

Keep Smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.⁴ Log in to our online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



NON-PPO

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

Plan Benefit Highlights for: CSURMA AORMA Employee Benefits Program (Plan B)
Group No: 19859

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	\$50 per person each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	\$1,500 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	80 %
Basic Services Fillings, denture repair/relining and sealants	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	\$1,500 Lifetime	\$1,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

Delta Dental of California
560 Mission St., Suite 1300
San Francisco, CA 94105

Customer Service
888-335-8227

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.



ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information

- New Enrollment
 Marital Status Change
 Terminate Enrollee Coverage
 SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- Add/Delete Dependent
 Address Change
 Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
____/____/____	____-____-____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
First Name	Last Name	Middle Initial		
Mailing Address (Street)		City	State	Zip Code
E-mail Address (internal use only)	Phone Number () -	Phone Type		
		Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>		
Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth		
		____/____/____		
Effective Date of Other Policy	Policy Holder Street Address	City	State	Zip Code
____/____/____				

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date	/	/
Hire Date	/	/
Name of Employer		
Location	Pay Code	Benefit Package

Enrollee Classification

- Full-Time
 Hourly
 Certified
- Part-Time
 Salaried
 Classified
- Retired
 Member/Other _____

COBRA (if applicable)

- Termination
- Reduction in Hours
- Divorce/Legal Separation*
- Widowed/Surviving Dependent*
- Dependent Child No Longer Eligible*

Indicate qualifying date: ____/____/____

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.**

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (coverage student)**
Spouse/Partner		<input type="checkbox"/> <input type="checkbox"/>	____-____-____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	____-____-____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	____-____-____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	____-____-____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	____-____-____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

Signature of Enrollee _____

Date ____/____/____

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-765-6003. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-765-6003. También puede recibir este documento en español o chino.

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 Delta Dental 1-800-765-6003 您也能取得這份文件的西班牙文或中文譯本。