DELTA DENTAL®

TUFTS Health Plan

## Under Age 19 Plan Benefits Summary (PPO ADVANTAGE SAVER MA)

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. Visit www.deltadentalma.com/ppo-find-a-dentist/ to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-844-260-6095.

**Deductibles:** Apply to certain services
**Annual Maximum:** None
**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 | Out of Network *** |
|---|---|---|---|
| Diagnostic | | 100% | 80% |
| Oral exam | Twice per policy year. | | |
| Comprehensive exam | Once per lifetime per dentist location | | |
| Bitewing x-rays | Two sets per policy year | | |
| Complete x-ray series and panoramic film | Once every 36 months | | |
| Single x-rays | Limitations apply | | |
| Preventive | | 100% | 80% |
| Cleaning | Twice per policy year | | |
| Fluoride treatment | Once every 3 months | | |
| Sealants | Once every 36 months on unrestored molars | | |
| Space maintainers | | | |
| Minor Restorative | | 75% ** | 55% ** |
| Amalgam (silver) fillings | Once per 12 months per tooth surface | | |
| Composite (white) fillings | Once per 12 months per tooth surface | | |
| Rebassing or relining of partial or complete dentures | Once every 24 months | | |
| Recommending crowns and onlays | | | |
| Major Restorative | | 50% ** | 30% ** |
| Crowns (over natural teeth when teeth cannot be restored with regular fillings). Stainless steel crowns are covered at a different coinsurance amount. * | Replacement limited to once every 60 months | | |
| Endodontics | | 75% ** | 55% ** |
| Root canal therapy on premanent teeth | One procedure per tooth per lifetime | | |
| Vital pulpotomy | One procedure per tooth per lifetime | | |
| Apicoectomy | One procedure per tooth per lifetime | | |
| Periodontics | | 75% ** | 55% ** |
| Root planning and scaling * | Once per quadrant every 36 months | | |
| Prosthodontics | | 50% ** | 30% ** |
| Partial and complete dentures * | Replacement limited to once every 60 months | | |
| Extractions and Oral Surgery | | 75% ** | 55% ** |
| Simple extractions not requiring surgery | | | |
| Surgical extractions and other routine oral surgery when not covered by a patient's medical plan | | | |
| Orthodontics | | 50% ** | 30% |
| Medically necessary braces and related services * **Requires prior authorization.** No payment will be made if not obtained. | Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 22 or higher and/or one or more auto qualifiers. | | |
| Other Services | | 75% ** | 55% ** |
| Palliative treatment (minor procedures necessary to relieve acute pain) | | | |
| General anesthesia or intravenous (I.V.) sedation | | | |

Dependent children are covered under these benefits up until the end of the month they turn age 19.

* Indicates Pre-treatment Estimate recommended/Prior Authorization as required.
** Indicates Deductible applies to this procedure.
*** Out-of-network care: This is the amount Delta Dental pays. For services received out-of-network, your costs will be greater because 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 computed 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 would not be covered again until the following year on July 2 or after.