PEDIATRIC PLANS • *Features & Benefit Details*

		altus dental	DELTA DENTAL	DELTA DENTAL	DELTA DENTAL	DELTA DENTAL
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***
PLAN NETWORK		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[1]		$50	$50	$50	$50	$100
Maximum annual out-of-pocket		$350				
Maximum annual per person benefit		None				
Waiting periods		None				
Type I Services: Preventative & Diagnostic Dental Co-Insurance percent (what you pay)		0% In-Network 20% Out-of-Network				
Benefit	**Standard Limits**	✓ 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	✓	✓	✓	✓	✓

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

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MASSACHUSETTS HEALTH CONNECTOR

PEDIATRIC PLANS • *Features & Benefit Details*

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*
Type II Services: Basic Restorative Services; Co-Insurance percent (what you pay)		25% In-Network 45% Out-of-Network				60 % In-Network 70% Out-of-Network
Benefit	**Standard Limits**	✓ means that the limits are the standard limits or the equivalent				
▪ Silver Fillings ▪ White Fillings[2]	1 procedure per tooth per surface per 12 months	✓	✓	✓	✓	✓
▪ Temporary Fillings	1 procedure per tooth per 60 months	Not Covered	✓	✓	✓	✓
▪ Prefabricated Stainless Steel Crowns	Covered	✓	✓	✓	✓	✓
▪ Root canals on permanent teeth ▪ Apicoectomy ▪ 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	✓	✓	✓	✓
▪ Simple Extractions ▪ Surgical Extractions	Covered	✓	✓	✓	✓	✓
▪ General Anesthesia ▪ Intravenous Conscious Sedation ▪ Minor Treatment for Pain Relief	Covered	✓	✓	✓	✓	✓

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

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MASSACHUSETTS HEALTH CONNECTOR

PEDIATRIC PLANS • *Features & Benefit Details*

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***
Type III Services: Major Restorative Dental Co-Insurance percent (what you pay)		50% In-Network 70% Out-of-Network				60 % In-Network; 70% Out-of-Network
Benefit	**Standard Limits**	✓ 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					
Type IV Services: Orthodontia Co-Insurance percent (what you pay)		50 % In-Network 70% Out-of-Network				50% In-Network; 70% Out-of-Network
Benefit	**Standard Limits**	✓ 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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