate Provider.

Access for the Hearing Impaired

The hearing impaired may contact us through our TDD/TTY number at 800-735-2922, Monday through Friday, from 7:00 a.m. to 5:00 p.m. Between 5:00 p.m. and 7:00 a.m. and on weekends, please call the California Relay Service TDD/TTY at 711 to get the help you need.

Access for the Vision Impaired

This Evidence of Coverage and Disclosure Form booklet and other important plan materials will be made available in large print, enlarged computer disk formats, and audiotape for the vision impaired. For alternative formats, or for direct help in reading the EOC and DF and other materials, please call us at 877-580-1042.

The Americans with Disabilities Act of 1990

Delta Dental complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects Members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

Disability Access Grievances

If you believe the plan or its Providers have failed to respond to your disability access needs, you may file a grievance with Delta Dental by calling 877-580-1042. If your disability access complaint remains unresolved, you may contact the:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA  95812-2769
916-324-4695

The hearing impaired should call the California Relay Service at 711 (TTY).
Using the Dental Plan

Remember you can keep your dental expenses down by:

- Using only DD–HFP participating dentists;
- Visiting your dentist regularly for checkups;
- Following your dentist's advice about regular brushing and flossing; and
- Seeking treatment before you have a major problem.

Facilities Locations

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

As a Member in this program, you have been sent an identification card, this booklet, and a directory of participating Providers. Review the directory and look for the name of a participating Provider in your area.

The directory also gives you information about office facilities including wheelchair accessibility and languages spoken within the office. You can select any dentist listed in the directory. If you need help finding a dentist in your area or if you have special health care needs and require assistance in finding a dentist who can best meet your needs (for example, wheelchair accessibility or translation services), contact Delta Dental's Customer Service Department toll-free at 877-580-1042.

Participating Providers are located throughout California. Look for the name of a dentist or dental group in your area in your Provider Directory of participating Providers. If you need services while away from home, you can call any dentist listed in the Provider Directory, or call Delta Dental's Customer Service Department.

Choosing a Primary Care Dental Provider

You can choose any participating Provider for your primary dental care. You must go to a participating Provider because only the services by a participating Provider are covered by Delta Dental. If you go to a dentist who is not a participating Provider (dentists who do not contract with Delta Dental), you must pay all of the cost of treatment, except in the case of an emergency. Our network also includes dental school clinics. Students of dentistry or instructors who are not licensed by the State of California may provide services at dental school clinics.

Scheduling Appointments

After you have selected a Participating Provider, call the dentist's office to schedule an appointment. Tell the dentist you are covered by Delta Dental–Healthy Families and ask the dentist to confirm that he or she is a participating Provider in the DD–HFP.

During your first appointment, be sure to give your dentist the following information:

- Your program name (on your ID Card): HF;
- The Member's identification number;
- The Member's date of birth; and
- Any other dental coverage you have.
Changing Your Provider

You can choose any participating Provider at any time. If you wish to change dentists, simply review the Provider Directory for dentists in your area and call to schedule an appointment. Delta Dental’s Customer Service Department is available to assist you in choosing a new dentist.

Continuity of Care for New Members

Under some circumstances, Delta Dental will provide continuity of care for new Members who are receiving dental services from a non-participating dental Provider when Delta Dental determines that continuing treatment with a non-participating Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving dental services from a non-participating Provider if you were receiving this care before enrolling in the Delta Dental–Healthy Families Program and if you have one of the following conditions:

- An acute dental condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Delta Dental in consultation with you and the non-participating Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with the Delta Dental–Healthy Families Program.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating Provider to occur within one-hundred eighty (180) days of the time you enroll with the Delta Dental–Healthy Families Program.

Please contact us at 877-580-1042 to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable co-payments under this plan.

We will request that the non-participating Provider agree to the same contractual terms and conditions that are imposed upon participating Providers providing similar services, including payment terms. If the non-participating Provider does not accept the terms and conditions, Delta Dental is not required to continue that Provider’s services. Delta Dental is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Healthy Families coverage. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement.
You may request authorization for continuity of care by contacting Delta Dental's Customer Service Department toll-free at 877-580-1042. The hearing impaired may contact us through our TDD/TTY number at 800-735-2922. If Delta Dental approves the continued treatment from a non-participating Provider, we will give you a written authorization. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see Delta Dental's Grievance and Appeals Process on page 34.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 888-HMO-2219; or at the TDD number for the hearing impaired, 877-688-9891; or online at www.hmohelp.ca.gov.

