

Visit [deltadentalma.com](http://deltadentalma.com) for detailed benefit information

## Delta Dental Individual and Family EPO

**Deductible: \$50 per individual / \$150 per family. Deductible waived for Diagnostic and Preventive categories.**

**Calendar Year Maximum: \$1,000 per person.**

|  |  | Co-insurance |
|--|--|--------------|
| Category / Procedure                       | Qualifications   | In Network   |
| <b>Diagnostic</b>                          |  | 100%         |
| Comprehensive Evaluation                   | Once every 60 months.  |              |
| Periodic Oral Exam                         | Twice every 12 months.   |              |
| Full Mouth X- rays                         | Once every 60 months.  |              |
| Bitewing X-rays                            | Twice every 12 months.   |              |
| Single Tooth X-rays                        | As needed.   |              |
| <b>Preventive</b>                          |  | 100%         |
| Teeth Cleaning                             | Twice every 12 months.   |              |
| Fluoride Treatments                        | Twice every 12 months for members under age 19.  |              |
| Space Maintainers                          | Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.  |              |
| Sealants                                   | Unrestored permanent molars, once per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who had a recent cavity and are at risk for decay.  |              |
| Chlorhexidine Mouthrinse                   | This is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing.   |              |
| Fluoride Toothpaste                        | This is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.  |              |
| <b>Restorative</b>                         |  | 70%          |
| Silver Fillings                            | Once every 24 months per surface per tooth.  |              |
| White Fillings (Front Teeth)               | Once every 24 months per surface per tooth.  |              |
| White Fillings (Back Teeth)                | Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings. |              |
| Temporary Fillings                         | Once per tooth.  |              |
| Stainless Steel Crowns                     | Once every 24 months per tooth.  |              |
| <b>Oral Surgery</b>                        |  | 70%          |
| Simple Extractions                         | Once per tooth.  |              |
| Surgical Extractions                       | Once per tooth.  |              |
| <b>Periodontics</b>                        |  | 70%          |
| Periodontal Surgery                        | One surgical procedure per quadrant in 36 months.  |              |
| Scaling and Root Planing                   | Once in 24 months, per quadrant.   |              |
| Periodontal Cleaning                       | Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings.  | 100%         |
| <b>Endodontics</b>                         |  | 70%          |
| Root Canal Treatment                       | Once per tooth.  |              |
| Vital Pulpotomy                            | Limited to deciduous teeth.  |              |
| <b>Prosthetic Maintenance</b>              |  | 70%          |
| Bridge or Denture Repair                   | Once within 12 months, same repair.  |              |
| Rebase or Reline of Dentures               | Once within 36 months.   |              |
| Recement of Crowns & Onlays                | Once per tooth.  |              |
| <b>Emergency Dental Care</b>               |  | 70%          |
| Minor treatment for Pain Relief            | Three occurrences in 12 months.  |              |
| General Anesthesia                         | General Anesthesia and IV sedation are allowed with covered surgical impacted wisdom teeth only.   |              |
| <b>Prosthodontics</b>                      |  | 40%          |
| Dentures                                   | Once within 60 months.   |              |
| Fixed Bridges and Crowns                   | When part of a bridge. Once within 60 months.  |              |
| Implants (only in lieu of a 3-unit bridge) | An Endosteal Implant: Only when it is to replace one missing tooth and when adjacent teeth are healthy and do not require crowns. Once per 60 months per Implant. (Pre-estimates recommended).   |              |
| <b>Major Restorative</b>                   |  | 40%          |
| Crowns                                     | When teeth cannot be restored with regular fillings. Once within 60 months per tooth.  |              |

**Dependent Eligibility:** Eligible dependents up to age 26.

## Additional Benefit Information

Deductible waived for periodontal cleanings.

**Waiting Period:** There is a six month waiting period on Type II services and a twelve month waiting period on Type III services. The waiting period may be waived for former Delta Dental of Massachusetts members under limited circumstances. In order for the waiting period to be waived, your coverage on a comparable Delta Dental of Massachusetts plan would need to have terminated for no more than 60 days prior to the effective date of your Delta Dental Individual and Family EPO plan. A comparable plan must include substantially similar coverage. Members with an in-force dental plan will be subject to the waiting periods under this policy.

**Note:** No Benefits are available for the replacement of teeth missing prior to the member's effective date of coverage.

# Delta Dental EPO



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

As a Delta Dental EPO subscriber, you have access to Delta Dental's EPO network of more than 1,300 dentists in Massachusetts. 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 283,000 participating dentist locations nationwide.

Services from a provider who does not participate in the Delta Dental EPO network in Massachusetts, or the Delta Dental PPO network outside of Massachusetts, are not covered except in some cases for an emergency.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at <http://www.deltadentalma.com/members/discounts-on-covered-services/>

To find a dentist, simply visit [www.deltadentalma.com](http://www.deltadentalma.com) (click on the *Find a Dentist* link and select *Delta Dental EPO*) 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 Member Guide, available online at [www.deltadentalma.com](http://www.deltadentalma.com) or by calling Customer Service. 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.

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 you can get by calling Customer Service at 1-800-872-0500.

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 EPO

## NONDISCRIMINATION NOTICE

Delta Dental of Massachusetts complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental of Massachusetts does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Massachusetts:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, and accessible electronic formats)
  
- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, visit: <http://www.deltadentalma.com> or call the number on your member ID card.

If you believe that Delta Dental of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu  
Civil Rights Coordinator  
Compliance Department  
465 Medford Street  
Boston, MA 02129  
Fax: 617-886-1390  
Phone: 617-886-1683  
Email: [FairTreatment@greatdentalplans.com](mailto:FairTreatment@greatdentalplans.com)  
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

*Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc. Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered DSM Massachusetts Insurance Company, Inc.*

# Delta Dental EPO

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-872-0500 (TTY: 1-844-233-4524).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-872-0500 (TTY: 1-844-233-4524).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-872-0500 (TTY: 1-844-233-4524)。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-872-0500 (TTY: 1-844-233-4524).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-872-0500 (TTY: 1-844-233-4524).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-872-0500 (TTY: 1-844-233-4524).

ملاحظة: إذا كنت تتحدث بلغة أخرى، يمكنك الحصول على خدمات الترجمة اللغوية مجاناً. اتصل بالرقم 1-800-872-0500 (TTY: 1-844-233-4524).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដទៃទៀតគឺអាចមានសំរាប់អ្នក។ ជូរ ទូរស័ព្ទ 1-800-872-0500 (TTY: 1-844-233-4524)។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-872-0500 (TTY: 1-844-233-4524).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-872-0500 (TTY: 1-844-233-4524).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-872-0500 (TTY: 1-844-233-4524) 번으로 전화해 주십시오.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-872-0500 (TTY: 1-844-233-4524).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-872-0500 (TTY: 1-844-233-4524).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-872-0500 (TTY: 1-844-233-4524) पर कॉल करें।

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-872-0500 (TTY: 1-844-233-4524).