DELTA DENTAL

Delta Dental PPO
Pediatric with Out-of-Network Coverage
Benefit Summary

Rates Effective 01/01/2014-12/31/2014

Individuals, Sole Proprietors, and Groups with 1 Eligible Employee

Child under age 19:	$45.73

Groups with 2+ Eligible Employees

Child under age 19:	$28.42

Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO subscriber, you have access to Delta Dental's extensive PPO network of more than 207,000 dentist locations nationwide.

With Delta Dental PPO with National Coverage, you enjoy the greatest savings in out-of-pocket expenses when visiting a dentist who participates in the Delta Dental PPO network. Participating dentists typically accept discounted fees for their services, and since your co-payments are based on these fees, you pay lower out-of-pocket costs for your care. You will still receive coverage if you visit a non-participating dentist, but your benefit will be at the out-of-network level shown in the right-hand column of this coverage summary.

To find a dentist, simply visit www.deltadentalma.com (click on the Find a Dentist link and select Delta Dental PPO) or call Delta Dental customer service at 1-800-872-0500.

Learn more at 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. 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 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

Delta Dental PPO Pediatric with Out-of-Network Coverage

Category / Procedure	Qualifications for members under age 19	Members under age 19	
		In Network	Out of Network
Diagnostic			
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%
Preventive			
Teeth Cleaning	Twice every 12 months.	100%	80%
Fluoride Treatments	Once every 3 months.	100%	80%
Space Maintainers	Covered.	100%	80%
Sealants	One per tooth per 36 months.	100%	80%
Restorative			
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 submitteed charge.	75%	55%
Temporary Fillings	Once per tooth per 60 months.	75%	55%
Stainless Steel Crowns	Four per patient per day.	75%	55%
Oral Surgery			
Simple Extractions	Covered.	75%	55%
Surgical Extractions	Covered.	75%	55%
Periodontics			
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%
Endodontics			
Root Canal Treatment	Once per tooth per lifetime.	75%	55%
Vital Pulpotomy	Once per tooth per lifetime.	75%	55%
Prosthetic Maintenance			
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%
Emergency Dental Care			
Minor treatment for Pain Relief		75%	55%
General Anesthesia	Allowed with covered surgical services only.	75%	55%
Prosthodontics			
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%
Major Restorative			
Crowns	One per tooth each 60 months.	50%	30%
Orthodontics			
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.