2024

Dental Handbook – Active Employees

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

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Introduction

The California Department of Human Resources (CalHR) prepared this dental benefits handbook to provide general information regarding state-sponsored dental coverage for State of California employees and their eligible dependents.

Information in this handbook is supplied solely to provide general information regarding eligibility and enrollment and to assist you in comparing dental plan options. This handbook has no legal force or effect; any discrepancy between the information contained herein and actual dental plan benefits is controlled by the contracts between the state and the dental plan carriers.

CalHR
The CalHR Benefits Division administers the state's dental program. CalHR secures and administers contracts with dental carriers to provide benefits to active state employees, retirees, and their dependents. CalHR is also responsible for communicating policies and procedures regarding dental eligibility and enrollment, coordinating dental Open Enrollment periods, and providing information, guidance, and training to departmental personnel offices on issues relating to the state's dental program.

State-Sponsored Dental Plans

CalHR currently contracts with four prepaid dental plans: DeltaCare USA, MetLife, Premier Access, and Western Dental. CalHR also contracts with Delta Dental for an indemnity plan and a preferred provider organization plan (PPO).

A prepaid plan requires you and your eligible dependents to select a dental provider from a list of dentists who contract with the plan. These dentists, located only in California, are paid a monthly contracted fee by the dental plan for every state employee and dependent who receives services from their office. (See page 8 for more details about the prepaid plans.)

An indemnity plan allows you to receive services from any licensed dentist throughout the United States and abroad. However, benefits are maximized when you receive services from a contracted Delta Dental dentist (PPO or Premier). The plan pays a percentage of the costs for each specific type of dental treatment. You are responsible for paying any remaining balance based on the type of dental treatment you receive. A monthly premium cost share will be deducted from your pay warrant. (See page 8 for more information about the state-sponsored indemnity plan.)

A PPO plan allows you to select any licensed dentist of your choice. However, you receive the maximum benefits under the program when you choose one of the dentists in the plan's PPO network. The plan pays a percentage of the costs for each specific type of dental treatment. You are responsible for paying any remaining balance based on the type of dental treatment you receive. A monthly premium cost share will be deducted from your pay warrant. (See page 9 for more information about the state-sponsored PPO plan.)

Union-Sponsored Dental Plans

California Association of Highway Patrolmen (CAHP) Dental Plan

The CAHP administers the dental indemnity plan for Bargaining Unit 5 (BU5) employees. The exclusive representative of BU5 contracts directly with Anthem Blue Cross to provide dental insurance to its members and has administrative responsibility for such coverage. All newly hired represented employees in BU5 must elect their dental coverage from one of the state-sponsored prepaid dental plans. After completing the 24-month restriction period, BU5 employees who are CAHP members may enroll in the CAHP Dental Trust administered by Anthem Blue Cross or remain in one of the state's prepaid plans.

Employees should contact their departmental personnel office for more information on the 24-month restriction period. For information regarding the CAHP dental plan, BU5 employees should contact the CAHP Benefits Trust at (916) 452-6751 or (800) 734-2247.

California Correctional Peace Officers Association (CCPOA) Dental Plans

The CCPOA Benefit Trust Fund (CCPOA BT) administers the Primary Dental (indemnity) and Western Dental (prepaid) plans for dues-paying BU6 employees. The exclusive representative of BU6 contracts directly with its dental carriers through the CCPOA BT for its members' dental benefits and has administrative responsibility for such coverage. Dues-paying BU6 employees have 60 days from the date they first become eligible to enroll in the union-sponsored prepaid dental plan (Western Dental). BU6 employees **must** enroll and maintain coverage in Western Dental for 12 consecutive months before they can change to the CCPOA's Primary Dental plan. This stipulation also applies to existing state employees who have recently transferred into BU6 and have previously satisfied the state's mandated 24-month prepaid dental plan restriction.

Exception: The only exception to the mandatory enrollment in the union-sponsored dental program is when a BU6 member is married to another state employee and receiving dental benefits under the spouse's state dental plan.

