Delta Dental of Colorado: Family Mesa Plan

Coverage Period: Effective on or after January 1, 2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | Coverage for: Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and cost, you can get the complete terms in the policy or plan document www.deltadentalco.com or by calling 1 (800) 610-0201.

DEDUCTIBLE and OUT OF POCKET MAXIMUM LEVEL	Your Share if you use a		DEDUCTIBLE and OUT OF POCKET MAXIMUM DESCRIPTION
	Preferred Provider (In Network)	Non Preferred Provider (Out of Network)	
Dental EHB Deductible: Individual Child Under 19 years old	$50	Not Covered	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).
Dental EHB Deductible: Three or more Children Under 19 years old	$150	Not Covered	
Maximum Out of Pocket for Dental EHB: Individual Child Under 19 years old	$350	Not Covered	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for Dental care expenses.
Maximum Out of Pocket for Dental EHB: Two or more Children Under 19 years old	$700	Not Covered	
Dental Deductible: Individual Adult	$50	Not Covered	The Annual benefit maximum is the most the carrier would pay during a coverage period (usually one year) for their share of the cost of covered services.
Dental Deductible: Family (Adults and Dependents age 19 years old)	$150	Not Covered	
Annual Benefit Maximum for Dental: Individual Adult	$1,000	Not Covered	

DIAGNOSTIC and PREVENTIVE SERVICES

Services You May Need		Your Share if you use a		Limitations & Frequency
		Preferred Provider (In Network)	Non Preferred Provider (Out of Network)	
Oral Exams	Child	0%	Not Covered	One exam in a 6-month period
	Adult	0%	Not Covered	One exam in a 6-month period
Bitewing X-Rays	Child	0%	Not Covered	One per 12 months
	Adult	0%	Not Covered	One per 12 months
Full Mouth X-Rays	Child	0%	Not Covered	One per 60 months
	Adult	0%	Not Covered	One per 60 months
Fluoride Treatments	Child	0%	Not Covered	Two times per 12 months
	Adult	Not Covered	Not Covered	
Routine Cleaning	Child	0%	Not Covered	One exam in a 6-month period
	Adult	0%	Not Covered	One exam in a 6-month period

Space Maintainer	Child	0%	Not Covered	
	Adult	Not Covered	Not Covered	
Sealants	Child	0%	Not Covered	One time per tooth per 36 months
	Adult	Not Covered	Not Covered	
Palliative Treatment (for pain relief)	Child	40%	Not Covered	
	Adult	40%	Not Covered	
BASIC and MAJOR SERVICE				
Services You May Need		**Your Share if you use a**		**Limitations & Frequency**
		Preferred Provider (In Network)	**Non Preferred Provider (Out of Network)**	
Resin (White) Fillings	Child	40%	Not Covered	Replacements covered after 24 months
	Adult	40%	Not Covered	Replacements covered after 24 months
Sedative Fillings	Child	40%	Not Covered	Not covered during course of endodontic therapy
	Adult	40%	Not Covered	Not covered during course of endodontic therapy
Amalgam (Metal) Fillings	Child	40%	Not Covered	Replacements covered after 24 months
	Adult	40%	Not Covered	Replacements covered after 24 months
Periodontics	Child	40%	Not Covered	See comments below
	Adult	Not Covered	Not Covered	
Oral Surgery	Child	40%	Not Covered	Covered one time in a 36 month period
	Adult	Not Covered	Not Covered	
Root canal therapy	Child	40%	Not Covered	Once per tooth, repeat therapy covered after 36 months
	Adult	Not Covered	Not Covered	
Medically Necessary Orthodontia	Child	40%	Not Covered	Only if Medically Necessary Orthodontic Services.
	Adult	Not Covered	Not Covered	No Adult Coverage
Implants	Adult	Not Covered	Not Covered	
Dentures and Bridges	Adult	Not Covered	Not Covered	
Dentures Repair and Realignment	Adult	Not Covered	Not Covered	

EXCLUDED SERVICES & OTHER COVERED SERVICES

Services Your Plan Does NOT (This isn't a complete list. Check your policy or plan document for other excluded services.)

Routine Orthodontia Any treatment provided primarily for cosmetic purposes Habit applicances, night guards, occlusal guards, and athletic mouth guards Treatment of temporomandibular joint (TMJ) problems	Initial placement of denture or fixed bridge unless needed to replace one functioning natural tooth	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services)

Additional Comments / Services

Periodontics:

- Root scaling and planing covered one time per quadrant in any 24-month period
- Periodontal maintenance covered if 3 months have passed since completion of active periodontal therapy, then one time in a 6 month period
- Osseous surgery covered one time per quadrant every 36 months

Dentures and Bridges:

- Initial fixed bridges or dentures are covered
- Replacement of bridges limited to every 84 months
- Replacement of dentures limited to every 60 months

Under this Delta Dental PPO plan, you must visit any PPO Dentist of your choice. You will receive no benefits if you do not see a PPO provider.