



## Delta Dental PPO<sup>SM</sup> plus Premier Plan State of Colorado - Group #7649 BASIC PLAN

<b>ANNUAL MAXIMUM BENEFIT</b>	<b>\$1,000</b> per person per plan year. Combination of in and out-of-network.
<b>PREVENTION FIRST BENEFIT</b>	<b>Diagnostic &amp; Preventive services do not count toward annual maximum benefit.</b>
<b>PLAN YEAR DEDUCTIBLE</b> Applies to Basic and Major Services only	Individual deductible per plan year - <b>\$50</b> . Combination of in and out-of-network. Family deductible per plan year - <b>\$150</b> . Combination of in and out-of-network.
<b>WHO CAN BE COVERED</b>	Employee, Spouse (including Common Law Spouse), Same Gender Domestic Partner, Opposite Gender Civil Union Partner, Same Gender Civil Union Partner, and Eligible Children until the end of the month in which the child turns age 26.

PPO *	PREMIER **	NON-PAR ***	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
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### DIAGNOSTIC & PREVENTIVE SERVICES (Prevention First benefit included for all networks)

PPO *	PREMIER **	NON-PAR ***	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
100%*	100%**	100%***	Oral Evaluations	Limited to 2 evaluations in a plan year.
			Bitewing X-rays	Limited to 2 sets in a plan year.
			Full Mouth X-rays or Panoramic X-rays	Limited to 1 in a 36 month period.
			Routine Cleaning	Limited to 2 cleanings in a plan year.
			Fluoride Treatments	Limited to 2 treatments in a plan year to age 15.
			Space Maintainers	For premature loss of baby teeth only to age 19.
			Sealants	1 per tooth in 36 months to age 15 on unrestored permanent molars.

### BASIC SERVICES (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (Extractions))

PPO *	PREMIER **	NON-PAR ***	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
70%*	70%**	70%***	Amalgam Fillings	Benefit on the same surface limited to 1 in 12 months.
			Resin, Composite Fillings	Benefit on the same surface limited to 1 in 12 months. Posterior and Anterior teeth.
			Oral Surgery (Extractions)	
			General Anesthesia	Benefit with covered oral surgery only.
			Surgical Periodontal (Gums)	Benefit once every 36 months.
			Root Canal Therapy	

### MAJOR SERVICES (Crowns, Bridges, Dentures, Partials, Implants)

PPO *	PREMIER **	NON-PAR ***	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
50%*	50%**	50%***	Crowns	Benefit 1 in 60 months on same tooth. Not a benefit under age 12.
			Bridges, Dentures, Partials	Benefit 1 in 60 months. Not a benefit under age 16.
			Implants	Benefit 1 in 60 months on same tooth.
			Denture Rebase/Reline	Benefit 6 months after initial insertion then benefit 1 in 36 months.
			Occlusal Guard (Night Guard)	Benefit limited to one per lifetime.

- \* **PPO Dentist** - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
- \*\* **Premier Dentist** - Payment is based on the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- \*\*\* **Non-Participating Dentist** - Payment is based on the PPO allowable fee. Members are responsible for the difference between the PPO allowable fee and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

**To Find a Dentist- [www.deltadentalco.com](http://www.deltadentalco.com) Customer Service Phone (800) 610-0201**

**Important Note:** This form provides only a brief description of services covered under your contract and does not list those services which are limited or excluded from coverage. Your Summary Plan Description provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this Summary of Benefits and your Summary Plan Description, the Summary Plan Description will govern.