

Under Age 19 Plan Benefits Summary (HMO ADVANTAGE SAVER MA)

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. 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
Diagnostic Oral exam Comprehensive exam Bitewing x-rays Complete x-ray series and panoramic film Single x-rays	Twice per policy year Once per lifetime per dentist location Two sets per policy year Once every 36 months Limitations apply	100%
Preventive Cleaning Fluoride treatment Sealants Space maintainers	Twice per policy year Once every 3 months Once every 36 months on unrestored molars	100%
Minor Restorative Amalgam (silver) fillings Composite (white) fillings Rebasing or relining of partial or complete dentures Recommending crowns and onlays	Once per 12 months per tooth surface Once per 12 months per tooth surface Once every 24 months	75% **
Major Restorative 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	50% **
Endodontics Root canal therapy on permanent teeth Vital pulpotomy Apicoectomy	One procedure per tooth per lifetime One procedure per tooth per lifetime One procedure per tooth per lifetime	75% **
Periodontics Root planing and scaling *	Once per quadrant every 36 months	75% **
Prosthetic Partial and complete dentures *	Replacement limited to once every 60 months	50% **
Extractions and Oral Surgery Simple extractions not requiring surgery Surgical extractions and other routine oral surgery when not covered by a patient's medical plan		75% **
Orthodontics 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.	50% **
Other Services Palliative treatment (minor procedures necessary to relieve acute pain) General anesthesia or intravenous (I.V.) sedation		75% **

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.

† 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.