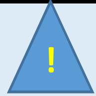
# Delta Dental of Colorado: Family Summit Plan

**Coverage Period: Effective on or after January 1, 2019**

**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 | $2,000 | 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 |

| Services You May Need | | Preferred Provider (In Network) | Non Preferred Provider (Out of Network) | Limitations & Frequency |
|---|---|---|---|---|
| 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 | 30% | Not Covered | |
| | Adult | 30% | 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 | 30% | Not Covered | Replacements covered after 24 months |
| | Adult | 30% | Not Covered | Replacements covered after 24 months |
| Sedative Fillings | Child | 30% | Not Covered | Not covered during course of endodontic therapy |
| | Adult | 30% | Not Covered | Not covered during course of endodontic therapy |
| Amalgam (Metal) Fillings | Child | 30% | Not Covered | Replacements covered after 24 months |
| | Adult | 30% | Not Covered | Replacements covered after 24 months |
| Periodontics | Child | 50% | Not Covered | See comments below |
| | Adult | 50% | Not Covered | See comments below |
| Oral Surgery | Child | 50% | Not Covered | Covered one time in a 36 month period |
| | Adult | 50% | Not Covered | Covered one time in a 36 month period |
| Root canal therapy | Child | 50% | Not Covered | Once per tooth, repeat therapy covered after 36 months |
| | Adult | 50% | Not Covered | Once per tooth, repeat therapy covered after 36 months |
| Medically Necessary Orthodontia | Child | 50% | Not Covered | Requires prior authorization to determine medical necessity |
| | Adult | 50% | Not Covered | Requires prior authorization to determine medical necessity |
| Implants | Adult | 50% | Not Covered | One time per tooth in an 84 month period |
| Dentures and Bridges | Adult | 50% | Not Covered | See comments below |
| Dentures Repair and Realignment | Adult | 50% | 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<br>Any treatment provided primarily for cosmetic purposes<br>Habit applicances, night guards, occlusal guards, and athletic mouth guards<br>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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-610-0201 (TTY: 1-800-659-2656).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-610-0201 (TTY: 1-800-659-2656).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-610-0201 (TTY: 1-800-659-2656)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-610-0201 (TTY: 1-800-659-2656) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-610-0201 (телетайп: 1-800-659-2656).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-610-0201 (መስማት ለተሳናቸው: 1-800-659-2656).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-610-0201 (رقم هاتف الصم والبكم: 1-800-659-2656).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-610-0201 (TTY: 1-800-659-2656).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-610-0201 (ATS: 1-800-659-2656).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-610-0201 (टिटिवाइ: 1-800-659-2656) ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-610-0201 (TTY: 1-800-659-2656).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-610-0201 (TTY: 1-800-659-2656) まで、お電話にてご連絡ください。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.  Bilbilaa 1-800-610-0201 (TTY: 1-800-659-2656).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-610-0201 (TTY: 1-800-659-2656) تماس بگیرید.

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá 1-800-610-0201 (TTY: 1-800-659-2656).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-610-0201 (TTY: 1-800-659-2656).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-610-0201 (TTY: 1-800-659-2656).