BU6 employees should contact Western Dental at (800) 992-3366 or CCPOA BT directly at (916) 779-6300 or (800) 468-6486 if they have questions about their dental coverage.

Eligibility

Employee Eligibility

If you are an employee who has a permanent or limited-term appointment lasting more than six months and a time base of half-time or more, you are eligible to enroll in dental benefits.

If you are a permanent-intermittent employee, you may enroll if you have been credited with a minimum of 480 hours during a six-month control period beginning January 1 and ending June 30 or beginning July 1 and ending December 31.

Dependent Eligibility

You may also enroll your eligible dependents in your dental plan. Eligible dependents include your spouse or registered domestic partner (as recognized by the State of California) and your eligible children as defined below.

Spouse or Registered Domestic Partner
A Dependent Eligibility Verification Checklist (CalHR 781) with required documents must be provided when a spouse or registered domestic partner is initially enrolled. These documents and the dental enrollment materials are maintained in your department's personnel file.

Eligible Children
Children under the age of 26 are eligible for enrollment. Children may include your birth children, adopted children or children placed for adoption, stepchildren, children of a registered domestic partner, and other children living in the household who are in a parent-child relationship with you. A Dependent Eligibility Verification Checklist (CalHR 781) with the required documents must be submitted with the enrollment form.

A "parent-child relationship" is established when you intentionally assume parental status or duties over a child who is not your adopted, step, or recognized natural child and meets specific enrollment criteria. To enroll a child in a parent-child relationship, you must complete an Affidavit of Parent-Child Relationship (CalHR 025).

A child may continue to be enrolled after age 26 if they are determined to be:

- Incapable of self-support because of physical disability or mental incapacity.
- Dependent on the eligible employee for support and care.
- Considered disabled at the time of the initial enrollment.

For more details regarding the enrollment criteria for disabled children, contact your departmental personnel office.

Loss of Eligibility

The following events will cause a family member or dependent to lose eligibility; coverage ends on the last day of the month in which this event occurred:

- A child turns 26.
- A final divorce decree is granted or a domestic partnership is terminated.

When a family member or other dependent ceases to be eligible, they must be deleted from your coverage. Notify your departmental personnel office of any changes to your dependent eligibility within 60 days of the permitting event date to ensure deductions are accurate. Do not wait until Open Enrollment. You will be liable for any expenses incurred after this person loses eligibility. Refer to page 13 for information about continuing coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If you have questions about eligibility, please contact your departmental personnel office.

Enrollment

Newly Hired or Newly Eligible Enrollment

The first opportunity to enroll in dental benefits is during your first 60 days as a new employee. This also applies to current employees who change status and become newly eligible for benefits.

Your enrollment will be effective the first day of the month following the month your enrollment is received by your departmental personnel office.

If you do not enroll at this time, your next opportunity to enroll will be during the annual Open Enrollment period.

Enrollment Restrictions for Newly Hired State Employees
All eligible newly hired represented employees in BUs 1, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15, 20, and 21 have the option of enrolling in a prepaid plan for the first 24 months of employment. At the end of the 24-month period, and without a permanent break in service, those employees will have **60 days** to change their enrollment to an indemnity or PPO plan. (See page 2 for information on the 24-month restriction for BU5 and the 12-month restriction for BU6.)

All eligible represented employees who reinstate after a permanent separation and previously had 24 months of state service may enroll in a prepaid, indemnity, or PPO plan at the time of hire.

All eligible newly hired represented employees in BUs 2, 7, 8, 16, 17, 18, and 19, and excluded employees (non-represented) may elect the Delta PPO or PPO plus Premier plan at the time of hire and are not restricted to state-sponsored prepaid plans.

Open Enrollment

Each year, an Open Enrollment period is held to allow eligible active state employees to enroll in a dental plan, change plans, and add or delete eligible dependents. Open Enrollment is typically held from September through mid-October. It is coordinated by CalHR in cooperation with the State Controller's Office (SCO) and the California Public Employees' Retirement System (CalPERS).

