



2016 Benefits for Active Employees



Dental



CAL HR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES
Benefits Division

additional information located at
www.calhr.ca.gov

Table of Contents

Introduction	1
State-Sponsored Dental Plans	1
Union-Sponsored Dental Plans	2
Eligibility	3
Dependent Eligibility	3
Loss of Eligibility	3
Enrollment	5
Initial Enrollment	5
Enrollment Restrictions for Newly Hired State Employees	5
Dual Coverage	5
Split Coverage	5
Open Enrollment.....	5
Levels of Coverage	6
Making Changes Outside of Open Enrollment	7
Plan Descriptions	8
Prepaid Dental Plans	8
Indemnity Dental Plan	8
Preferred Provider Option Dental Plan	9
Dental Premiums	10
Continuing Benefits into Retirement	11
Survivor Benefits	12
COBRA Group Continuation Coverage	13
Dental Benefits Assistance—Who to Call	16
Directory of State-Sponsored Dental Plans	17
Frequently Asked Questions	18
General	18
Prepaid Dental Plans	18
Indemnity Dental Plan	21
Preferred Provider Option Plan	22
Comparison Charts	23
Benefit Overview: Prepaid, Indemnity, and PPO Plans	23
Coverage and Costs for Certain Procedures: Prepaid Plans	25
Coverage and Costs for Certain Procedures: Indemnity and PPO Plans.....	26
Attachment	
Affidavit of Eligibility	

Introduction

This dental benefits handbook was prepared by the California Department of Human Resources (CalHR) 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. While it is our intention to be as accurate as possible, 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.

California Department of Human Resources

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

Questions regarding eligibility for enrollment in the state's dental program should be directed to your personnel office.

State-Sponsored Dental Plans

CalHR currently contracts with four prepaid dental plans. These prepaid plans are: DeltaCare USA, Premier Access, SafeGuard, and Western Dental. CalHR also contract with Delta Dental (Delta) for an indemnity plan and a preferred provider option plan.

Below are brief descriptions of the three kinds of dental plans: prepaid, indemnity, and preferred provider option plans.

A prepaid plan requires you and your eligible dependents to select a dental provider when you enroll, choosing 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 that chooses to receive services from their office. No monthly premium is deducted from your pay warrant; the premium is paid in full by the state. (See page 8 for more details about the prepaid plans.)

An indemnity plan allows you to receive services from any licensed dentist worldwide. However, benefits are maximized when you receive services from a contracting Delta dentist. 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 pages 8 and 9 for more information about the state-sponsored indemnity plan.)

A preferred provider option plan allows you to select any licensed dentist you wish. However, you receive the maximum benefits available under the program when you choose one of the dentists in the plan's preferred provider 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 preferred provider option plan.)

Union-Sponsored Dental Plans

California Association of Highway Patrolmen (CAHP) Dental Plan

The CAHP administers the indemnity dental plan for bargaining unit (BU) 5 employees. The exclusive representative of BU 5 contracts directly with Blue Cross to provide dental insurance to its members and has administrative responsibility for such coverage. All newly hired represented employees in BU 5 must elect their dental coverage from one of the state-sponsored prepaid dental plans. After completing the 24-month restriction period, BU 5 employees who are CAHP members must enroll or change to Blue Cross.

For more information on the 24-month restriction period, employees should contact their personnel office. For information regarding the CAHP dental plan, BU 5 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 administers the Primary Dental (indemnity) and Western Dental plans (prepaid) for BU 6 employees. The exclusive representative of BU 6 contracts directly with its dental carriers for dental benefits for its members and has administrative responsibility for such coverage. BU 6 employees have 60 days from the date they are hired, or the date they become eligible, to enroll in the union-sponsored dental plan. All newly hired or newly eligible BU 6 employees are required to enroll in Western Dental for 12 consecutive months from the effective date of their enrollment before they can change to the Primary Dental Plan.

