

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

Individual, sole proprietors and groups with 1 eligible employee:

PMPM by Age

Individual under age 21 = \$61.47

Individual age 21 and over = \$34.64

Employers with 2+ enrolled employees:

Individual under age 19 = \$39.86

Individual age 19 and over = \$21.60

Individual & Spouse = \$52.34

Individual & Child = \$52.34

Ind & Children = \$109.78

Family = \$115.76

## Delta Dental Premier Family Value

# Benefit Summary

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

As a Delta Dental Premier with National Coverage subscriber, you have access to Delta Dental's extensive national network — Delta Dental Premier is the largest dental network in the country with over 314,000 dentist locations. Three out of four dentists nationwide participate in this network.

With Delta Dental Premier, you enjoy the greatest savings in out-of-pocket expenses when visiting a dentist who participates in the Delta Dental Premier 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](http://www.deltadentalma.com) (click on the Find a Dentist link and select Delta Dental Premier) or call Delta Dental customer service at 1-800-872-0500.

### 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. 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	
<b>Deductible</b>		
Individual	\$50	Deductible waived for Diagnostic and Preventive categories.
Family	\$150	Deductible waived for Diagnostic and Preventive categories.
Maximum Per Member for members age 19 and over	\$750	
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](http://www.deltadentalma.com)

**465 Medford Street**  
**Boston, MA 02129**

## Delta Dental Premier Family Value (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*
<b>Diagnostic</b>						
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%
<b>Preventive</b>						
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	One per tooth per 36 months.	Not covered.	100%	80%	0%	0%
<b>Restorative</b>						
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 a silver filling and the patient is responsible up to the submitted charge.	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%	75%	55%
Temporary Fillings	Once per tooth per 60 months.	Once per tooth per 60 months.	75%	55%	75%	55%
Stainless Steel Crowns	Four per patient per day.		75%	55%	Not Covered	Not Covered
<b>Oral Surgery</b>						
Simple Extractions	Covered.	Once per tooth.	75%	55%	75%	55%
Surgical Extractions	Covered.	Once per tooth.	75%	55%	75%	55%
<b>Periodontics</b>						
Periodontal Surgery	One per quadrant every three years.	Once every 36 months per quadrant.	75%	55%	75%	55%
Scaling and Root Planing	Once 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 Premier Family Value (pg 3)

<b>Endodontics</b>						
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%
<b>Prosthetic Maintenance</b>						
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%
<b>Emergency Dental Care</b>						
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%
<b>Prosthodontics</b>						
Dentures	One per patient per 84 months.	Not covered.	50%	30%	0%	0%
Fixed Bridges and Crowns	Once per tooth per 60 months.	Not covered.	50%	30%	0%	0%
Implants	Not covered.	Not covered.	0%	0%	0%	0%
<b>Major Restorative</b>						
Crowns	One per tooth each 60 months.	Not covered.	50%	30%	0%	0%
<b>Orthodontics</b>						
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.