2023 DENTAL COMPARISON CHART

COUNTY DENTAL PLANS COMPARISON CHART				
These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.				
	DeltaCare USA DHMO	**Local Advantage EPO Plus**	**Delta Dental PPO**	
	High-Option Plan (10A)	**In-Network**	**Delta Dental PPO Dentists**	**Premier Dentists Out-of-Network Dentists**
Annual deductible	None	None	None	$50 individual | $150 family
Calendar year maximum benefit	None	$2,000/person	$2,000/person	$1,500/person
Diagnostic and Preventive				
Exams	No charge	No charge	No charge	No charge
Cleaning	No charge	No charge	No charge	No charge
Full mouth X-rays	No charge	No charge	No charge	No charge
Topical fluoride – child	No charge	No charge	No charge	No charge
Sealants (per tooth)	$5	No charge (under age 14)	No charge	No charge
Restorative				
Fillings – amalgam (silver)	No charge	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Fillings – composite resin (tooth-colored) for anterior (front) teeth	No charge	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Fillings – composite resin (tooth-colored) for posterior (back) teeth	$45–$75	When decay is present, you pay the cost difference between amalgam and resin For cosmetic purposes to replace an alloy/amalgam filling, you pay 50%	Not covered[4]	Not covered
Endodontics				
Single root canal	$45	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO f ee after the deductible
Bicuspid root canal	$90	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Molar root canal	$205	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Periodontics				
Periodontal scaling and root planing 4 or more teeth/quadrant	No charge	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Crowns, Bridges and Implants				
Crowns	$35–$195	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Bridges	$55–$195	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Implants	Not covered	Not covered	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible

2023 DENTAL COMPARISON CHART

COUNTY DENTAL PLANS COMPARISON CHART (CONTINUED)				
These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.				
	DeltaCare USA DHMO	**Local Advantage EPO Plus**	**Delta Dental PPO**	
	High-Option Plan (10A)	**In-Network**	**Delta Dental PPO Dentists**	**Premier Dentists Out-of-Network Dentists**
Prosthodontics				
Complete upper denture	$100	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Complete lower denture	$100	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Oral Surgery				
Simple extraction	No charge	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Impaction	$25–$90	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Cosmetic				
Veneers	No benefit	You pay 50%	Not covered	Not covered
Teeth whitening	$125	You pay 50%	Not covered	Not covered
Replacement of existing amalgam filling with composite	Not covered	You pay 50%	Not covered	Not covered
Orthodontics				
Child	$1,700	Plan pays $120 down, $120 per month for 24 months[2]	You pay 50% of the PPO fee	You pay 50% of the PPO fee after the deductible
Adult (19 and up)	$1,900		You pay 50% of the PPO fee	You pay 50% of the PPO fee after the deductible
Lifetime maximum benefit	None	None	$2,000/person	$1,500/person

VSP HIGHLIGHTS		
Benefit Duration	**Participating Provider**	**Non-Participating Provider**
Exams (every 12 months)	$20 copayment	$20 copayment
Lenses (every 12 months)	$20 copayment	$20 copayment
Frames (every 12 months)	$20 copayment	$20 copayment
Contacts		
- Visually necessary (every 24 months)	No copayment	No copayment
- Elective (every 24 months)	No copayment	No copayment