**Continuity of Care for Termination of Provider**

If your primary care or other dental care Provider stops working with Delta Dental, we will let you know by mail sixty (60) days before the contract termination date.

Delta Dental will provide continuity of care for covered services rendered to you by a Provider whose participation has terminated if you were receiving this care from this Provider prior to the termination and if you have one of the following conditions:

- An acute dental condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Delta Dental in consultation with you and the terminated Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Delta Dental.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the terminated Provider to occur within one-hundred eighty (180) days of the Provider’s contract termination date.

Continuity of care will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. You must be under the care of the participating Provider at the time of our termination of the Provider’s participation. The terminated Provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his/her agreement with Delta Dental prior to termination. If the Provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the Provider’s services beyond the contract termination date.

Please contact us at 877-580-1042 to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable co-payments under this plan.
We will send you a letter advising you of our decision regarding your request for continuity of care. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see Delta Dental’s Grievance and Appeals Process on page 34.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 888-HMO-2219; or at the TDD number for the hearing impaired, 877-688-9891; or online at www.hmohelp.ca.gov.

**Prior Authorization for Services**

Your participating Provider will coordinate your dental care needs and, when necessary, will arrange specialty services for you. In some cases, Delta Dental must authorize the specialty services before you receive the services. Your primary care dentist will obtain the necessary referrals and authorizations for you. Some specialty services, such as emergency care, do not require prior authorization before you receive the services.

If you see a specialist or receive specialty services before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If Delta Dental denies a request for specialty services, Delta Dental will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

**Referrals to Specialists**

Your participating Provider may refer you to another dentist for consultation or specialized treatment.

In consultation with you, your dentist will choose a specialist dentist from whom you may receive services. In the event that there is no participating Provider available to perform the needed service, you or your Provider may contact Delta Dental's Customer Service Department toll-free at 877-580-1042 for help in locating a specialist.

**Obtaining a Second Opinion**

Sometimes you may have questions about your condition or your primary care dentist’s recommended treatment plan; you may want to get a second opinion. You may request a second opinion for any reason including the following:

- You question the reasonableness or necessity of a recommended procedure;
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function or substantial impairment;
- Your Provider's advice is not clear or it is complex and confusing;
- Your Provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results;
- The treatment plan in progress has not improved your dental condition within an appropriate period of time;
- You have attempted to follow the treatment plan or consulted with your initial Provider regarding your concerns about the diagnosis or the treatment plan.
If you wish a second opinion for any reason you may contact any network dentist to schedule an exam at no cost to you. If you need assistance in locating another network dentist you may contact Delta Dental’s Customer Service Department at 877-580-1042. A Customer Service Telephone Representative will take your request for the second opinion and will assist you in selecting another dentist. If your request for a second opinion is an emergency situation, the customer service representative will immediately route the information to a Customer Relations Analyst for processing.

A second opinion may also be requested by Delta Dental prior to authorizing treatment when it is necessary to make a benefit determination. Both you and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is requested by Delta Dental, the program will pay all charges.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to Delta Dental’s Grievance and Appeals Process on page 34. This is a summary of Delta Dental’s policy regarding second opinions. To obtain a copy of our policy, please contact us at 877-580-1042.

**Utilization Review**

The goal of Delta Dental’s Utilization Management (UM) Program is to ensure that dental services provided to you are necessary and appropriate, the services are provided in an appropriate setting, the services are delivered in a timely manner, and the services are provided in accordance with the scope of benefits of the Delta Dental–Healthy Families Program. The Delta Dental Utilization Review (UR) system includes an automated information processing system, employees who use that system, and policies and procedures that govern that usage.

Delta Dental’s UR system identifies Providers who have unusual treatment patterns, which require corrective action. Treatment patterns are accumulated through claim and encounter information submitted by Providers, focus studies, dental facility reviews, dental chart reviews, and Member calls and grievances. The data is then analyzed to determine if any Providers have unusual treatment patterns. If necessary, corrective action may include Provider education, sanctions, or even termination of a Provider from our network.

Members may obtain information regarding Delta Dental’s UM/UR Program by contacting our Customer Service Department at 877-580-1042.

