MASSACHUSETTS HEALTH CONNECTOR

# PLANS FOR FAMILIES AND ADULTS • *Features & Benefit Details*

Plans with Comprehensive Coverage

Plans with Basic Coverage

| PLAN NAME | Altus Dental High Plan | Delta Dental Premier Family Enhanced* | Delta Dental EPO Family Enhanced* | Altus Dental Low Plan | Delta Dental Premier Family Value* | Delta Dental EPO Family Value* | Delta Dental Individual and Family EPO Basic Exclusive Network Plan* |
|---|---|---|---|---|---|---|---|
| **PLAN NETWORK** | Altus Dental Participating Dentists | Delta Dental Premier | Delta Dental EPO | Altus Dental Participating Dentists | Delta Dental Premier | Delta Dental EPO | Delta Dental EPO |
| Is this a smaller network? | No | No | Yes | No | No | Yes | Yes |
| Annual deductible – one enrollee | $50 | | | $50 | | | $100 |
| Annual deductible –family[1] | $150 | | | $150 | | | $300 |
| Maximum annual out-of-pocket – child under 19 years | $350 | | | $350 | | | $350 |
| Maximum annual out-of-pocket – 2 or more children | $700 | | | $700 | | | $700 |
| Maximum annual per person benefit (adults 19 and over only) | $1,250 | | | $750 | | | $750 |
| Maximum annual per person benefit (child) | No Maximum | | | No Maximum | | | |

[1] Deductible is waived for diagnostic and preventative procedures.

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| | Plans with Comprehensive Coverage | | | Plans with Basic Coverage | | | |
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| **PLAN NAME** | **Altus Dental High Plan** | **Delta Dental Premier Family Enhanced*** | **Delta Dental EPO Family Enhanced*** | **Altus Dental Low Plan** | **Delta Dental Premier Family Value*** | **Delta Dental EPO Family Value*** | **Delta Dental Individual and Family EPO Basic Exclusive Network Plan*** |
| **Type I services: Preventative & Diagnostic Dental Co-Insurance percent (what you pay)** | All ages: In-network 0% Out-of-network 20% | | | All ages: In-network 0% Out-of-network 20% | | | All ages: In-network 0%; Out-of-network 100% |
| **For enrollees under 19 years** | | | | | | | |
| **Benefit** | **Standard Limits** | ✓ mean that the limits are the standard limits or the equivalent | | | | | |
| ▪ Comprehensive Evaluation | 1 per patient per location per lifetime | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Periodic Oral Exams<br>▪ Oral Evaluation under 3 years of age<br>▪ Teeth cleaning | 2 Procedures per patient per12 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Full Mouth X-Rays<br>▪ Panoramic X-Rays | 1 Procedure per patient per 36 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Single Tooth X-Rays | As Needed | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Bitewing X-Rays | 2 Procedures per patient per 12 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Periodontal Cleaning | Not Covered | | | | Not Covered | | | |
| ▪ Fluoride Treatments | 1 Procedure per 3 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Space Maintainers | Covered | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Sealants | 1 Procedure per tooth per 36 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

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| **For enrollees 19 years and over** | | | | | | | | |
| **Benefit** | **Standard Limits** | | | | | | | |
| ▪ Comprehensive Evaluation | 1 per patient per 60 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Periodic Oral Exams<br>▪ Teeth Cleaning | Once every 6 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Full Mouth X-Rays<br>▪ Panoramic X-Rays | 1 procedure per patient per 60 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Bitewing X-Rays | Once every 6 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Single Tooth X-Rays | Covered | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Periodontal Cleaning | 1 procedure per 3 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Fluoride Treatments<br>▪ Space Maintainers<br>▪ Sealants | Not Covered | | | | Not Covered | | | |

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| **Type II Services: Basic Restorative Services Co-Insurance percent (what you pay)** | | In-network 25% Out-of-network 45% | | | In-network 25% Out-of-network 45% | | | In-network 60% Out-of-network 100% |
| **For enrollees under 19 years** | | | | | | | | |
| **Benefit** | **Standard Limits** | | | | | | | |
| ▪ Silver Fillings<br>▪ White Fillings[2] | 1 procedure per tooth per surface per 12 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Temporary Fillings | 1 procedure per tooth per 60 months | Not Covered | ✓ | ✓ | Not Covered | ✓ | ✓ | ✓ |
| ▪ Prefabricated Stainless Steel Crowns | Four per patient per day | No Limit per day | ✓ | ✓ | No Limit per day | ✓ | ✓ | ✓ |
| ▪ Root canals on permanent teeth<br>▪ Apicoectomy<br>▪ Vital pulpotomy | 1 procedure per tooth per lifetime | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Periodontal Scaling and Root Planing | 1 procedure per quadrant per 24 months | 1 procedure per quadrant per 36 months | ✓ | ✓ | 1 procedure per quadrant per 36 months | ✓ | ✓ | ✓ |
| ▪ Simple Extractions<br>▪ Surgical Extractions | Covered | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ General Anesthesia<br>▪ Intravenous<br>▪ Conscious Sedation | Allowed with covered surgeries | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Minor Treatment for Pain Relief | Covered | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

[2] Check with your provider for out-of-pocket costs prior to services.