This year's Open Enrollment starts **September 18 and ends October 13, 2023**. Changes made during the Open Enrollment period are effective January 1, 2024. Please contact your departmental personnel office to enroll or make changes to your dental coverage.

Dual Coverage

A person cannot be enrolled in a state-sponsored dental plan as both a member and a dependent. If a situation involving dual coverage is discovered, it must be corrected retroactively to the date dual coverage began. In addition, a dental plan may request reimbursement for any claims paid.

Split Coverage

Married employees or registered domestic partners can enroll in a state-sponsored plan separately if they both work for the state; however, they cannot split coverage for their dependent children.

In other words, all eligible children in a household enrolled in a state-sponsored dental plan must be covered by the same employee.

Levels of Coverage

The cost of coverage depends on the plan you select and how many eligible dependents you elect to cover. Levels of coverage are:

- Yourself (Party Code 1).
- Yourself and one dependent (Party Code 2).
- Yourself and two or more dependents (Party Code 3).

The 2024 dental premiums are listed on page 10. Employees in BU5 and BU6 should contact their Benefit Trust for information on their union-sponsored dental plan premiums.

Making Changes Outside of Open Enrollment

Once enrolled, you cannot make changes until the next annual Open Enrollment period unless you experience a change in family or employment status — generally referred to as a "permitting event." Permitting events include, but are not limited to:

- Marriage or domestic partnership.
- Birth, adoption, or gaining legal custody of a child.
- Loss or gain of eligibility due to dependent employment status changes.
- Divorce or termination of domestic partnership.
- Death of an eligible dependent.

When a permitting event occurs, you must complete and submit a Dental Plan Enrollment Authorization Form (STD. 692) to your departmental personnel office within 60 days of the permitting event. Enrollment changes must be consistent with your permitting event. You will be required to provide the date of the family status change to your departmental personnel office.

Note: If you need to delete a dependent from coverage because they become ineligible, you must take this action as soon as possible. Do not wait for Open Enrollment, as you will be liable for any costs incurred by this person after they cease to be eligible. The event must happen first before deleting dependents.

Any allowable changes made during the year become effective the first day of the month following the date your departmental personnel office receives your completed STD. 692.

Contact your departmental personnel office to enroll or make changes to your dental coverage.

Cancellation/Termination of Dental Enrollment Coverage

Your coverage ceases at midnight on the last day of the month following the month in which the last premium was paid.

Plan Descriptions

Note: The information provided in this section offers only brief descriptions of the currently available prepaid dental plans. Please consult each plan's evidence of coverage booklet or call the plan directly for more detailed explanations.

Prepaid Dental Plans

DeltaCare USA, MetLife, Premier Access, and Western Dental are the four state-sponsored prepaid dental plan providers. MetLife offers two plans: a standard plan for represented employees and an enhanced plan for excluded employees.

There are no claim forms, deductibles, or maximum allowable benefits. Prepaid plans provide dental services through pre-selected participating dentists throughout California. When you enroll in one of these plans, you select a dentist from the list of dentists who participate in the plan you have chosen. You may change to another dentist who participates in your plan either upon your request or if your dentist leaves the plan. You may change dental plans if you move and your plan has no participating dentists within 50 miles of your new residence.

A prepaid dental plan pays its participating dentists a contracted monthly fee for each person enrolled in the plan served by that dentist. In return, the dentist provides all basic, preventive, and diagnostic services (e.g., cleanings, checkups, x-rays, fillings, oral surgery, and treatment of tooth pulp and gums). The level of coverage for you and your dependents is the same.

While most dental services are performed at little or no charge to you, there may be a specific fixed charge for certain types of complex procedures, such as root canals. There is a limit on the amount a prepaid provider can charge you for orthodontic services.