BU 6 employees should contact Western Dental at (800) 992-3366 or contact CCPOA directly at (916) 372-6060 or (800) 468-6486 if they have questions or issues concerning 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 starting January 1 and ending June 30, or starting July 1 and ending December 31.

Dependent Eligibility

You may enroll eligible dependents. Eligible dependents include your spouse or domestic partner (as recognized by the State of California), and your eligible children. Eligible children are defined below.

Spouse or Domestic Partner

A copy of the marriage certificate or Declaration of Domestic Partnership, and a Dependent Eligibility Verification Checklist (CalHR 781) with required documents must be provided at the time of initial enrollment of a spouse or domestic partner.

For audit purposes, these documents are maintained along with the dental enrollment materials in your official 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, domestic partner's children, and other children living in the household who are in a parent-child relationship with you. A Dependent Eligibility Verification Checklist with required documents must be submitted with the enrollment form.

To enroll a child in a parent-child relationship with you, you will need to complete a State-Sponsored Dental Program Affidavit of Eligibility (CalHR 025).

A child may continue to be enrolled after age 26 if he or she is 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 personnel office.

Loss of Eligibility

Any of the following events would cause a family member or dependent to lose eligibility; his or her coverage would end on the last day of the month in which this event occurred:

- 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, he or she must be deleted from your coverage. Notify your personnel office as soon as possible. Do not wait until open enrollment. You will be liable for any expenses incurred after this person loses eligibility. Refer to pages 13 through 15 for information about continuation coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA).

You may also voluntarily delete dependents from coverage by submitting a request to your personnel office. Such requests may be submitted at any time. Please contact your personnel office for further information. Dependents that are voluntarily deleted from coverage may not be reenrolled until open enrollment.

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

Enrollment

Initial 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 personnel office.

If you do not enroll at this time your next opportunity to enroll will be during the annual dental 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 only have the option of enrolling in a prepaid plan until they have completed 24 months of state service without a break in coverage. At the end of the 24-month period, those employees will have **60 days** to change their enrollment to an indemnity or preferred provider option plan. (See page 2 for information on the 24-month restriction for BU 5, and the 12-month restriction for BU 6.)

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

All eligible newly hired excluded employees may select a prepaid plan, indemnity, or preferred provider option plan at the time of hire.

Dual Coverage

A person cannot be covered under more than one state-sponsored dental plan. 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 domestic partners, may not 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 through the same employee.

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 CalPERS.

This year's open enrollment takes place **September 14–October 9, 2015**. Changes made during open enrollment period are effective January 1, 2016. Please contact your personnel office to enroll or make changes to your dental coverage during open enrollment.

Levels of Coverage

The cost of coverage depends on the plan you select and how many eligible dependents you elect to cover. You can elect to cover yourself only, or you can elect coverage for yourself and all eligible dependents. Levels of coverage are:

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

The 2016 dental premiums are listed on page 10. Employees in BUs 5 and 6 should contact their Benefit Trust for information on their union-sponsored dental plan premiums.

Making Changes Outside of Open Enrollment

Once you are enrolled, you cannot make changes until the next annual open enrollment unless you experience a change in family or employment status normally 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 this happens you will need to complete and submit a Dental Plan Enrollment Authorization Form (STD. 692) within 60 days of when the permitting event occurred. Enrollment changes must be consistent with your permitting event. You will be required to provide the date of the family status change to your personnel office.

Note: If you need to delete a dependent from coverage because he or she becomes 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 he or she ceases to be eligible.

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

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

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

The state pays 100 percent of the monthly premium for the prepaid plans, so there is no monthly premium cost share deducted from your pay warrant. 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 dentists, either upon your request or if your dentist leaves the plan, to another dentist who participates in your 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
Premier Access	(888) 534-3466
SafeGuard	(800) 880-1800
Western Dental	(866) 859-7525

Indemnity Dental Plan

Delta Dental PPO plus Premier Plan—Group #9949

Delta is the carrier for the state-sponsored indemnity dental plan (Delta Dental PPO plus Premier) available to all excluded employees, and represented employees in BUs 1 through 21 with the exception of BUs 5 and 6, which have their own union indemnity plans (see page 2). Delta Dental PPO plus Premier provides two levels of benefit coverage:

- Basic plan for rank-and-file employees and their dependents.

