Delta Dental of California
City of Pinole – Group # 4215/0028
Police Officers & Dispatch

Effective 1/1/2023

Highlights of your Delta Dental PPO Plan

	IN-NETWORK	OUT-OF-NETWORK	
	PPO Dentist[1]	**Delta Premier Dentist[2]**	**Non-Delta Dentist[3]**
WHO IS COVERED	Primary enrollee and spouse as well as children to age 26		
DEDUCTIBLES **BENEFITS MAXIMUM** Waived on Diagnostic and Preventive	**$25 Initial Per Patient** The Maximum benefit paid per calendar year is **$1,500 per person**	**$50 Initial Per Patient** The Maximum benefit paid per calendar year is **$1,500 per person**	**$50 Initial Per Patient** The Maximum benefit paid per calendar year is **$1,500 per person**
DIAGNOSTIC AND PREVENTIVE BENEFITS Oral examinations, cleanings, x-rays, biopsy/tissue examinations, fluoride treatment, space maintainers, specialist consultation	**90%** of a ***PPO*** Dentist fees	**80%** of a ***Delta Premier*** Dentist fee	**80%** of ***UCR***
BASIC BENEFITS Oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, sealants	**80%** of a ***PPO*** Dentist fees	**80%** of a ***Delta Premier*** Dentist fee	**80%** of ***UCR***
CROWNS, JACKETS AND CAST RESTORATIONS	**80%** of a ***PPO*** Dentist fees	**80%** of a ***Delta Premier*** Dentist fee	**80%** of ***UCR***
PROSTHODONTIC BENEFITS- 12 MONTH WAIT Bridges, partial dentures, full dentures Implant coverage	**50%** of a ***PPO*** Dentist fees	**50%** of a ***Delta Premier*** Dentist fee	**50%** of ***UCR***
ORTHODONTIC BENEFITS Adults and Dependent Children **Lifetime Maximum-$1,500 Per Patient**	**50%** of a ***PPO*** Dentist fee	**50%** of a ***Delta Premier*** Dentist fee	**50%** of ***UCR***

[1]The approved fee for the PPO dentist is based on the PPO fee schedule
[2] The approved fee for DeltaPremier dentist is the filed fee
[3] The non-Delta dentist payment is based on the fee that satisfies the majority of Delta dentists (**UCR**).
*** UCR – Usual, Customary and Reasonable Fee**

- A **Usual** fee is the amount which an individual dentist regularly charges and received for a given service or the fee actually charged, whichever is less
- A **Customary** fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area.
- A **Reasonable** fee schedule is reasonable if it is Usual and Customary.

SERVICES THAT ARE *NOT* COVERED

- Extra-oral grafts
- Cosmetic surgery or dentistry or services to correct congenital malformation
- Services for injuries/conditions covered under Workers' Compensation or Employer's Liability Laws
- Anesthesia (except for general anesthesia for oral surgery)

This Preferred Provider Option program is administered by the **HEALTH CARE EMPLOYEES/EMPLOYER DENTAL TRUST.** If you have specific questions regarding benefit structure, limitations or exclusions, consult the Evidence of Coverage or contact the Customer and Member Services department at (925) 803-1880.

Delta Dental Online at www.deltadentalins.com

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Delta Dental of California
City of Pinole – Group 4215/0024

Updated 1/1/2023

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	IN-NETWORK	OUT-OF-NETWORK	
	PPO Dentist[1]	**Delta Premier Dentist[2]**	**Non-Delta Dentist[3]**
WHO IS COVERED	Primary enrollee and spouse as well as children to age 26		
DEDUCTIBLES – lifetime, waived on Diagnostic and Preventive Benefits **BENEFITS MAXIMUM**	**$25 per individual** The Maximum benefit paid per calendar year is **$1,500 per person**	**$50 per individual** The Maximum benefit paid per calendar year is **$1,500 per person**	**$50 per individual** The Maximum benefit paid per calendar year is **$1,500 per person**
DIAGNOSTIC AND PREVENTIVE BENEFITS Oral examinations, cleanings, x-rays, biopsy/tissue examinations, fluoride treatment, space maintainers, specialist consultation	**90%** of a ***PPO*** Dentist fees	**80%** of a ***Delta Premier*** Dentist fee	**80%** of ***UCR***
BASIC BENEFITS Oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, sealants	**80%** of a ***PPO*** Dentist fees	**80%** of a ***Delta Premier*** Dentist fee	**80%** of ***UCR***
CROWNS, JACKETS AND CAST RESTORATIONS	**80%** of a ***PPO*** Dentist fees	**80%** of a ***Delta Premier*** Dentist fee	**80%** of ***UCR***
PROSTHODONTIC BENEFITS Bridges, partial dentures, full dentures Implant coverage – **12 month wait**	**50%** of a ***PPO*** Dentist fees	**50%** of a ***Delta Premier*** Dentist fee	**50%** of ***UCR***
ORTHODONTIC BENEFITS-adults & children **ORTHO MAXIMUM – Lifetime**	**50%** of a ***PPO*** Dentist fees **$1,500 per person**	**50%** of a ***Delta Premier*** Dentist fee $1,500 per person	**50%** of ***UCR*** $1,500 per person

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ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

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

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

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

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 ________

Enrollee Classification

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

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth / /	Gender ❑ Male ❑ Female	Marital Status ❑ Single ❑ 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 ❑ Work ❑ Home ❑		
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

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 (overage student)**
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	

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.

❑ I decline coverage at this time.

Signature of Enrollee ______________________ Date ____/____/____