DELTA DENTAL

Delta Dental PPO Plan
CU Health Plan-Dental PPO

MAXIMUM BENEFIT - Plan Year 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
PLAN YEAR DEDUCTIBLE Applies to Basic and Major Services	**Per Person Deductible**: $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)
PREVENTIVE AND DIAGNOSTIC SERVICES				
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
BASIC SERVICES (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	
MAJOR SERVICES (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
ORTHODONTICS (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, go to **deltadentalco.com** or call **customer service at 1-800-610-0201.**

Important Note: This form provides only a brief description of services covered under your contract and does not list those services that are limited or excluded from coverage. Your benefit booklet provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this summary of benefits and your benefit booklet, the benefit booklet will govern.