- Enhanced plan for managerial, supervisory, confidential, exempt, and excluded employees, Constitutional Officers, employees of the Judicial Council, and all State Superior, Appellate, Supreme Court Judges, and their dependents.

Delta Dental PPO plus Premier allows you to choose 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. Through Delta’s participating dentists, you have full access to specialty care and guaranteed benefits through Delta’s large network of dentists throughout the United States and abroad.

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

If you receive treatment from a non-Delta dentist, you are responsible for paying the dentist’s entire bill. To claim reimbursement, you need to submit an itemized receipt with a standard dental claim form to Delta. Your reimbursement will be based on Delta’s Usual, Customary, and Reasonable (UCR) fee schedule for California.

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

Preferred Provider Option Dental Plan

Delta Dental Preferred Provider Option Plan–Group #9946

Delta is also the carrier for the state-sponsored “preferred provider option” dental plan, called Delta Dental Preferred Provider Option (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 discounted fee agreement between Delta and the PPO dentist.

If you receive services from a Delta dentist who is a non-PPO dentist, your benefits will be reduced. You will be responsible for your share of the costs up to Delta’s allowed amounts under the provider’s filed fee agreement with Delta for the services you received. Fees are based on the UCR fee for California.

If you receive services from a non-Delta dentist, you are responsible for paying the full bill directly to the dentist at the time of service and up to the billed amount. Your reimbursement from Delta may be substantially lower. To claim reimbursement, submit your itemized receipt with a standard claim form to Delta. The reimbursement will be sent directly to you. You may obtain a claim form from Delta by contacting Delta 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 at (800) 225-3368.

Dental Premiums

The following tables show dental premiums effective January 1, 2016.

Delta Dental PPO plus Premier Basic Plan for Represented Employees

Level of Coverage	State Share	Employee Share	Total Premium
Party Code 1	\$37.28	\$12.43	\$49.71
Party Code 2	65.09	21.70	86.79
Party Code 3	94.09	31.36	125.45

Delta Dental PPO plus Premier Enhanced Plan for Excluded Employees

Level of Coverage	Total Premium
Party Code 1	\$ 51.70
Party Code 2	101.76
Party Code 3	142.95

Delta Dental Preferred Provider Option (PPO) for Excluded and Represented Employees

Level of Coverage	State Share	Employee Share	Total Premium
Party Code 1	\$34.07	\$11.36	\$45.43
Party Code 2	66.23	22.08	88.31
Party Code 3	99.66	33.22	132.88

For employees in Consolidated Benefits (CoBen), the state share and employee share does not apply. Therefore, the total dental premium will be deducted from the monthly CoBen allowance.

Prepaid Dental Plan

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

Level of Coverage	DeltaCare USA	Premier Access	SafeGuard Standard	SafeGuard Enhanced	Western Dental
Party Code 1	\$17.99	\$16.63	\$16.58	\$16.92	\$15.16
Party Code 2	29.52	26.94	26.86	28.63	25.02
Party Code 3	40.83	37.73	37.62	35.27	35.49

Union-Sponsored Dental Plans: BUs 5 and 6

Employees in BUs 5 and 6 should contact their Benefit Trust for information on their union-sponsored dental plan premiums and benefits.

Continuing Benefits into Retirement

In order 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.

BU 5 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.

BU 6 employees (CCPOA) who are 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 have 30 days prior to or 60 days following the date of your retirement to enroll in a dental plan.

If you enroll prior to retirement, your enrollment will be processed through your personnel office. If you enroll following retirement, your enrollment is handled through CalPERS. If you do not enroll within this time period, you must wait until the next open enrollment.

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

Survivor Benefits

Departments are required to continue paying for a covered employee's spouse, 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 your 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 continuation of dental plan coverage should be directed to your personnel office.

