

## Delta Dental PPO PLAN

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

<b>MAXIMUM BENEFIT</b> (Plan Year Benefit 7/1-6/30)			<b>\$3,000 per person</b> (Combination of in and out of network)	
<b>ORTHODONTIC</b> (Lifetime Benefit)			<b>\$2,000 per person</b> (Combination of in and out of network)	
<b>IMPLANTS</b> (Lifetime Benefit)			<b>\$2,000 per person</b> (Combination of in and out of network)	
<b>PLAN YEAR DEDUCTIBLE</b> Applies to Basic and Major only			<b>Individual Deductible</b> - \$50 (Combination of in and out-of-network) <b>Family Deductible</b> - \$150 (Combination of in and out-of-network)	
<b>WHO CAN BE COVERED</b>			Employee, Spouse and Dependent Children to age 26, including orthodontics.	
IN-NETWORK		Out of Network	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
*PPO Dentist	**PREMIER Dentist	***NON-PAR Dentist		
<b>PREVENTIVE AND DIAGNOSTIC SERVICES</b>				
100%	80%	80%	Oral Evaluation	Limited to 2 evaluations per plan year
			Bitewing X-rays	Limited to 2 sets 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 (2 additional cleanings may be covered with documentation of special need)
			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 17 on unrestored molars
<b>BASIC SERVICES</b> [Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions)]				
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</b> (Crowns, Bridges, Partials, Dentures)				
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
<b>IMPLANTS</b>				
50%	50%	50%	Implant Services	
<b>ORTHODONTICS</b> (Braces)				
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.