Do you have questions?

The Fund Office: 800.325.5214 mpefund.org
- You have questions about your eligibility for benefits
- You want to verify your dental plan enrollment
- You need an Enrollment Form to add your eligible dependents (you may also download a form from mpefund.org)
- You need a Student Verification Form (you may also download a form from mpefund.org)
- You need to inform the Fund of a change in dependent status

MPE Dental Unit: 800.553.6277
- You need a MPE dental plan identification card
- You need to locate a MPE Exclusive Provider Network dentist in your area (you may also visit mpefund.org for a current listing)
- You have questions about which dental procedures are covered under this program

Alliance Dental Center, LLC: 617.984.5300 mpefund.org/adc
- You want to learn more about our new MPE Member Only office
- You want to make an appointment for dental care

Vision Care Processing Unit: 800.406.1656 davisvision.com
- You need to confirm the date on which you are eligible to receive vision services
- You are using the Davis Vision Provider Network and need to locate a provider in your area
- You are not using the Davis Vision Provider Network and need a Claim Form
- You wish to access the Laser Vision Correction Discount program
- You need a vision plan identification card

EPIC Hearing: 844.246.0544 epichearing.com/davisvision
- You want to learn more about the discount hearing aid benefit

Massachusetts Public Employees Fund
PO Box 3319
Peabody, Massachusetts 01961-3319
Phone: 800.325.5214
Fax: 617.426.4411
mpefund.org

For benefits effective July 1, 2019
July 1, 2019

Dear Fund Member:

July 1, 2019 marks the beginning of the Massachusetts Public Employees Fund’s thirty-fifth year of providing vision and dental benefits to public workers in Massachusetts. Because the Fund is purchasing these benefits on behalf of its over 34,000 members, you can obtain quality vision and dental services at significant cost savings.

The Fund’s Board of Trustees is committed to the development of a model program for delivering quality vision and dental health plans.

Please review this booklet carefully and select the benefit plan options which best meet your needs and the needs of your family. We hope you will take advantage of these valuable benefit programs.

Sincerely,

Union Trustees
Mr. Mark Bernard
AFSCME Council 93
Mr. Michael Grunko
SEIU Local 509
Mr. Edward Hunter
State Police Association of Massachusetts (SPAM)
Mr. Antonio Nunes
SEIU Local 888

Management Trustees
Mr. Matthew Hale
Human Resource Division
Office of Employee Relations
Ms. Maryellen Lyons
Massachusetts Department of Transportation
Mr. Michael Murray
Department of Higher Education
Ms. Catherine Starr
Executive Office of Health & Human Services

Executive Director
Susan M. Fournier
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Your Vision and Dental Health Plans are provided by the Massachusetts Public Employees Fund. The Fund’s Board of Trustees develops the plan design and eligibility policies offered to you and your dependents. Your union has secured these dental and vision benefits completely free of charge for you and eligible family members. The cost of this coverage is paid entirely by employer contributions required by the collective bargaining agreement negotiated by your union.

The Fund has retained Delta Dental of Massachusetts as a third-party administrator, responsible for processing and paying dental claims according to the policies and guidelines developed and established by the Trustees of the MPE Fund.

The Fund provides three dental plan options. The MPE Exclusive Provider Network (EPN) and Wellness Exclusive Provider Network (WEPN) are unique networks of dentists that have agreed to participate in the MPE Fund plan. They may, or may not, also participate in a Delta Dental plan. The Fund’s Indemnity Plan allows you to go to any dentist that you choose. The Fund provides the Vision Health benefit through Davis Vision.

What employees are eligible for this benefit?

The Massachusetts Public Employees Fund provides benefits to eligible public employees. New employees become eligible for benefits on the first day of the month following the completion of six (6) full months of employment. Eligible employees must be regularly scheduled to work at least half-time per week. Eligible City of Boston employees must be regularly scheduled to work twenty or more hours per week. You are eligible if you work for:

- The Commonwealth and are represented by:
  - AFSCME COUNCIL 93, Bargaining Unit 2 or 10; or
  - SEIU LOCAL 509 or 888, Bargaining Unit 2, 8 or 10; or
  - The State Police Association of Massachusetts (SPAM); or
  - The Coalition of Public Safety (COPS), Bargaining Unit 5; or
  - MA Department of Transportation Unit B, Teamsters Local 127 or USW; or
  - Mass Military Reservation, IAFF Local S-28; or
- A State College, Community College or the University of Massachusetts and are represented by AFSCME Council 93, SEIU Local 886 or certain MTA Units; or
- The Brookline Housing Authority and are represented by AFSCME Council 93; or
- Essex Registry of Deeds and are represented by AFSCME Local 653; or
- Middlesex South Registry of Deeds and are represented by AFSCME Local 414; or
- The Middlesex Sheriff’s Office and are represented by Teamsters Local 122; or
- The Plymouth County Sheriff’s Office and are represented by ACE; or
- The Suffolk County Sheriff’s Department and are represented by AFSCME Council 93, Local 419, Local 3643 and RNs; by Local 3; or by SEIU Local R1-298; or
- The City of Revere DPW and are represented by AFSCME Local 1383; or
- The Boston Public School Department and are in one of the following groups: Cafeteria Workers; Administrative Guild; Headmasters and Principals; Plant Administrators Association; Storekeepers and Store Deliverymen; Prof. Employees in Dept. of Planning & Engineering; Boston School Patrolmen’s Assoc.; Boston School Custodians Local 1952; Boston School Police Superior Officers Assoc.; Boston Assoc. of School Administrators and Supervisors; or
- The Boston Public Health Commission and are represented by AFSCME Council 93, I.B. Firemen and Oilers, SENA, SEIU Local 888 (Programs, Clerical-Technical, Homeless Services), SEIU-Public Health Nurses/LPN; or
- The City of Boston and are employed in a covered group. Please contact the Fund office for more information. City of Boston Emergency and Seasonal Employees are not eligible.
- Long-term seasonal employees, as defined by the Fund, are eligible under these guidelines:
  - If you work for the Commonwealth and are considered a “long-term seasonal” employee, you are eligible for benefits beginning the first day of the month following completion of six full months of employment. You will be eligible when you return to your seasonal position on the first day of the month following a full calendar month (e.g., if you return May 1st, you will be eligible July 1st) as long as you return to your position each year. You and your dependents are eligible for an annual plan maximum that is equal to 50% of the annual plan maximum extended to non-seasonal employees. Payments for covered preventive, diagnostic and orthodontic services are not deducted from this annual maximum.

How do I enroll and when does coverage start?

When an employee is first hired or transfers into a covered bargaining unit position, the employer reports the information to the Fund office. The Fund automatically sends an enrollment package to the address on file prior to the completion of six (6) full months of employment in a covered position. You must maintain a current address with your employer to ensure that you receive all mailings from the Fund office.

Members must return the enrollment form with a dental plan choice, a list of eligible dependents and any required documentation. Members who fail to submit an enrollment form before their effective date of eligibility will be automatically enrolled in the MPE Exclusive Provider Network (EPN) dental plan with individual coverage. No dental plan changes will be allowed until the next open enrollment period. Your dependents may be added at any time during the plan year.

Members who transfer from a position in the Commonwealth who were eligible for another employer-sponsored dental plan may not have to wait the six (6) full months before becoming eligible with the Fund. You must call the Fund office at (800) 325-5214 to verify your effective date of eligibility. Members who transfer during a plan year may be subject to a prorated annual plan maximum.
Is my family eligible for benefits?

Coverage will be extended to family members that are considered “eligible dependents” as defined by the MPE Fund.

Spouse: The Fund provides benefits to your spouse if you are legally married under the laws of the Commonwealth of Massachusetts.

If you were legally married and added coverage for a spouse, but subsequently divorce, your ex-spouse will continue to be covered by this plan:

a) Unless your divorce decree states that you are no longer required to provide coverage for your ex-spouse; or

b) Unless or until your ex-spouse is eligible for their own dental plan coverage; or

c) Until either you or your ex-spouse remarries. In the event of a remarriage, your ex-spouse ceases to be considered an eligible dependent. You must notify the Fund office immediately upon a remarriage.

Children: The Fund provides benefits to your unmarried:

- Natural or adopted children;
- Children for whom you have legal custody;
- Residential stepchildren (your spouse’s children whose primary residence is your home).

Children who meet the Fund’s definition are eligible for benefits through the last day of the month during which they turn 19, or 26 if enrolled as a full-time student. The Fund requires student verification for each term that your child is enrolled as a full-time student. Verification forms are available from the Fund Office or may be downloaded from mpefund.org.

Children who are considered developmentally disabled as defined by the MPE Fund and qualify as a disabled person under the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) may be eligible for benefits regardless of age. You must submit acceptable verification forms and a copy of the current Award Letter.

The Fund is not subject to MA Health Care Reform or the Patient Protection and Affordable Care Act.

When do dental and vision benefits stop?

Employees:

When an employee stops working in a covered bargaining unit, coverage for the employee (and any eligible dependents) will end one calendar month after the last day worked.

Employees on certain employer-approved leaves of absence may be eligible for an additional 90-day extension of benefits.

Dependents:

Dependents will lose coverage on the “qualifying event” date – the day they cease being considered an eligible dependent per Fund policy. You must notify the Fund within 60 days of this event.

Continuation Coverage (COBRA)

Dependents continued:

Examples of a child who no longer meets the Fund’s definition of an eligible dependent include, but may not be limited to:

- Stepchild(ren) who no longer live in your home (and/or you are no longer married to their parent);
- Legal custody order has expired;
- Full-time student dependent who withdraws from school, reduces their course load to less than full-time, takes a leave of absence, or graduates;
- Your child marries.

Examples of an ex-spouse who no longer qualifies as an eligible dependent include, but may not be limited to:

- You or your ex-spouse remarries;
- Your ex-spouse is eligible, or becomes eligible, for their own dental plan;
- Your divorce decree states that you are not required to continue covering your ex-spouse on your medical and/or dental plan.

What is Continuation Coverage (COBRA)?

The Fund provides Continuation Coverage (COBRA) in accordance with the Public Health Service Act. COBRA — the Consolidated Omnibus Budget Reconciliation Act — requires the Fund to offer continuation coverage to you and your dependents when coverage would otherwise stop due to certain specific events ("qualifying events"). COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

You and/or your dependents must pay the full COBRA premium. You will be provided with monthly cost information when you become eligible for Continuation Coverage. The benefits under Continuation Coverage are a continuation of the same benefits received as an active Fund member.

Alternatives to Continuation Coverage (COBRA)

If you become entitled to elect Continuation Coverage (COBRA) when your benefits with the Fund stop, you should consider all dental coverage options that may be available to you before you make your decision. Other options may include coverage through the Massachusetts Health Connector at mahealthconnector.org. You may be able to enroll in coverage through the MA Health Connector that costs less than Continuation Coverage.

If your coverage with the MPE Fund is ending because you retired from a position with the Commonwealth of Massachusetts, you may be offered the option to participate in the retiree program administered by the Group Insurance Commission (GIC). Contact the GIC at (617) 727-2310 to inquire about this program. You can only select one dental plan option (e.g., either Continuation Coverage or the GIC Retiree Dental Plan). Please review all your options carefully before signing up for a dental plan.
Who is Entitled to Continuation Coverage (COBRA)?

As an employee, you have the right to purchase Continuation Coverage from the Fund if:

- Your employment terminates (either voluntarily or involuntarily) for any reason other than gross misconduct; or
- Your hours are reduced to less than the minimum amount required for eligibility; or
- Your employment terminates due to your being on an employer approved unpaid leave.