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

CalPERS
Member Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715

(888) 225-7377 / TTY (877) 249-7442

Note: Surviving dependents who do not qualify to continue their current coverage are eligible for continuation coverage under COBRA (refer to pages 13 through 15 for details).

COBRA Group Continuation Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires employers to offer continuation of dental, medical, 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 coverage and the time period of the extended coverage.

COBRA Qualifying Events

Benefits Continued for 18 Months	Benefits Continued for 36 Months
<ul style="list-style-type: none"> • 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. <p>Reduction of hours may include:</p> <ul style="list-style-type: none"> • Full-time to part-time • Strike • Layoff • Leave of Absence • Military call-up 	<ul style="list-style-type: none"> • 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 marries or turns age 26.

*State of California Legislation

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 cancelled back to the end of the prior month in which a premium payment had been made. If COBRA coverage is cancelled 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 amount of the deficiency and allow 30 days for payment of the deficiency. 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, it is the qualified beneficiary's responsibility to 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 who are 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 his or her eligible beneficiaries are entitled to continuation coverage of 29 months (from the date of the 18-month 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 type of 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 with respect to 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.
- 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 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.

Call 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/dropping dependents from your dental 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.

Call CalHR Benefits Division

- For assistance resolving problems with your dental plan or dentist that you are unable to resolve through your dental plan's customer service department or through the complaint procedure outlined in your dental plan's evidence of coverage booklet.
- For questions or concerns regarding your monthly dental plan cost share premium.
- 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 Resources Benefits Division

1515 S Street, North Bldg., Suite 500
Sacramento, CA 95811-7258
(916) 322-0300
(916) 322-3769 FAX

Prepaid Dental Plans

DeltaCare USA
12898 Towne Center Drive
Cerritos, CA 90703
(800) 422-4234
www.deltadentalcains.com/state

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

SafeGuard
5 Park Plaza, Suite 1850
Irvine, CA 92614
(800) 880-1800
www.safeguard.net/

Western Dental
530 South Main Street, 6th Floor
Orange, CA 92868
(866) 859-7525
www.westerndentalbenefits.com/stateofca

Delta Dental Plans

Delta Dental
P.O. Box 429086
San Francisco, CA 94142
(800) 225-3368
www.deltadentalins.com/state

Frequently Asked Questions

General

1. **Once I've selected a dental plan, may I change dental plans if my dentist cancels their contract with the dental carrier?**

No. You may change dental plans outside the annual open enrollment period **only** if your dental plan is no longer available to you. For example, if you move to an area where your dental plan is more than 50 miles from your residence, you may enroll in another plan. If you have any questions, contact your personnel office.

2. **What should I do if I have a problem or complaint regarding my dental plan or dentist?**

Many problems can be resolved by contacting your dental plan's customer service department. You should also refer to the complaint procedure outlined in your dental plan evidence of coverage booklet, available from your personnel office or your dental carrier. If you are unable to resolve your complaint through your carrier, you may contact CalHR for assistance (see page 17 for contact information).

3. **What should I do if the payroll deduction for my dental plan is incorrect, or is not shown on my warrant stub?**

When you enroll in a state-sponsored dental plan or change the coverage, it is important to carefully check your pay warrant to verify that the premium is being paid to the correct dental plan. If the deduction is incorrect, or has not started by the effective date, report the discrepancy to your personnel office.

4. **Can a surviving spouse add other dependents during open enrollment?**

Yes, but only if the dependents had a relationship to the deceased employee prior to the employee's death (e.g., the active employee's unborn child).

Prepaid Dental Plans

1. **If I enroll in a prepaid dental plan, will I receive an identification card?**

Yes. Shortly after your eligibility is established by your dental plan and you have selected a dentist, you will receive an identification card. The card is a reminder of which dental office you selected. Please confirm the address and telephone number of your selected dental provider with your dental plan carrier.

2. **What if there are no participating dentists in my service area for any of the prepaid plans?**

If you are unable to locate a participating provider within 50 miles of your residence, contact the plan's customer service for assistance. If it is determined that there are no prepaid providers in your service area, contact your personnel office for further assistance.