To obtain brochures describing each prepaid plan and a list of the dentists participating in those plans, contact the dental carriers directly. Their toll-free numbers are:

DeltaCare USA	(800) 422-4234
MetLife	(800) 880-1800
Premier Access	(888) 534-3466
Western Dental	(866) 859-7525

Indemnity Dental Plans

Delta Dental PPO plus Premier Plans–Group #9949
Delta Dental is the carrier for the state-sponsored indemnity dental plans. The indemnity dental plans provide two levels of benefit coverage:

- **Basic** plan for represented rank-and-file employees and their dependents is available to all employees in BUs 1 through 21 except for BU5 and dues-paying BU6 employees, which have their own union-sponsored indemnity dental plans (see page 2).

- **Enhanced** plan for managerial, supervisory, confidential, exempt, and excluded employees, constitutional officers, employees of the Judicial Council, and all state superior, appellate, and supreme court judges and their dependents.

The indemnity plans allow you to receive services from any licensed dentist, although you may have higher out-of-pocket costs if you receive services from a non-Delta dentist. You have full access to specialty care and guaranteed benefits through Delta Dental's large network of dentists (PPO and Premier) throughout the United States and abroad.

When you receive services from a participating Delta Dental dentist, Delta Dental pays the dentist directly based on the fee agreement between Delta Dental and the dentist. If the dentist's charges exceed the fee paid by Delta Dental, you are responsible for paying the remainder of the bill and any applicable annual deductible.

If you receive treatment from a non-Delta Dental dentist, you are responsible for paying the dentist's entire bill. To claim reimbursement, you must submit an itemized receipt with a standard dental claim form to Delta Dental. Your reimbursement will be based on Delta Dental's usual, customary, and reasonable fee schedule for California.

For more information on the Delta Dental PPO plus Premier Basic or Enhanced dental plans, contact Delta Dental at (800) 225-3368.

PPO Dental Plan

Delta Dental PPO Plan–Group #9946

Delta Dental is also the carrier for the state-sponsored PPO. The Delta Dental PPO offers higher benefit levels when you receive services from a participating PPO dentist. However, you may choose a non-PPO dentist and still be covered. When you receive services from a participating PPO dentist, your costs are based on a contracted fee agreement between Delta Dental and the PPO dentist.

If you receive services from a Delta Dental Premier dentist who is not a Delta Dental PPO dentist, your benefits will be reduced. You will be responsible for your share of the costs up to Delta Dental's allowed amounts under the provider's filed fee agreement with Delta Dental for the services you received. Fees are based on the usual, customary, and reasonable fee for California.

If you receive services from a dentist who is not a Delta Dental contracted provider, you are responsible for paying the entire bill directly to the dentist at the time of service. Your reimbursement from Delta Dental may be substantially lower. To claim reimbursement, submit your itemized receipt with a standard claim form to Delta Dental. The reimbursement will be sent directly to you. You may obtain a claim form from Delta Dental by contacting Delta Dental at (800) 225-3368.

To see if your current dentist is a participating PPO dentist or for more information on the PPO dental plan, contact Delta Dental at (800) 225-3368.

Dental Premiums

The following tables show dental premiums effective January 1, 2024. For employees in Consolidated Benefits (CoBen), the state and employee share do not apply. The total dental premium will be deducted from the monthly CoBen allowance.

Delta Dental PPO for Excluded and Represented Employees

Level of Coverage	State Share	Employee Share	Total Premium
Party Code 1	$ 34.84	$11.61	$ 46.45
Party Code 2	$ 67.73	$22.58	$ 90.31
Party Code 3	$101.91	$33.97	$135.88

Delta Dental PPO plus Premier Basic for Represented Employees

Level of Coverage	State Share	Employee Share	Total Premium
Party Code 1	$38.12	$12.71	$ 50.83
Party Code 2	$66.56	$22.19	$ 88.75
Party Code 3	$96.21	$32.07	$128.28

Delta Dental PPO plus Premier Enhanced for Excluded Employees

Level of Coverage	Total Premium
Party Code 1	$ 52.87
Party Code 2	$104.06
Party Code 3	$146.18

Prepaid Dental Plans

The state will pay 100 percent of the premium for employees not in CoBen.

