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

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				
100%	100%	100%	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 through age 15
			Space Maintainers	For premature loss of baby teeth only to age 16
			Sealants	1 per tooth in 36 months to age 16 on unrestored permanent molars
BASIC SERVICES (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions)				
80%	60%	60%	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.
70%	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%	40%	40%	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%	40%	40%	Complete Orthodontic Evaluation	
			Active Orthodontic Treatment.	

*__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 **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.