Keenan & Associates

Sacramento City Unified School District

Summary of Dental PPO Plans - Active Mgmt/Conf/Supv

Effective Date	01/01/2016		01/01/2016	
Carrier Name	Delta Dental Insurance Company		Delta Dental Insurance Company	
Plan Name	PPO - Classified/Management/All Certificated Retirees		Delta Dental Premier Plan (Buy-Up Plan)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
Annual Deductible/Individual	$0	$0	$0	$0
Annual Deductible/Family	$0	$0	$0	$0
Waived for Preventive	Not applicable	Not applicable	Not applicable	Not applicable
Annual Plan Maximum	$1,700	$1,500	$3,000	$3,000
Lifetime Orthodontia Plan Maximum	$500 for adults & dependent children	$500 for adults & dependent children	$2,500	$2,500
Reasonable & Customary Percentile	* 70-100%	* 70-100%		
Waiting Period	None	None	None	None
Covered Services				
Diagnostic and Preventive Services				
Diagnostic and Preventive	* 70-100% of Delta PPO Provider fees	* 70-100% of Delta Premier Provider fees	100%	100%
Oral Exams	* 70-100% twice per calendar year	* 70-100% twice per calendar year	100%	100%
Bitewing X-Rays	* 70-100% once in a 6-month period to age 18, once every 12 months thereafter	* 70-100% once in a 6-month period to age 18, once every 12 months thereafter	100%	100%
Full Mouth X-Rays	* 70-100% once every 5 years	* 70-100% once every 5 years	100% once every 5 years	100% once every 5 years
Cleaning and Scaling	* 70-100% once every 24 months	* 70-100% once every 24 months	100%	100%
Prophylaxis Treatments	* 70-100% twice per calendar year	* 70-100% twice per calendar year	100%	100%
Fluoride Treatments	* 70-100% twice per calendar year	* 70-100% twice per calendar year	100%	100%
Space Maintainers	* 70-100%	* 70-100%		
Sealants (dependent children under age 14)	* 70-100%	* 70-100%	100%	100%
Basic Services				
Basic	* 70-100% of Delta PPO Provider fees	* 70-100% of Delta Premier Provider fees	100%	100%
Oral Surgery: Extractions and Other Surgical Procedures; Restorative: Amalgam, Synthetic Porcelain and Plastic Restorations (Fillings); Endodontic Treatment; Periodontic Treatment	* 70-100%	* 70-100%	100%	100%
Re-linings and Re-basings of Existing Removable Dentures	Not covered	Not covered	Not covered	Not covered
Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	* 70-100%	* 70-100%	100%	100%
Major Services				
Major	* 70-100% of Delta PPO Provider fees	* 70-100% of Delta Premier Provider fees	70%	60%
Crowns, Jackets and Cast Restoration Benefits	* 70-100% service on the same tooth, once every five years	* 70-100% service on the same tooth, once every five years	70%	60%
TMJ	Not covered	Not covered	50% with lifetime maximun of $2,500	50% with lifetime maximum of $2,500
Prosthodontic Benefits (Fixed Bridges, Partial / Complete Dentures)	50% once every five years	50% once every five years	50% once every five years	50% once every five years
Implants	Not covered	Not covered	Included	Included
Orthodontia Services				
Orthodontia	50% of Delta PPO Provider fees	50% of Delta Premier Provider fees	50% of Delta PPO Provider fees	50% of Delta Premier Provider fees
Dependent Children	Covered	Covered	Covered	Covered
Adults (and Covered Full-Time Students, if Eligible)	Covered	Covered		
Adult Lifetime Maximum	$500	$500		

* Benefits increase annually, from 70% year one; to 80% year two; 90% year three; 100% every year thereafter as long as the dentist is visited each calendar year.

Sacramento City Unified School District

Summary of Vision Benefits - Active Mgmt/Conf/Supv

Effective Date	01/01/2016	
Carrier Name	**Vision Service Plan**	
Plan Name	Mgmt/Conf/Supp/PLT	
Benefit Attributes	**In-Network**	**Out-of-Network**
General Plan Information		
Copay		
Examination	100%	Reimbursed up to $40
Benefit Frequency		
Examination	12 months	12 months
Lenses	12 months	12 months
Frames	24 months	24 months
Contacts	12 months (in addition to glasses)	12 months (in addition to glasses)
Covered Services		
Lenses		
Single Vision Lens	100%	Reimbursed up to $40
Bifocal Lens	100%	Reimbursed up to $60
Trifocal Lens	100%	Reimbursed up to $80
Lenticular	100%	Reimbursed up to $125
Basic Progressive	$50 copay	Reimbursed up to $80
Lens Options		
UV Coating	Discount available	Not covered
Tint (Solid and Gradient)	Discount available	Not covered
Scratch Resistance	Discount available	Not covered
Basic Polycarbonate	Covered in Full for dependent children	Not covered
Standard Anti-Reflective	Discount available	Not covered
Other Add-Ons and Services	Discounts available	Not covered
Contact Lenses		
Medically Necessary	100%	Reimbursed up to $250
Elective	$50 copay for annual supply of contacts and fitting exam	$50 copay; Reimbursed up to $250
Frames	100% up to $105 frame allowance; Costco frame allowance $70	Reimbursed up to $45
Other Services		
Corrective Vision Services (e.g. Laser Surgery)	Discount available	Not covered
Second Pair of Glasses	$20 Material copay; same as Signature Plan	Same reimbursement amounts on glasses