Level of Coverage	DeltaCare USA	MetLife Standard	MetLife Enhanced	Premier Access	Western Dental
Party Code 1	$19.44	$13.85	$16.06	$14.21	$15.77
Party Code 2	$31.90	$22.44	$27.18	$23.02	$26.02
Party Code 3	$44.13	$31.42	$33.48	$32.24	$36.91

Union-Sponsored Dental Plans: BU5 and BU6

Employees in BU5 and BU6 should contact their Benefit Trust for information on their union-sponsored dental plan premiums and benefits.

Continuing Benefits into Retirement

To continue state-sponsored dental coverage into retirement, you must:

- Be enrolled in (or eligible for) a state-sponsored dental plan on the date of your separation from employment.
- Retire within 120 days of your separation.
- Receive a monthly retirement allowance from CalPERS.

Note: If you are enrolled in Delta Dental PPO plus Premier Enhanced as an active employee, your coverage will be changed to Delta Dental PPO plus Premier Basic as a retiree. You may change plans during Open Enrollment or if you move out of a service area.

BU5 employees (CAHP) who retired on or after September 30, 1992, may elect to continue enrollment in their union-sponsored indemnity plan or change to a state-sponsored dental plan. Under the terms of the Memorandum of Understanding (MOU) between the CAHP and CalHR, this is an irrevocable one-time election.

BU6 employees (CCPOA) enrolled in a union-sponsored dental plan must change to a state-sponsored dental plan and retire within 120 days after their date of separation to continue their dental coverage.

If you are enrolled in a cash option in lieu of dental benefits when you retire, your enrollment will automatically stop. You may enroll in in a dental plan up to 30 days before or 60 days following the date of your retirement.

Your departmental personnel office is responsible for enrolling you in dental benefits when you retire from state service. If you do not enroll in dental benefits at the time of your retirement, you may do so during any subsequent Open Enrollment period by contacting CalPERS.

New dependents cannot be added at this time. Retirement is not a permitting event to change plans or add dependents.

Survivor Benefits

Departments are required to continue paying for a covered employee's spouse or domestic partner and other eligible family members for up to 120 days following an employee's death. During this time, CalPERS will determine if the spouse or other family members are eligible for survivor benefits.

After 120 days, your surviving dependent(s) will be eligible to continue their current coverage if they meet all the following criteria:

- They were enrolled as your dependents at the time of your death.
- They qualify for a monthly survivor allowance from CalPERS.
- They continue to qualify as surviving dependents.

Questions regarding the continuation of dental plan coverage should be directed to your departmental personnel office.

To report the death of a dental plan employee, call or write to CalPERS at:

CalPERS Disability & Survivor Benefits Division
P.O. Box 1652
Sacramento, CA 95812-1652

(888) 225-7377 / TTY (916) 795-3240

Note: Surviving dependents who do not qualify to continue their current coverage are eligible for continuation of coverage under COBRA (refer to page 13 for details).

COBRA Group Continuation Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires employers to offer continuation of health, dental, and vision benefits to covered employees, spouses, domestic partners, and eligible children who lose coverage due to certain qualifying events. Benefits may be continued for 18 or 36 months depending on the qualifying event. The coverage period is measured from the time of the qualifying event and applies to each qualified beneficiary, including the covered employee, spouse, domestic partner, and eligible children.

The chart below lists the qualifying events for continuation of coverage and the time period of the extended coverage.

COBRA Qualifying Events

Benefits Continued for 18 Months	Benefits Continued for 36 Months

• **Voluntary Termination**–Covered employee voluntarily terminates or separates from employment (e.g., retires or quits), and the termination/separation will cause a loss of coverage.
 	
• **Involuntary Termination**–Covered employee is involuntarily terminated from employment (other than for gross misconduct), and the termination will cause a loss of coverage. If the termination is due to "gross misconduct," the state is not obligated to offer COBRA continuation coverage.
 	
