



**Delta Dental PPO<sup>SM</sup>**  
**DENVER HEALTH ELEVATE - Group # W2978**

<b>MAXIMUM BENEFIT</b> Calendar Year Maximum			None	
<b>CALENDAR YEAR DEDUCTIBLE</b> Applies to Basic and Major Services			None	
<b>PPO</b> Dentist	<b>PREMIER</b> Dentist	<b>NON-PAR</b> Dentist	<b>COVERED SERVICES</b>	<b>BENEFIT INFORMATION</b> (subject to Delta Dental guidelines)
<b>SERVICES</b>				
100%	N/A	N/A	Oral Exams and Cleanings	Twice each in a calendar year. For history of prior definitive periodontal treatment, or certain medical conditions, 2 additional cleanings will be provided during the calendar year.
			Bitewing X-Rays	Once in a calendar year
			Full Mouth X-Rays	Covered once per calendar year under any Delta Dental plan unless documentation of special need is provided

You are enrolled in a Delta Dental PPO Only plan. There is no benefit outside of the PPO network.

**PPO Provider** – Payment is based on the PPO provider’s allowable fee, or the actual fee charged, whichever is less.

**Premier Provider** – No benefit.

**Non-Participating Provider** – No benefit.

This is a brief description of services covered under your dental plan. Please refer to the Benefit Booklet for full plan details. If differences exist between this summary and the Benefit Booklet, the Benefit Booklet will govern.

Delta Dental of Colorado Customer Service: 1-800-610-0201 | [customer\\_service@ddpco.com](mailto:customer_service@ddpco.com). Find us online at [deltadentalco.com](http://deltadentalco.com).

This Delta Dental benefit applies to adult Elevate Exchange members age 19 and above.