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| **Benefit** | **Standard Limits** | In-network: 25%<br>Out-of-network: 45% | | | In-Network: 25%<br>Out-of-network: 45% | | | In-network: 70%<br>Out-of-network: 100% |
| ▪ Silver Fillings<br>▪ White Fillings[3] | 1 procedure per tooth per surface per 24 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Temporary Fillings | 1 procedure per tooth per 60 months | 1 procedure per tooth per lifetime | ✓ | ✓ | 1 procedure per tooth per lifetime | ✓ | ✓ | ✓ |
| ▪ Periodontal Scaling and Root Planing | 1 procedure per quadrant per 24 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Root canals on permanent teeth<br>▪ Apicoectomy | 1 procedure per tooth per lifetime | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Simple Extractions<br>▪ Surgical Extractions | Covered | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ General Anesthesia<br>▪ Intravenous<br>▪ Conscious Sedation | Allowed with covered surgical procedures | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Minor Treatment for Pain Relief | 3 occurrences in 12 months | Twice per year | ✓ | ✓ | Twice per year | ✓ | ✓ | ✓ |

[3] Check with your provider for out-of-pocket costs prior to services.

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| **Type III Services: Major Restorative Dental Co-Insurance Percent (what you pay)** | ✓means that the limits are the standard limits or the equivalent. | | | | | | |
| **For enrollees under 19 years** | | | | | | | |
| **Benefit** / **Standard Limits** | In-network: 50%<br>Out-of-network: 70% | | | In-network: 50%<br>Out-of-network: 70% | | | In-network 60%; Out-of-network 100% |
| ▪ Waiting Period | None | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Crowns | 1 procedure per tooth per 60 months | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ▪ Partial & Complete Dentures | 1 procedure per arch per 60 months | ✓ | 1 procedure per arch per 84 months | ✓ | 1 procedure per arch per 84 months | 1 procedure per arch per 84 months | 1 procedure per arch per 84 months |
| ▪ Implants | Not Covered | | | Not Covered | | | |
| **For enrollees 19 years and over** | | | | | | | |
| **Benefit** / **Standard Limits** | In-network: 50%<br>Out-of-network: 70% | | | In-network: 100%<br>Out-of-network: 100% | | | In-network 100%; Out-of-network 100% |
| ▪ Waiting Period | 6 months | ✓ | ✓ | ✓ | N/A | N/A | N/A | N/A |
| ▪ Crowns | 1 procedure per tooth per 60 months | 1 procedure per tooth per 84 months | ✓ | ✓ | Not Covered | Not Covered | Not Covered | Not Covered |
| ▪ Partial & Complete Dentures | 1 procedure per tooth per 60 months | 1 procedure per tooth per 84 months | ✓ | ✓ | Not Covered | Not Covered | Not Covered | Not Covered |
| ▪ Implants | Not Covered | | | Not Covered | | | |

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| **Type IV Services: Orthodontia Co-Insurance percent (what you pay)** | | | | | | | | |
| **For enrollees under 19 years** | | | | | | | | |
| **Benefit** | **Standard Limits** | In-network: 50%<br>Out-of-network: 70% | | | In-network: 50%<br>Out-of-network: 70% | | | In-network 60%<br>Out-of-network 100% |
| ▪ Medically necessary orthodontia | Prior authorization is required; 1 procedure per patient per lifetime | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **For enrollees 19 years and over** | | | | | | | | |
| **Benefit** | **Standard Limits** | In-network: 100%<br>Out-of-network: 100% | | | In-network: 100%<br>Out-of-network: 100% | | | |
| ▪ Medically necessary orthodontia | Not Covered | | | | Not Covered | | | |
| **Lock-Out Periods** | | | | | | | | |
| A lock-out period occurs if you purchase a plan and then drop coverage. You cannot re-purchase the plan for the following amount of time: | | 24 months | 12 months | 12 months | 24 months | 12 months | 12 months | 12 months |

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| **For enrollees under 19 years** | | | | | | | | | |
| **Benefit** | **Standard Limits** | In-network 50% Out-of-network 70% | | | | In-network 50% Out-of-network 70% | | | In-network 60% Out-of-network 100% |
| Medically necessary orthodontia | Prior authorization is required; 1 procedure per patient per lifetime | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| **For enrollees 19 years and over** | | | | | | | | | |
| **Benefit** | **Standard Limits** | In-network 100% Out-of-network 100% | | | | In-network 100% Out-of-network 100% | | | |
| Medically necessary orthodontia | Not Covered | | | | | Not Covered | | | |
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| A lock-out period occurs if you purchase a plan and then drop coverage. You cannot re-purhcase the plan for the following amount of time: | | 24 months | 12 months | 12 months | | 24 months | 12 months | 12 months | 12 months |

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