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DeltaCare USA Enhanced and Delta Dental PPO Level II Enhanced Plans Benefits Comparison

For eligible employees in the following categories: Units 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and C99, M98, M80, FERP Annuitants
Other Annuitants (Non FERP) may enroll for an additional fee

Plan Benefit	DeltaCare USA Enhanced Plan Charges	Delta Dental PPO of California Enhanced Level II 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	No charge	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 – covered for extractions only and only when medically necessary	80% – limited to oral surgery and select endodontic and periodontic procedures.
Injection of Antibiotics	Not covered	Not covered
Extractions	No charge	80%
Oral Surgery	No charge	80%
Endodontics	No charge	80%
Periodontics	No charge	80%
Denture Relining	No charge	80%
PROSTHETIC DENTISTRY	**No Deductible***	**Deductible***
Crowns and Bridges	No charge: however, additional cost for precious metals and porcelain on molars is applicable	80%
Prosthetic Appliance Repair	No charge	80%
Dentures	No charge	80%
Implants	Not covered	80%
ORTHODONTICS	**No Deductible***	**No Deductible***
Orthodontics	$1,400 maximum co-payment (only for covered children up to age 26) $1,600 maximum co-payment for adults. Plus $350 start-up costs for 24-month treatment plan. Orthodontic 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 $100	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 pedodontic 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.**

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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 pedodontic 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.**

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DeltaCare USA Basic and Delta Dental PPO Basic Plans Benefits Comparison

For eligible employees in the following categories: Excluded (E99) and Annuitants

Plan Benefit	DeltaCare USA Basic Plan Charges	Delta Dental PPO of California Basic Plan Pays**
PREVENTIVE AND DIAGNOSTIC DENTISTRY	**No Deductible***	**No Deductible***
Prophylaxis (cleaning)	No charge – limit 2 per calendar year	75% – limit 2 per calendar year+
Fluoride Application	No charge – only to age 19	75%
Oral Exams	No charge	75% – limit 2 per calendar year
Space Maintainers	$10	75%
Emergency Office Visits	No charge	75%
X-rays	No charge (Full mouth X-rays: 1 set per 24 consecutive months. Bitewings: 1 set (4 films) per every 6-month period.)	75% (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	75%
Anesthesia	Local – no charge; General – not covered	75% – 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)	75%
Oral Surgery	No charge	75%
Endodontics	Root canal – $20 anterior, $40 bicuspid, $60 molars	75%
Periodontics	$10 for scaling/root planning per quadrant $20 for gingivectomy per quadrant $80 for osseous surgery per quadrant	75%
Denture Relining	Office – no charge; Lab – $15	75%
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). Orthodontic 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***	**$1,500 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 pedodontic 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.**