



**Delta Dental Premier – Low Option Plan – Benefit Summary**  
**Available Statewide**

<b>Maximum Benefit</b> Calendar Year	\$400	
<b>Calendar Year Deductible</b>	None	
<b>Who Can be Covered</b>	Determined by employer.	
<b>Covered Services</b>	<b>Benefit</b>	
<b>Premier Network and Nonparticipating dentists</b>		
<b>Diagnostic and Preventive Services</b>		
100%*	Oral Evaluation	Limited to 1 in a 6 month period.
	Routine Cleaning	Limited to 1 in a 6 month period.
	Fluoride treatments	Limited to 1 in a 12 month period to age 16.
	All X-rays	Limited to: Bitewings 1 in 12 months, Full-mouth & Panoramic 1 in 60 months.
	Space maintainers	For premature loss of baby teeth only under age 14.
	Sealants	1 per tooth in 36 months under age 15.
<b>BENEFITS LISTED BELOW ARE NOT A COVERED BENEFIT. DISCOUNTS APPLY WHEN YOU VISIT A PARTICIPATING DENTIST.</b>		
<b>BASIC SERVICES – DISCOUNTS APPLY</b>		
<b>MAJOR SERVICES - DISCOUNTS APPLY</b>		
<b>ORTHODONTICS (Braces) - DISCOUNTS APPLY</b>		
<b>Participation Options – Please choose one option:</b>		
<input type="checkbox"/> <b>Contributory</b>	All eligible employees have the option to enroll in the Delta Dental plan. Employees who enroll in the dental plan may enroll or waive enrollment for their spouse and/or dependent children. Minimum employer contribution is 50% of the Employee Only premium. The greater of 2 or 50% of all eligible employees are required to enroll in the dental plan.	
<input type="checkbox"/> <b>Voluntary</b>	All eligible employees have the option to enroll in the Delta Dental plan. Employees who enroll in the dental plan may enroll or waive enrollment for their spouse and/or dependent children. Employers may contribute 0% to 49% of the Employee Only premium. The greater of 2 or 20% of all eligible employees are required to enroll in the dental plan.	

\*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.

Important Note: This form provides only a brief description of services covered under the contract and does not list those services which are limited or excluded from coverage. The Employee Benefit Booklet provides a more complete explanation of the coverage. If differences exist between this Summary of Benefits and the Employee Benefit Booklet, the Benefit Booklet will govern.

**This plan is offered with your group health plan through Rocky Mountain Health Plans.**