Delta Dental of Colorado: Individual / Family Alpine

Coverage Period: Effective on or after January 1, 2022

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	20%	Not Covered	One exam in any 6 month period
	Adult	20%	Not Covered	One exam in any 6 month period
Bitewing X-Rays	Child	20%	Not Covered	One set per 12 month period
	Adult	20%	Not Covered	One set per 12 month period
Full Mouth X-Rays	Child	20%	Not Covered	One per 60 month period
	Adult	20%	Not Covered	One per 60 month period
Fluoride Treatments	Child	20%	Not Covered	Up to 2 per 12 month period
	Adult	Not Covered	Not Covered	No Adult Coverage
Routine Cleaning	Child	20%	Not Covered	One cleaning per 6 month period
	Adult	20%	Not Covered	One cleaning per 6 month period
Space Maintainer	Child	20%	Not Covered	Covered to maintain space left by prematurely lost back baby teeth
	Adult	Not Covered	Not Covered	No Adult Coverage
Sealants	Child	20%	Not Covered	One time per tooth in a 36 month period. Only for chewing surfaces of unrestored teeth.
	Adult	Not Covered	Not Covered	No Adult Coverage
Palliative Treatment (for pain relief)	Child	40%	Not Covered	Only a benefit if no other treatment provided
	Adult	40%	Not Covered	Only a benefit if no other treatment provided

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	One per tooth per 24 months Posterior white fillings only paid at level of metal fillings.
	Adult	40%	Not Covered	
Sedative Fillings	Child	40%	Not Covered	Not covered during the course of endodontic therapy.
	Adult	40%	Not Covered	
Amalgam (Metal) Fillings	Child	40%	Not Covered	One per tooth per 24 months Multiple fillings on same surface payable as one filling.
	Adult	40%	Not Covered	
Periodontics	Child	50%	Not Covered	Scaling/Root Planing - Once per quadrant per 24 mos. One perio surgery per quadrant per 36 mos. Periodontal maintenance covered once every 6 months if 3 months since completion of periodontal therapy.
	Adult	50%	Not Covered	
Oral Surgery	Child	50%	Not Covered	One oral surgery per 36 month period. Local anesthesia and routine post-op care not separately covered.
	Adult	50%	Not Covered	
Root canal therapy	Child	50%	Not Covered	Once per tooth. Repeat treatment only covered 36 months after initial treatment.
	Adult	50%	Not Covered	
Medically Necessary Orthodontia	Child	50%	Not Covered	Only covered as defined in Medically Necessary Orthodontic Services.
	Adult	50%	Not Covered	
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	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 Any treatment primarily for cosmetic purposes Habit appliances, night guards, occlusal guards or athletic mouth guards Treatment of temporomandibular joint (TMJ) problems Initial placement of denture or fixed bridge unless needed to replace one functioning natural tooth.	Services provided by providers other than Delta Dental PPO providers are not covered by this plan.	

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

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

Six-month waiting period for basic services (fillings, basic extractions). Twelve-month waiting period for root canal therapy, periodontics, and oral surgery. 24-month waiting period for other major services (implants, dentures, bridges, crowns).

This plan has no out-of-network benefits. No payment will be made for any services performed by any provider other than a Delta Dental PPO provider.