



**Delta Dental PPO  
City of Boulder—Group # 7572 (Low Option)**

<b>MAXIMUM BENEFIT (Calendar Year)</b>			\$1,000 per person (Covered Diagnostic & Preventive services do not count toward your calendar year maximum.)	
<b>TMJ Lifetime</b>			\$800 per person	
<b>CALENDAR YEAR DEDUCTIBLE</b> Applies to Basic and Major only if PPO dentist is used. Applies to Preventive, Diagnostic, Basic and Major Services if a Non-PPO dentist is used.			Individual Deductible - \$ 50.00 Family Deductible - \$150.00	
<b>WHO CAN BE COVERED</b>			Employee, Spouse and Dependent Children to age 26.	
<b>PPO Dentist</b>	<b>PREMIER Dentist</b>	<b>Non-Network</b>	<b>COVERED SERVICES</b>	<b>BENEFIT INFORMATION</b> (subject to Delta Dental guidelines)
<b>PREVENTIVE AND DIAGNOSTIC SERVICES</b>				
100%	80%	80%	Oral Evaluations	Limited to 2 evaluations in a 12 month period
			Bitewing X-rays	Limited to 2 sets in a 12 month period
			Full Mouth X-rays	Limited to 1 in a 36 month period
			Routine Cleaning	Limited to 2 cleanings in a 12 month period
			Fluoride Treatments	Limited to 2 treatments in a 12 month period- 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%	50%	50%	Fillings	Benefits on the same surface limited to 1 in 12 months
			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 (Crowns, Bridges, Partials, Dentures)</b>				
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
<b>ORTHODONTIA SERVICES: NOT COVERED</b>				
<b>TMJ (Temporomandibular Joint Dysfunction)</b>				
80%	50%	50%	TMJ	

PPO Dental Provider- The PPO percentage of benefits is based on the PPO Schedule of Allowance.  
 Premier Dental Provider- The PREMIER percentage of benefits is limited to the Maximum Plan Allowance.  
 Non-participating Dental Provider- The non-participating percentage of benefits is limited to the out of network maximum. You will be responsible for the difference between the non-participating plan allowance and the full fee charged by the dental provider.

Group has Annual Open Enrollment

To Find a Dental Provider- [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 Employee Benefit Booklet provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this Summary of Benefits and your Employee Benefit Booklet, the Benefit Booklet will govern.*