3. What happens if I am enrolled in a prepaid plan and move out of California?

The state-sponsored prepaid plans are only offered in California. **Before** you move out of the state, contact your personnel office to change your dental plan; be sure to inform them of your moving date.

4. May I choose any dentist I want if I enroll in a prepaid plan?

No. The dentists available through each prepaid plan have contracted with that plan to provide services to its enrollees. Your choice is restricted to dentists who have contracted with your plan (called “participating dentists”). Contact the dental plan directly to obtain a list of its participating dentists or to verify whether a particular dental provider is on the plan’s list.

5. Once I have selected a prepaid dentist and/or dental office, do I have to remain there?

No. If for any reason you feel you need to change dental providers, simply contact your dental plan; the customer service representative will assist you in locating another dentist from the plan’s list of participating dental providers.

6. What happens if my dentist decides to no longer participate in my prepaid plan?

Your dental plan will notify you if your dentist stops participating in the plan. You will be provided with the name of a new dentist or given the opportunity to select another participating dentist within 50 miles of your residence. If you are unable to locate another participating dentist in your service area, contact your personnel office.

7. Do I have to pay monthly premiums for my dependents or myself if I enroll in a prepaid plan?

No. The State of California pays 100 percent of the monthly premium for you and your dependents enrolled in a prepaid plan.

8. Do I have to pay an annual deductible if I am enrolled in a prepaid plan?

No. There is no annual deductible.

9. What cost share can I expect to pay if I enroll in a prepaid plan?

Depending on the type of dental service performed, you could be charged a co-payment. Co-payments are payable at the time the service is rendered. For a listing of covered dental services and applicable co-payments, you may view the information on pages 23 through 27.

10. What actions should I take in an emergency if I am enrolled in a prepaid plan?

Contact your dentist or dental office. If the emergency occurs after normal business hours, or you are advised that there is no plan provider available, or you are more than 50 miles from your selected plan provider, you may receive treatment for the **relief of pain** from any non-plan provider. You **must** call your dental plan before obtaining out-of-area emergency care. Your plan will reimburse up to \$400 per enrolled member, per calendar year for emergency services.

11. How do I access specialist services?

The prepaid plans offer services in most dental specialties, including periodontics (treatment of diseased gums and bones), endodontics (root canal therapy), and oral surgery procedures. If your dental provider refers you to a specialist, the referral must be approved by the prepaid dental plan.

12. Do my dependents have the same level of benefits that I do in my prepaid plan?

Yes.

13. If I am not currently enrolled in a prepaid plan, what things should I consider before I decide to change dental plans?

- **Is it important to you to maintain your current dentist?**

If your answer is NO, enrolling in a prepaid plan and selecting one of its participating dental providers may be a good choice for you.

- **Is the location of your dentist an issue for transportation purposes?**

If your answer is YES, you may want to review the list of participating dental providers for each prepaid plan. You may find a provider within easy access by car or public transportation.

- **Are your out-of-pocket dental costs a significant financial consideration?**

If your answer is YES, you should be aware that the prepaid plans have **no** monthly premium cost share or annual deductible, and most services are provided at little or no cost to you.

- **Do you live outside of California?**

If your answer is YES, you need to be aware that the prepaid plans are only available in California.

14. How can I find out more about the state-sponsored prepaid dental plans?

Refer to the Directory on page 17. It contains the addresses and toll-free telephone numbers of all four state-sponsored prepaid dental plans. Before changing plans, it is recommended that you request a copy of the plan brochure and list of participating dental providers for any plans you are considering. Review this information and select a dentist from the provider list **prior** to changing plans.

If you decide to change dental plans, be aware that the prepaid plans provide less flexibility in that you are required to choose your dentist from a list of dental providers. However, the prepaid plans provide benefits at less cost to you. (There is a comparison of dental plans on pages 23 through 27.)

Indemnity Dental Plan

1. What is my Delta Dental PPO plus Premier Group Number?

Your Delta Dental PPO plus Premier group number is 9949.

