DELTA DENTAL

Delta Dental PPO^{SM} plus Premier Plan
State of Colorado - Group #7650 BASIC PLUS PLAN

ANNUAL MAXIMUM BENEFIT **PREVENTION FIRST BENEFIT**	**$3,000** per person per plan year. Combination of in and out-of-network. **Diagnostic & Preventive services do not count toward annual maximum benefit**.
ORTHODONTIC LIFETIME BENEFIT	**$3,000** per person per lifetime. Combination of in and out-of-network. **Please note:** the $3000 orthodontic benefit per person per lifetime will only apply to **new** orthodontic treatment plans that start on or after 7/1/2016.
PLAN YEAR DEDUCTIBLE Applies to Basic and Major Services only	Individual deductible per plan year - **$50**. Combination of in and out-of-network. Family deductible per plan year - **$150**. Combination of in and out-of-network.
WHO CAN BE COVERED	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)
DIAGNOSTIC & PREVENTIVE SERVICES (Prevention First benefit included for all networks)				
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)				
80%*	80%**	80%***	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)				
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.
ORTHODONTICS (Braces) For each eligible employee or their eligible dependents				
50%*	50%**	50%***	Complete Orthodontic Evaluation.	
			Active Orthodontic Treatment.	

* **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 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.