DELTA DENTAL®

NASRO
National Association of Socially Responsible Organizations

Rates effective 1/1/2015 - 12/31/2015

Individual, sole proprietors and groups with 1 eligible employee:

PMPM by Age
Individual under age 21 = $47.32
Individual age 21 and over = $41.26

Groups with 2+ enrolled employees

Individual under age 19 = $29.76
Individual age 19 and over = $25.52
Individual & Spouse = $53.15
Individual & Child = $53.15
Ind & Children = $96.27
Family = $109.25

Delta Dental EPO Family Enhanced

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 228,000 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, Delta Dental contracted rates and the no balance billing policy do not apply.

Simply visit **www.deltadentalma.com** to find a participating dentist in your area.

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. 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 Family	$50 $150	Deductible waived for Diagnostic and Preventive categories. Deductible waived for Diagnostic and Preventive categories.
Maximum Per Member for members age 19 and over	$1,250	
Out of Pocket Maximum for members under age 19	$350	Limited to $700 per family

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your 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:
Delta Dental of Massachusetts
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

Delta Dental EPO Family Enhanced (pg 2)

Category / Procedure	Qualifications for members under age 19	Qualifications for members age 19 and over	Members under age 19		Members age 19 and over	
			In Network	Out of Network	In Network	Out of Network*
Diagnostic						
Comprehensive Evaluation	Once per patient per location.	Once every 60 months per location.	100%	80%	100%	80%
Periodic Oral Exam	Twice per patient per location per 12 months.	Once every 6 months.	100%	80%	100%	80%
Full Mouth X- rays	Once every 36 months.	Once every 60 months.	100%	80%	100%	80%
Bitewing X-rays	Two per patient per location per 12 months.	Once every 6 months.	100%	80%	100%	80%
Single Tooth X-rays	As needed.	As needed.	100%	80%	100%	80%
Preventive						
Teeth Cleaning	Twice every 12 months.	Once every 6 months.	100%	80%	100%	80%
Fluoride Treatments	Once every 3 months.	Not covered.	100%	80%	0%	0%
Space Maintainers	Covered.	Not covered.	100%	80%	0%	0%
Sealants	Once per patient per location every 3 years.	Not covered.	100%	80%	0%	0%
Restorative						
Silver Fillings	One per tooth per surface each 12 months.	Once every 24 months per surface per tooth.	75%	55%	75%	55%
White Fillings (Front Teeth)	One per tooth per surface per 12 months.	One per tooth per surface per 24 months.	75%	55%	75%	55%
White Fillings (Back Teeth)	One per tooth per surface per 12 months. Multi surfaces will be processed as silver filling and the patient is responsible up to the submitted charge.	One per tooth per surface per 24 months. Multi surfac-es will be processed as a silver filling and the patient is responsible up to the submitted charge.	75%	55%	75%	55%
Temporary Fillings	Once per tooth per 60 months.	Once per tooth per 60 months.	0%	0%	75%	55%
Stainless Steel Crowns	Four per patient per day.		75%	55%	Not Covered	Not Covered
Oral Surgery						
Simple Extractions	Covered.	Once per tooth.	75%	55%	75%	55%
Surgical Extractions	Covered.	Once per tooth.	75%	55%	75%	55%
Periodontics						
Periodontal Surgery	One per quadrant every 36 months.	Once every 36 months per quadrant.	75%	55%	75%	55%
Scaling and Root Planing	One per quadrant every 24 months.	Once per quadrant every 24 months.	75%	55%	75%	55%
Periodontal Cleaning	Not Covered.	Once every 3 months.	0%	0%	100%	80%

Delta Dental EPO Family Enhanced (pg 3)

Endodontics						
Root Canal Treatment	Once per tooth per lifetime.	Once per tooth.	75%	55%	75%	55%
Vital Pulpotomy	Once per tooth per lifetime.	Not covered.	75%	55%	0%	0%
Prosthetic Maintenance						
Bridge or Denture Repair		Once per 12 months, same repair.	75%	55%	75%	55%
Rebase or Reline of Dentures	Once per patient every 24 months.	Once within 36 months.	75%	55%	75%	55%
Recement of Crowns & Onlays		Once per tooth.	75%	55%	75%	55%
Emergency Dental Care						
Minor treatment for Pain Relief		Three occurrences in 12 months.	75%	55%	75%	55%
General Anesthesia	Allowed with covered surgical services only.	Allowed with covered surgical services only.	75%	55%	75%	55%
Prosthodontics		**A 6 month waiting period applies.**				
Dentures	One per patient per 84 months.	Once within 60 months.	50%	30%	50%	30%
Fixed Bridges and Crowns	Once per tooth per 60 months.	When part of a bridge. Once within 60 months.	50%	30%	50%	30%
Implants	Not covered.	Not covered.	0%	0%	0%	0%
Major Restorative		**A 6 month waiting period applies.**				
Crowns	One per tooth each 60 months.	When teeth cannot be restored with regular fillings. Once within 60 months per tooth.	50%	30%	50%	30%
Orthodontics						
Medically Necessary Orthodonture**	Once per lifetime.	Not covered.	50%	30%	0%	0%

Dependents are covered to age 26.

*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.

**Orthodontic services for children under the age of nineteen (19) for severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto Qualifier. Requires prior authorization.

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