SOLANO COUNTY
DENTAL & VISION PLAN OPTIONS
Effective January 1, 2025 - December 31, 2025

BENEFIT COMPARISON	DELTA DENTAL PPO ENHANCED Group # 2808-1004	UNITEDHEALTHCARE DENTAL Group # 711892-0001
Calendar Year Deductible **In-Network** Individual Family	 $25 per Calendar Year $75 per Calendar Year	 No Charge
Calendar Year Deductible **Outside-Network** (Premier or Non-Delta) Individual Family	 $50 per Calendar Year $150 per Calendar Year	 No Charge
Calendar Year Maximum	$1,250 per Patient	Unlimited
Preventive and Diagnostic Oral examinations, routine cleanings, and x-rays	100% In-network 80% Outside Network *Two visits per Calendar Year*	No Charge
Basic Services Extractions, Fillings, Sealants Periodontics	 90% In-network 80% Outside Network	 No Charge
Restoration Benefits Crowns and Cast Restorations	50% In-network 50% Outside network	No Charge
Prosthodontics Bridges, Dentures	50% In-network 50% Outside network *12-Month Waiting Period*	No Charge
Orthodontics	Child Only 50% up to $1,000	*See Benefit Description for Limits& CoPay*
Implant Services	None	*See Benefit Description for Limits& CoPay*
MONTHLY CONTRIBUTIONS	**DELTA DENTAL PPO ENHANCED**	**UNITEDHEALTHCARE DENTAL**
Employee **Monthly Contribution** Single Family	 -0- -0-	 -0- -0-
County-Paid **Monthly Premium** Single Family	 $ 39.20 $ 99.40	 $ 35.00 $ 81.26

BENEFIT DESCRIPTION	VISION SERVICE PLAN Grp #00-333000 0005 0002	VISION SERVICE PLAN BUY-UP Grp #00-333000 0008 0002
Deductible Vision Examination Materials	 $10 Once every 12 months $25 once every 24 months	 $10 Once every 12 months $0 Once every 12 months
MONTHLY CONTRIBUTIONS	**Standard Plan**	**Buy-Up Plan**
Employee Contribution County-Paid Monthly Premium	-0- $ 11.97	$9.47 $11.97

This is a summary only. Please see the Evidence of Coverage Booklet for detailed benefit description.

Please Note: The above rates are based on an employee's full-time equivalent (100%FTE) work status. PART-TIME employees (working at least 20 hours per week but less than 100% FTE) may enroll in Dental and Vision coverage on a voluntary basis by paying the proportionate share of the County's cost for Dental and Vision. For example, a part-time employee working 50% FTE would pay $49.70 for the above Family Enhanced Delta Dental plan, i.e. $99.40 X .50 = $49.70