TUFTS Health Plan

DentaQuest

BENEFIT SUMMARY

Under Age 19 Plan

(HMO-RI)
In-Network Coverage Only

This is a summary of benefits. Refer to the Evidence of Coverage for a full description of the plan provisions. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

MAXIMUMS		DEDUCTIBLES
Annual Maximum	None	* Indicates Pre-treatment Estimate recommended. ** Prior authorization as required.
Medically Necessary Orthodontic Lifetime Maximum	None	
Maximum Lifetime Cap	Unlimited	
Please refer to your Tufts Health Plan Summary of Benefits and Coverage for information about your out-of-pocket maximum and deductible		

Procedure	Frequency/Limitations †	In-Network
Diagnostic		
Oral Exam	Twice per calendar year	100%
Bitewing x-rays	Two sets per calendar year	100%
Complete x-ray series and panoramic film	Once every 60 months	100%
Single x-rays	As required	100%
Preventive		
Cleaning	Twice per calendar year	100%
Flouride treatement	Twice per calendar year	100%
Sealants	Once every 36 months on unrestored permanent molars	100%
Space maintainers	Once every 60 months for lost deciduous (baby) teeth	100%
Minor Restorative		
Amalgam (silver) fillings	Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.	75%
Repairs to existing partial or complete dentures	Once per calendar year	75%
Recementing crowns or bridges	Once every 60 months	75%
Rebasing or relining of partial or complete dentures	Once every 36 months	75%
Major Restorative		
Crowns, buildups, post and cores *	Covered over natural teeth when teeth cannot be restored with regular fillings. Replacement limited to once every 60 months.	50%
Endodontics		
Root canal therapy		75%
Periodontics		
Periodontal maintenance following active therapy	Twice per calendar year	50%
Root planing and scaling *	Once per quadrant every 24 months	50%
Osseous (bone) surgery *	Once per quadrant every 36 months (bone grafts are not covered)	50%
Gingivectomies *	Once per site every 24 months	50%
Soft tissue grafts *	Once per site every 60 months	50%
Crown lengthening *	Once per site every 60 months	50%

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Prosthodontics		
Bridge and crowns over implants *	Replacement is limited to once every 60 months	50%
Partial and complete dentures *	Replacement is limited to once every 60 months	50%
Surgical placement of endosteal implants and abutment *	Once per tooth site per lifetime	50%
Extractions and Oral Surgery		
Extractions and other routine oral surgery when not covered by a patient's medial plan		75%
Orthodontics		
Medically necessary braces and related services **	**Requires prior authorization.** No payment will be made if not obtained. Covered only when medically. Patient must have severe and handicapping malocclusion as defined by our guidelines. Once per lifetime.	50%
Other Services		
Palliative treatment (minor procedures necessary to relieve acute pain)	Twice per calendar year	75%
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures		75%
Dependent children are covered under these benefits up until the end of the month that they turn age 19.		

★ **Out-of-network care:** This is the amount DentaQuest pays. For services received out-of-network, *your* costs will be greater. *Non-participating dentists* are paid at a reduced level. Please refer to your *Certificate of Coverage* for further details.
† **Time limits** on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Member Services: 844-241-5612
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