Your spouse (or ex-spouse if a ‘qualified beneficiary’) has the right to purchase Continuation Coverage from the Fund if:

- Your employment terminates (either voluntarily or involuntarily) for any reason other than gross misconduct; or
- Your hours are reduced to less than the minimum amount required for eligibility; or
- You are on an employer approved unpaid leave; or
- You die while participating in the plan; or
- You are divorced or legally separated and a judgment has been granted terminating your ex-spouse’s eligibility; or
- You or your ex-spouse remarries, as long as your ex-spouse was eligible on the date of remarriage and the divorce was less than 36 months ago.

Your dependent children have the right to purchase Continuation Coverage if:

- Your employment terminates (either voluntarily or involuntarily) for any reason other than gross misconduct; or
- Your hours are reduced to less than the minimum amount required for eligibility; or
- You are on an employer approved unpaid leave; or
- You die while participating in the plan; or
- Your dependent child ceases to meet the definition of “dependent child” used by the Fund (e.g., your stepchild no longer resides in your home).

The Fund must be notified within 60 days of the date on which dependent coverage would stop in order for the dependent to be eligible for Continuation Coverage (COBRA).

You, your spouse or your dependent children are not entitled to Continuation Coverage (COBRA) if:

- You transfer to a management position and are eligible for the Group Insurance Commission dental plan; or
- You retire and elect the GIC Retiree Dental Plan; or
- You transfer to a position in another bargaining unit that offers dental benefits.

Duration of Continuation Coverage (COBRA)

Continuation Coverage benefits are temporary.

Eighteen months: If you, your spouse or your dependent children become eligible for Continuation Coverage due to the termination (either voluntary or involuntary) of your employment for a reason other than retirement, a reduction in your hours or your being on an employer approved non-medical leave, Continuation Coverage may continue for up to 18 months.

Thirty-six months: If you retire from your position, or if your spouse and/or dependent children become eligible for Continuation Coverage due to your retirement, medical leave of absence, death, the loss of dependent status, your divorce or the remarriage of you or your ex-spouse, Continuation Coverage may continue for up to 36 months.

Twenty-nine months: Any beneficiary who is determined under title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of Continuation Coverage shall be eligible for up to 29 months of coverage, but only if the qualified beneficiary notifies the Fund before the end of the initial 18 months. The premium for this 11-month extension will be 150% of the cost of the plan. This 11-month extension of the usual 18 month Continuation Coverage period is available to all qualified beneficiaries covered on the Continuation Coverage plan from the date of the qualifying event.

The benefits under this program are a continuation of the same benefits received as an active Fund member.

You, your spouse or your dependent children will lose Continuation Coverage if:

- You, your spouse or your dependent children fail to promptly pay the monthly Continuation Coverage premium. Failure to pay your monthly Continuation Coverage premium by the end of the 30-day grace period will result in permanent loss of coverage; or
- You, your spouse or your dependent children begin coverage under another group dental plan after electing Continuation Coverage; or
- You, your spouse, or your dependent child(ren) engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving Continuation Coverage (such as fraud); or
- The Fund no longer provides benefits.

COBRA Notice and Election Procedures

Employee:

Your employer must notify the Fund within 30 days of your termination from employment, reduction in hours or your death (your “qualifying event”). Once the Fund receives this information, your coverage stops one calendar month after the “qualifying event.”

An Election Form and notice of your Continuation Coverage rights will be mailed to the address on file with the Fund. It is your responsibility to maintain an accurate address with the Fund.

You have 60 days from the date your coverage stops or the date the Election Form is sent by the Fund, whichever is later. If you do not receive the Election Form, you must contact the Fund within this 60 day period. If you do not apply for Continuation Coverage within 60 days of the date on which notification was sent by the Fund, you will lose your Continuation Coverage eligibility.
Dependents:
You, your ex-spouse or your dependent children must notify the Fund in the event of a remarriage or other change in dependent status (e.g., cessation of full-time student status, stepchild no longer living in your home, etc.). Once notified, the Fund will send a notice to qualified beneficiaries regarding Continuation Coverage (COBRA).
Failure to notify the Fund in the event of a remarriage or change in dependent status within the required 60 days of the date on which coverage would stop as a result of the qualifying event will result in the loss of Continuation Coverage (COBRA) rights.
You must submit written notification of the event to:

MPE Fund
PO Box 3319
Peabody, MA 01961-3319

The Fund reserves the right to request additional information.

Your additional obligations:
Failure to submit any information required by the Fund may result in your being held responsible for the reimbursement of any claims paid on behalf of an ineligible dependent. The Fund also reserves the right to suspend or terminate your eligibility and that of any eligible dependent(s) until such reimbursement is made. Additionally, you may be held liable for any overpayments plus interest, and for any costs and attorney’s fees incurred by the Fund in connection with any legal proceeding undertaken by the Fund or the Trustees to recover such overpayments. Please see page 76 for additional information regarding the Fund’s Legal Rights and Obligations.

This is intended to be a general, informational discussion of your rights under the Continuation Coverage program. If you have any questions regarding your eligibility for Continuation Coverage, please contact the Fund Office at (800) 325-5214.

Frequently Asked Questions — COBRA

Q: I am planning on retiring from my position. What happens to my dental and vision benefits with the MPE Fund?
A: Your dental and vision benefits with the MPE Fund will stop one calendar month after your retirement date. For example, if you retire from your position on December 31st, your dental and vision coverage will stop on February 1st.

Q: How long can I continue my dental and vision benefits with the MPE Fund after I retire?
A: You may continue your dental and vision benefits with the MPE Fund for a total of 36 months.

Q: I retired from my position with the Commonwealth and I received information about the Group Insurance Commission (GIC). I am confused.
A: After filing your retirement paperwork, you will receive information about an alternative option available to you under the Group Insurance Commission (GIC) Retiree Dental Plan, and a vision benefit offered to you as a retiree. You will also receive a Continuation Coverage (COBRA) Election Form from the MPE Fund Office.
If you want dental coverage, you may select only one of the following options:
1. You may continue your current vision and dental benefits with the MPE Fund for a maximum of 36 months by electing the Continuation Coverage (COBRA) plan; or
2. You may waive your COBRA rights and enroll in the GIC Retiree Dental Plan; or
3. You may also have other options, such as your spouse’s plan, or the Massachusetts Health Connector (mahealthconnector.org).

Q: I received the GIC Retiree Dental Plan information before I received the COBRA Election Form. I enrolled in the GIC Retiree Dental Plan and deductions are being made from my retirement check, but I want the COBRA coverage with the MPE Fund. Can I elect COBRA now?
A: Generally, no. Once you enroll in the GIC Retiree Dental Plan option, you cannot elect Continuation Coverage (COBRA). And, if you ‘dis-enroll’ from the GIC Retiree Dental Plan option, you may not be able to re-enroll at a later date. You must contact the GIC at (617) 727-2310 to see if you can revoke your selection.

Q: I am a retiree of the City of Boston. Can I enroll in the GIC Retiree Dental Plan?
A: No, that is not a benefit offered to the City of Boston retirees.
Vision Health Plans

The Fund offers members coverage for routine comprehensive eye exams and eyewear from either:

- the Davis Vision Provider Network Plan, consisting of private vision care providers and retail locations; or
- the Alternative Vision Plan, a direct reimbursement option for services received by an out-of-network provider of your choice.

Members age 61 and over and dependents age 14 and under may receive a vision benefit once every 12 months. All other eligible employees and dependents may receive the vision benefit once every 24 months.

How do I receive services from the Davis Vision Provider Network Plan?

To receive coverage, you must visit a participating Davis Vision provider. You may call the automated Provider Locate System at (800) 406-1656 to hear a recorded list or to request a printed list of the participating providers. You may also visit [davisvision.com](http://davisvision.com). Currently, over 300 vision care offices located throughout Massachusetts and the surrounding area participate in the Davis Vision Provider Network.

To receive services from a Davis Vision participating provider, simply contact a provider and schedule an appointment. You may wish to contact the Vision Care Processing Unit at (800) 406-1656 to ensure it has been at least 24 months since you last received services (12 months if you are age 61 and over or age 14 and under) and that the provider still participates in the Davis Vision network. Your provider will contact Davis Vision for authorization.

What services are covered using the Davis Vision Provider Network Plan?

When you utilize the Davis Vision Provider Network Plan, you may receive a comprehensive eye examination, including dilation as professionally indicated, and one pair of prescription eyeglasses from the ‘Davis Vision Designer Frame Collection’. These are all paid in full by the plan as outlined on page 11. As professionally indicated, UV (ultraviolet) protective coating is also provided at no cost to the patient.

The Davis Vision Designer Frame Collection includes over 220 contemporary eyeglass frames. You may select a frame from the ‘Davis Vision Premier Collection’ for a $25 co-payment. You can obtain other optional lens types and coatings if you make the co-payment listed on page 11. If you obtain any services that require a co-payment, you must pay the Davis Vision provider directly.

Contact lenses from the Davis Vision Premium Contact Lens Collection are available for most prescriptions for a $50 co-payment. The contact lens benefit is in lieu of the eyeglass benefit.

---

### Davis Vision Provider Network Plan

#### Services and Co-Payments:

<table>
<thead>
<tr>
<th>Services/Materials Paid in Full</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td></td>
</tr>
<tr>
<td>including dilation, as professionally indicated</td>
<td></td>
</tr>
<tr>
<td>One pair of lenses</td>
<td>$50.00</td>
</tr>
<tr>
<td>includes single vision, bifocals, trifocals, and cataract lenses; includes plastic or glass lenses; includes oversized lenses and fashion tinted plastic lenses; includes prescription sunglasses.</td>
<td></td>
</tr>
<tr>
<td>UV protective coating</td>
<td></td>
</tr>
<tr>
<td>Scratch resistant coating</td>
<td></td>
</tr>
</tbody>
</table>

#### Materials Requiring Patient Co-payment

<table>
<thead>
<tr>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>One pair of progressive addition multifocals (in place of standard bifocals):</td>
</tr>
<tr>
<td>Standard</td>
</tr>
<tr>
<td>Premium</td>
</tr>
<tr>
<td>Ultra</td>
</tr>
<tr>
<td>Photogrey lenses (in place of standard lenses)</td>
</tr>
<tr>
<td>High-index lenses (in place of standard lenses)</td>
</tr>
<tr>
<td>Polycarbonate lenses (in place of standard lenses)*</td>
</tr>
<tr>
<td>Blended segment lenses (in place of standard lenses)</td>
</tr>
<tr>
<td>Polarized lenses (in place of standard lenses)</td>
</tr>
<tr>
<td>Anti-reflective coating:</td>
</tr>
<tr>
<td>Standard</td>
</tr>
<tr>
<td>Premium</td>
</tr>
<tr>
<td>Ultra</td>
</tr>
<tr>
<td>Plastic photosensitive lenses (in place of standard lenses), i.e., Transitions Intermediate vision lenses</td>
</tr>
<tr>
<td>Scratch protection plan:</td>
</tr>
<tr>
<td>Single vision</td>
</tr>
<tr>
<td>Multifocal lenses</td>
</tr>
<tr>
<td>One pair frames (frames selected from the Davis Vision Premier Collection)</td>
</tr>
<tr>
<td>Collection contact lenses (in lieu of allowance): Materials Disposable (4 boxes/multi-packs) Planned replacement lenses (2 boxes/multi-packs) Evaluation, fitting and follow-up care included</td>
</tr>
</tbody>
</table>

*Polycarbonate lenses are covered in full for dependent children, monocular patients, and patients with +/- 6.00 diopters or greater.

