DeltaCare USA Basic and Delta Dental PPO Basic Plans Benefits Comparison

For eligible employees in the following categories: Unit 8, (Excluded) E99 (except SFSU Headstart E99), and Annuitants

<table>
<thead>
<tr>
<th>Dental Procedures</th>
<th>DeltaCare USA Enhanced Plan Charges</th>
<th>Delta Dental PPO of California Enhanced Level II Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and Diagnostic Dentistry</td>
<td>(No Deductible)*</td>
<td>(No Deductible)*</td>
</tr>
<tr>
<td>Prophylaxis (cleaning)</td>
<td>No charge – limit 2 per calendar year</td>
<td>75% of UCR – limit 2 per calendar year+</td>
</tr>
<tr>
<td>Fluoride Application</td>
<td>No charge – only to age 19</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Oral Exams</td>
<td>No charge</td>
<td>75% of UCR – limit 2 per calendar year</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>No charge</td>
<td>75% of UCR (without deductible)</td>
</tr>
<tr>
<td>Emergency Office Visits</td>
<td>No charge</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>X-rays</td>
<td>No charge (Full mouth x-rays: 1 set per 24 consecutive months. Bitewings: 1 set (4 films) per every 6-month period.)</td>
<td>75% of UCR (Full mouth x-rays: 1 set in a 3-year period. Bitewings: 1 set per calendar year for age 18 and over**)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic Dentistry</th>
<th>(No Deductible)*</th>
<th>(Deductible)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings</td>
<td>No charge for amalgam</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Local – no charge; General – not covered</td>
<td>75% of UCR – limited to required anesthesia applied by dentist during oral surgery.</td>
</tr>
<tr>
<td>Injection of Antibiotics</td>
<td>Not covered</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Extractions</td>
<td>Uncomplicated – no charge; $15-$25 for bony impactions (not covered for orthodontia)</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>No charge</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Endodontics</td>
<td>Root canal – $20 anterior, $40 bicuspid, $60 molars</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Periodontics</td>
<td>$10 for curette per quadrant</td>
<td>75% of UCR</td>
</tr>
<tr>
<td></td>
<td>$20 for gingivectomy per quadrant</td>
<td>75% of UCR</td>
</tr>
<tr>
<td></td>
<td>$80 for osseous surgery per quadrant</td>
<td>75% of UCR</td>
</tr>
<tr>
<td>Denture Relining</td>
<td>Office – no charge; Lab – $15</td>
<td>75% of UCR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthetic Dentistry</th>
<th>(No Deductible)*</th>
<th>(Deductible)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns</td>
<td>$35-$50 per crown + cost of precious metals</td>
<td>50% of UCR</td>
</tr>
<tr>
<td>Prosthetic Appliance Repair</td>
<td>Up to $15</td>
<td>50% of UCR</td>
</tr>
<tr>
<td>Dentures</td>
<td>Full – $60 each; Partial – $70 each</td>
<td>50% of UCR</td>
</tr>
<tr>
<td>Bridges</td>
<td>$50 per unit + cost of precious metals</td>
<td>50% of UCR</td>
</tr>
<tr>
<td>Implants</td>
<td>Not covered</td>
<td>50% of UCR</td>
</tr>
<tr>
<td>Maximum Benefit for Preventive, Basic and Prosthetic Dentistry</td>
<td>No maximum*</td>
<td>$1,500 per calendar year per person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthodontics</th>
<th>(No Deductible)*</th>
<th>(Deductible)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,400 maximum co-payment plus $350 start-up costs for 24-month treatment plan (only for covered children up to age 23). Orthodontic extractions are not covered.</td>
<td>50% of UCR. $1,000 maximum per patient per case (for employees, spouse and dependent children).</td>
</tr>
</tbody>
</table>

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<tr>
<th>Special Provisions, Limitations, Exclusions</th>
<th>DeltaCare USA Enhanced Plan Charges</th>
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<tr>
<td>Work in progress when you join</td>
<td>Not covered. (Examples: in-progress orthodontics, root canals started, teeth prepped for crowns, etc.)</td>
<td>Only covers charges for services the member receives on and after effective date of coverage.</td>
</tr>
<tr>
<td>Predetermination of benefits</td>
<td>Not required</td>
<td>Not required; however, suggested for services proposed over $100.</td>
</tr>
<tr>
<td>Alternative to treatment provision</td>
<td>May be additional cost.</td>
<td>If dentist determines alternative treatment is necessary, approval is subject to Delta review.</td>
</tr>
<tr>
<td>Referral to specialist</td>
<td>Approval is subject to review by dental consultant.</td>
<td>N/A</td>
</tr>
<tr>
<td>Missing teeth</td>
<td>No exclusion against replacing missing teeth.</td>
<td>No exclusion against replacing missing teeth.</td>
</tr>
<tr>
<td>Out-of-area emergency</td>
<td>Maximum of $50</td>
<td>Out of California – submit dentist’s billing statement to Delta Dental of California.</td>
</tr>
<tr>
<td>Deductible</td>
<td>No deductible</td>
<td>$50/person up to maximum of $150/family deductible per calendar year for both basic and prosthetic dentistry. Any part of deductible satisfied during last 3 months of calendar year is credited toward the next calendar year deductible.</td>
</tr>
<tr>
<td>Prosthetic replacements</td>
<td>Limited to one each 5 years.</td>
<td>Limited to one each 5 years.</td>
</tr>
</tbody>
</table>

*Refer to the Evidence of Coverage (EOC) booklet. **Children under 18 are eligible for 2 sets of bitewing x-rays per calendar year. There is a $500 maximum, per year, per child for pediatric procedures only when performed by a specialist (applies to DeltaCare USA only).

+Under certain guidelines Delta Dental participants who are pregnant are eligible to receive an additional cleaning and/or periodontal examination in a calendar year.