

**MARICOPA COUNTY**  
**COVERED DENTAL SERVICES**  
**DELTA DENTAL OF ARIZONA**  
**PPO Plus Premier Plan Network**  
**Group #4500**  
**Benefits Effective 07/01/11**

**ROUTINE SERVICES**

**100%**

DIAGNOSTIC:

Exams, evaluations or consultations (Twice in a benefit year)  
X-rays: Full Mouth/Panorex or vertical bitewings (Once in a three-year period)  
    Bitewing (Twice in a benefit year)  
    Periapical

PREVENTIVE:

Routine Cleanings (limited to twice in a benefit year, or one difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to not more than once in a five-year period.)  
Topical Application of Fluoride (children through age 17 -Twice in a benefit year)  
Sealants for Children (Once per three-year period for permanent molars & bicuspids up to age 19)  
Space Maintainers (For missing posterior primary (baby) teeth)

EMERGENCY: (Palliative treatment)

Treatment for the relief of pain

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**BASIC SERVICES**

**80%**

RESTORATIVE:

Fillings consisting of silver amalgam; and, for front teeth only, synthetic tooth color fillings  
Stainless Steel Crowns (For primary (baby) teeth only)

ORAL SURGERY:

Extractions

ENDODONTICS: Root Canal Treatment (Permanent Teeth); Pulpotomy (Primary (baby) Teeth)

PERIODONTICS:

Treatment of Gum Disease (Non-surgical-once every two years/Surgical once every three years)  
Periodontal maintenance following periodontal treatment (limited to two cleanings per year in addition to routine cleanings)

BRIDGE AND DENTURE REPAIR:

Repair of such appliances to their original condition including relining of dentures.

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**MAJOR SERVICES**

**50%**

PROSTHODONTICS:

Bridges (Does not provide for lost, misplaced or stolen bridges or dentures.)  
Partial Dentures Five-year waiting period for replacement last performed)  
Complete Dentures

RESTORATIVE: (Five-year waiting period for replacement last performed)

Cast Crowns - Jackets – Onlays – Inlays – synthetic posterior fillings - Implants

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**ORTHODONTIC SERVICES:**

**50%**

For adults & children age 8 and older. Benefits are limited to a maximum of **\$3,000** per lifetime of the patient. This Orthodontic Maximum is separate from the Benefit Year Maximum.

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**BENEFIT YEAR BENEFIT MAXIMUM:**

**\$2,000**

**BENEFIT YEAR DEDUCTIBLE: \$50.00 per Person; \$100.00 per Family**

Note: Deductible does not apply to Routine Services or Orthodontic Services

(\*\*) Predetermination recommended for services over \$250

Student Age – 19-25

[www.deltadentalaz.com](http://www.deltadentalaz.com)

**BENEFITS SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP CONTRACT.**