(continued on page 12)
Davis Vision Provider Network Plan (continued from page 11):

Other Services

Value Advantage Program: Eligible Fund members may purchase additional eyewear at any time at a discounted wholesale price, directly from Davis Vision, through the Value Advantage Program. Please contact Davis Vision at (800) 406-1656 for more information.

Contact lens allowance: Eligible Fund members who choose not to select a contact lens from the Collection will be eligible for a $74 allowance toward the purchase of non-Collection contact lenses. Please contact Davis Vision for more information.

Lens 1-2-3° Program: Each eligible Fund member has access to Lens 1-2-3°, a mail-order contact lens replacement service offering brand-name additional or replacement contact lenses at the guaranteed lowest prices. First-time contact lens wearers must receive their lenses from a Davis Vision Network Provider. Please call (800) 536-7123 [800-LENS-123] for more information.

Laser Vision Correction Discount: Eligible members may receive a discount of up to twenty-five percent (25%) off providers' usual and customary fee or a minimum of five percent (5%) off any advertised special for either PRK or conventional LASIK laser vision correction from the Davis Vision laser vision correction provider. Alternatively, some facilities may offer a flat rate, which equates to these comparable discount levels. Please contact Davis Vision for further information and requirements. The Fund is not recommending or endorsing this procedure, but simply allowing members access to this discount.

Comprehensive eye examinations provide early detection of eye diseases such as glaucoma, cataract, macular degeneration and retinal detachment. Exams can also detect serious health problems such as diabetes, hypertension, arteriosclerosis, neurological disorders and brain tumors. The Fund encourages all members to receive comprehensive eye exams, even if they are not experiencing vision problems. You may also wish to coordinate receiving annual eye examinations with your health insurance plan, if available.

Alternative Vision Plan

Under a direct reimbursement option, you may obtain services and materials from any vision care provider you choose. Only a portion of your actual expenses will be reimbursed under this plan.

To file a claim under this option, you must first contact the Vision Care Processing Unit at (800) 406-1656 to verify your eligibility for services and to order a claim form. You may also obtain a claim form at davisvision.com. Bring your claim form with you when you obtain services from a provider that does not participate in the Davis Vision Provider Network. Your vision provider(s) should complete the applicable sections of the claim form when services are rendered. You are responsible for paying your provider in full. You must then submit the completed, signed claim form with an itemized bill from the provider to:

Vision Care Processing Unit
P. O. Box 1525
Latham, New York 12110

Alternative Vision Plan continued

You will be reimbursed according to the following schedule:

<table>
<thead>
<tr>
<th>Services/Materials</th>
<th>You will be reimbursed up to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td>$ 30.00</td>
</tr>
<tr>
<td>One frame</td>
<td>$ 25.00</td>
</tr>
<tr>
<td>One pair lenses (single vision)</td>
<td>$ 23.25</td>
</tr>
<tr>
<td>One pair lenses (bifocal)</td>
<td>$ 37.50</td>
</tr>
<tr>
<td>One pair lenses (trifocal)</td>
<td>$ 50.50</td>
</tr>
<tr>
<td>One pair contact lenses (materials and fitting)</td>
<td>$ 82.00</td>
</tr>
</tbody>
</table>

Are there any limitations or exclusions under either plan?

If this booklet does not expressly provide for a vision benefit or service, such benefit or service shall not be covered under either vision plan. In addition, the following limitations and exclusions apply to both the Davis Vision Provider Network Plan and the Alternative Vision Plan:

- There is no additional coverage in the event of lost or stolen eyewear, or if a medical condition necessitates more frequent exams and/or materials;
- Non-prescription eyeglasses are not covered by either plan;
- Benefits for medical treatment of an eye injury or an eye disease are not provided under either plan;
- No benefits will be paid under either plan for non-covered plan services or materials, including vision training, nor will reimbursement be made for any vision services or supplies for which you or your dependents are not required to pay or for any charges that would not have been made if no Fund coverage was available.

EPIC Hearing Service Plan

Davis Vision members have access to the largest hearing care provider network in the country and substantial savings on top tier manufacturer brand devices and related professional services through EPIC Hearing Service Plan.

Davis Vision members save up to 60% off of retail on brand name hearing aids from major manufacturers through the EPIC Hearing Service Plan.

All hearing care service and products described are provided by EPIC Hearing Healthcare as a value-added service to Davis Vision members.

To find out more, visit epichearing.com/davisvision or visit our website at mpefund.org/hearing-aid-discount.
You are eligible for the MPE Fund dental plan. This is not a Delta Dental Plan. The Fund retains Delta Dental of MA as a third-party administrator, responsible for processing and paying claims according to the MPE Fund’s policies and schedule of benefits.

What are my dental health plan options?

The Fund offers its members a choice between three dental health plans:

1. **Exclusive Provider Network (EPN) Plan**: Members enrolled in the Exclusive Provider Network (EPN) Plan receive their dental treatment from the Plan’s over 950 general practitioners and dental specialists offices listed in this booklet on pages 20 to 46.

2. **Dental Wellness Exclusive Provider Network (WEPN) Plan**: Members enrolled in the Dental Wellness Exclusive Provider Network (WEPN) Plan receive all of their dental care at one of the Wellness Exclusive Provider Network (WEPN) offices listed on page 49. You must select one office.

3. **Indemnity Plan**: Members enrolled in the Indemnity Plan receive dental treatment from any dentist they select.

- Each member must select the dental plan option that best serves their needs, and the needs of their family members.
- New members who fail to submit an enrollment form by their effective date (as described on page 3) will be automatically enrolled in the MPE Exclusive Provider Network (EPN) dental plan with individual coverage.
- All family members will be enrolled in the same MPE Fund dental plan option.
- Members must remain enrolled in the same MPE Fund dental plan option for the entire plan year (July 1st to June 30th). Members may only change their dental plan during the Fund’s Open Enrollment period.
- All MPE Fund dental plan options have a $1,400 annual plan maximum for family members age 13 and above each plan year. This is the maximum amount of money the Fund will pay each year for covered dental services, excluding orthodontics, preventive, diagnostic and periodontal scaling and root planing services. Children age 12 and under have an unlimited plan maximum.
- The WEPN plan offers a Level 2 annual maximum. Please refer to the plan description on page 47.
- Patient out-of-pocket expenses are generally lower in the Exclusive Provider Network (EPN) Plan and Wellness Exclusive Provider Network (WEPN) Plan than in the Indemnity Plan.
- If you are enrolled in the MPE EPN dental plan and receive services from a dentist that does not participate in the plan, no benefits are payable.
How do I choose the dental plan that is right for me?

MPE Exclusive Provider Network (EPN) Plan
You may want to enroll in this plan if you and your family members:
- Want to keep your out-of-pocket expenses at a minimum, and
- Are willing and able to receive all of your dental care from a provider that participates in this network.

Dental Wellness Exclusive Provider Network (WEPN) Plan
You may want to enroll in this plan if you and your family members:
- Want to keep your out-of-pocket expenses at a minimum, and
- Are willing and able to work with a WEPN office on reducing your risk of future dental disease.

Indemnity Plan
You may want to enroll in this plan if you and your family members:
- Want to receive services from a specific dental office that does not participate in either the MPE EPN or WEPN network, and
- Are willing to pay more out-of-pocket, or are able to coordinate coverage through a spouse or other dental plan, so that you can receive dental care from an office that does not participate in the MPE EPN or WEPN network.

Dental plan selection is an individual decision based on determining which MPE Fund dental plan best serves the needs of each member. The above is presented to assist with plan selection. Please refer to the chart on page 15 for a high level comparison, as well as the individual dental plan descriptions for detailed information regarding each dental plan.

The MPE Exclusive Provider Network (EPN) Plan
The Fund’s Exclusive Provider Network (EPN) is administered by DSM Insurance Services, a wholly owned subsidiary of Delta Dental of Massachusetts. This is not a Delta Dental plan. Members enrolled in the EPN Plan must receive all dental treatment from a dental office that participates in the MPE Exclusive Provider Network (EPN) listed on pages 20-46. Preventive and diagnostic services are covered in full under the MPE EPN Plan. Other services require a patient co-pay, which can be found on pages 51-59. Patients must pay the dentist directly for co-paid services.

If you are enrolled in the EPN Plan and receive services from a dentist that does not participate in the MPE EPN Plan, no benefits will be paid by the Fund.

How do I file claims under the MPE EPN Plan?
- Your dentist will submit all claims to the MPE Unit at Delta Dental of Massachusetts.
- You will receive a written Explanation of Benefits statement (also called an EOB) whenever services are paid under the Exclusive Provider Network (EPN) Plan. Please review each EOB statement carefully and immediately report any discrepancy to the MPE Unit at (800) 553-6277.
- You have the right to appeal any determination in accordance with the procedure noted on your EOB statement and in accordance with the Appeal Process on page 74.

How can I protect myself from unexpected dental costs?
Prior to receiving treatment you should:
- Call the Fund Office at (800) 325-5214 to verify that you are enrolled in the Exclusive Provider Network (EPN) Plan; and
- Call the MPE Unit at (800) 553-6277 to confirm that the provider you selected still participates in the Exclusive Provider Network. This is necessary since the list of Exclusive Provider Network dentists is subject to change at any time, with or without prior notice. Be sure to tell your dentist that you are a member of the MPE Exclusive Provider Network (EPN) Plan when you schedule an appointment.

It is your responsibility to confirm your dentist’s participation in the MPE Exclusive Provider Network (EPN) Plan. Failure to do so may result in your paying the dentist’s submitted charge.
- If you make a dental appointment and circumstances prevent you from keeping this commitment, you must call the dentist’s office to cancel the appointment at least 24 hours in advance. Your dentist can bill you if you miss an appointment and do not cancel it at least 24 hours in advance.
- Before undergoing any treatment which you consider costly, you should obtain prior approval by requesting that your Exclusive Provider Network (EPN) dentist submit a pre-treatment estimate to the MPE Unit at Delta Dental of Massachusetts.
- Call the MPE Unit to make sure you have met any required time limitations and to check your proposed treatment costs against your annual maximum.
How can I receive dental services from a provider that does not participate in the MPE EPN Plan?

There is no out-of-network benefit under the MPE EPN Plan. This means that if you are enrolled in the MPE EPN and receive services from a provider that does not participate in the MPE EPN, there is no coverage for these services. In very specific situations (Approved Referral), the Fund may pay for covered services received from an out-of-network provider. Under an Approved Referral, a referral must be made by your MPE EPN dentist and that referral for specific services must be authorized by the MPE Unit at Delta Dental of Massachusetts prior to treatment. The following steps must also be followed for coverage to be provided under an Approved Referral:

- You must be a patient of record, as defined by the Fund, with a general dentist within the Exclusive Provider Network (EPN). A patient of record is defined by the Fund as a general dentist who you have visited during the past 12 months for treatment and/or evaluation.

- Your Exclusive Provider Network (EPN) dentist will refer you to a specialist for either (1) a consultation or evaluation, or (2) a specific service(s). If there is a specialist that participates in the MPE EPN, you will be required to obtain these services from the participating provider. If there is no specialist in the network, the out-of-network referral must be approved by the MPE Unit at Delta Dental of Massachusetts prior to receiving treatment.

