Carpenters Southwest Administrative Corporation

ADMINISTRATIVE OFFICE: 533 S. Fremont Ave. • Los Angeles, CA 90071-1706 • Tel: (213) 386-8590 • Toll Free (800) 293-1370

www.carpenterssw.org

Active

Comparison of Dental Benefits

2017

Note: This document constitutes only a brief summary of the benefits available. Refer to your Summary Plan Description Booklet (SPD) or HMO Evidence of Coverage document for details. You may also visit us on-line at www.carpenterssw.org.

COMPARISON OF DENTAL PLANS
FOR ACTIVE PARTICIPANTS ELIGIBLE FOR DENTAL COVERAGE AS OF JANUARY 1, 2017

This benefit summary has been prepared for a comparison of benefits only. Refer to your Summary Plan Description booklet (SPD) or DHMO Evidence of Coverage document for complete details. You may also visit us on-line at www.carpenterssw.org.

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST **visit us at www.carpenterssw.org**
COMPARISON OF DENTAL PLANS
FOR ACTIVE PARTICIPANTS ELIGIBLE FOR DENTAL COVERAGE AS OF JANUARY 1, 2017

DESCRIPTION OF BENEFITS	Delta Dental DPPO Plan (scheduled allowances)	DeltaCare DHMO Plan	UnitedHealthCare		Liberty DHMO Plan
			DHMO Plan	DHMO Plan with Out-of-Network Coverage	
REGIONS AVAILABLE	***All States but available only if you reside outside a DHMO service area***	***AZ, CA, CO, NM, NV, TX, UT, WY***	***CA ONLY***	***NV ONLY***	***CA ONLY***
	What the Plan Pays	*Your Cost*	*Your Cost*	*Your Cost at a Network Provider Office*	*Your Cost*
Calendar Year Deductible	None	None	None	None	None
Calendar Year Maximum	$1,500 per person	No maximum	No maximum	No maximum	No maximum
Diagnostic & Preventive					
X-Rays, Intraoral, full mouth series with bitewings (D0210)	$69	No charge	No charge	No charge	No charge
X-Rays, bitewings, two films (D0272)	$22	No charge	No charge	No charge	No charge
Teeth cleaning (D1110 & D 1120)	$50 adult; $36 child	No charge	No charge	No charge	No charge
Space maintainer, fixed, bilateral (D1515)	$247	$25	No charge	$46	$20

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Restorations					
Amalgam filling, one surface, primary or permanent tooth (D2140)	$40	No charge	$10	$12	No charge
Amalgam filling, three surfaces, primary or permanent tooth (D2160)	$63	No charge	$20	$18	No charge
Porcelain crown /base Metal (D2751)	$366	$140	$110[1]	$201	$115[2]
Full cast crown / base Metal (D2791)	$365	$110	$110	$219	$99
Full cast noble metal Crown (D2792)	$375	$150	$120[1]	$223	$99[2]
Periodontics					
Gingivectomy, per Quadrant (D4210)	$250	$130	$25	$89	$38
Scaling and root planing, per quadrant (D4341)	$89	$25	$40	$57	$18

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Endodontics					
Root canal, anterior (D3310)	$231	$55	$40	$114	$15
Root canal, bicuspid (D3320)	$270	$120	$75	$157	$49
Root canal, molar (D3330)	$346	$250	$100	$200	$99
Apicoectomy per tooth (D3410)	$212	$60	$35	$109	$45
Prosthetics					
Complete upper denture (D5110)	$540	$145	$170	$323	$145
Complete lower denture (D5120)	$544	$145	$170	$323	$145
Partial denture, upper, cast metal (D5213)	$584	$160	$170[1]	$173	$170
Partial denture, lower, cast metal (D5214)	$582	$160	$170[1]	$345	$170

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Oral Surgery					
Extraction, erupted tooth (D7140)	$65	$5	$10	$26	No charge
Surgical extraction, erupted tooth (D7210)	$98	$25	$10	$36	$12
Surgical extraction, complete bony impaction (D7240)	$179	$90	$40	$80	$45
Adjunctive General Services					
Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment (D9243)	$77	$80	$10	Not covered unless medically necessary	$125
Occlusal guard (D9940)	By report	$100	$35	$25	$160
External teeth bleaching for home application, per arch (D9975)	Not covered	$125	$125	Not covered	Not covered
Specialist Consultation (D9310)	$45	$10	$5	No charge	No charge

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Orthodontic - Full banded treatment (not including diagnostic x-rays)					
Children to age 19 (D8070, 8080)	(Children to age 26) 50% up to $1,500 lifetime maximum	$1,700	$1,500	$2,900	$1,700
DHMO Adults & Children age 19-26 (D8090)	Adults Not covered	$1,900	$1,500	Not covered	$1,900
	What the Plan Pays	*What the Plan Pays*	*What the Plan Pays*	*What the Plan Pays*	*What the Plan Pays*
Care Received From a Non-Network Provider	Plan benefits are the same for network and non-network providers	Not covered except for emergency care up to a benefit maximum of $100 per emergency	Not covered except for emergency care as specified in the plan's evidence of coverage booklet	$50 deductible per person per calendar year; benefits based on fee schedule; $1,000 maximum benefit per person per calendar year[3]	Not covered except for emergency care up to a benefit maximum of $75 less any applicable copayments

[1]If titanium, noble or high noble metals are requested for fillings, crowns, inlays, onlays, pontics, bridges, or prosthetic devices, there will be an additional charge, based on the amount of metal used.
[2]The total maximum amount chargeable to a member for elective upgraded procedures is $250 per tooth.
[3]See full fee schedule in the UnitedHealthcare packet. For a list of DHMO panel providers, contact your Administrative Office at (702) 851-4510 or (800) 501-0210.