



## PEDIATRIC PLANS • 2018 Features & Benefit Details

		<b>altus dental</b>	<b>DELTA DENTAL</b>	<b>DELTA DENTAL</b>	<b>DELTA DENTAL</b>	<b>DELTA DENTAL</b>
<b>PLAN NAME</b>		<b>Altus Dental Under Age 19 Plan</b>	<b>Delta Dental Premier Pediatric*</b>	<b>Delta Dental PPO Pediatric*</b>	<b>Delta Dental EPO Pediatric*</b>	<b>Delta Dental EPO Pediatric Basic*</b>
<b>PLAN NETWORK</b>		Altus Dental Participating Dentists	Delta Dental Premier	Delta Dental PPO	Delta Dental EPO	Delta Dental EPO
Is this a smaller network?		No	No	Yes	Yes	Yes
Out-of-network allowed?		Yes	Yes	Yes	Yes	Yes
Annual deductible <sup>1</sup>		\$50	\$50	\$50	\$50	\$100
Maximum annual out-of-pocket				\$350		
Maximum annual per person benefit				None		
Waiting periods				None		
<b>Type I Services: Preventative &amp; Diagnostic Dental Co-Insurance percent (what you pay)</b>		0% In-Network 20% Out-of-Network				
<b>Benefit</b>	<b>Standard Limits</b>	✓ means that the limits are the standard limits or the equivalent				
▪ Comprehensive Evaluation	1 per patient per lifetime	✓	✓	✓	✓	✓
▪ Periodic Oral Exams ▪ Oral Evaluation under 3 years of age ▪ Teeth Cleaning	2 procedures per patient per 12 months	✓	✓	✓	✓	✓
▪ Full Mouth X-Rays ▪ Panoramic X-Rays	1 procedure per patient per 36 months	✓	✓	✓	✓	✓
▪ Single Tooth X-Rays	Covered As Needed	✓	✓	✓	✓	✓
▪ Bitewing X-Rays	2 procedures per patient per 12 months	✓	✓	✓	✓	✓
▪ Periodontal Cleaning		Not Covered				
▪ Fluoride Treatments	1 procedure per 3 months	✓	✓	✓	✓	✓
▪ Space Maintainers	Covered	✓	✓	✓	✓	✓
▪ Sealants	1 procedure per tooth per 36 months	✓	✓	✓	✓	✓

<sup>1</sup> Deductible is waived for diagnostic and preventative procedures.

\*Delta Dental of Massachusetts EPO insurance products are offered by DSM Massachusetts Insurance Company, Inc. Delta Dental of Massachusetts Premier and PPO insurance products are offered by Dental Service of Massachusetts, Inc. Premiums may vary depending on your age, effective date, and family composition. Please call 1-877-MA-ENROLL to obtain a quote.

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PLAN NAME		Altus Dental Under Age 19 Plan	Delta Dental Premier Pediatric*	Delta Dental PPO Pediatric*	Delta Dental EPO Pediatric*	Delta Dental EPO Pediatric Basic*
<b>Type II Services: Basic Restorative Services; Co-Insurance percent (what you pay)</b>		25% In-Network 45% Out-of-Network				60 % In-Network 70% Out-of-Network
<b>Benefit</b>	<b>Standard Limits</b>	✓ means that the limits are the standard limits or the equivalent				
<ul style="list-style-type: none"> <li>▪ Silver Fillings</li> <li>▪ White Fillings<sup>2</sup></li> </ul>	1 procedure per tooth per surface per 12 months	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>▪ Temporary Fillings</li> </ul>	1 procedure per tooth per 60 months	Not Covered	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>▪ Prefabricated Stainless Steel Crowns</li> </ul>	Covered	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>▪ Root canals on permanent teeth</li> <li>▪ Apicoectomy</li> <li>▪ Vital Pulpotomy</li> </ul>	1 procedure per tooth per lifetime	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>▪ Periodontal Scaling and Root Planing</li> </ul>	1 procedure per quadrant per 24 months	1 procedure per quadrant per 36 months	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>▪ Simple Extractions</li> <li>▪ Surgical Extractions</li> </ul>	Covered	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>▪ General Anesthesia</li> <li>▪ Intravenous Conscious Sedation</li> <li>▪ Minor Treatment for Pain Relief</li> </ul>	Covered	✓	✓	✓	✓	✓

<sup>2</sup> Check with your provider for out-of-pocket costs prior to services.

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PLAN NAME		Altus Dental Under Age 19 Plan	Delta Dental Premier Pediatric*	Delta Dental PPO Pediatric*	Delta Dental EPO Pediatric*	Delta Dental EPO Pediatric Basic*
<b>Type III Services: Major Restorative Dental Co-Insurance percent (what you pay)</b>		50% In-Network 70% Out-of-Network				60 % In-Network; 70% Out-of-Network
<b>Benefit</b>	<b>Standard Limits</b>	✓ means that the limits are the standard limits or the equivalent				
▪ Crowns	1 procedure per tooth per 60 months	✓	✓	✓	✓	✓
▪ Partial & Complete Dentures	1 procedure per arch per 84 months	1 procedure per arch per 60 months	✓	✓	✓	✓
▪ Implants	Not Covered					
<b>Type IV Services: Orthodontia Co-Insurance percent (what you pay)</b>		50 % In-Network 70% Out-of-Network				50% In-Network; 70% Out-of-Network
<b>Benefit</b>	<b>Standard Limits</b>	✓ means that the limits are the standard limits or the equivalent				
▪ Medically Necessary Orthodontia	Prior authorization is required; 1 procedure per patient per lifetime	✓	✓	✓	✓	✓
A lock-out period occurs if you purchase a plan and then drop coverage. You cannot repurchase the plan for the following amount of time:		24 months	12 months	12 months	12 months	12 months

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