

# Delta Dental EPO Pediatric with Out-of-Network Coverage Benefit Summary

## Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental EPO subscriber, you have access to Delta Dental's EPO network in Massachusetts (MA). Participating providers have agreed to offer discounted fees and a no balance billing policy. Should you require care outside of Massachusetts, you have access to Delta Dental's extensive national PPO network with more than 199,000 participating dentist locations nationwide. If you choose to receive services from a provider who does not participate in the EPO in MA, or the PPO out of MA, you will have higher out-of-pocket costs as your benefit is lower and Delta Dental contracted rates and the no balance billing policy do not apply.

Simply visit [www.deltadentalma.com](http://www.deltadentalma.com) to find a participating dentist in your area.

### Learn more at [deltadentalma.com](http://deltadentalma.com)

You can find more information about your benefits plan in the Delta Dental Subscriber Agreement, available from your benefits administrator or online at [www.deltadentalma.com](http://www.deltadentalma.com). In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how the claims and appeal processes work, and more about keeping a healthy mouth for life.

Visit [www.deltadentalma.com](http://www.deltadentalma.com) 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 1-800-872-0500.

## Coverage Summary

Type	Amount	
Deductible Individual	\$50	Deductible waived for Diagnostic and Preventive categories.
Out of Pocket Maximum for members under age 19	\$1,000	

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator. If you receive a treatment after you have exhausted your maximum or if you receive a treatment that will cause you to exceed your maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.

### Your Plan is Administered by:

National Association of  
Socially Responsible Organization  
60 State Street, Suite 700  
Boston, Massachusetts, 02109  
617-308-1525

Rates Effective 01/01/2014-12/31/2014	
<u>Individuals, Sole Proprietors, and Groups with 1 Eligible Employee</u>	
Child under age 19:	\$44.00
<u>Groups with 2+ Eligible Employees</u>	
Child under age 19:	\$27.76

## Delta Dental EPO Pediatric with Out-of-Network Coverage

Category / Procedure	Qualifications for members under age 19	Members under age 19	
		In Network	Out of Network*
<b>Diagnostic</b>			
Comprehensive Evaluation	Once per patient per location.	100%	80%
Periodic Oral Exam	Twice per patient per location per 12 months.	100%	80%
Full Mouth X- rays	Once every 36 months.	100%	80%
Bitewing X-rays	Two per patient per location per 12 months.	100%	80%
Single Tooth X-rays	As needed.	100%	80%
<b>Preventive</b>			
Teeth Cleaning	Twice every 12 months.	100%	80%
Fluoride Treatments	Once every 3 months.	100%	80%
Space Maintainers	Covered.	100%	80%
Sealants	Once per patient per location every 3 years.	100%	80%
<b>Restorative</b>			
Silver Fillings	One per tooth per surface each 12 months.	75%	55%
White Fillings (Front Teeth)	One per tooth per surface per 12 months.	75%	55%
White Fillings (Back Teeth)	One per tooth per surface per 24 months. Multi surfaces will be processed as a silver filling and the patient is responsible up to the submitted charge.	75%	55%
Temporary Fillings	Once per tooth per 60 months.	75%	55%
Stainless Steel Crowns	Four per patient per day.	75%	55%
<b>Oral Surgery</b>			
Simple Extractions	Covered.	75%	55%
Surgical Extractions	Covered.	75%	55%
<b>Periodontics</b>			
Periodontal Surgery	One per quadrant every 36 months.	75%	55%
Scaling and Root Planing	Once per quadrant every 24 months.	75%	55%
Periodontal Cleaning	Not covered.	0%	0%
<b>Endodontics</b>			
Root Canal Treatment	Once per tooth per lifetime.	75%	55%
Vital Pulpotomy	Once per tooth per lifetime.	75%	55%
<b>Prosthetic Maintenance</b>			
Bridge or Denture Repair		75%	55%
Rebase or Reline of Dentures	Once per patient every 24 months.	75%	55%
Recement of Crowns & Onlays		75%	55%
<b>Emergency Dental Care</b>			
Minor treatment for Pain Relief		75%	55%
General Anesthesia	Allowed with covered surgical services only.	75%	55%
<b>Prosthodontics</b>			
Dentures	One per patient per 84 months.	50%	30%
Fixed Bridges and Crowns	Once per tooth per 60 months.	50%	30%
Implants	Not covered	0%	0%
<b>Major Restorative</b>			
Crowns	One per tooth each 60 months.	50%	30%
<b>Orthodontics</b>			
Medically Necessary Orthodonture	Once per lifetime.	50%	30%

\*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.