Delta Dental Plan Options through the Associations

Effective Date: December 01, 2017 - November 30, 2018

Insurance Carrier	DeltaCare USA	Delta Dental
Plan Name	Plan 11B	Fee For Service
Plan Type	HMO	DPO
Provider Network	DeltaCare USA Network ONLY	PPO or Premier Network
Calendar Year Maximum	Unlimited	$1,000
Deductible:	None	Single $50/Family $ 150
Waived for Preventive	Not Applicable	Yes
Diagnostic		*"Delta Pays" (A)*
Office Visit	$20 copay	$26.00
Periodic Oral Evaluation	No Charge	$17.00
Comprehensive Oral Evaluation	No Charge	$22.00
Bitewing X-rays	No Charge	$12.00 - $26.00
Other X-rays	No Charge	$5.00 - $50.00
Preventive		*"Delta Pays" (A)*
Cleanings Adult	No Charge	$40.00
	Additional Cleanings: $45.00	Not Applicable
Child through Age 13	No Charge	$32.00
	Additional Cleanings: $35.00	Not Applicable
		"Delta Pays" (A)
Restorative	No Charge - $240 copay	$53.00 - $148.00
Oral Surgery	No Charge - $110 copay	$26.00 - $175.00
Endodontics (Root Canals)	No Charge - $250 copay	$50.00 - $402.00
Periodontics (Deep Cleaning)	$80 copay - $280 copay	$39.00 - $448.00
		"Delta Pays" (A)
Waiting Period	None	None
Crowns	$55 copay - $240 copay	$343.00 - $391.00
Prosthodontics, Removable	$20 copay - $210 copay	$255.00 - $676.00
Prosthodontics, Fixed	$40 copay - $240 copay	$191.00 - $605.00
Orthodontia		
Pretreatment/Post Treatment	$200 copay / $70 copay	NOT COVERED
Limited Treatment Child to 19	$950 copay	
Limited Treatment 19 to Adult	$1,150 copay	
Comprehensive Treatment Child to 19	$1,700 copay	
Comprehensive Treatment 19 to Adult	$1,900 copay	
Monthly Premium Rate		
Subscriber Only	$38.80	$55.84
Subscriber+1	$58.47	$98.45
Subscriber+2 or more	$82.42	$129.24

(A) For each procedure, you are responsible for the portion of the dentist's fee that is more than the amount listed in the "Delta Dental Pays" column.

ENROLLMENT/CHANGE FORM - CA
DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan: ❑ DPO / PPO OR ❑ DeltaCare® USA HMO[1]

FOR GROUP USE ONLY

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

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information

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

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contract.

Change Dental Plan*

- ❑ Fee-For-Service - Cancel
- ❑ DeltaCare USA - Cancel

Enrollee Classification

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

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 ❑
Network Facility Name (DeltaCare USA only)	Network Facility Number (DeltaCare USA only)			
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 name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School (overage student)***	Network Facility Number ‡ (DeltaCare USA only)
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑		
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. ‡Maximum of three facilities per family.

❑ 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 ____ / ____ / ____

[1]DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.