DELTA DENTAL®

TUFTS Health Plan

a Point32Health company

Pediatric Dental Care Plan Benefit Summary

(Applies to Tufts Health Direct plans)

In-Network Coverage Only

This is a summary of benefits. For deductible plans, deductibles do apply. To be covered, services must be dentally necessary and appropriate as per our review guidelines. **Note:** Coverage for pediatric dental services runs through the last day of the month in which a Member turns 19 years old.

Visit www.deltadentama.com/epo-find-a-dentist/ 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 1-844-260-6095.

Deductibles: Apply to certain services
Annual Maximum: None
Medically Necessary Orthodonic Lifetime Maximum: None
Maximum Lifetime Cap: Unlimited
Please refer to your Tufts Health Direct Summary of Benefits and Coverage for information about your out-of-pocket maximum and deductible.

Procedure	Frequency/Limitations†	In Network
Diagnostic		100% **
Oral exam	Twice per policy year	
Comprehensive exam	Once per lifetime per dentist location	
Bitewing x-rays	Two sets per policy year	
Complete x-ray series and panoramic film	Once every 36 months	
Single x-rays	Limitations apply	
Preventive		100% **
Cleaning	Twice per policy year	
Fluoride treatment	Once every 3 months	
Sealants	Once every 36 months on unrestored molars	
Space maintainers		
Minor Restorative		75% **
Amalgam (silver) fillings	Once per 12 months per tooth surface	
Composite (white) fillings	Once per 12 months per tooth surface	
Rebassing or relining of partial or complete dentures	Once every 24 months	
Recommending crowns and onlays		
Extractions and Oral Surgery		75% **
Simple extractions not requiring surgery		
Surgical extractions and other routine oral surgery when not covered by a patient's medical plan		
Endodontics		75% **
Root canal therapy on permanent teeth	One procedure per tooth per lifetime	
Vital pulpotomy	One procedure per tooth per lifetime	
Apicoectomy	One procedure per tooth per lifetime	
Periodontics		75% **
Root planing and scaling *	Once per quadrant every 36 months	
Other Services		75% **
Palliative treatment (minor procedures necessary to relieve acute pain)		
General anesthesia or intravenous (I.V.) sedation		
Prosthodontics		50% **
Partial and complete dentures *	Replacement limited to once every 60 months	
Major Restorative		50% **
Crowns (over natural teeth when teeth cannot be restored with regular fillings). Stainless steel crowns are covered at a different coinsurance amount. *	Replacement limited to once every 60 months	
Orthodontics	Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 22 or higher and/or one or more auto qualifiers.	50% **
Medically necessary braces and related services * Requires prior authorization. No payment will be made if not obtained.		

* Indicates Pre-treatment Estimate recommended/Prior Authorization as required.
** For members with a deductible plan, deductible applies to this procedure.

† Time Limits on services (e.g. 6, 12, 24, 36, or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it would not be covered again until the following year on July 2 or after.