Sacramento City Unified School District

Summary of Dental PPO Plans - Active Certificated

Effective Date	01/01/2017		01/01/2017	
Carrier Name	Delta Dental Insurance Company		Premier Access Insurance Company	
Plan Name	PPO - Certificated		Premier Choice PPO - Certificated	
Benefit Attributes	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	$1,100	$1,100	$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 Non-Delta Dental PPO dentists 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 for adults age 18+	* 70-100% once in a 6-month period to age 18, once every 12 months for adults age 18+	100%	100%
Full Mouth X-Rays	* 70-100% once every 5 years	* 70-100% once every 5 years	100%	100%
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%	100%	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 Non-Delta Dental PPO dentists 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	100%	100%
Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	* 70-100%	* 70-100%	100%	100%
Major Services				
Major	50% of Delta PPO Provider fees	50% of Non-Delta Dental PPO dentists 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% (Lifetime max $2,500)	50% (Lifetime max $2,500)
Prosthodontic Benefits (Fixed Bridges, Partial / Complete Dentures)	50% once every five years	50% once every five years	70%	60%
Implants	Not covered	Not covered	70%	60%
Orthodontia Services				
Orthodontia	50% of Delta PPO Provider fees	50% of Delta Premier Provider fees	50%	50%
Dependent Children	Covered	Covered	Covered	Covered
Adults (and Covered Full-Time Students, if Eligible)	Covered	Covered	Covered	Covered
Adult Lifetime Maximum	$1,100	$1,100	$2,500	$2,500

* 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.

Keenan & Associates

Sacramento City Unified School District

Summary of Vision Benefits - Active Certificated

Effective Date	01/01/2017		01/01/2017	
Carrier Name	Vision Service Plan		Vision Service Plan	
Plan Name	Certificated Family Plan		Certificated Member Only Plan	
Benefit Attributes	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
Copay				
Examination	100%	Reimbursed up to $40	100%	Reimbursed up to $40
Benefit Frequency				
Examination	12 months	12 months	12 months	12 months
Lenses	24 months	24 months	12 months	12 months
Frames	24 months	24 months	12 months	12 months
Contacts	24 months (instead of glasses)	24 months (instead of glasses)	12 months (in addition to glasses)	12 months (in addition to glasses)
Covered Services				
Lenses				
Single Vision Lens	100%	Reimbursed up to $40	100%	Reimbursed up to $40
Bifocal Lens	100%	Reimbursed up to $60	100%	Reimbursed up to $60
Trifocal Lens	100%	Reimbursed up to $80	100%	Reimbursed up to $80
Lenticular	100%	Reimbursed up to $125	100%	Reimbursed up to $125
Basic Progressive	$50 copay	Reimbursed up to $80	$50 copay	Reimbursed up to $80
Lens Options				
UV Coating	Discount available	Not covered	Discount available	Not covered
Tint (Solid and Gradient)	Discount available	Not covered	100% Tints/Photochromic lenses-Transitions	Reimbursed up to $5
Scratch Resistance	Discount available	Not covered	Discount available	Not covered
Basic Polycarbonate	Covered in Full for dependent children	Not covered	Covered in full for dependent children	Not covered
Standard Anti-Reflective	Discount available	Not covered	Discount available	Not covered
Other Add-Ons and Services	Discounts available	Not covered	Discounts available	Not covered
Contact Lenses				
Medically Necessary	100%	Reimbursed up to $210	100%	Reimbursed up to $250
Elective	100% up to $105 allowance for contacts and fitting exam	Reimbursed up to $105	$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	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	Discount available	Not covered
Second Pair of Glasses	Discount available	Not covered	$20 Materials copay; same as Signature Plan coverage	Same reimbursement amounts on glasses