**Getting Urgent Care**

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed. Delta Dental covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered by Delta Dental, the urgent care service must be needed because the illness or injury will become much more serious, if you wait for a regular doctor’s appointment. On your first visit, talk to your primary care dentist about what he or she wants you to do when the office is closed and you feel urgent care may be needed.
**Getting Emergency Services**

An emergency is a dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member’s dental health in serious jeopardy; or
- Causing serious impairment to the Member’s dental functions; or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.

Emergency dental care services are available to you twenty-four (24) hours a day, both inside and outside our service area. If you have a dental emergency, you should call your regular network dentist or any other network dentist. If you need additional assistance call Delta Dental’s Customer Service Department toll-free at 877-580-1042. The hearing impaired may contact our Customer Service Department through our TDD/TTY number at 800-735-2922.

If you are outside of California, you can get emergency dental services from any licensed dentist without prior approval from Delta Dental. All emergency services by out-of-state dentists are paid at the allowable rate by Delta Dental for emergency treatment. The treating dentist should call 800-838-4337 for payment and benefits information.

**If you have a medical emergency, call 911 or go to the nearest emergency room.**

**What to Do If You Are Not Sure If You Have an Emergency**

If you are not sure whether you have an emergency or require urgent care, please contact Delta Dental’s Customer Service Department toll-free at 877-580-1042, 24 hours per day, 7 days a week.

**Non-Covered Services**

Delta Dental does not cover dental services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You will be responsible for all charges related to these services.

**Follow-Up Care**

After receiving any emergency or urgent care services, you will need to call your participating Provider for any necessary follow-up care. If you don’t have a regular participating Provider, you may select one from the Delta Dental Provider Directory. If you need help selecting a Provider, contact Delta Dental’s Customer Service Department toll-free at 877-580-1042.

**Co-payments**

You will be required to pay a small amount of money for some services. This is called a co-payment. You are responsible to pay the co-payment to the dental Provider at the time services are provided. There are no co-payments for the preventive and diagnostic services listed in the “Benefits” section of this EOC. Additionally, there are no co-payments for Members who are determined by the Healthy Families Program to be American Indians or Alaska Natives. For information pertaining to co-payment waivers for American Indians or Alaskan Natives, please refer to the Healthy Families Program Handbook or contact the Healthy Families Program at 800-880-5305.
The annual co-payment maximum that you have in your Healthy Families health plan does not apply to dental benefits. No deductibles are charged for dental benefits.
**Member Liabilities**

Generally, the only amount a member pays for covered services is the required co-payment. You may have to pay for services you receive that are NOT covered services, such as:

- Non-emergency services received in the emergency room;
- Non-emergency or non-urgent services received outside of Delta Dental–Healthy Families service area if you did not get authorization from Delta Dental–Healthy Families before receiving such services;
- Specialty services you receive if you did not get a required referral or authorization from Delta Dental–Healthy Families before receiving such services (see page 13 *Prior Authorization for Services and Referrals to Specialist*);
- Services from a non-participating provider, unless the services are for situations allowed in this Evidence of Coverage and Disclosure Form booklet (for example, emergency services, urgent services outside of the plan’s service area, or specialty services approved by the plan (see page 10, *Choosing a Primary Care Dental Provider*); or
- Services you received that are greater than the limits described in this Evidence of Coverage and Disclosure Form booklet unless authorized by Delta Dental-Healthy Families.

**IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 877-580-1042 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Delta Dental–Healthy Families is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If Delta Dental–Healthy Families does not pay a non-participating provider for **covered services**, you do not have to pay the non-participating provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage and Disclosure Form booklet. The non-participating provider must bill Delta Dental–Healthy Families, not you, for any covered service. But remember, services from a non-participating provider are not “covered services” unless they fall within the situations allowed by this Evidence of Coverage and Disclosure Form booklet.

If you receive a bill for a covered service from any provider, whether participating or non-participating, contact the Delta Dental–Healthy Families Customer Service department at 877-580-1042.
**Missed or Broken Appointments**

Your dentist may charge you a $10.00 fee if you fail to cancel an appointment at least twenty-four (24) hours prior to the appointment. This fee will be waived if it was not reasonably possible for you to cancel your appointment.

