



Dental Coverage at a Glance

Individuals and families

A healthier smile leads to a healthier life. That's why HAP is here with high-quality dental care. Our partnership with Delta Dental benefits 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 can purchase pediatric dental coverage elsewhere. We don't offer adult dental coverage if you purchase a plan somewhere else.

2022 dental plan rates:


- **Pediatric** – \$27.83 per child per month up to the three oldest children. The fourth child and up are free.
- **Adult** – \$28.04 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 (mention HAP group #2195).

2022 Delta Dental pediatric benefits

Pediatric dental coverage is required under the Affordable Care Act for members age 18 and under with a HAP health plan.

- 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 | | | |
|--|---|-----------------------|--------------------------|
|  | In network | | Out of network |
| | Delta Dental PPOSM | 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 | \$375 per eligible member or \$750 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 \$375 per benefit year on all in-network covered services and \$750 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.

2022 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 | | | |
|--|---|-----------------------|--------------------------|
|  | In network | | Out of network |
| | Delta Dental PPOSM | 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 | | | |
| Prosthetic services – bridges, implants and dentures | 50% | 50% | 50% |
| MAXIMUM PAYMENT 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.

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, including 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.



Individual • Group • Medicare • Medicaid

hap.org | hap.org/blog

Subsidiaries

Alliance Health and Life Insurance Company® | ASR Health Benefits | HAP Empowered Plan, Inc. | HAP Preferred Inc.

HAP 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.

©2021 HAP – a nonprofit company