CSU The California State University

THE CALIFORNIA STATE UNIVERSITY DENTAL PROGRAM OVERVIEW
Plan Year: January 1, 2027 – December 31, 2027

The California State University Dental Program consists of two types of plans: Delta Dental PPO and DeltaCare USA. This overview provides the most important features of each dental plan offered by the university. It is designed to help you select the plan that best suits your personal needs. The Evidence of Coverage (EOC) booklet provides a detailed explanation of benefits, services, limitations, and exclusions. A copy of the EOC booklet and additional information about the CSU Dental Program is available online at deltadentalins.com/csu, or can be obtained from the Benefits Office.

EXPLANATION OF PLAN TYPES

Delta Dental PPO

- Your current dentist may participate in the Delta Dental PPO Network and/or the Delta Dental Premier Network in California. If so, he/she has claim forms and will file your claim. Both you and Delta Dental have a shared responsibility of paying the dentist for services received (see appropriate comparison chart).
- If you select a dentist from the Delta Dental PPO Network, you will typically pay a lower amount on your out-of-pocket expenses.
- If you choose a non-Delta dentist, you must pay entirely for services obtained and then submit a claim form with appropriate documentation to Delta Dental PPO for reimbursement. Claims should be sent to: P.O. Box 997330, Sacramento, CA 95899-7330.
- Since you are not assigned to a specific dentist, you will not receive an identification card. Simply inform the particular dental office you seek services at that you are covered under the Delta Dental PPO plan through California State University.
- Refer to the EOC booklet for coverage details and plan limitations. Benefits described in this comparison are guaranteed only when you select a participating dentist from Delta's networks. You also may contact Delta Dental PPO customer service at (800) 626-3108.

DeltaCare USA,

- This is a prepaid dental maintenance organization plan, which means that all covered dental care for you and your dependents is prepaid and must be performed by the DeltaCare USA panel dentist that you are assigned. (You may change dentists by contacting DeltaCare USA.)
- Under this plan, each covered dental service has a specific co-payment amount, and some services are covered at no charge.
- No claim forms are required under this plan.
- You will receive an identification card and welcome letter. The welcome letter will show the name of your contract dentist.
- All covered dental services deemed necessary by your dentist will be provided subject to plan limitations explained in the EOC booklet. You also may contact DeltaCare USA customer service at (844) 519-8751.

CHANGES FOR 2027

The monthly employer paid premiums for Delta Dental PPO will increase for the 2027 plan year. The employer paid premiums for Delta Care USA will remain unchanged. All coverage levels and plan benefits will remain the same for the 2027 plan year.

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DeltaCare USA Basic and Delta Dental PPO Level I Enhanced Benefits Comparison

For eligible employees in the following categories: Unit 11 (Teaching Associates) and Unit 13

Plan Benefit	DeltaCare USA Basic Plan Charges	Delta Dental PPO of California Enhanced Level I Plan Pays**
PREVENTIVE AND DIAGNOSTIC DENTISTRY	**No Deductible***	**No Deductible***
Prophylaxis (cleaning)	No charge – limit 2 per calendar year	100% – limit 2 per calendar year+
Fluoride Application	No charge – only to age 19	100%
Oral Exams	No charge	100% – limit 2 per calendar year
Space Maintainers	$10	100%
Emergency Office Visits	No charge	100%
X-rays	No charge (Full mouth X-rays: 1 set per 24 consecutive months. Bitewings: 1 set (4 films) per every 6-month period.)	100% (Full mouth X-rays: 1 set in a 3-year period. Bitewings: 1 set per calendar year for age 18 and over**)
BASIC DENTISTRY	**No Deductible***	**Deductible***
Fillings	No charge for amalgam	80%
Anesthesia	Local – no charge; General – not covered	80% -limited to oral surgery and select endodontic and periodontic procedures.
Injection of Antibiotics	Not covered	Not covered
Extractions	Uncomplicated – no charge; $15-$25 for bony impactions (not covered for orthodontia)	80%
Oral Surgery	No charge	80%
Endodontics	Root canal – $20 anterior, $40 bicuspid, $60 molars	80%
Periodontics	$10 for scaling/root planning per quadrant $20 for gingivectomy per quadrant $80 for osseous surgery per quadrant	80%
Denture Relining	Office – no charge; Lab – $15	80%
PROSTHETIC DENTISTRY	**No Deductible***	**Deductible***
Crowns and Bridges	$35-$50 per unit; plus additional cost for precious metals and porcelain on molars	50%
Prosthetic Appliance Repair	Up to $15	50%
Dentures	Full – $60 each; Partials – $70 each	50%
Implants	Not covered	50%
ORTHODONTICS	**No Deductible***	**No Deductible***
Orthodontics	$1,400 maximum co-payment plus $350 start-up costs for 24-month treatment plan (only for covered children up to age 26). Orthodontics extractions are not covered.	50% - $1,000 maximum per patient per case (for employees, spouse and dependent children).
SPECIAL PROVISIONS, LIMITATIONS, EXCLUSIONS		
Work in progress when you join	Not covered. (Examples: in-progress root canals, teeth prepped for crowns, etc.)	Only covers charges for services the member receives on and after effective date of coverage.
Pre-determination of benefits	Not required	Not required; however, suggested for services proposed over $300.
Alternative to treatment provision	May be additional cost.	If dentist determines alternative treatment is necessary, approval is subject to Delta review.
Referral to specialist	Approval is subject to review by dental consultant.	N/A
Missing teeth	No exclusion against replacing missing teeth.	No exclusion against replacing missing teeth.
Out-of-area emergency	Maximum of $50	PPO dentists available nationwide. Submit non-network dentist's billing statement to Delta Dental of California for reimbursement.
Deductible	No deductible	$50/person up to maximum of $150/family deductible per calendar year for basic and prosthetic dentistry. Any part of deductible satisfied during last 3 months of calendar year is credited toward the next calendar year deductible.
Prosthetic replacements	Limited to one each 5 years.	Limited to one each 5 years.
MAXIMUM BENEFIT FOR PREVENTIVE, BASIC AND PROSTHETIC DENTISTRY	**No maximum***	**$2,000 per calendar year per person****

*Refer to the Evidence of Coverage (EOC) booklet. **Children under 18 are eligible for 2 sets of bitewing x-rays per calendar year.
There is a $500 maximum, per year, per child for pedodontics procedures only when performed by a specialist (applies to DeltaCare USA only.)
+Under certain guidelines Delta Dental participants who are pregnant are eligible to receive an additional cleaning and/or periodontal examination in a calendar year.
**** When visiting a PPO dentist, diagnostic and preventative services (like cleaning and exams) will not count against the annual maximum.**