In the event Delta Dental does not pay a participating Provider for covered services, you will not be liable to the Provider for any money owed by Delta Dental. In the event that Delta Dental fails to pay a non-participating Provider, you may be liable to the non-participating Provider for the costs of services rendered.
**Dental Plan Benefits and Coverage Matrix**

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

**NOTE:** Your monthly premium and copayments are determined by your income category. For more information about Income Categories A, B and C go to the HFP website address below and read about the HFP Income Categories.


<table>
<thead>
<tr>
<th>Benefits*</th>
<th>Services</th>
<th>Cost to Member (co-payment)</th>
<th>Cost to Member (co-payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Income Category A</strong></td>
<td><strong>Income Categories B &amp; C</strong></td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive Care Services</strong></td>
<td>Initial and periodic oral examinations, Consultations, including specialist consultations, Topical fluoride treatment, Preventive dental education and oral hygiene instruction, Roentgenology (x-rays), Prophylaxis services (cleanings), Space Maintainers, Dental sealant treatments.</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td><strong>Restorative Dentistry (Fillings)</strong></td>
<td>Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, Micro filled resin restorations which are noncosmetic, Replacement of a restoration, Use of pins and pin build-up in conjunction</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (co-payment)</td>
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<tr>
<td></td>
<td>with a restoration, Sedative base and sedative fillings.</td>
<td><strong>Income Category A</strong></td>
<td><strong>Income Categories B &amp; C</strong></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Extractions, including surgical extractions, Removal of impacted teeth, Biopsy of oral tissues, Alveolecetomies, Excision of cysts and neoplasms, Treatment of palatal torus, Treatment of mandibular torus, Frenectomy, Incision and drainage of abscesses, Post-operative services, including exams, suture removal and treatment of complications, Root recovery (separate procedure).</td>
<td>No co-payment, except • $5 co-payment for the removal of impacted teeth for a bony impaction • $5 co-payment per root recovery</td>
<td>No co-payment, except • $10 co-payment for the removal of impacted teeth for a bony impaction • $10 co-payment per root recovery</td>
</tr>
<tr>
<td>Endodontic</td>
<td>Direct pulp capping, Pulpotomy and vital pulpotomy, Apexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy,</td>
<td>No co-payment, except • $5 co-payment per canal for root canal therapy or retreatment of previous root canal therapy • $5 co-payment per root for an apicoectomy</td>
<td>No co-payment, except • $10 co-payment per canal for root canal therapy or retreatment of previous root canal therapy • $10 co-payment per root for an apicoectomy</td>
</tr>
<tr>
<td>Benefits*</td>
<td>Services</td>
<td>Cost to Member (co-payment) Income Category A</td>
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<tr>
<td>Income Category A</td>
<td>Vitality tests.</td>
<td>No co-payment, except</td>
<td>No co-payment, except</td>
</tr>
<tr>
<td>Income Categories B &amp; C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery.</td>
<td>No co-payment, except</td>
<td>No co-payment, except</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5 co-payment per quadrant for osseous or muco-gingival surgery</td>
<td>$10 co-payment per quadrant for osseous or muco-gingival surgery</td>
</tr>
<tr>
<td>Crown and Fixed Bridge</td>
<td>Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics.</td>
<td>No co-payment, except</td>
<td>No co-payment, except</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns</td>
<td>$10 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns</td>
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<tr>
<td></td>
<td></td>
<td>$5 co-payment per pontic</td>
<td>$10 co-payment per pontic</td>
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<td>The co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used</td>
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<td>Benefits*</td>
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</tbody>
</table>
| Removable Prosthetics | Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Stayplates. | No co-payment, except:  
- $5 co-payment for a complete maxillary or mandibular denture  
- $5 co-payment for partial acrylic upper or lower denture with clasps  
- $5 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles  
- $5 co-payment for removable unilateral partial denture  
- $5 co-payment for reline of upper, lower or partial denture when performed by a Laboratory  
- $5 co-payment for denture duplication | No co-payment, except:  
- $10 co-payment for a complete maxillary or mandibular denture  
- $10 co-payment for partial acrylic upper or lower denture with clasps  
- $10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles  
- $10 co-payment for removable unilateral partial denture  
- $10 co-payment for reline of upper, lower or partial denture when performed by a Laboratory  
- $10 co-payment for denture duplication |
<p>| Other Benefits        | Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a | No Charge                                                                                                          | No Charge                                                                                                              |</p>
<table>
<thead>
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<td><strong>Income Category A</strong></td>
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<td><strong>B &amp; C</strong></td>
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<td></td>
<td>dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with member’s health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.</td>
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</tr>
<tr>
<td>Orthodontia Services</td>
<td>Not a Healthy Families Program covered benefit.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td>Services are provided to members under the age of 19 through the California Children’s Services Program (CCS) when condition meets the CCS program criteria.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Deductibles | No deductibles will be charged for covered benefits. |
| Annual Maximums | $ There is no annual maximum under this dental plan. |
| Lifetime Maximums | No lifetime maximum limits on benefits apply under this plan. |