• **Reduction of hours**–Covered employee's work hours are reduced voluntarily or involuntarily and the reduction of hours will cause a loss of coverage. Reduction of hours may include:
 	
  • Full-time to less than half-time
  • Strike
  • Layoff
  • Leave of absence
  • Military call-up
	• **Death**–Covered employee dies and the surviving family member is not eligible for a monthly survivor allowance from CalPERS.
	
	• **Medicare coverage begins**–Covered employee becomes entitled to Medicare benefits.
	
	• **Divorce or legal separation**–Covered employee is divorced or legally separated.
	
	• **Domestic partnership termination**–Covered employee terminates a domestic partnership registered in the State of California.
	
	• **Change in dependent status**–An eligible child of a covered employee turns age 26.

Premiums
Under COBRA, the administrator is permitted to charge a two-percent administrative fee in addition to the premium. Therefore, the cost of COBRA continuation coverage to a state employee and/or eligible dependent of an employee is 102 percent of the premium previously charged to the active employee.

Premium Payment
Once enrolled, the enrollee's monthly premiums are due by the first of each following month. While due on the first, the enrollee will have a maximum thirty (30) day grace period in which to make these premium payments. The plan or its COBRA administrator is not required to send a monthly bill. All claims occurring during the month will be held pending payment of premium. If the applicable payment is not made within the grace period, then coverage will be canceled back to the end of the prior month in which a premium payment had been made. If COBRA coverage is canceled due to non-payment of premiums, the enrollee will not be reinstated.

Partial Premium Payment
If the dental plan receives a partial monthly premium, the plan will notify the enrollee of the deficiency amount and allow 30 days for payment. All claims incurred during the month when the deficiency exists will be held pending receipt of the deficient amount.

Secondary COBRA Event Occurs During the 18-Month Period
If during the 18 months of continuation coverage, a second event takes place (divorce, termination of domestic partnership, legal separation, death, or a dependent child ceases to be a dependent), then the original 18 months of continuation coverage can be extended to 36 months from the original date of loss of coverage for eligible dependent qualified beneficiaries. If a second event occurs, the qualified beneficiary must notify the plan in writing within 60 days of the second event and within the original 18-month COBRA timeline. In no event will continuation coverage last beyond three years (36 months) from the original date of loss of coverage.

29-Month Qualifying Event (Social Security Disability)
COBRA contains a provision that provides additional protection for qualified beneficiaries deemed disabled by the Social Security Administration. If a state employee who experiences one of the 18-month qualifying events meets the Social Security definition of disability, the employee and their eligible beneficiaries are entitled to continuation coverage for 29 months from the date of the qualifying event.

Open Enrollment Period
COBRA enrollees have the same rights as active employees to make allowable changes to their coverage during the annual Open Enrollment period. Specific instructions will be sent to all COBRA enrollees by CalHR prior to the beginning of the Open Enrollment period.

Loss of COBRA Eligibility
COBRA eligibility ceases for an employee, spouse, domestic partner, or eligible child if any of the events listed below occurs prior to the expiration of the 18- or 36-month COBRA continuation period. The state does not offer any conversion plan after the 18- or 36-month period has expired. The enrollee should contact the dental plan directly for information about a potential individual conversion plan if any of the following occur:

- State employer ceases to offer dental insurance plans.
- Covered employee fails to pay required premiums on time.
- A covered state employee becomes covered under another employer's plan that does not contain any exclusion or limitation concerning preexisting health conditions.

- A state employee who received extended COBRA coverage of 29 months due to a Social Security approved disability is no longer disabled.
- A covered state employee's former spouse remarries or domestic partner establishes a new domestic partnership and obtains coverage under another group dental plan.
- A covered employee becomes entitled to Medicare benefits while enrolled in COBRA.
- Coverage terminates for cause on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Note: All termination of COBRA coverage notices will be provided by the plan.

For more information about COBRA group continuation coverage, including eligibility, monthly premiums, enrollment procedures, or qualifying events that cause termination of COBRA eligibility, contact your departmental personnel office.

