Health Alliance Plan®
by Henry Ford Health

Dental Coverage at a Glance

Individuals and families

A healthier smile leads to a healthier life. Health Alliance Plan offers high-quality dental care with Delta Dental benefits for your whole family.

There are two coverage options:

- **Pediatric-only coverage:** Required by the Affordable Care Act if you have children age 18 or under.
- **Adult coverage:** For all adults age 19 and older on your health plan. It includes pediatric dental coverage for children age 18 and under. Adults without children will not be charged the pediatric premium. Children on your plan will automatically move to the adult plan and rate on January 1 of the year after the child's 19th birthday.

You may purchase pediatric dental coverage through another provider. Adult dental coverage is only available when purchased with one of our plans and cannot be purchased separately if you obtain your health plan elsewhere.

2027 dental plan rates:

- **Pediatric:** $33.09 per child per month up to the three oldest children. There is no charge for the fourth child and up.
- **Adult:** $31.93 per adult per month.

Find dental benefits and search for affiliated dentists. Visit: **deltadentalmi.com**.

Questions?
Call Delta Dental Customer Service at **(800) 971-4108** and mention member group #2195.

2027 Delta Dental pediatric benefits

Pediatric dental coverage is included in your health plan for covered dependents age 18 and under, as required by the Affordable Care Act.

- Have a pediatric-only dental plan? Your child's coverage will stop at the end of the year they turn 19.
- Have adult dental coverage? Your child's benefit will move to the adult plan and premium on January 1 of the year following the child's 19th birthday.

Pediatric dental

DELTA DENTAL®	In network		Out of network
	Delta Dental PPO™	Delta Dental Premier®	Nonparticipating dentist
	Plan pays	*Plan pays*	*Plan pays*
DIAGNOSTIC AND PREVENTIVE SERVICES			
Diagnostic and preventive services – exams, cleanings, fluoride and space maintainers	100%	80%	80%
Brush biopsy – oral cancer detection	100%	80%	80%
Emergency palliative treatment – temporary pain relief	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Sealants – to prevent decay of permanent teeth	100%	80%	80%
BASIC SERVICES			
Minor restorative services – fillings and crown repair	50%	50%	50%
Major restorative services – crowns	50%	50%	50%
Oral surgery services – extractions and dental surgery	50%	50%	50%
Endodontic services – root canals	50%	50%	50%
Periodontic services – gum disease treatment	50%	50%	50%
Relines and repairs – bridges and dentures	50%	50%	50%
Other basic services – miscellaneous	50%	50%	50%
MAJOR SERVICES			
Prosthodontic services – bridges and dentures	50%	50%	50%
OUT-OF-POCKET MAXIMUM AND DEDUCTIBLE			
Out-of-pocket maximum	$450 per eligible member or $900 per family		
Deductible (does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment, brush biopsy or sealants)	Limited to a maximum deductible of $75 per family per benefit year		

Note: The benefits in this chart are for pediatric dental care only. It's an essential health benefit under the Affordable Care Act. Adult dental benefits are listed on a separate chart.

In-network annual out-of-pocket maximum: This is the most you or an eligible dependent will pay for covered pediatric dental care. The max amount when your coverage includes one member under age 19 will be $450 per benefit year on all in-network covered services and $900 for two or more members under age 19. Coinsurance, copayments and deductibles paid for in-network covered services count toward the out-of-pocket max. Payments that do not count toward your in-network out-of-pocket max include premiums; noncovered services; out-of-network dentists; and coinsurance, copayments or deductibles for nonpediatric dental care. It also does not include coinsurance, copayments or deductibles for covered services for members age 19 and older.

Once you reach your out-of-pocket max for the year, in-network covered services for members under 19 will be covered at 100 percent of Delta Dental's maximum approved fee.

Out-of-network out-of-pocket maximum: There is no annual out-of-pocket max for out-of-network covered services. You must pay all coinsurance, copayments, deductibles and bills for out-of-network covered services you or your eligible dependents receive.

Annual and lifetime maximum payments: There are no annual or lifetime maximum payments for covered services for members under 19.

Waiting period: There is no waiting period for members under 19 seeking covered services.

This document is meant to supplement your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to them for costs and coverage details. They also contain policy exclusions and limitations. Or call us at the number listed in this brochure.

This policy is underwritten by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation.

2027 Delta Dental adult benefits

All eligible dependents age 18 and over must be covered when you purchase an adult dental plan.

- Adults without children under age 19 will not be charged a pediatric plan premium.
- Delta Dental will provide proof of compliance with the pediatric coverage requirement.
- Have children? Only the three oldest children age 18 and under are charged the pediatric rate. If you purchase coverage elsewhere, adult-only coverage isn't available.

Adult dental

DELTA DENTAL®	In network		Out of network
	Delta Dental PPO™	Delta Dental Premier®	Nonparticipating dentist
	Plan pays	*Plan pays*	*Plan pays*
DIAGNOSTIC AND PREVENTIVE SERVICES			
Diagnostic and preventive services – exams, cleanings, fluoride and space maintainers	100%	80%	80%
Brush biopsy – oral cancer detection	100%	80%	80%
Emergency palliative treatment – temporary pain relief	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
BASIC SERVICES			
Minor restorative services – fillings and crown repair	50%	50%	50%
Major restorative services – crowns	50%	50%	50%
Oral surgery services – extractions and dental surgery	50%	50%	50%
Endodontic services – root canals	50%	50%	50%
Periodontic services – gum disease treatment	50%	50%	50%
Relines and repairs – bridges and dentures	50%	50%	50%
Other basic services – miscellaneous	50%	50%	50%
MAJOR SERVICES			
Prosthodontic services – bridges and dentures	50%	50%	50%
OUT-OF-POCKET MAXIMUM AND DEDUCTIBLE			
Maximum payment per benefit year	$1,000 per individual per benefit year		
Deductible (does not apply to diagnostic and preventive services, brush biopsy and emergency palliative treatment)	Limited to a maximum deductible of $75 per family per benefit year		

Note: This chart and the benefits listed here are for adult dental care only. Pediatric dental benefits are listed on a separate chart. But they are included in all adult dental plans.

Annual and lifetime maximum payments: The maximum payment is $1,000 total per person per benefit year. This applies to all services for members age 19 or older. It also applies to covered services that are not essential health benefits for members under age 19.

Out-of-pocket maximum payment: This is the most you or your eligible dependents will pay for covered services in one benefit year. This plan does not have an out-of-pocket max. You have to pay all coinsurance, copayments, deductibles and bills for all covered services you or your eligible dependents receive.

Waiting period: There are no waiting periods for covered services under this plan.

Eligibility: You, your spouse and your children under age 26 are eligible for this policy. This includes your children who are married, don't live with you, aren't permanently disabled or aren't your dependents for federal income tax purposes.

Anyone who chooses this dental plan must stay enrolled for 12 months. If a member drops coverage after that time, they may not re-enroll until 12 months after dropping coverage.

Benefits will end on the last day of the month for which the premium is paid.

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Health Alliance Plan®
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Health Alliance Plan of Michigan and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

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