

Coverage Summary for
Hologic, Inc. – Enhanced Plan
 Group # 001495-9901
 Effective Date: 07/01/2025

Visit deltadentalma.com for detailed benefit information

Plan Year Deductible (7/1-6/30): \$50 per individual /\$150 per family. Deductible waived for Diagnostic and Preventive categories.

Plan Year Maximum (7/1-6/30): \$2,000 per person. Diagnostic and Preventive services DO NOT apply to plan year maximum.

****The Right Start 4 Kids benefit offers 100% coverage for Diagnostic, Preventive, Basic and Major services for children up to their 13th birthday (see page 2 for details).**

Category / Procedure	Qualifications	Co-insurance	
		In Network	Out of Network*
Diagnostic		100%	100%*
Comprehensive Evaluation	Once every 60 months.		
Periodic Oral Evaluation	Twice every 12 months.		
Consultation	Once every 12 months.		
Panoramic or Full Mouth X-rays	Once every 60 months.		
Bitewing X-rays	Twice every 12 months.		
Single Tooth X-rays	As needed.		
Preventive		100%	100%*
Teeth Cleaning	Twice every 12 months.		
Fluoride Treatments	Twice every 12 months for members under age 19. Also covered for members age 19 and over who have had a recent cavity and are at risk for decay.		
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 bicuspid and permanent molars, once per 48 months per tooth for members to age 19.		
Application of caries arresting medicament	Twice per tooth per 12 months.		
Restorative (Basic)		80%	80%*
Silver and White Fillings	Once every 24 months per surface per tooth.		
Inlays	Once every 60 months per tooth, inlays are processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for an inlay.		
Protective Restorations	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth (on primary teeth only).		
Oral Surgery (Basic)		80%	80%*
Extractions	Once per tooth.		
General Anesthesia	General Anesthesia and IV sedation allowed with covered surgical impacted teeth only (up to one hour).		
Periodontics (Basic) (On natural teeth only)		80%	80%*
Periodontal Surgery	One surgical procedure per quadrant in 36 months. No more than 2 quadrants per date of service.		
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning	Four per plan year following active periodontal treatment (scaling and root planing or osseous surgery). Not to be combined with preventive cleanings.	100%	100%*
Bone Grafts/GTR	No more than two teeth per quadrant per 36 months on natural teeth.		
Endodontics (Basic)		80%	80%*
Root Canal Treatment	Once per tooth.		
Root Canal Retreatment	Once per tooth after 24 months have elapsed from initial treatment		
Vital Pulpotomy	Limited to deciduous teeth.		
Prosthetic Maintenance (Basic)		80%	80%*
Bridge or Denture Repair	Once per bridge/denture per 12 months, after 24 months of initial insertion.		
Crown or Onlay Repair	Once per tooth per 12 months after 24 months of initial placement		
Rebase or Reline of Dentures	Once per denture within 36 months.		
Recement of Crowns & Onlays, Bridges	Once per crown, onlay or bridge.		
Emergency Dental Care (Basic)		80%	80%*
Palliative Treatment	Three occurrences in 12 months.		
Prosthodontics (Major)		60%	60%*
Dentures	Once within 60 months. Aged 16 and older.		
Fixed Bridges	Once within 60 months Aged 16 and older.		
Implants	Once per 60 months per Implant. Aged 16 and older. (Pre-estimate recommended).		
Bone Grafts	Once per 60 months, covered when placement is in an extraction or implant site.		
Implant Abutments	Once per 60 months.		
Major Restorative (Major)		60%	60%*
Crowns or Onlay	When teeth cannot be restored with regular fillings due to fracture or decay. Once within 60 months per tooth (age 12 and older).		
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.		
Orthodontics:	Covered at 50% of covered charges up to \$2,500 separate LIFETIME maximum. Orthodontic treatment must be administered/supervised by a licensed dentist. Mail order kits are not covered by this plan.		

* Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Additional Benefit Information

****Right Start 4 Kids benefit:**

- Includes 100% coverage with no deductible for Diagnostic, Preventive, Basic and Major services for children up to their 13th birthday.
- Pays 100% of the costs of covered care with participating (in network) dentists up to your plan year maximum.
- Non-participating dentist may balance bill and members are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Benefit	Right Start 4 Kids Benefit
Deductible	None
Preventive and Diagnostic Coinsurance	100%
Basic Coinsurance	100%
Major Coinsurance (for applicable services)	100%
Plan Year Maximum	Subject to your plan's benefit limit

Rollover Maximum: Rollover Max dollars do not apply to orthodontic services. To qualify for Rollover Max, you must receive at least one cleaning or oral evaluation in the plan year. You must be enrolled for dental coverage before the 4th quarter of the plan year (4/1-6/30) and your paid claims must not exceed the maximum "threshold" amount.

Your plan year maximum benefit amount.	If your total yearly claims don't exceed this threshold amount...	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total is capped at this amount.
Enhanced Plan: \$2,000	\$800	\$600	\$1,500

- Eligible dependents are covered up to the end of the month in which they turn age 26.
- Deductible waived for periodontal cleanings.
- Domestic partner coverage, same and opposite sex.
- Temporomandibular joint treatment is paid under Prosthodontics category at 50%. Occlusal orthodontic appliances limited to one in a lifetime. Complete occlusal adjustments (limited to once every five years).
- **Pre-treatment estimates:** Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds \$300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage.

Delta Dental PPO Plus Premier™



Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO Plus Premier subscriber, you have access to two of Delta Dental's extensive national networks—Delta Dental PPO, with more than 350,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 450,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees, but will be subject to the out-of-network co-insurance level shown on the front of this summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown on the front of this summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

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/>

Learn more at deltadentalma.com

Visit the member area of 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 800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at www.deltadentalma.com. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
Delta Dental of Massachusetts
 800-872-0500
www.deltadentalma.com

465 Medford Street, Ste. 400
 Boston, MA 02129

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, sex, gender identity, sexual orientation, age, or disability. Delta Dental of Massachusetts does not exclude people or treat them differently because of race, color, national origin, sex, gender identity, sexual orientation, age, or disability.

Delta Dental of Massachusetts:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - 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:
 - Qualified interpreters
 - Information written in other languages

If you need these services, visit: 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, sex, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Civil Rights Coordinator
Compliance Department
P.O. Box 2907
Milwaukee, WI 53201-2907
Fax: 617-886-1390
Phone: 800-872-0500
Email: 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, the Civil Rights Coordinator 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/oice/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
800-368-1019, 800-537-7697 (TDD)

Language Assistance

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 بنا على الرقم 1-800-872-0500 (TTY: 1-844-233-4524).

ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ 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 છો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-872-0500 (TTY: 1-844-233-4524).