

## Delta Dental PPO PLAN

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

<b>MAXIMUM BENEFIT (Plan Year Benefit 7/1-6/30)</b>			\$2,000 per person <b>Combination of in and out of network</b>	
<b>ORTHODONTIC (Lifetime Benefit)</b>			\$2,000 per person <b>Combination of in and out of network</b>	
<b>IMPLANTS (Lifetime Benefit)</b>			\$2,000 per person <b>Combination of in and out of network</b>	
<b>PLAN YEAR DEDUCTIBLE</b> Applies to Basic and Major only			Individual Deductible- \$ 50.00 <b>Combination of in and out-of-network</b> Family Deductible - \$150.00 <b>Combination of in and out-of-network</b>	
<b>WHO CAN BE COVERED</b>			Employee, Spouse and Dependent Children to age 26. Orthodontics for Employee, Spouse and Dependent Children to age 26.	
<b>IN- NETWORK</b>		<b>Out of Network</b>	<b>COVERED SERVICES</b>	<b>BENEFIT INFORMATION (subject to Delta Dental guidelines)</b>
<u>*PPO Dentist</u>	<u>**PREMIER Dentist</u>	<u>***NON-PAR Dentist</u>		
<b>PREVENTIVE AND DIAGNOSTIC SERVICES</b>				
100%	80%	80%	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
<b>BASIC SERVICES (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions))</b>				
80%	60%	60%	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	
<b>MAJOR SERVICES (Crowns, Bridges, Partial, Dentures)</b>				
50%	40%	40%	Crowns	Benefit 1 in 60 months on same tooth- not a benefit under age 12
			Dentures, Partial, Bridges	Benefit 1 in 60 months- not a benefit under age 16
<b>IMPLANTS</b>				
50%	50%	50%	Implant Services	
<b>ORTHODONTICS (Braces)</b>				
50%	50%	50%	Active Orthodontic Treatment	

\*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](http://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.