# Delta Dental PPO Plan
# State of Colorado Group #7649 BASIC PLAN

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| **MAXIMUM BENEFIT**<br>**Plan Year** | $1,000 per person Combination of in and out-of-network |
| **PLAN YEAR DEDUCTIBLE**<br>Applies to Basic and Major only. | Individual Deductible- $ 50.00 Combination of in and out-of-network<br>Family Deductible - $150.00 Combination of in and out-of-network |
| **WHO CAN BE COVERED** | Employee, Spouse, Same Gender Domestic Partner and Dependent Children to the end of the month age 25 |

| PPO* | NON-PPO *Premier & *Non-Par | COVERED SERVICES | BENEFIT INFORMATION (subject to Delta Dental guidelines) |
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| **PREVENTIVE AND DIAGNOSTIC SERVICES** | | | |
| 100% | 100% of PPO allowable * | Oral Evaluations | Limited to 2 evaluations in the plan year |
| | | Bitewing X-rays | Limited to 2 sets in the plan year |
| | | Full Mouth X-rays or Panoramic | Limited to 1 in a 36 month period |
| | | Routine Cleaning | Limited to 2 cleanings in the plan year |
| | | Fluoride Treatments | Limited to 2 treatments in the 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)) | | | |
| 70% | 70% of PPO allowable * | 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<br>Posterior and anterior |
| | | 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, Partials, Dentures, Implants) | | | |
| 50% | 50% of PPO allowable * | Crowns | Benefit 1 in 60 months on same tooth. Not a benefit under age 12 |
| | | Dentures, Partials, Bridges | Benefit 1 in 60 months. Not a benefit under age 16 |
| | | Bridge/Denture Repair | |
| | | Denture Rebase/Reline | Benefit 6 months after initial insertion then benefit 1 in 36 months |
| | | Implants | |

* If you do not use a PPO dentist, and the dentist's charges are more than the PPO Dentist's Allowable Fee, **you will be responsible for any excess**. If you see a Premier Dentist, **you will be responsible for the difference between the PPO Dentist's Allowable Fee and the fee from the Premier Maximum Allowance**. If you see a non participating dentist, **you will be responsible for the difference between the PPO Dentist's Allowable Fee and the full billed charges**.

To Find a Dentist- www.deltadentalco.com Customer Service Phone- (303) 741 9305 or (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.