2. Will I receive an ID card?

Delta will send you an identification card indicating your enrollment in the Delta Dental PPO plus Premier plan and your dental group number. When you or a covered dependent goes to the dentist, you will need to provide this group number (9949) and the Social Security number of the state employee. The dental office will verify your eligibility and covered benefits directly with Delta.

3. Do I have to complete a claim form when I go to a Delta dentist?

Although claim forms are required, the forms will be completed for you at no charge if you receive services from a participating Delta dentist. If you receive services from a non-Delta dentist, you may be required to complete the forms yourself or pay a fee to have the dentist's office do it for you.

4. How do I obtain an evidence of coverage booklet for the Delta Dental PPO plus Premier plan?

When you enroll in the Delta Dental PPO plus Premier plan, Delta mails you an evidence of coverage booklet with your ID card. Your personnel office also may have a small supply of these booklets. If you do not receive your booklet, contact Delta at **(800) 225-3368** to request an evidence of coverage booklet for group number 9949. Evidence of coverage booklets are also available on Delta's website at www.deltadentalca.ins.com/state.

5. What is the level of benefits under the Delta Dental PPO plus Premier plan?

For represented employees in the Delta Dental PPO plus Premier Basic plan, there is an annual maximum benefit of \$2,000 for employees and \$1,000 for each dependent. For some services, the level of benefits for the enrolled dependent is less than the level of benefits for the employee. There is a \$50 deductible for each family member (maximum of \$150 per family per year). The required \$50 deductible for each participant is waived for preventive and diagnostic care.

For excluded employees in the Delta Dental PPO plus Premier Enhanced plan, there is an annual maximum benefit of \$2,000 for both the employee and each eligible dependent. The level of benefits for each participating family member is the same as the level of benefits for the employee. There is a \$25 deductible for each family member (maximum of \$100 per family per year). The required \$25 deductible for each participant is waived for preventive and diagnostic care.

The annual deductibles do not apply to diagnostic and preventive benefits such as x-rays, examinations, and cleanings. If the dental costs exceed the annual maximum, the employee is responsible for paying the difference.

The charts on pages 23 through 27 provide additional information. For a detailed explanation of the limitations and exclusions of the Delta Dental PPO plus Premier plans, consult the evidence of coverage booklet, available by calling Delta at (800) 225-3368.

Preferred Provider Option Plan

1. What is my PPO group number?

Your PPO group number is 9946.

2. Will I receive an ID card?

Delta will send you an identification card indicating your enrollment in the PPO plan and your dental group number. When you or a covered dependent/family member goes to the dentist, you will need to provide this group number (9946) and the Social Security number of the state employee. The dental office will verify your eligibility and covered benefits directly with Delta.

3. Do I have to complete a claim form when I go to a PPO dentist?

Although claim forms are required, the forms will be completed for you at no charge if you receive services from a participating PPO dentist.

If you receive services from a non-Delta dentist, you may be required to complete the forms yourself or pay a fee to have the dentist's office do it for you. The dental office should be able to provide you with the claim form, or you may contact Delta to have a claim form sent to you.

4. How do I obtain an evidence of coverage booklet for the PPO plan?

When you enroll in the PPO plan, Delta will mail you an evidence of coverage booklet with your ID card. Your personnel office also may have a small supply of these booklets. If you do not receive your booklet, contact Delta at (800) 225-3368 to request an evidence of coverage booklet for group number 9946. Evidence of coverage booklets are also available on Delta's website at www.deltadentalca.ins.com/state.

5. What is the level of benefits under the PPO plan?

In-Network: The PPO plan provides an annual in-network maximum benefit of \$2,000 for the employee and all enrolled dependents that use a participating PPO dentist. There is also a \$25 annual deductible for each enrollee (maximum of \$100 per family) using a participating PPO dentist.

Out-of-Network: The PPO plan provides an annual out-of-network maximum benefit of \$1,000 for the employee and all enrollment dependents that use a participating non-PPO dentist. There is also a \$75 annual deductible for each enrollee (maximum of \$200 per family) using a non-PPO dentist.