Dental Benefits Assistance—Who to Call

If you need assistance with your dental coverage, the information below shows who you need to call.

Your Departmental Personnel Office

- To find out who your current dental carrier is. **Note**: This information also appears on your pay warrant.
- To determine whether a particular enrollment change is permitted outside the dental Open Enrollment period.
- For questions regarding the dental Open Enrollment process.
- To verify dental enrollment effective dates.
- For information regarding adding or deleting dependents from your dental coverage, including deleting a dependent who turns age 26 and is no longer eligible for coverage.
- To report the death of a spouse or dependent.
- To continue dental coverage of enrolled dependents following the death of an active state employee.
- To report an incorrect premium deduction or dental plan coverage on your pay warrant or statement.

Your Dental Plan Provider

- For questions about your dental coverage.

Mailing addresses and telephone numbers for CalHR and the individual dental plans are listed on page 17.

Directory of State-Sponsored Dental Plans

Dental Plan Administrator

California Department of Human ResourcesBenefits Division
1515 S Street, North Bldg., Suite 500
Sacramento, CA 95811-7258
(916) 322-0300
(855) 290-0158 FAX
Dental@calhr.ca.gov

Prepaid Dental Plans

DeltaCare USA
P.O. Box 1803
Alpharetta, GA 30023
(800) 422-4234

MetLife
P.O. Box 14410
Lexington, KY 40512-4401
(800) 880-1800

Premier Access
8890 Cal Center Drive
Sacramento, CA 95826
(888) 534-3466

Western Dental
530 South Main Street, 1st Floor
Orange, CA 92868
Attn: Group Services
(866) 859-7525

Delta Dental Plans

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
(800) 225-3368

Comparison Charts

Benefits Overview: Prepaid, Indemnity, and PPO Plans

The following chart provides a general overview of the benefits available under the state-sponsored dental plans. Consult each plan's brochure and evidence of coverage booklet for detailed information and plan limitations.

Plan Details	Prepaid	Indemnity	PPO
Type of Plan	The plan pays your chosen dentist a monthly fixed rate to provide services as needed.	Fee-for-service plan. The plan provides reimbursement for services rendered.	The plan provides maximum benefit when you visit an in-network PPO dentist.
Dental Providers	Must select a dental provider affiliated with the prepaid plan.	Any licensed dentist. However, out-of-pocket expenses may be lower when visiting a Delta Dental PPO or Premier dentist.	Any licensed dentist, but maximum benefit when visiting an in-network PPO dentist. If an out-of-network dentist is used, benefits are lower.
Orthodontic Providers	Must use an orthodontist affiliated with the prepaid plan.	May visit any orthodontist. However, out-of-pocket expenses may be lower when visiting a Delta Dental PPO or Premier dentist.	Must visit an in-network PPO orthodontist to receive maximum benefit.
Changing Providers	May change to another dentist affiliated with the plan with prior approval.	May change dentists at anytime.	May change dentists at anytime.
Deductibles	No deductible.	**Basic:** $50 per person, up to $150 annual maximum per family. **Enhanced:** $25 per person, up to $100 annual maximum per family.	$25 per person, up to $100 annual maximum per family for in-network PPO dentists. $75 per person, up to $200 annual maximum per family for non-PPO network dentists.
Co-payments	Co-payments for certain covered procedures may require payment at the time of treatment.	You pay only the co-payment and any deductibles and charges above the annual maximum for covered services when visiting a Delta Dental dentist. When visiting a non-Delta Dental dentist, you also pay the difference between the dentist's submitted charges and Delta Dental's approved fees.	You pay only the co-payment and any deductibles and charges above the annual maximum for covered services when visiting a Delta Dental dentist. When visiting a non-Delta Dental dentist, you also pay the difference between the dentist's submitted charges and Delta Dental's approved fees.

