

Delta Dental PPO PLAN

SBCCOE Benefit and Trust Fund Group #9581 (Option II)

MAXIMUM BENEFIT (Plan Year Benefit 7/1-6/30)			\$1,000 per person Combination of in and out of network		
IMPLANTS (Lifetime Benefit)			\$1,000 per person Combination of in and out of network		
PLAN YEAR DEDUCTIBLE Applies to Basic and Major only			Individual Deductible- \$ 50.00 Combination of in and out-of-network Family Deductible - \$150.00 Combination of in and out-of-network		
WHO CAN BE COVERED			Employee, Spouse and Dependent Children to age 26.		
IN- NETWORK		Out of Network	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)	
*PPO Dentist	**PREMIER Dentist	***NON- PAR Dentist			
PREVENTIVE AND DIAGNOSTIC SERVICES					
50%	50%	50%	Oral Evaluation	Limited to 2 evaluations per plan year	
			Bitewing X-rays	Limited to 1 set per plan year	
			Full Mouth X-rays or Panoramic	Limited to 1 in a 36 month period	
			Routine Cleaning	Limited to 2 cleanings per plan year	
			Fluoride Treatments	Limited to 1 treatment per plan year to age 16	
			Space Maintainers	For posterior primary teeth- to age 14	
			Sealants	1 per tooth in 36 months- to age 15 on unrestored molars	
BASIC SERVICES (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions))					
50%	50%	50%	Amalgam Fillings	Benefits on the same surface limited to 1 in 12 months	
			Resin or Composite Fillings	Benefit for anterior teeth only- allowance for amalgam on posterior teeth	
			General Anesthesia	Benefit with covered Oral Surgery only	
			Surgical Periodontal (gums)	Benefit once every 36 months	
			Periodontal Maintenance Cleanings	Limited to 2 per plan year (in addition to routine cleanings)	
			Root Canal Therapy		
MAJOR SERVICES (Crowns, Bridges, Partials, Dentures)					
50%	50%	50%	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	
IMPLANTS					
50%	50%	50%	Implant Services		

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

**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 # is 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 Delta Dental Summary Plan Description Booklet 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 Booklet the Booklet will govern.