DELTA DENTAL

Delta Dental PPO PLAN

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

MAXIMUM BENEFIT (Plan Year Benefit 7/1-6/30) **IMPLANTS** (Lifetime Benefit)	**$1,000 per person** (Combination of in and out of network) **$1,000 per person** (Combination of in and out of network)
PLAN YEAR DEDUCTIBLE (Applies to Basic and Major only)	**Individual Deductible** - $50 (Combination of in and out-of-network) **Family Deductible** - $150 (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 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
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.*