

## Delta Dental PPO Plan University of Colorado & Affiliates - PPO PLAN

<b>MAXIMUM BENEFIT - Plan Year</b> Orthodontic Lifetime – Eligible dependents to age 19			\$2,000 per person - Combination of in and out-of-network \$1,500 per person - Combination of in and out-of-network	
<b>PLAN YEAR DEDUCTIBLE</b> Applies to Basic and Major Services			<b>Per Person Deductible:</b> \$50 PPO Dentist; \$75 Premier & Non-Par Dentists (Combination of in and out-of-network) There is No Family Deductible Limit	
PPO*	Premier **	Non Par ***	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
<b>PREVENTIVE AND DIAGNOSTIC SERVICES</b>				
0%	0%	0%	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 17
			Space Maintainers	For premature loss of baby teeth only to age 17
			Sealants	1 per tooth in 36 months to age 17 on unrestored permanent molars
<b>BASIC SERVICES</b> (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions))				
20%	40%	40%	Amalgam Fillings	Benefit on the same surface limited to 1 in 12 months on posterior teeth.
			Resin, Composite Fillings	Benefit for anterior teeth on the same surface in a 12 month period. Not a recognized benefit on posterior teeth.
30%	50%	50%	Oral Surgery (Extractions)	
			General Anesthesia	Benefit with covered oral surgery only
			Surgical Periodontal (gums)	Benefit once every 36 months
			Root Canal Therapy	
<b>MAJOR SERVICES</b> (Crowns, Bridges, Partials, Dentures, Implants)				
50%	60%	60%	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	Benefit 1 in 60 months on same tooth
<b>ORTHODONTICS</b> (Braces) For each eligible dependent to age 19				
50%	60%	60%	Complete Orthodontic Evaluation	
			Active Orthodontic Treatment.	

Percentages listed above are Member responsibility, except for potential balance billing from Non-Participating providers as outlined below.

\*The PPO percentage of benefits is based on the PPO Schedule of Allowances.

\*\* The Premier percentage of benefits is limited to the Premier Maximum Plan Allowance.

\*\*\* The non-participating percentage of benefits is limited to the non-participating Maximum Plan Allowance. You will be responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the 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.