* Benefits are provided if the plan determines them to be medically necessary.
Benefits

This section lists the dental benefits and services you are allowed to obtain through the Delta Dental–Healthy Families Program when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exception and limitations listed here and in the Exclusions section of this EOC.

NOTE: Members in the Income Category A (see the HFP Income Categories A, B & C Table) shall pay no more than $5 copayment for applicable covered services as described in this Benefit Descriptions Section of this EOC/DF.

Your monthly premium and copayments are determined by your income category. For more information about Income Categories A, B and C go to the HFP website address below and read about the HFP Income Categories.


Diagnostic and Preventive Benefits

Cost to Member
No co-payment

Description
Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

Limitations
Roentgenology (x-rays) is limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis
- Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months
- Panoramic film x-rays are limited to once every twenty-four (24) consecutive months
- Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period
- Dental sealant treatments are limited to permanent first and second molars only
**Restorative Dentistry**

Cost to Member
No co-payment

Description
Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are noncosmetic
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations
Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional
- Composite resin or acrylic restorations in posterior teeth are 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
No co-payment, except:

$5-$10 co-payment for the removal of impacted teeth for a bony impaction (no co-payment for the removal of a soft tissue impaction).

$5-$10 co-payment per root recovery.

Description
Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
• Post-operative services, including exams, suture removal and treatment of complications
• Root recovery (separate procedure)

Limitation

• The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists

Endodontic

Cost to Member
No co-payment, except:

$5-$10 co-payment per root canal therapy.

$5-$10 co-payment per canal for retreatment of previous root canal.

$5-$10 co-payment for an apicoectomy when performed as a separate procedure.

Description

Endodontics benefits include:

• Direct pulp capping
• Pulpotomy and vital pulpotomy
• Apexification filling with calcium hydroxide
• Root amputation
• Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
• Apicoectomy
• Vitality tests

Limitations

Root canal therapy, including culture 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

Periodontics

Cost to Member
No co-payment, except:

$5-$10 co-payment per quadrant for osseous or muco-gingival surgery.

Description

Periodontics benefits include:
- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

**Limitation**

- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months

**Crown and Fixed Bridge**

**Cost to Member**

No co-payment, except:

$5-$10 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.

$5-$10 co-payment per pontic.

The co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

**Description**

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

**Limitation**

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional as determined by the dental plan
- Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (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
The fixed bridge benefit is limited as follows:

- 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.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient’s oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- 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.
- The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

**Removable Prosthetics**

**Cost to Member**

No co-payment, except:

- $5-$10 co-payment for a complete maxillary denture.
- $5-$10 co-payment for a complete mandibular denture.
- $5-$10 co-payment for partial acrylic upper or lower denture with clasps.
- $5-$10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles.
- $5-$10 co-payment for removable unilateral partial denture.
- $5-$10 co-payment for reline of upper, lower or partial denture when performed by a Laboratory.
- $5-$10 co-payment for denture duplication.

**Description**

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
• Tissue conditioning
• Denture duplication
• Space Maintainer
• Stayplate

Limitations

The removable prosthetics benefit is limited as follows:

• Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
  2. 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 is not necessary to satisfactorily restore an arch, the patient 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 dental arch. Other treatments of such cases are considered optional

• Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair

• The covered dental benefit for complete dentures 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 will be responsible for all additional charges

• Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months

• Tissue conditioning is limited to two (2) per denture

• Implants are considered an optional benefit

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

Other Benefits

Cost to Member
No co-payment

Description

Other dental benefits include:

• Local anesthetics
• Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
• Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
• Emergency treatment, palliative treatment
• Coordination of benefits with Member’s health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

**Orthodontic Benefits**

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. For more information about the CCS program, see “Coordination of Services” on the next page.
Coordination of Services

California Children’s Services (CCS)

As part of the services provided through the HFP, Members needing specialized dental care may be eligible for services through the CCS Program.