- There is a six month time limitation on all approved out-of-network referrals. If you receive services after the six month time limit, you will be responsible for the out-of-network provider’s fee.

- If the out-of-network specialist determines that you require additional treatment that was not approved on the initial out-of-network referral, the specialist must contact your MPE Exclusive Provider Network dentist. If your MPE EPN dentist is not able to perform these services, they must call the MPE Unit at Delta Dental of Massachusetts for approval of an out-of-network referral for the specific services prior to treatment.

- Payments made to an out-of-network provider for authorized services when a referral has been approved are subject to a maximum allowable fee. Patients will be responsible for the difference between the maximum allowable fee and the submitted fee and any plan co-payment. You may ask the specialist to submit a pre-treatment estimate prior to receiving services so that you understand your financial responsibility.

- If no referral was made, or if a referral was not pre-approved, you may be responsible for the dentist’s submitted charge.

How do I get dental services in an emergency?

To receive services in an emergency, you must:

1. Call a participating Exclusive Provider Network (EPN) dentist. Each office is prepared to handle emergency situations. If one of the MPE EPN dentists cannot deliver prompt emergency service, they will refer you to another dentist, and;

2. Confirm that this dentist participates in the Exclusive Provider Network (EPN) by calling the MPE Unit at (800) 553-6277.

3. If you receive care outside of normal business hours and are unable to contact the MPE Unit, you must verify with the dental office that they participate in the MPE Exclusive Provider Network (EPN) as no benefits are payable to an out-of-network provider. You must also call the MPE Unit at (800) 553-6277 prior to receiving any additional treatment to verify the dentist’s participation in the Exclusive Provider Network (EPN) and to inquire about your co-payment.

4. If you are out of state and have an emergency, you must call the MPE Unit at (800) 553-6277 and they will advise you on how to proceed. The only services payable to an out-of-network dentist in an emergency situation will be for Palliative Treatment.

If you do not follow these procedures, you will be responsible for the dentist’s submitted charge. No benefits will be payable for services received from an out-of-network provider unless you have received both a referral for specific services from an EPN or WEPN dentist and an approval of that referral by the MPE Unit at (800) 553-6277.

What if I have reached my annual plan maximum and receive more services?

You and any eligible dependents aged 13 and above each have an annual plan maximum of $1,400*. This is the maximum amount of money the plan will pay, each year, for covered dental services you receive, excluding orthodontics, preventive, diagnostic and periodontal scaling and root planing services. Dependent children aged 12 and under have an unlimited plan maximum.

If you and any eligible dependents age 13 and over receive any co-paid services listed on pages 51-59 during the plan year after the plan has paid the annual plan maximum amount, you will only be responsible for the negotiated EPN/WEPN fee per the provider fee schedule.

*Commonwealth of Massachusetts Seasonal Employee annual plan maximum is equal to 50% of stated maximum.
Please note: This list of MPE Exclusive Provider Network (EPN) dentists is subject to change at any time and without prior notice. You must call the MPE Unit at (800) 553-6277 to confirm that a provider still participates in the EPN or WEPN Plan, or to find any new offices that may have joined since this list was published. You may also visit www.mpefund.org for an updated list of providers. Prior to each appointment, you must confirm that the office does still participate in the MPE EPN or WEPN Plan to protect yourself from unexpected costs.

**Barnstable County**

6. Bourne Bridge Dental, LLC
   9 County Road
   Bourne, MA 02532
   (508) 759-8331

7. Langston Oral & Maxillofacial Surgery, LLC
   114 Waterhouse Road
   Bourne, MA 02532
   (508) 759-4495
   (oral surgery)

8. CanalSide Family Dental Care, Inc.
   Dr. John Winterle
   Dr. Gary Peterson
   258 Main Street, Suite C-1
   Buzzards Bay, MA 02532
   (508) 759-2721
   (general, periodontics)

9. Mid-Cape Dental Center
   800 Main Street
   P.O. Box 605
   Dennis, MA 02638
   (508) 385-9992

10. Merit Dental of Massachusetts, PC
    119 Route 137
    East Harwich, MA 02645
    (508) 432-8866

11. Bravman, Langston & Associates
    236 Main Street
    Falmouth, MA 02540
    (508) 495-3700
    (oral surgery)

12. Falmouth Dental Associates
    Dr. Thomas E. Derroser
    210 Jones Road
    Falmouth, MA 02540
    (508) 540-0303
    (general, endodontics, pediatrics)

13. Ellen Jones Community Health Center
    351 Pleasant Lake Avenue
    Harwich, MA 02645
    (508) 778-5400

14. Arch Orthodontics, PC
    297 Winter Street
    Hyannis, MA 02601
    (508) 775-1401
    (orthodontics)

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    Hyannis, MA 02601
    (508) 775-1401
    (orthodontics)
Coming Soon!!!...The new Alliance Dental Center, LLC

The Massachusetts Public Employees Fund Board of Trustees is proud to announce the opening of our brand new dental office—a unique and caring dental center designed and built just for you...our MPE members!

This exciting state-of-the-art dental office will be located at 111 Washington Street in Quincy. We expect the office to be ready in late spring...so stay tuned!

You must be a member of the MPE Fund to be a patient of the Alliance Dental Center (ADC).

Our expert clinical and wellness team will partner with you to determine your individual risk factors and how we can work together to create a personalized course of treatment.

You will not have to change your current dental plan enrollment to become a patient—as long as you are an active member of the MPE Fund, you can receive care at the Alliance Dental Center. Care that cannot be provided at the ADC will be covered under the guidelines of the plan you are enrolled in for the year.

Please visit our website (mpefund.org/ADC) frequently for the latest news and grand opening date. Once the date is set, we will be sending informational brochures to our MPE members who live and work in the South Shore area. You may also contact the Fund office to request a brochure be mailed to your home.

We are so excited to be able to offer this one-of-a-kind opportunity to our MPE members and we hope you will take advantage of our extraordinary new dental center!

The Dental Wellness Exclusive Provider Network (WEPN) Plan

What is the Dental Wellness Exclusive Provider Network Plan and why would I want to enroll?

The Dental Wellness Exclusive Provider Network (WEPN) Plan is designed to provide coverage for the appropriate treatments and therapies that have been proven to stop or reverse the disease process that results in tooth decay and gum disease.

Members who enroll in this dental plan will receive an assessment that will identify known indicators of risk for future dental disease. Rather than a ‘one-size fits all’ plan design, patients will receive appropriate preventive care and healing therapies if indicated based on current scientific research.

This unique dental plan, based on your unique needs, is designed to help you obtain and maintain optimal oral health. You must work together with your WEPN dentist and be willing to follow the treatment protocols that you and your dentist develop. However, if you choose not to follow the advice of your WEPN dentist, including the use of preventive therapies prescribed, you will not benefit from the added features of the Dental Wellness Plan. In that case, you should consider not participating in the Dental Wellness Plan and select a different plan during the Fund’s Open Enrollment. Also, if it is determined that you are not following the advice of your WEPN dentist, the Fund reserves the right to ‘dis-enroll’ you and your family from the Dental Wellness Plan.

What dental services are covered under the Dental Wellness Plan?

In addition to the benefits you are eligible to receive under the Exclusive Provider Network (EPN) Plan, the Dental Wellness Exclusive Provider Network Plan provides all necessary general dental care needed to restore and maintain your oral health. All patients will be assessed for risk of dental disease, which includes a Caries Management by Risk Assessment (CAMBRA) evaluation. CAMBRA protocols will help you and your dentist determine what services are necessary and appropriate to treat your individual needs.

Level 2 Annual Plan Maximum

If a WEPN patient reaches the annual plan maximum and requires additional co-paid services, an additional annual plan maximum of $1,000 will be available upon payment of a $250 deductible. All additional services under the Level 2 maximum are subject to the same co-payments and time limitations of the plan.

“Enhancing Wellness”
Covered Services

In addition to the services covered under the MPE Exclusive Provider Network (EPN) Plan and included in the MPE Schedule of Covered Services on pages 50 to 59, the Dental Wellness Exclusive Provider Network (WEPN) Plan includes the following services performed as necessary based on the risk status determined by your WEPN dentist. There are no time limitations or age limitations on these services. The frequency is based on what is appropriate according to your risk of future disease:

Procedure

Caries Management by Risk Assessment (CAMBRA) analysis
Periodic oral evaluations
Fluoride varnish applications
Dental sealants on both restored and unrestored tooth surfaces
Tooth remineralization procedures and prescriptions (e.g., xylitol, MI Paste)
Chlorhexidine prescription to control dental disease infections
Prescription strength fluoride toothpaste
Prescription strength fluoride mouthrinse
Xylitol products

Are there any special requirements to participate in the WEPN Plan?

Yes, patients must agree to the following:

1. You must select a participating WEPN office for you and your family to receive all dental care.

2. You and your family must receive all your dental care from the WEPN office you select, unless your WEPN dentist refers you to a specialist in the MPE Exclusive Provider Network (EPN) Plan. Your WEPN dentist may provide you with a referral after they have examined you and determined that you require specialty services from another office. If you receive services at another dental office, or if you do not have a referral from your WEPN dentist for specialty services you receive, no benefits are payable and you will be responsible for the dentist’s submitted fees.

3. Patients must agree to follow the sequential treatment plan discussed with the WEPN dentist and use the preventive therapies as recommended. This is the only way to ensure success for obtaining and maintaining good oral health. If your WEPN dentist feels, for good reason, that they cannot continue to provide you with the care necessary for you to obtain and maintain optimal oral health, the WEPN dentist has a right to refuse to treat you as a patient, and you must request a change in your dental plan enrollment with the Fund Office.
The Indemnity Plan

The Fund’s Indemnity Plan is administered by Delta Dental of MA. Under the Indemnity Plan, patients may see any licensed general dentist of their choice. The Fund will make a payment for the covered treatment as per the Indemnity Plan Pay in the MPE Schedule of Covered Services listed on pages 51 to 59. Patients are responsible for the difference between the Fund payment and the dentist’s charges.

Because the Fund retains the services of Delta Dental of MA to provide third-party administrative services, Fund members are able to take advantage of some benefits offered to Delta Dental members. Your out-of-pocket costs may differ based on whether your dentist participates in Delta Dental in Massachusetts, Delta Dental outside of Massachusetts, or does not participate with Delta Dental. You should confirm with your dentist whether they participate in Delta Dental of MA.

How can I know in advance what my treatment will cost?

Before starting any dental treatment, you are strongly encouraged to request that your dentist submit a pre-treatment estimate to the MPE Unit at Delta Dental of MA. The MPE Unit will tell you, in writing, the maximum reimbursement you will receive. Your benefit is limited to your plan maximum.

If you are enrolled in the Indemnity Plan and receive services from an MPE Exclusive Provider Network (EPN) dentist, claims will be paid according to the Indemnity Plan reimbursement schedule.

If your dentist participates in Delta Dental:

Delta Dental manages the Delta Dental Premier network and the Delta Dental PPO network. If your dentist participates in one of those networks, they agree to accept a fee for service that is determined by Delta Dental of MA. This fee is called a “maximum allowable fee.” You are responsible for the difference between the Fund’s reimbursement schedule and the dentist’s maximum allowable fee. If your dentist is a “participating Delta Dental PPO provider,” the savings to you may be greater.

If your dentist does not participate in Delta Dental:

You must pay the dentist’s actual charges directly, and file a claim with Delta Dental of MA to be reimbursed directly.