(continued on next page)

Plan Details	Prepaid	Indemnity	PPO
Plan Payments	The plan pays the dentist's monthly contract fee.	Payments are based on Delta Dentist contracted fees or the maximum plan allowance when non-Delta Dental dentists are used.	Payments are based on Delta Dentist contracted fees or the maximum plan allowance when non-Delta Dental dentists are used.
Calendar Year Maximum (CYM)	No maximum.	**Basic:** $2,000 for employee, $1,500 per dependent. **Enhanced:** $2,000 for employee and each eligible dependent.	$2,000 for employee, $2,000 per eligible dependent when PPO network dentists are used.
Implant Benefit	Premier Access and Western Dental only.	Implants at 50% (subject to CYM).	Implants at 50% (subject to CYM).

Coverage and Costs for Certain Procedures: Prepaid Plans

The following chart compares employee costs for certain types of procedures under each prepaid dental plan. Consult each plan's brochure and evidence of coverage booklet for detailed information and plan limitations.

Type of Plan	DeltaCare USA, MetLife (Standard), Premier Access, and Western Dental	MetLife (Enhanced)
Who is Covered?	Employees and Dependents	Excluded Employees and Dependents
Diagnostic and Preventive (Two cleanings annually)	No charge	No charge*
Basic Benefits	No charge	No charge
Crowns	$50	No charge
Bridges, Full and Partial Dentures	$65 and up	No charge
Implants	Premier Access and Western Dental only	Not covered
Orthodontia	$1,000, plus up to $250 for start-up costs	$1,000, plus up to $250 for start-up costs

*MetLife Enhanced plan provides the availability for a third cleaning to the employee and all enrolled dependents.

Coverage and Costs for Certain Procedures: Indemnity and PPO Plans

The following chart compares employee costs for certain types of procedures under the Indemnity and PPO plans. Consult each plan's evidence of coverage booklet for detailed information and plan limitations.

Type of Plan	**Delta Dental PPO plus Premier Basic No. 9949**	**Delta Dental PPO plus Premier Basic No. 9949**	**Delta Dental PPO plus Premier Enhanced No. 9949**	**Delta Dental PPO In-Network[1]** (PPO Dentist) **No. 9946**	**Delta Dental PPO Out-of-Network** (Non-PPO Dentist) **No. 9946**
Who is Covered?	Represented Employees	Dependents of Represented Employees	Excluded Employees and Dependents	Employees and Dependents	Employees and Dependents
Diagnostic and Preventive (two cleanings annually)	No charge[2,3]	No charge[2,3]	No charge[2,3]	No charge[2,3]	20%[3]
Basic Benefits	10%	10%	10%	10%	20%
Crowns	20%	50%	20%	20%	50%
Bridges, Full and Partial Dentures	50%	50%	50%	40%	50%
Implants[4]	50%	50%	50%	50%	50%
Orthodontia	Will pay up to 50% of the approved fee for orthodontia, with a lifetime maximum for this benefit of $1,000	Will pay up to 50% of the approved fee for orthodontia, with a lifetime maximum for this benefit of $1,000	Will pay up to 50% of the approved fee for orthodontia, with a lifetime maximum for this benefit of $1,000	Will pay up to 50% of the approved fee, with a lifetime maximum of $1,000 for each eligible adult and $1,500 for covered employee's eligible children	Will pay up to 50% of the approved fee, with a lifetime maximum of $1,000 for each eligible adult and covered employee's eligible children
Annual Deductibles	$50	$50 per person	$25 per person	$25 per person	$75 per person
Maximum Deductible	$50	$150 per family	$100 per family	$100 per family	$200 per family
CYM	$2,000	$1,500 per person	$2,000 per person	$2,000 per person	$1,000 per person

[1]The level of benefits and covered services shown here are based on services provided by a PPO Plan dentist; for services provided by a non-PPO plan dentist, the level of benefits is lower.
[2]Diagnostic and Preventive Benefits are exempt from the deductible.
[3]A third cleaning allowed with periodontal history.
[4]Implants subject to the CYM.

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