CCS is a California medical program that treats children who have 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 Healthy Families Program 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 Member’s primary dental care provider suspects or identifies a possible CCS eligible condition, he or she must refer the Member to the local CCS program. Delta Dental can assist with this referral. Delta Dental will also make a referral to CCS when the plan suspects or identifies a possible CCS condition. The CCS Program will determine whether the Member’s condition is eligible for CCS services.

If the CCS Program determines that the condition is a CCS eligible condition, and the CCS Program is providing services to treat the CCS eligible condition, the Member will remain enrolled in the Healthy Families Program. He or she will be referred to the specialized network of CCS providers and/or CCS approved specialty centers. These CCS Providers and specialty centers are highly trained to treat CCS eligible conditions. Delta Dental will continue to provide primary dental care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. Delta Dental will also work with the CCS Program and Providers to coordinate care provided by both the CCS Program and Delta Dental. If a condition is determined not to be eligible for CCS Program services, the Member will continue to receive all medically necessary dental services from the Delta Dental–Healthy Families Program. In addition, Delta Dental is responsible for all covered services if CCS does not authorize or does not actually provide those specific services. If the CCS Program does not provide the services to treat a CCS eligible condition, Delta Dental shall provide medically necessary covered services to treat the condition.

Although all children enrolled in the Healthy Families Program 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 a Member is referred to the CCS Program, the Member’s parents or legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the Member’s care after the referral has been made.

Additional information about the CCS Program can be obtained by calling Delta Dental’s Customer Service Department toll-free at 877-580-1042 or by calling the local county CCS Program.
<table>
<thead>
<tr>
<th>County Name</th>
<th>CCS Phone#</th>
<th>County Name</th>
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<tr>
<td>Alameda</td>
<td>510-208-5970</td>
<td>Orange</td>
<td>714-347-0300</td>
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<td>Alpine</td>
<td>530-694-2146</td>
<td>Placer</td>
<td>530-886-3630</td>
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<td>Amador</td>
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<td>Riverside</td>
<td>951-358-5401</td>
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<td>Calaveras</td>
<td>209-754-6460</td>
<td>Sacramento</td>
<td>916-875-9900</td>
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<td>Colusa</td>
<td>530-458-0380</td>
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<td>619-528-4000</td>
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<td>El Dorado</td>
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<td>805-681-5360</td>
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<td>530-251-8183</td>
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<td>Los Angeles</td>
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<td>Sutter</td>
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<td>Mendocino</td>
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<td>Merced</td>
<td>209-381-1114</td>
<td>Trinity</td>
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<td>Modoc</td>
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<td>Tuolumne</td>
<td>209-533-7400</td>
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<tr>
<td>Monterey</td>
<td>831-755-4747</td>
<td>Ventura</td>
<td>805-981-5281</td>
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<td>Napa</td>
<td>707-253-4391</td>
<td>Yolo</td>
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<tr>
<td>Nevada</td>
<td>530-265-1450</td>
<td>Yuba</td>
<td>530-749-6340</td>
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</tbody>
</table>
Excluded Services

The following dental services are excluded under the plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the "Benefits" section above.
4. General anesthesia or intravenous/conscious sedation, unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
5. Experimental procedures.
6. Dental conditions arising out of and due to a Member's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.
7. Services which were provided without cost to the Member by the State government or an agency thereof, or any municipality, county or other subdivisions.
8. Hospital charges of any kind.
10. Loss or theft of dentures or bridgework.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
12. Any service that is not specifically listed as a covered benefit.
15. 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.
16. The cost of precious metals used in any form of dental benefits.
17. The surgical removal of implants.
18. Services of a pedodontist/pediatric dentist for a Member, except when the Member is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric dentist.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.
Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Plan Providers to the courtesy extended to you by our telephone representatives.

If you have questions about the services you receive from a Plan Provider, we recommend that you first discuss the matter with your Provider. If you continue to have a concern regarding any service you received, call Delta Dental’s Customer Service Department toll-free at 877-580-1042 or TDD/TTY for the hearing impaired at 800-735-2922.