You can obtain claim forms by calling the MPE Unit at Delta Dental of MA at (800) 553-6277. Completed claim forms should be submitted to:

MPE Claims
PO Box 2907
Milwaukee, WI 53201-2907

When benefit payments are made directly to you it is your responsibility to pay your dentist. You are responsible for the difference between the Indemnity Plan Pay in the MPE Schedule of Covered Services on pages 51 to 59 and the dentist’s full charge.

MPE Schedule of Covered Services*

EPN & WEPN Plans: you and your eligible dependents shall pay no more than the amounts listed under “EPN & WEPN Patient will pay,” subject to all other plan limitations.

Indemnity Plan: the Fund will reimburse the amount listed under “Indemnity Plan Pay” for the following covered dental services, subject to all other plan limitations. Indemnity Plan Patients are responsible for the difference between the Indemnity Plan Pay and the dentist’s charges.

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>0</td>
<td>32.00</td>
</tr>
<tr>
<td>D0140</td>
<td>0</td>
<td>62.00</td>
</tr>
<tr>
<td>D0145</td>
<td>0</td>
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</tr>
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<td>D0150</td>
<td>0</td>
<td>55.00</td>
</tr>
<tr>
<td>D0160</td>
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<td>75.00</td>
</tr>
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<td>D0170</td>
<td>0</td>
<td>55.00</td>
</tr>
<tr>
<td>D0171</td>
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<td>55.00</td>
</tr>
<tr>
<td>D0180</td>
<td>0</td>
<td>80.00</td>
</tr>
<tr>
<td>D0210</td>
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<td>105.00</td>
</tr>
<tr>
<td>D0220</td>
<td>0</td>
<td>21.00</td>
</tr>
<tr>
<td>D0230</td>
<td>0</td>
<td>15.00</td>
</tr>
<tr>
<td>D0240</td>
<td>0</td>
<td>33.00</td>
</tr>
</tbody>
</table>

*Fee schedule is for reference only. Procedures may be subject to additional limitations and exclusions not stated herein. As such, a pre-treatment estimate is highly recommended.
Indemnity Plan Patients are responsible for the difference between the Plan Pay and the dentist’s charges.

<table>
<thead>
<tr>
<th>EPN and WEPN Patients are responsible for the stated co-pay.</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1110 Prophylaxis (cleaning) adult, once every 6 consecutive months</td>
<td>0</td>
<td>76.00</td>
</tr>
<tr>
<td>D1120 Prophylaxis child, under age 14, once every 6 consecutive months</td>
<td>0</td>
<td>59.00</td>
</tr>
<tr>
<td>D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, payable up to four times per year</td>
<td>0</td>
<td>33.00</td>
</tr>
<tr>
<td>D1208 Topical application of fluoride, payable up to four times per year</td>
<td>0</td>
<td>29.00</td>
</tr>
<tr>
<td>D1351 Sealant per tooth, only on unrestored permanent molars, once every 48 months for patients age 18 and under</td>
<td>0</td>
<td>48.00</td>
</tr>
<tr>
<td>D1352 Preventive resin restoration in a moderate to high risk patient-permanent tooth, once every 48 months</td>
<td>0</td>
<td>48.00</td>
</tr>
<tr>
<td>D1354 Interim caries arresting medication application - per tooth</td>
<td>0</td>
<td>15.00</td>
</tr>
<tr>
<td>Space maintainers, once per quadrant, per lifetime, age 14 and under:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1510 Space maintainer - fixed unilateral</td>
<td>0</td>
<td>300.00</td>
</tr>
<tr>
<td>D1516/1517 Space maintainer - fixed bilateral, maxillary/mandibular</td>
<td>0</td>
<td>411.00</td>
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<tr>
<td>D1520 Space maintainer - removable unilateral</td>
<td>0</td>
<td>291.00</td>
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<tr>
<td>D1526/1527 Space maintainer - removable bilateral, maxillary/mandibular</td>
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<td>444.00</td>
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<td>D1550 Re-cementation of space maintainer, once per appliance per lifetime</td>
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<td>58.00</td>
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<tr>
<td>D1555 Removal of fixed space maintainer, once per appliance per lifetime</td>
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<td>58.00</td>
</tr>
<tr>
<td>D1575 Distal shoe space maintainer - fixed - unilateral</td>
<td>0</td>
<td>304.00</td>
</tr>
<tr>
<td>D1999 Prescription fluoride toothpaste</td>
<td>0</td>
<td>17.00</td>
</tr>
<tr>
<td>D1999 Chlorhexidine</td>
<td>0</td>
<td>17.00</td>
</tr>
<tr>
<td>D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation</td>
<td>0</td>
<td>84.00</td>
</tr>
<tr>
<td>D4910 Periodontal maintenance, once every 3 months following active periodontal treatment</td>
<td>0</td>
<td>75.00</td>
</tr>
<tr>
<td><strong>Restorative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam (silver) filling and composite resin (white) filling, once every 24 months on the same surface of the same tooth:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2140 Amalgam - one surface, primary or permanent</td>
<td>17.00</td>
<td>43.00</td>
</tr>
<tr>
<td>D2150 Amalgam - two surfaces, primary or permanent</td>
<td>22.00</td>
<td>51.00</td>
</tr>
<tr>
<td>D2160 Amalgam - three surfaces, primary or permanent</td>
<td>26.00</td>
<td>62.00</td>
</tr>
<tr>
<td>D2161 Amalgam - four or more surfaces, primary or permanent</td>
<td>31.00</td>
<td>80.00</td>
</tr>
<tr>
<td>D2330 Resin-based composite - one surface, front teeth</td>
<td>21.00</td>
<td>54.00</td>
</tr>
<tr>
<td>D2331 Resin-based composite - two surface, front teeth</td>
<td>27.00</td>
<td>64.00</td>
</tr>
<tr>
<td>D2332 Resin-based composite - three surfaces, front teeth</td>
<td>32.00</td>
<td>85.00</td>
</tr>
<tr>
<td>D2335 Resin-based composite - four or more surfaces, front teeth</td>
<td>41.00</td>
<td>102.00</td>
</tr>
<tr>
<td>D2390 Resin-based composite crown, front baby teeth only</td>
<td>55.00</td>
<td>102.00</td>
</tr>
<tr>
<td>D2391 Resin-based composite - one surface, posterior</td>
<td>26.00</td>
<td>54.00</td>
</tr>
<tr>
<td>D2392 Resin-based composite - two surfaces, posterior</td>
<td>30.00</td>
<td>64.00</td>
</tr>
<tr>
<td>D2393 Resin-based composite - three surfaces, posterior</td>
<td>61.00</td>
<td>85.00</td>
</tr>
</tbody>
</table>

Fee schedule is for reference only. Procedures may be subject to additional limitations and exclusions not stated herein. As such, a pre-treatment estimate is highly recommended.

---

Indemnity Plan Patients are responsible for the difference between the Plan Pay and the dentist’s charges.

<table>
<thead>
<tr>
<th>EPN and WEPN Patients are responsible for the stated co-pay.</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resin-based composite - four or more surfaces, posterior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2394 Resin-based composite - four or more surfaces, posterior</td>
<td>71.00</td>
<td>102.00</td>
</tr>
<tr>
<td>Onlays, per tooth, once every 84 months:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2543 Onlay - metallic - three surfaces</td>
<td>300.00</td>
<td>281.00</td>
</tr>
<tr>
<td>D2544 Onlay - metallic - four or more surfaces</td>
<td>400.00</td>
<td>306.00</td>
</tr>
<tr>
<td>D2643 Onlay - porcelain/ceramic - three surfaces</td>
<td>300.00</td>
<td>281.00</td>
</tr>
<tr>
<td>D2644 Onlay - porcelain/ceramic - four or more surfaces</td>
<td>350.00</td>
<td>306.00</td>
</tr>
<tr>
<td>Crowns, once per tooth every 84 months due to fracture or decay:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2710 Crown - resin-based composite (indirect)</td>
<td>150.00</td>
<td>204.00</td>
</tr>
<tr>
<td>D2740 Crown - porcelain/ceramic substrate</td>
<td>425.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2750 Crown - porcelain fused to high noble metal</td>
<td>425.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2751 Crown - porcelain fused to predominantly Base metal</td>
<td>325.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2752 Crown - porcelain fused to noble metal</td>
<td>375.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2780 Crown - 3/4 cast high noble metal</td>
<td>400.00</td>
<td>306.00</td>
</tr>
<tr>
<td>D2781 Crown - 3/4 cast predominantly base metal</td>
<td>385.00</td>
<td>306.00</td>
</tr>
<tr>
<td>D2782 Crown - 3/4 cast noble metal</td>
<td>385.00</td>
<td>306.00</td>
</tr>
<tr>
<td>D2790 Crown - full cast high noble metal</td>
<td>425.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2791 Crown - full cast predominantly base metal</td>
<td>325.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2792 Crown - full cast noble metal</td>
<td>375.00</td>
<td>342.00</td>
</tr>
<tr>
<td>D2794 Crown - titanium</td>
<td>425.00</td>
<td>342.00</td>
</tr>
<tr>
<td>Recement - once per item per lifetime when performed by same dental office:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2910 Recement inlay, onlay, or partial coverage restoration</td>
<td>30.00</td>
<td>29.00</td>
</tr>
<tr>
<td>D2915 Recement cast or prefabricated post and core</td>
<td>30.00</td>
<td>43.00</td>
</tr>
<tr>
<td>D2920 Recement crown</td>
<td>30.00</td>
<td>43.00</td>
</tr>
<tr>
<td>D2929 Prefabricated porcelain/ceramic crown - primary tooth</td>
<td>85.00</td>
<td>92.00</td>
</tr>
<tr>
<td>D2930 Prefabricated stainless steel crown - primary tooth</td>
<td>85.00</td>
<td>92.00</td>
</tr>
<tr>
<td>D2931 Prefabricated stainless steel crown - permanent tooth</td>
<td>85.00</td>
<td>92.00</td>
</tr>
<tr>
<td>D2934 Prefabricated esthetic coated stainless steel crown, primary tooth</td>
<td>85.00</td>
<td>92.00</td>
</tr>
<tr>
<td>D2940 Protective restoration - direct placement of a restorative material to protect the tooth and/or tissue form, once per tooth per 60 months</td>
<td>30.00</td>
<td>33.00</td>
</tr>
<tr>
<td>D2941 Interim therapeutic restoration-primary dentition</td>
<td>30.00</td>
<td>33.00</td>
</tr>
<tr>
<td>D2950 Core buildup, including any pins, once per tooth every 84 months due to fracture or decay</td>
<td>80.00</td>
<td>91.00</td>
</tr>
<tr>
<td>D2951 Pin retention, per tooth not per pin, only with fillings</td>
<td>18.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Post and core, in additions to crown, once per tooth every 84 months:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2952 Post and core in addition to crown, indirectly fabricated</td>
<td>140.00</td>
<td>136.00</td>
</tr>
<tr>
<td>D2954 Prefabricated post and core in addition to crown</td>
<td>110.00</td>
<td>100.00</td>
</tr>
<tr>
<td>D2971 Additional procedures to construct new crown under existing partial denture framework, once every 84 months in addition to crown</td>
<td>85.00</td>
<td>51.00</td>
</tr>
</tbody>
</table>

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Indemnity Plan Patients are responsible for the difference between the Plan Pay and the dentist’s charges.

