

DENTAL PLAN**Delta Dental Plan #7302-1051 with PPO Option**

Benefits and Covered Services		Out-of-Network using a non-PPO Dentist	PPO OPTION ** In-Network using a Delta PPO Dentist
Annual Maximum		\$3,000 per person each calendar year	\$3,200 per person each calendar year
Annual Deductible		\$0	\$0
Co-Pay	For Diagnostic, Preventive and Basic Services, Cleanings, Endodontics (root canals), Periodontics (gum treatment), Oral Surgery, Crowns, Inlays, Onlays and Cast Restorations	70-100%	70-100%
		This is an incentive plan. Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive and basic services and 70% of the contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.	
# Cleanings		3 per year	3 per year
Prosthodontics	Bridges and Dentures	70%	70%
Dental Accident Benefits		100% (separate \$1,000 maximum per person each calendar year)	100% (separate \$1,000 maximum per person each calendar year)
Excluded Services		Implants and Orthodontia are not covered.	Implants and Orthodontia are not covered.

Monthly Dental Billed Rates	Employee only	\$68.04
	Employee + one	\$136.08
	Family	\$197.32

Delta Dental contact information:

1-800-765-6003

www.deltadentalins.com

THIS ILLUSTRATION IS NOT A COMPLETE LISTING of all of the benefit provisions, limitations and qualifications. The above is intended for informational use only. If this information conflicts with the Delta Dental contract in any way, the contract will prevail.

Payroll & Benefits: (415) 492-3712 or email: aerlandson@dixieschooldistrict.org