Grievances

You may file a grievance with Delta Dental at any time. You can obtain a copy of Delta Dental’s Grievance Policy and Procedure by calling our Customer Service number in the above paragraph. To begin the grievance process, you can call, write, or fax the Plan at:

Delta Dental of California
State Government Programs
P.O. Box 537010
Sacramento, CA  95853-7010
Telephone Number:  877-580-1042
Fax Number:  866-828-4122
deltadentalins.com/gov

Delta Dental will acknowledge receipt of your grievance within five (5) days and send you a decision letter within thirty (30) days. If your grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your Provider may request that Delta Dental expedite its grievance review. Delta Dental will evaluate your request for an expedited review and, if your grievance qualifies as an urgent grievance, we will process your appeal within three (3) days from receipt of your request.

You are not required to file a grievance with Delta Dental before asking the Department of Managed Health Care (DMHC) to review your case on an expedited review basis. If you decide to file a grievance with Delta Dental in which you ask for an expedited review, Delta Dental will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your grievance involving an imminent and serious threat to health; and
2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the grievance no later than seventy-two (72) hours from receipt of your request to expedite review of your grievance.

Independent Medical Review

If dental care that is requested for you is denied, delayed, or modified by Delta Dental or a Plan Provider, you may be eligible for an Independent Medical Review (IMR). The IMR has limited application to your dental program. You may request an IMR only if your dental claim
concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care, information about your case will be submitted to a specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, Delta Dental will provide coverage for the dental services.

**Independent Medical Review for Denials of Experimental/Investigational Therapies**

You may also be entitled to an Independent Medical Review through the Department of Managed Health Care when we deny coverage for treatment we have determined to be experimental or investigational:

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in Delta Dental’s grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/investigational therapy.
- If a physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

**Review by the Department of Managed Health Care**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone Delta Dental at **877-580-1042** or TDD/TTY for the hearing impaired at **800-735-2922** and use Delta Dental’s grievance process before contacting the department. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Delta Dental, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, **888-HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the department’s TDD line 877-688-9891 number to contact the department. The Department’s Internet Website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

Delta Dental’s grievance process and DMHC’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.
General Information

Coordination of Benefits

This dental plan coverage is not designed to duplicate any dental benefits. Coverage provided under this program is secondary to all other coverage, except Denti-Cal. Benefits paid under this program are determined after benefits have been paid as a result of a member’s enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental care service plan, Delta Dental shall provide services at the time of need, and the member or member’s legal guardian will cooperate to assure that Delta Dental is reimbursed for such benefits.

By enrolling in the Healthy Families Program, each member agrees to complete and submit to Delta Dental such consents, releases, assignments and any other document reasonably requested by Delta Dental in order to assure and obtain reimbursement and to coordinate coverage with other dental plans or insurance policies. The payable benefits will be reduced when benefits are available to a member under such other plan or policy whether or not claim is made for the same.

The fact that a member has double coverage under Delta Dental will in no way reduce member’s obligation to make all required copayments. When a primary dental benefit plan is coordinating its benefits with one or more secondary dental benefits plans, it shall pay the maximum amount required by its contract with the enrollee or subscriber.

A health care service plan covering dental services or a specialized health care service plan contract covering dental services, when acting as a secondary dental benefit plan, shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee’s total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan. Be sure to advise your provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact Delta Dental’s Member Services department at 877-580-1042. Delta Dental shall coordinate benefits with the member’s health plan through a plan assigned liaison>>.

Third Party Recovery Process and Member Responsibilities

The Member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the Member is made whole for all other damages resulting from the wrongful act or omission before the Delta Dental–Healthy Families Program is entitled to reimbursement, Member shall:

- Reimburse Delta Dental for the reasonable cost of services paid by Delta Dental to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Delta Dental’s effectuation of its lien rights for the reasonable value of services provided by Delta Dental to the extent permitted under California Civil Code section 3040. Delta Dental’s lien may be filed with the person whose act caused the injuries, his or her agent, or the court.
Delta Dental shall be entitled to payment, reimbursement and subrogation in third party recoveries and Member shall cooperate to fully and completely effectuate and protect the rights of Delta Dental including prompt notification of a case involving possible recovery from a third party.

