

**Delta Dental of Colorado: Individual/Family Foothills Plan****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](http://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 any 6-month period
	Adult	0%	Not Covered	One exam in any 6-month period
Bitewing X-Rays	Child	0%	Not Covered	One set per 12 month period
	Adult	0%	Not Covered	One set per 12 month period
Full Mouth X-Rays	Child	0%	Not Covered	One per 60 month period
	Adult	0%	Not Covered	One per 60 month period
Fluoride Treatments	Child	0%	Not Covered	Up to 2 per 12 month period
	Adult	Not Covered	Not Covered	No Adult Coverage
Routine Cleaning	Child	0%	Not Covered	One cleaning per 6 month period
	Adult	0%	Not Covered	One cleaning per 6 month period
Space Maintainer	Child	0%	Not Covered	Covered to maintain space left by prematurely lost back baby teeth
	Adult	Not Covered	Not Covered	No Adult Coverage
Sealants	Child	0%	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	40%	Not Covered	See Comments Below No Adult Coverage
	Adult	Not Covered	Not Covered	
Oral Surgery	Child	40%	Not Covered	One oral surgery per 36 month period. Local anesthesia and routine post-op care not separately covered.
	Adult	Not Covered	Not Covered	
Root canal therapy	Child	40%	Not Covered	Once per tooth. Repeat treatment only covered 36 months after initial treatment.
	Adult	Not Covered	Not Covered	
Medically Necessary Orthodontia	Child	40%	Not Covered	Only if Medically Necessary Orthodontic Services. No Adult Coverage
	Adult	Not Covered	Not Covered	
Implants	Adult	Not Covered	Not Covered	No Adult Coverage
Dentures and Bridges	Adult	Not Covered	Not Covered	See Comments Below - No Adult Coverage
Dentures Repair and	Adult	Not Covered	Not Covered	No Adult Coverage

**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 appliances, 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:**

- Scaling and root 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

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).

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.