



Delta Dental PPO Plan State of Colorado Group #7650 BASIC PLUS PLAN

MAXIMUM BENEFIT - Plan Year Orthodontic Lifetime – Eligible employee and dependents		\$2,000 per person Combination of in and out-of-network \$2,000 per person Combination of in and out-of-network	
PLAN YEAR DEDUCTIBLE Applies to Basic and Major only.		Individual Deductible- \$ 50.00 Combination of in and out-of-network 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)
PREVENTIVE AND DIAGNOSTIC SERVICES			
100%	100% of PPO allowable *	Oral Evaluation	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	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))			
80%	80% 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 Posterior or 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	
ORTHODONTICS (Braces) For each eligible employee or their eligible dependents			
50%	50% of PPO Allowable *	Complete Orthodontic Evaluation	
		Active Orthodontic Treatment.	

*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.