**Non-Duplication of Benefits with Workers’ Compensation**

If, pursuant to any Workers’ Compensation or Employer’s Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services provided by Delta Dental, Delta Dental will provide the benefits of this Agreement at the time of need. The Member will agree to provide Delta Dental with a lien to the extent of the reasonable value of the services provided by Delta Dental. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, Members agree to cooperate in protecting the interest of Delta Dental under this provision and to execute and to deliver to Delta Dental or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of Delta Dental or its nominee. Members also agree to fully cooperate with Delta Dental and not take any action that would prejudice the rights of Delta Dental under this provision.

**Limitations of Other Coverage**

This dental coverage is not designed to duplicate any benefits to which Members are entitled under government programs, including CHAMPUS, Medi-Cal, or Workers’ Compensation. By executing an enrollment application, a Member agrees to complete and submit to Delta Dental such consents, releases, assignments, and other documents reasonably requested by Delta Dental in order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers’ Compensation Law.

**Provider Payment**

Delta Dental pays network dentists directly. Our agreement with network dentists makes sure that you will not be responsible to the dentist for any money for a covered service other than the co-payments listed in the Benefits Matrix beginning on page 19 of this booklet.

Your dentist does not receive payment for any procedure, which is a covered service, until the procedure is complete. Delta Dental does not pay network dentists any incentive as an inducement to deny, reduce, limit, or delay any appropriate service. If you wish to know more about the method of reimbursement to the DD–HFP network dentists, you may call the DD–HFP Customer Service Department for more information.

If your network dentist files a claim for services more than six (6) months after the date you received these services, payment may be denied. If the payment is denied because your dentist failed to turn the claim in on time, you are not responsible for that payment.
Dentists must certify that the services listed on the treatment form have been personally provided to the patient by the dentist or, under their direction, by another person(s) eligible under the Delta Dental–Healthy Families Program to provide such services, and such person(s) must be designated on the treatment form. The dentist must also certify that the services were, to the best of the dentist’s knowledge, necessary to the health of the patient. The dentist must further acknowledge that they understand payment for services rendered will be made from Federal and/or State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws.

The dentist agrees to file all claims for services provided to Delta Dental–Healthy Families Program Members and to submit such claims on the required forms to Delta Dental within six (6) months after the date services were performed. Payment of claims for services will be issued directly to the contracted billing dentist. Completed claim forms should be mailed to the Delta Dental–Healthy Families Program at the following address:

Delta Dental of California
State Government Programs
P.O. Box 537010
Sacramento, CA  95853-7010

We explain to all network dentists how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided, and the program’s limitations and exclusions. If any claims are not covered, or if limitations or exclusions apply to services you have received from a network dentist, you may be responsible for the payment. In the event Delta Dental fails to pay the dentist for covered services, you will not be responsible to the dentist for any money owed by Delta Dental.

Reimbursement Provisions–If You Receive a Bill

If you have any questions about what your dentist is charging you, processing policies and/or what is paid, contact Customer Service toll-free at 877-580-1042. The hearing impaired may contact us through our TDD/TTY number at 800-735-2922.

Public Participation

Delta Dental’s Board of Directors includes Subscribers and Members who participate in establishing Delta Dental’s public policy regarding Members through periodic review of Delta Dental’s Quality Assessment program reports and communications from Members. Members may submit any suggestions regarding Delta Dental's public policy in writing to: Delta Dental of California, Customer Service Department, P.O. Box 7736, San Francisco, CA, 94120.

Notifying You of Changes in the Plan

Throughout the year we may send you updates about changes in the Plan. This can include updates for the Provider Directory, Handbook and Evidence of Coverage and Disclosure Form booklet. We will keep you informed and are available to answer any questions you may have. Call us toll-free at 877-580-1042 if you have any questions about changes in the Plan. The hearing impaired may contact us through our TDD/TTY number at 800-735-2922.
Privacy Practices

Section 56.10 of the California Civil Code prohibits health care service plans from disclosing a Member's medical or dental information without the Member's authorization. However, there are some important exceptions to this law that allow plans to disclose Member information such as the purposes of diagnosis or treatment, billing, or peer review committees.

A statement describing Delta Dental's policies and procedures for preserving the confidentiality of medical records is available to you and will be furnished upon request.

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet Website (http://www.organdonor.gov) has additional information on donating your organs and tissues.