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2980 - Crown repair necessitated by restorative material failure once every 12 months, only after 24 months of initial insertion</td>
<td>65.00</td>
<td>97.00</td>
</tr>
<tr>
<td>D2982 - Onlay repair necessitated by restorative material failure once every 12 months, only after 24 months of initial insertion</td>
<td>65.00</td>
<td>97.00</td>
</tr>
</tbody>
</table>

**Endodontics**

Endodontic treatments are once per tooth per lifetime:

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220 - Therapeutic pulpotomy (excluding final restoration), baby teeth only</td>
<td>30.00</td>
<td>51.00</td>
</tr>
<tr>
<td>D3221 - Gross pulpal debridement, age 13 and under</td>
<td>30.00</td>
<td>33.00</td>
</tr>
<tr>
<td>D3310 - Root canal therapy, anterior tooth (excluding final restoration)</td>
<td>165.00</td>
<td>219.00</td>
</tr>
<tr>
<td>D3320 - Root canal therapy, bicuspid tooth (excluding final restoration)</td>
<td>180.00</td>
<td>270.00</td>
</tr>
<tr>
<td>D3330 - Root canal therapy, molar tooth (excluding final restoration)</td>
<td>210.00</td>
<td>357.00</td>
</tr>
<tr>
<td>D3332 - Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
<td>50.00</td>
<td>46.00</td>
</tr>
<tr>
<td>D3346 - Retreatment of previous root canal therapy, anterior tooth, by report</td>
<td>200.00</td>
<td>255.00</td>
</tr>
<tr>
<td>D3347 - Retreatment of previous root canal therapy, bicuspid tooth, by report</td>
<td>300.00</td>
<td>306.00</td>
</tr>
<tr>
<td>D3348 - Retreatment of previous root canal therapy, molar tooth, by report</td>
<td>400.00</td>
<td>383.00</td>
</tr>
</tbody>
</table>

Apicoectomy, once per root per lifetime:

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3410 - Apicoectomy/periradicular surgery - anterior</td>
<td>115.00</td>
<td>235.00</td>
</tr>
<tr>
<td>D3421 - Apicoectomy/periradicular surgery - bicuspid (first root)</td>
<td>135.00</td>
<td>242.00</td>
</tr>
<tr>
<td>D3425 - Apicoectomy/periradicular surgery - molar (first root)</td>
<td>140.00</td>
<td>278.00</td>
</tr>
<tr>
<td>D3426 - Apicoectomy/periradicular surgery (each additional root)</td>
<td>90.00</td>
<td>102.00</td>
</tr>
<tr>
<td>D3430 - Retrograde filling - once per root per lifetime</td>
<td>40.00</td>
<td>71.00</td>
</tr>
<tr>
<td>D3450 - Root amputation - once per root per lifetime</td>
<td>80.00</td>
<td>153.00</td>
</tr>
<tr>
<td>D3920 - Hemisection (including any root removal), not including root canal therapy</td>
<td>85.00</td>
<td>112.00</td>
</tr>
</tbody>
</table>

**Periodontics**

Periodontic treatments are once every 36 months unless otherwise noted:

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>112.00</td>
<td>255.00</td>
</tr>
<tr>
<td>D4211 - Gingivectomy or gingivoplasty - one to three teeth or tooth bounded spaces per quadrant</td>
<td>42.00</td>
<td>84.00</td>
</tr>
<tr>
<td>D4240 - Gingival flap procedure, including root planing four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>150.00</td>
<td>301.00</td>
</tr>
<tr>
<td>D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>80.00</td>
<td>112.00</td>
</tr>
<tr>
<td>D4249 - Clinical crown lengthening - hard tissue, once every 84 months</td>
<td>170.00</td>
<td>316.00</td>
</tr>
<tr>
<td>D4260 - Osseous surgery (including flap entry &amp; closure) - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>220.00</td>
<td>408.00</td>
</tr>
</tbody>
</table>

Fee schedule is for reference only. Procedures may be subject to additional limitations and exclusions not stated herein. As such, a pre-treatment estimate is highly recommended.

Prosthodontics – removable

Prosthodontics include routine post-delivery care and are once every 84 months unless otherwise noted:

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>EPN &amp; WEPN Patient will pay</th>
<th>Indemnity Plan Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110 - Complete denture - maxillary</td>
<td>400.00</td>
<td>373.00</td>
</tr>
<tr>
<td>D5120 - Complete denture - mandibular</td>
<td>400.00</td>
<td>373.00</td>
</tr>
<tr>
<td>D5130 - Immediate complete denture - maxillary</td>
<td>410.00</td>
<td>406.00</td>
</tr>
<tr>
<td>D5140 - Immediate complete denture - mandibular</td>
<td>410.00</td>
<td>406.00</td>
</tr>
<tr>
<td>D5211 - Maxillary partial denture - resin base</td>
<td>250.00</td>
<td>347.00</td>
</tr>
<tr>
<td>D5212 - Mandibular partial denture - resin base</td>
<td>250.00</td>
<td>347.00</td>
</tr>
<tr>
<td>D5213 - Maxillary partial denture - cast metal framework with resin denture bases</td>
<td>410.00</td>
<td>500.00</td>
</tr>
<tr>
<td>D5214 - Mandibular partial denture - cast metal framework with resin denture bases</td>
<td>410.00</td>
<td>500.00</td>
</tr>
<tr>
<td>D5221 - Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>250.00</td>
<td>347.00</td>
</tr>
</tbody>
</table>

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## Indemnity Plan

Patients are responsible for the difference between the Plan Pay and the dentist’s charges.

<table>
<thead>
<tr>
<th>EPN and WEPN</th>
<th>Indemnity Plan Pay</th>
<th>EPN &amp; WEPN Patient will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>250.00</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>410.00</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>410.00</td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary partial denture - flexible base</td>
<td>360.00</td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular partial denture - flexible base</td>
<td>360.00</td>
</tr>
<tr>
<td>D5282/2</td>
<td>Removable unilateral partial denture - one piece cast metal</td>
<td>175.00</td>
</tr>
<tr>
<td>D5283</td>
<td>(including clasps and teeth) maxillary/mandibular</td>
<td>175.00</td>
</tr>
<tr>
<td>D5410/1</td>
<td>Adjust complete denture - maxillary</td>
<td>15.00</td>
</tr>
<tr>
<td>D5421/2</td>
<td>Adjust complete denture - mandibular</td>
<td>15.00</td>
</tr>
<tr>
<td>D5422/3</td>
<td>Adjust partial denture - mandibular</td>
<td>15.00</td>
</tr>
</tbody>
</table>

Repairs are once every 12 months unless otherwise noted:

<table>
<thead>
<tr>
<th>Indemnity Plan Pay</th>
<th>EPN &amp; WEPN Patient will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth complete denture (each tooth)</td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin denture base, mandibular</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin denture base, maxillary</td>
</tr>
<tr>
<td>D5621</td>
<td>Repair cast framework, mandibular</td>
</tr>
<tr>
<td>D5622</td>
<td>Repair cast framework, maxillary</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
</tr>
<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary), once every 84 months</td>
</tr>
<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular), once every 84 months</td>
</tr>
</tbody>
</table>

Rebase and reline procedures are once every 36 months:

<table>
<thead>
<tr>
<th>Indemnity Plan Pay</th>
<th>EPN &amp; WEPN Patient will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline partial denture (chairside)</td>
</tr>
</tbody>
</table>

---

### Prosthodontics – fixed

All services under “Prosthodontics – fixed” must be pre-approved.

Implants are only covered in very specific situations per Plan guidelines.

To ensure you know how much, if any, of the treatment will be covered, you must have your dentist submit a pre-treatment for review.

<table>
<thead>
<tr>
<th>Indemnity Plan Pay</th>
<th>EPN &amp; WEPN Patient will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6010</td>
<td>Surgical placement of implant body: endosteal implant (this code includes second stage surgery and placement of healing cap where indicated)</td>
</tr>
<tr>
<td>D6013</td>
<td>Surgical placement of mini implant</td>
</tr>
<tr>
<td>D6056</td>
<td>Prefabricated abutment (includes modification &amp; placement)</td>
</tr>
<tr>
<td>D6057</td>
<td>Custom abutment (includes placement)</td>
</tr>
<tr>
<td>D6058</td>
<td>Abutment supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6059</td>
<td>Abutment supported porcelain fused to metal crown (base metal)</td>
</tr>
<tr>
<td>D6060</td>
<td>Abutment supported porcelain fused to metal crown (noble metal)</td>
</tr>
<tr>
<td>D6061</td>
<td>Abutment supported porcelain fused to metal crown (noble metal)</td>
</tr>
<tr>
<td>D6062</td>
<td>Abutment supported cast metal crown (high noble metal)</td>
</tr>
<tr>
<td>D6063</td>
<td>Abutment supported cast metal crown (base metal)</td>
</tr>
<tr>
<td>D6064</td>
<td>Abutment supported cast metal crown (noble metal)</td>
</tr>
<tr>
<td>D6065</td>
<td>Implant supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6066</td>
<td>Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)</td>
</tr>
<tr>
<td>D6067</td>
<td>Implant supported metal crown (titanium, titanium alloy, high noble metal)</td>
</tr>
<tr>
<td>D6069</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (high noble metal)</td>
</tr>
<tr>
<td>D6070</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)</td>
</tr>
<tr>
<td>D6071</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (noble metal)</td>
</tr>
<tr>
<td>D6092</td>
<td>Recement implant/abutment supported crown</td>
</tr>
<tr>
<td>D6093</td>
<td>Recement implant/abutment supported fixed partial denture</td>
</tr>
<tr>
<td>D6094</td>
<td>Abutment supported crown – titanium</td>
</tr>
</tbody>
</table>

---

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### Indemnity Plan

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>EPN &amp; WEPN Patients will pay</th>
<th>Indemnity Pay</th>
<th>EPN &amp; WEPN Plan Pay</th>
<th>Indemnity Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7280</td>
<td>Surgical access of an unerupted tooth</td>
<td>125.00</td>
<td>90.00</td>
<td>25.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth, once per tooth per lifetime, allowed with orthodontics only</td>
<td>40.00</td>
<td>30.00</td>
<td>10.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6240</td>
<td>Porcelain fused to high noble metal crown</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6241</td>
<td>Porcelain fused to predominantly base metal crown</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6242</td>
<td>Porcelain fused to noble metal crown</td>
<td>375.00</td>
<td>342.00</td>
<td>33.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6245</td>
<td>Porcelain/ceramic crown</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis (Maryland bridge)</td>
<td>125.00</td>
<td>90.00</td>
<td>35.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6549</td>
<td>Resin retainer - for resin bonded fixed prosthesis</td>
<td>125.00</td>
<td>90.00</td>
<td>35.00</td>
<td>0.00</td>
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<tr>
<td>D6740</td>
<td>Crown - porcelain/ceramic</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
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<tr>
<td>D6751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
<td>325.00</td>
<td>342.00</td>
<td>17.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6752</td>
<td>Crown - porcelain fused to noble metal</td>
<td>375.00</td>
<td>342.00</td>
<td>33.00</td>
<td>0.00</td>
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<tr>
<td>D6790</td>
<td>Full cast high noble metal crown</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6791</td>
<td>Full cast predominantly base metal crown</td>
<td>325.00</td>
<td>342.00</td>
<td>17.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6792</td>
<td>Full cast noble metal crown</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
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<tr>
<td>D6794</td>
<td>Crown - titanium</td>
<td>425.00</td>
<td>342.00</td>
<td>83.00</td>
<td>0.00</td>
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<tr>
<td>D6930</td>
<td>Recement fixed bridge</td>
<td>30.00</td>
<td>22.00</td>
<td>8.00</td>
<td>0.00</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair, by report</td>
<td>65.00</td>
<td>41.00</td>
<td>24.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### Adjunctive General Services

Once per lifetime per person

### Fee schedule is for reference only. Procedures may be subject to additional limitations and exclusions not stated herein. As such, a pre-treatment estimate is highly recommended.
Orthodontics (braces)

EPN and WEPN Plans

Patients must receive treatment from an EPN or WEPN plan-approved orthodontist to receive the benefit.