These deductibles do not apply to diagnostic and preventive benefits such as x-rays, examinations, and cleanings.

The charts on pages 23 through 27 provide additional information. For a detailed explanation of the limitations and exclusions of the Delta Dental PPO plan, consult the evidence of coverage booklet, available by calling Delta at (800) 225-3368.

Comparison Charts

Benefit 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	Preferred Provider Option
Type of Plan	Plan pays your chosen dentist a monthly fixed rate to provide services as needed.	Fee-for-service plan. Plan provides reimbursement for services rendered.	Plan provides maximum benefit when you visit an in-PPO network 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 dentist.	Any licensed dentist, but maximum benefit when visiting a PPO network dentist. If an out-of-PPO network dentist is used, benefits are lower.
Orthodontic Providers	Must use orthodontist affiliated with the prepaid plan.	May visit any orthodontist. However, out-of-pocket expenses may be lower when visiting a Delta Dental PPO dentist.	Must visit an in-PPO network orthodontist to receive maximum benefit.
Changing Providers	You may change to another dentist affiliated with the plan, with prior approval.	May change dentist at any time.	May change dentist at any time.
Deductibles	No deductible.	<u>Basic</u> : \$50 per person, up to \$150 annual maximum per family. <u>Enhanced</u> : \$25 per person, up to \$100 annual maximum per family.	\$25 per person, up to \$100 annual maximum per family, for PPO network 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 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	Preferred Provider Option
Plan Payments	Plan pays dentist monthly contract fee.	Payments based on Delta Dentist contracted fees or the maximum plan allowance when non-Delta Dental dentists are used.	Payments based on Delta Dentist contracted fees or the maximum plan allowance when non-Delta Dental dentists are used.
Maximum Benefits per Calendar Year	No maximum.	<u>Basic</u> : \$2,000 for employee, \$1,000 per dependent. <u>Enhanced</u> : \$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.	Not a covered benefit.	Maximum lifetime benefit of \$2,500 for each employee and dependent, if using a PPO plan provider.

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, SafeGuard, Premier Access, Western (Standard)	SafeGuard (Enhanced)
Who is Covered?	Represented 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, Partials and Dentures	\$65 and up	No charge
Implants	Premier Access and Western Dental only	Not covered

*SafeGuard 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	Delta Dental PPO plus Premier Basic	Delta Dental PPO plus Premier Enhanced	PPO/using Participating Provider	PPO/using Non-Participating Provider
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*	No charge*	No charge*	No charge**	20%
Basic Benefits (UCR)	10 %	20%	10%	10%	20%
Crowns	20%	50%	20%	20%	50%
Bridges, Partials and Dentures	50%	50%	50%	40%	50%
Implant Benefit	N/A	N/A	N/A	Will pay up to 50% up to a lifetime maximum of \$2,500	Will pay up to 50% up to a lifetime maximum of \$2,500
Orthodontia	Will pay up to 50% of approved fee for orthodontia, with a lifetime maximum for this benefit of \$1,000 for employee	Will pay up to 50% of approved fee for orthodontia, with a lifetime maximum for this benefit of \$1,000 for dependent	Will pay up to 50% of approved fee for orthodontia, with a lifetime maximum for this benefit of \$1,000 for dependent	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*	\$25*	\$25*	\$75
Maximum Deductible	\$150 per family	\$150 per family	\$100 per family	\$100 per family	\$200 per family
Annual Maximum	\$2,000	\$1,000	\$2,000	\$2,000	\$1,000

* Diagnostic and Preventive Benefits are exempt from the deductible.

** The level of benefits and covered services reflected in the chart 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. Additionally, the PPO includes a 3rd cleaning for high-risk patients and a benefit for dental implants (up to \$2,500 lifetime maximum).

