DELTA DENTAL

Delta Dental PPO™ plus Premier Plan
State of Colorado – Group #7649 BASIC PLAN

MAXIMUM BENEFIT Plan Year Maximum	$1,500 per person, per plan year. (Combination of in and out of network)
PLAN YEAR DEDUCTIBLE Applies to Basic and Major Services only	Individual Deductible per plan year – $50.00 Combination of in and out-of-network Family Deductible per plan year – $150.00 Combination of in and out-of-network
Prevention First	Diagnostic and Preventive services do not count against the annual maximum.
Right Start 4 Kids® (RS4K) PPO and Premier Networks only	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics, if selected as part of the group's plan, is not covered at 100% but at the plan's listed coinsurance.
WHO CAN BE COVERED?	Employee, Spouse (including Common Law Spouse), 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 Dentist*	PREMIER Dentist**	NON-PAR Dentist***	Covered Services	Benefit Information (Subject to Delta Dental Guidelines)
DIAGNOSTIC AND PREVENTATIVE SERVICES				
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 through age 14.
			Space Maintainers	For premature loss of baby teeth only through age 18.
			Sealants	1 per tooth in 36 months to age 15 on unrestored permanent molars.
BASIC SERVICES				
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				
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.

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.