**All orthodontic cases must be pre-approved.** Your MPE EPN or WEPN Plan approved orthodontist must submit a pre-treatment estimate to the MPE Unit at Delta Dental of Massachusetts prior to the start of the treatment. Once the pre-treatment is reviewed, you will receive an Explanation of Benefits (EOB) statement with the approved level of treatment. Cases not approved prior to the start of treatment may not be a covered benefit.

The level of treatment approved will be based on the appropriate American Dental Association definition, case complexity and length of treatment. The Fund pays the orthodontist in periodic payments.

You will pay:

| Orthodontic Diagnostic Workup | 175.00 |
| Orthodontic Treatment (Class I, Class II, and Class III Malocclusion) | | |
| Case 1: Interceptive | 535.00 |
| Case 2: Limited | 890.00 |
| Case 3: Comprehensive: | |
| Level A | 1,140.00 |
| Level B | 1,310.00 |
| Level C | 1,630.00 |
| Level D | 1,700.00 |
| Level E | 2,450.00 |

- Treatment not received from an MPE EPN or WEPN plan approved orthodontist is not a covered benefit.
- The Fund will not provide a benefit for both a Case 1 and a Case 2.
- If you had Case 1 and/or Case 2 services at any time prior to being enrolled in the MPE EPN or WEPN Plan, and regardless of what dental insurance you had at that time, the amount paid by your prior insurance will be deducted from any payment approved for a MPE EPN or WEPN Case 3. If the payment made for these prior services exceeded the MPE EPN or WEPN approved payment for the Case 3 level, no payment will be made.
- Patients must agree to complete their treatment with the same orthodontist. The patient co-payment will not be guaranteed if you change to a new orthodontist during the course of treatment, nor can any payments be made by the Fund to a second orthodontist.
- Invisalign treatment is not a covered benefit. If your plan-approved orthodontist submits pre-treatment estimates and records, and that treatment is approved by the Fund, the Fund may agree to provide an alternate benefit, whereby the patient will be responsible for the difference between the Fund payment and the full charge for Invisalign treatment.

Orthodontics (braces) continued

Indemnity Plan Orthodontic Coverage

The maximum reimbursement per individual, per lifetime is $1,200.00.

Your orthodontic benefit is based on the total case fee and the estimated length of treatment submitted by your dental provider. Benefits are subject to a 50% co-payment and a $1,200 lifetime maximum per patient, regardless of what coverage, if any, you had on the original treatment date. Orthodontic benefits are also subject to verification of continuing treatment and eligibility.

“Enhancing Wellness”

Limitations and Exclusions under all Orthodontic Plans

- Lost or broken orthodontic appliances are not a covered benefit.
- Orthodontic treatment that began prior to the date on which you became eligible for MPE Fund benefits is not a covered benefit.
- If you change your dental plan enrollment or terminate coverage before the orthodontic treatment is completed or before all Fund periodic payments have been made, no further payments will be made by the Fund.
- No additional coverage will be provided for patients that do not comply with the agreed-upon treatment plan. Successful orthodontic treatment requires the patient to keep regularly scheduled appointments, to maintain good oral health, and to follow specific instructions of the orthodontist.
- Each Orthodontic Case is considered once per lifetime, per patient, regardless of what coverage, if any, you had on the original treatment date.
MPE Fund Exclusive Wellness Programs

The MPE Fund Board of Trustees is committed to offering a dental benefit program that contributes to improving the oral health of Fund members and their families. The Trustees are continually exposed to current research regarding the causes and treatment of dental disease. Enhancements to the benefits extended to our members are based on the most recent, validated evidence which has been proven to address the risk factors known to cause tooth decay.

In addition to a comprehensive dental health care benefit plan, unique programs are developed by the MPE Fund and provided exclusively for our members. We are proud to be able to offer these extremely valuable benefits that are not covered by most other dental programs.

As we have learned more about the causes of tooth decay and gum disease, the Trustees have been better able to design benefits and programs that offer preventive treatments to patients with risk factors for these diseases. We hope that these valuable, unique wellness programs will help you and your families achieve a lifetime of healthy smiles.

Pregnancy

Tooth decay is the result of a transmitted bacterial infection. Current research has shed light on the direct relationship between the oral health of mothers and their children. Higher levels of bacteria that cause tooth decay (mutans streptococci and lactobacilli) in mothers is associated with an increased presence of caries (cavities) in their children. The results of this study were published in the Journal of Dental Research (March 2014, Vol. 99:3, pp. 238-244).

The Trustees want to keep your baby tooth-decay free for their life. We understand the importance of preventive care for the mom-to-be so that any active disease can be controlled and the bacteria not transmitted to the baby.

If you are pregnant, or plan to become pregnant, we encourage you to discuss your oral health with your dentist or physician. Also, call the MPE Fund office to receive a free sample of xylitol mints. If your dentist feels you need additional preventive therapies that are not covered under the MPE Fund dental plan, call the Fund to learn about how to receive those additional therapies.

Caries Risk Assessment Training

The American Dental Association, working with the CAMBRA Coalition, added risk assessment codes to the approved list of dental procedures. These codes enable your dentist to perform and record a caries (cavity) risk assessment and evaluate your risk of future dental disease as low, moderate, or high.

The MPE Fund is working with the dental offices in our Exclusive Provider Network to provide them with training on how to perform and record the risk assessment. Dental offices on the EPN that complete this training will be reimbursed for performing a formal risk assessment for MPE patients.

If you are interested in having your dentist perform a risk assessment, speak to them about this training. The dental office may contact the MPE Unit at (800) 553-6277 to learn more about this program.

Early Childhood Dental Care — Dental Home Program

Childhood caries (cavities) is a preventable, infectious disease caused by specific acid-producing bacteria. It is the result of an untreated, transmitted bacterial infection. Bacteria are usually passed from a mother or other caregiver to a child via saliva.

The MPE Fund realizes how important it is to begin promoting good oral health at an early age.

- If you are pregnant, make sure you visit the dentist before your baby is born to learn what you can do to reduce your chance of transmitting tooth decay.
- If you are a parent of a young child, please make sure you have enrolled them in your vision and dental health care plans. There is no cost to you to enroll eligible dependents.

In order to prevent dental problems, your child should see a dentist when the first tooth appears or no later than their first birthday. Specific treatment is generally not performed at this visit; rather the visits create a “dental home” for your child. A “dental home” gives your child the opportunity to become comfortable in a dental setting and the dentist will get to know your child and any concerns you may have regarding their oral health.

The MPE Fund office will send your child a birthday card on their first birthday. This will remind you that it is time to make your child’s first dental visit. You will also be offered a toothbrush designed specifically for children age 4-24 months and a tube of xylitol gel at that time.

If your child is over the age of one, and has previously received restorative services from an MPE Exclusive Provider Network (EPN) dentist, we will be working with that dentist to reach out to you to encourage you to bring your child back to the dentist for recommended preventive services.

Please refer to page 67 of this handbook for additional information.

MPE Fund Cancer Treatment Program

Head and neck radiation and chemotherapy help treat cancer, but they can also have side effects. Some of these side effects can affect the mouth and could cause you to delay or stop your cancer treatment.

To help prevent serious problems, see a dentist prior to starting chemotherapy or radiation. Your dentist should work with your oncologist to determine appropriate and necessary treatment.

The MPE Fund may provide additional preventive benefits for patients undergoing chemotherapy and radiation. All co-payments and plan year maximums under the plan guidelines will be in effect. For more information please call the MPE Unit at (800) 553-6277.
MPE Fund Fluoride Varnish Program

Fluoride varnish is a protective gel that is painted onto the teeth, providing important topical fluoride. Topical fluoride has been shown in many scientific studies to prevent cavities and to delay the progression of cavities.

The MPE Fund is committed to improving the oral health of our members. We feel that as many children as possible should have access to this important treatment that may reduce or prevent cavities. Fluoride varnish is a covered benefit under the MPE Fund’s dental plans.

The American Academy of Pediatric Dentistry recommends that children be seen by a dentist no later than the age of twelve (12) months. We know, however, that many young children have not been seen by a dentist. On average, by the age of 2, a child has been seen seven (7) times by a physician but not once by a dentist.

Because we want to encourage children to receive this important disease prevention treatment, we have created the MPE Fluoride Varnish Program. This program will reimburse you up to $33 for the cost of having your child’s physician or medical health professional apply fluoride varnish if this treatment is recommended. Your child must be under the age of 3 to be eligible. The Fund will reimburse up to three (3) applications per year. This is in addition to any applications received at a dental office.

Please contact the MPE Fund office at (800) 325-5214 for a brochure which describes this benefit in more detail, including how to submit for reimbursement. You may also visit our website at mpefund.org to download the brochure.

Also, we strongly recommend you establish a “dental home” for your child. If your child is not currently enrolled in the MPE Vision and Dental Health Plans, please contact us immediately for an enrollment form. There is no cost to you to add eligible dependents to your vision and dental health plans. We want to ensure that your child has access to all necessary and appropriate benefits that may help them grow up cavity free!

Xylitol Program

Xylitol helps prevent cavities! Xylitol is a 100% natural product. It is a sweetener that occurs naturally and can be found in berries, fruit, vegetables and mushrooms. It also occurs naturally in our bodies.

Pure xylitol looks and tastes like sugar, however it is considered a “sugar-free” sweetener. Xylitol is a safe sweetener for foods. There are many dental products that use xylitol, such as toothpaste, oral rinses, gum and mints. Use of these products is proven to reduce tooth decay disease.

The MPE Fund has a special arrangement for Fund members with Xlear, Inc., a leading manufacturer of Spry xylitol products. Fund members who purchase Spry xylitol products through the MPE Fund website will receive a 20% discount off of retail prices. Please visit mpefund.org to learn more about the important oral health benefits of xylitol and to obtain the discount code to use for purchases.

Tufts Special Needs Program

The MPE Fund has partnered with Tufts Dental Facilities (TDF) and Delta Dental of Massachusetts to better serve our members with special needs. This partnership has provided access to dental facilities and oral health providers around the Commonwealth who are dedicated and experienced in working with individuals with developmental disabilities who may require specialized care.

The partnership will allow Fund members, who meet the eligibility requirements for the developmentally disabled as determined by Massachusetts law, to receive individualized care based on their risk for dental disease and current oral health status. The providers in the facilities are qualified and have been trained in assessing a patient’s level of risk for developing dental disease and in providing appropriate care. Since many patients with special needs have high risk factors for dental disease, they may require additional preventive therapies not normally covered by insurance plans.

In addition to the benefits available to members enrolled in either the MPE Indemnity or Exclusive Provider Network (EPN) Plan, members who qualify for treatment in the TDF are also eligible for additional preventive therapies as determined by your TDF provider. All co-payments and plan year maximums outlined in the EPN Plan and Indemnity Plan descriptions will be in effect.