State of California
California Department of Human Resources
State-Sponsored Dental Program
AFFIDAVIT OF ELIGIBILITY
For Dependent Children, As Defined Under California Code of Regulations Section
599.500 (o)

I, _____ understand that the California Department of Human Resources (CalHR) allows for the enrollment of a child(ren) other than a natural, adopted or step child(ren), who is considered a family member(s) and where the employee or annuitant has established a parent-child relationship, on or before the time of enrollment, through the assuming of parental duties in the same or similar manor as the child(ren)'s biological parents. I also recognize this affidavit is a legally binding document and I accept full and unconditional responsibility for notifying my departmental personnel office immediately and in writing, if there are any changes in the child(ren)'s status as my dependent under the conditions set forth herein. I further agree to provide supporting documentation, such as tax, court, or custody records, if available, when at any time requested by my employing department, CalPERS or CalHR, as long as the child is enrolled on my state-sponsored dental coverage as my eligible dependent.

By signing this affidavit, I also attest to and certify under penalty of perjury that I am exercising parental authority and responsibility, as defined under federal and California state law. If I have legal custody (sole or joint) of the child(ren), I agree to provide proof of legal custody of the child(ren) at the time of enrollment or when those documents are first available to me.

I acknowledge I have read and understand the declarations on this page:

Signature: _____ Date: _____

Child's Name						
Child's SSN						
Child's DOB						
Parent's Names (if available)						
Child's Relationship to Employee/Retiree						
Is Child Your Tax Dependent?	Yes	No	Yes	No	Yes	No

For other dependent children, please attach list or use another affidavit. **Please note that this affidavit is subject to yearly renewal.**

By signing this affidavit I understand that making, or causing to be made, any knowingly false material statement or material representation; knowingly failing to disclose a material fact, or to otherwise provided false information with the intent to use it, or allow it to be used, to obtain, receive, continue, and/or increase, benefits administered by CalHR, may constitute fraud and may result in financial liability to me, and possible employment action up to and including termination of employment.

State of California
California Department of Human Resources
State-Sponsored Dental Program
AFFIDAVIT OF ELIGIBILITY
(continued)

By signing this document, I therefore swear (or affirm), under penalty of perjury, that I understand the eligibility requirements described in this document and that all information provided is true and correct to the best of my knowledge. The child(ren) listed on this affidavit is/are for benefit enrollment purposes my dependent(s); is/are in a parent-child relationship with me, and that I act as a primary care parent in the relationship. I also swear (or affirm) that I understand that spouses of my recognized natural, adopted, step, or child(ren) enrolled under this affidavit, are not eligible for enrollment; that the dependent child(ren) is/are not a foster child(ren); and, is/are not enrolled in dental benefit coverage from any other California State-sponsored civil service employment or California State University employment source.

Employee/Retiree Signature: _____ Date Signed _____

Social Security Number: _____ - _____ - _____

Employing Agency: _____

City: _____ Daytime Phone Number: (_____) _____

EMPLOYING DEPARTMENT USE ONLY

The personnel office must maintain this document in the employee's official personnel file, attached to the agency copy of the Dental Enrollment Authorization (STD. 692). Do not send a copy of affidavit to SCO or CalHR.

Date received in authorized departmental personnel office: _____

I have verified that all portions of this affidavit are complete to the best of my knowledge and any requested documentation has been submitted to the personnel office at the time this document was submitted.

Employing Department Personnel - Authorized Signatory

PRIVACY NOTICE

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the California Department of Human Resources and the dental insurance company for the purpose of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The California Department of Human Resources requires a social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code sections 1151, 1153, sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, section 404.1256, Code of Federal Regulations, under section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the dental carrier providing coverage. Copies of the Affidavit of Eligibility for Dependent Children are maintained in confidential files of your personnel office for five years. For retirees, these forms are maintained with the California Public Employees' Retirement System (CalPERS) for five years. Individuals have the right of access to copies of their Affidavit of Eligibility for Dependent Children upon request. For active employees, please send requests to your personnel office. For retirees, please send your request to CalPERS, Attn: Member Account Management Division, P.O. Box 942715, Sacramento, CA. 94229-2715