inshore

DELTA DENTAL®

Delta Dental PPO VOLUNTARY Benefit and Rate Sheet

Available in CO[1]
Group Size: 2+

PPO VOLUNTARY DELTA DENTAL PLANS												
Plan Name	PPO $750 W2881			PPO + PREMIER $1500 W2882			MAC PPO $2000 W2883			MAC PPO $1000 w/ORTHO W2884		
Network	PPO Provider	Premier Provider	Non-Participating Provider	PPO Provider	Premier Provider	Non-Participating Provider	PPO Provider	Premier Provider	Non-Participating Provider	PPO Provider	Premier Provider	Non-Participating Provider
Deductible												
Individual	$50	N/A	N/A	$100			$50			$50		
Family	$150	N/A	N/A	$300			$150			$150		
Waived for Preventive	Yes	N/A	N/A	Yes			Yes			Yes		
Annual Max Benefit	$750	N/A	N/A	$1500			$2000			$1000		
Orthodontic Lifetime Max	N/A	N/A	N/A	N/A			N/A			$1000		
Dental Benefit												
Preventive Services	100%	N/A	N/A	100%	100%	50%	100%	50%	50%	100%	50%	50%
Cleaning Allowances	2 per calendar year	N/A	N/A	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year	2 per calendar year
Basic Services	40%	N/A	N/A	80%	80%	50%	80%	50%	50%	80%	50%	50%
Endodontic	40%	N/A	N/A	Major Service 50%	Major Service 50%	40%	80%	50%	50%	80%	50%	50%
Periodontal	40%	N/A	N/A	Major Service 50%	Major Service 50%	40%	80%	50%	50%	80%	50%	50%
Oral Surgery	40%	N/A	N/A	Major Service 50%	Major Service 50%	40%	80%	50%	50%	80%	50%	50%
Major Services	40%	N/A	N/A	50%	50%	40%	50%	40%	40%	50%	40%	40%
Prosthodontics	40%	N/A	N/A	50%	50%	40%	50%	40%	40%	50%	40%	40%
Implants	Yes	N/A	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Missing Tooth Clause	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Major Service Waiting Period	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Reimbursement Schedule	PPO[2]			PPO or Premier[3]			PPO[4]			PPO[4]		
Orthodontic Benefit												
Orthodontics	N/A			N/A			N/A			50%		
Orthodontics Available To	N/A			N/A			N/A			Adult and Child		
Orthodontic Waiting Period	N/A			N/A			N/A			12 months		
Rates for 2024 Effective Dates - $15 administration fee applies to each monthly invoice.												
Member Only	$25.38			$36.72			$34.83			$29.29		
Member + Spouse/DP	$45.88			$67.43			$63.85			$54.79		
Member + 1 Child	$45.88			$67.43			$63.85			$54.79		
Member + Children	$76.64			$113.51			$107.38			$100.72		
Member + Family	$76.64			$113.51			$107.38			$100.72		
Rate Guarantee	1 year			1 year			1 year			1 year		

SIC code is required. Certain industries are ineligible to purchase these plans, such as: Dental Offices 8021, Dental Labs 8071, Medical Labs 8072, and Seasonal Employees, Part-time help and groups without an SIC. This is a summary of benefits. For more detailed information, view the carrier's Summary of Benefits.

1 Delta Dental plans are available to groups of 2 or more enrolled employees. Group must be headquartered in CO. Employees and their enrolled dependents can reside in any state. Voluntary plans assume employer is paying 0%-100% of the member's premium.

2 If you do not use a participating Delta Dental PPO Provider, you will be responsible for all charges incurred.

3 Reimbursement is based on PPO allowable fees for PPO dentists, Premier maximum allowable fees for Premier dentists and program allowance for non-Delta Dental dentists. You may incur additional out-of-pocket costs at Premier or a non-participating provider.

4 Reimbursement for all providers is based on the PPO contracted fee.

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