Final eligibility will be determined by the facility using the specified criteria for developmental disabilities outlined in Massachusetts law.

To learn more about the facility locations in your area and to receive more information please call the MPE Unit at (800) 553-6277.
What is a cavity?
A cavity results from loss of minerals in a tooth. Specific bacteria in the mouth consume sugars and produce acid. Acid attack removes essential minerals from your tooth (demineralization). If there isn’t enough protection for the tooth (healthy saliva with essential minerals), the enamel will eventually break down and cause a cavity. Cavities are preventable!

What is dental caries?
Caries refers to the process of tooth decay that may lead to a cavity. Tooth loss may result if left unchecked.

What is caries risk?
Risk is the chance that something will happen in the future. There are known disease indicators that increase a patient’s risk of developing cavities. Certain protective factors reduce a patient’s risk of developing cavities.

Disease indicators and risk factors include recent cavities, frequent snacking, family history of cavities, reduced saliva flow and orthodontic appliances.

Protective factors include proper diet, topical fluoride sources, adequate saliva flow, regular brushing and flossing, and use of xylitol.

A patient can reduce their risk of future cavities by decreasing the factors that contribute to the disease, and increasing protective factors.

Please visit mpefund.org for additional literature on tips to keep you and your baby healthy.

Do you have a child under age three?
The American Academy of Pediatric Dentistry recommends that children be seen by a dentist by twelve months of age. Even if your child is not experiencing dental problems, establishing a dental home is important for their overall health.

Your dental professional examines your child’s teeth and gums and makes recommendations for home care that will keep your child healthy.

In order for your child to be eligible for benefits under your MPE Vision and Dental Health Plans, you must enroll each child in your plan. You need to submit an enrollment form with a copy of the birth certificate. There is no cost to you when you add eligible dependents. Contact the MPE Fund office to inquire about your child’s vision and dental health plan coverage for these important benefits.

When you enroll your child, you will be sent information on Early Childhood Dental Care and the Fund’s Fluoride Varnish Program. This information is also accessible on our website, mpefund.org.

Orthodontic (Braces) CAMBRA Program
CAMBRA stands for CAries Management by Risk Assessment. It is a method for assessing caries (cavity) risk and making treatment recommendations based on an individual patient’s risk for cavities. Patients in orthodontic (braces) treatment are at higher risk of developing cavities in the future.

Successful orthodontic treatment – a healthy and beautiful smile – is the result of a team effort among you, your orthodontist and your family dentist. You as the patient play the key part.

If plaque, a sticky, colorless film, accumulates around your braces, it can leave permanent white stains on your teeth called decalcification (white spot lesions). Lines and spots from decalcification will remain on your teeth for life. This may result in restorative treatment after the braces are removed.

You must keep your teeth clean and maintain good dental hygiene while you’re wearing braces. Regular brushing and flossing is critical. Proper dental care may take a little extra time and effort, but it is well worth it, as it will help you obtain the best possible results from your orthodontic treatment and reduce your risk of permanent decalcification and decay.

Orthodontic treatment always requires following the orthodontist’s instructions, keeping scheduled orthodontic appointments and maintaining excellent oral hygiene to achieve the best results. You will also need to see your general dentist as recommended to continue your general dental care.

Your MPE Fund dental plan will cover the following additional benefits while you are in active orthodontic treatment:

- Oral evaluations will be covered once every four months while you are in active orthodontic treatment, rather than once every six months. If your dentist feels it is necessary for you to have more frequent cleanings, you will be eligible to have a cleaning every four months as well.
- Payment for fluoride varnish, prescription fluoride toothpaste, and MI Paste are paid by the Fund when dispensed by your dentist at a covered oral evaluation appointment.

“Enhancing Wellness”
Limitations and Exclusions — All Dental Plans

The Fund provides benefits only for necessary and appropriate services.

The Fund provides benefits for a covered dental service that is determined by our third-party administrator (Delta Dental of Massachusetts) to be necessary and appropriate to diagnose or treat your dental condition. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment, on (1) those teeth that are decayed or fractured or (2) those teeth where supporting periodontium is weakened by disease, in accordance with standards of good dental practice and not solely for your convenience or the convenience of your dentist.

Delta Dental of Massachusetts determines what is necessary and appropriate based on a review of your dental records describing your condition and treatment. It may be determined that a service is not necessary and appropriate even if your dentist has furnished, prescribed, ordered, recommended or approved that service.

If this booklet does not expressly provide for a benefit or service, such benefit or service shall not be covered under the plan. By way of example, your expenses will not be covered and no benefits will be paid by the Fund for:

- dental treatment for which an alternate course of treatment is recommended based on materials and methods of treatment which cost the least and which meet generally accepted dental standards. You may be reimbursed only the benefit allowed on the procedures specified under this alternate course of treatment;
- treatment for the dental condition known as temporomandibular joint (TMJ) syndrome;
- dental treatment, including orthodontics, which commenced prior to the date on which the member or dependent became eligible for benefits or for dental treatment which continues after the date on which eligibility is terminated;
- dental treatment which is meant primarily to change or improve your appearance (cosmetic);
- restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition;
- transplants or laminate veneers;
- replacement of dentures, bridges, space maintainers or periodontal appliances due to theft, loss, or breakage;
- claims submitted to Delta Dental of Massachusetts more than one year from the date on which you received dental treatment;
- charges for services received after your annual plan maximum has been reached, excluding eligible preventive, diagnostic, periodontal scaling and root planing, and orthodontic services;
- repair of crown or fixed partial denture if less than 24 months after initial placement;
- more than one periodontal surgical procedure per quadrant in a 36 month period;
- any portion of your dental expenses which are payable under any other dental or medical plan. You must inform the MPE Unit at Delta Dental of MA if your family has another dental insurance plan. The Fund will coordinate your total benefits in those cases where another family member has their own dental insurance. When benefits are coordinated, your children’s primary insurance plan will be the plan of the parent whose birthday comes earlier in the calendar year;
- treatment performed by anyone other than a duly licensed dentist, except for services performed by a licensed dental hygienist or dental assistant under the supervision of a licensed dentist in accordance with state laws;
- a dentist’s charge to you for any appointment which you miss;
- dental treatment due to accidental bodily injuries in the course of employment, or due to sickness resulting from an occupational disease, for which the member or dependent is entitled to benefits under applicable Workers Compensation Law, occupational disease law, or similar legislation, except as mandated by law;
- dental treatment performed in a hospital owned and operated by the United States Government, or performed elsewhere at the expense of the Federal Government;
- any dental services and supplies for which you or your dependents are not required to pay or charges that would not have been made if no Fund coverage was available;
- dental treatment received which is subject to stated time limitations if received more frequently than the stated time limitations allow, regardless of what coverage, if any, was in effect at the time of the original treatment;
- travel time and related expenses;
- dietary advice and instructions in dental hygiene including methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests;
- a service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion;
- services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting;
- dental treatment which is determined to be inappropriate per CAMBRA protocols based on your assessed risk of disease.

Please be advised that procedure codes are subject to change during the Plan Year.

Important Note: Some services indicate that they are a covered benefit only once during the stated period of time (e.g., a crown is payable once every 84 months). If you have previously received any of these services, no benefits will be payable if you receive the same service again within the stated period of time—even if you were not a member of the Fund, and regardless of what coverage you may have had (if any), on the original treatment date. For example, if you had a crown (regardless of the type or material used) on July 1, 2013, you will not be eligible for another crown on the same tooth until an 84 month period has elapsed (July 1, 2020). Again, this rule applies even if you were not a member of the Fund, and regardless of what coverage you may have had (if any), on July 1, 2013. To avoid any unexpected costs you should discuss any prior treatment received with your dentist and submit a pre-treatment estimate.
Member Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review it carefully.

By law, the Massachusetts Public Employees Fund Plan (herein after “the Fund”) is required to maintain the privacy of your personal health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice, or if you want more information about the privacy practices at the Fund, please contact the Fund’s Privacy Officer at:

Massachusetts Public Employees Fund
ATTN: Privacy Officer
PO Box 3319, Peabody, MA 01961-3319
(800) 325-5214 privacy@mpefund.org

The Fund is also required to give you this notice to tell you how the Fund may use and disclose your personal health information held by the Fund. Information held by the Fund includes information regarding claims paid or denied for payment by the Fund for health or dental health services you have received, or other information used to resolve appeals.

How the Fund May or May Not Use or Disclose Your Health Information

The following categories describe ways that the Fund may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and/or present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories.

- **Health Care Operations.** The Fund may use or disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, long-term care, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

- **Treatment.** The Fund may use or disclose your health information to a dentist or other health care provider to treat you. For example, we may disclose health information to dental hygienists, technicians, optometrists, opticians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with dental and/or vision care.

- **Required by Law.** As required by law, we may use and disclose your health information. For example, we may disclose dental and/or vision information when required by a court order in a litigation proceeding such as a malpractice action.

- **Data Breach Notification Purposes.** The Fund may use or disclose your Protected Health Information for purposes related to your health care to remind you of unauthorized access to or disclosure of your health information.

- **Public Health.** Information may be reported to a public health authority or other appropriate government authority authorized by law to collect health information for purposes related to: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

- **Health Oversight Activities.** We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

- **Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding.

- **Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

- **Public Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release health information to funeral directors as necessary for their duties.

- **National Security and Protective Services for the President and Others.** We may release health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

- **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

- **Worker’s Compensation.** We may disclose your health information to a worker’s compensation claims administrator or other person authorized by law to conduct such claims proceedings to the extent necessary to comply with worker’s compensation or similar laws.

- **Marketing.** We may contact you to give you information about health-related benefits and services that may be of interest to you. If we receive compensation from a third party for providing you with information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this third party.

- **Business Associates.** We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All or our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

- **Organ and Tissue Donation.** If you are an organ donor, we may use or release health information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release health information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Disclosures to Plan Sponsor (Board of Trustees) We may disclose your health information to the Fund’s Board of Trustees, for purposes of administering benefits under the plan.

- **Research.** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

Uses and Disclosures that require the Fund to give you an opportunity to object

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a close friend or any other person you identify, your Protected Health Information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Uses and Disclosures that require your written authorization

The Fund must generally obtain your written authorization (each of these include defined exceptions under which the Fund uses or discloses your Protected Health Information for these purposes without your authorization) before using or disclosing:

1. Psychotherapy notes about you from your psychotherapist.
2. Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in
Member Notice of Privacy Practices continued

reliance on your authorization before you revoked it will not be affected by the revocation.

Additionally, the Fund is prohibited from using or disclosing (and does not use or disclose) genetic information for underwriting purposes, including determination of benefit eligibility. If we obtain any health information for underwriting purposes and the policy or contract of health insurance or health benefits is not written with us or not issued by us, we will not use or disclose that health information for any other purpose, except as required by law.

Disclosing only the minimum necessary Protected Health Information

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

The minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment;
2. Uses or disclosures made to you;
3. Uses or disclosures required by law;
4. Uses or disclosures required for the Fund’s compliance with legal regulations; and
5. Disclosures made to the Secretary of the U.S. Department of Health and Human Services.

Statement of your Health Information Rights

- **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. The Fund is not required to agree to your request. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Official at the address listed previously. We will let you know if we can comply with the restriction or not.
- **Right to Accounting of Disclosures.** You have the right to receive a written statement of the reasons for the delay and the date by which the accounting will be provided. The Fund will provide one list per 12 month period free of charge; we may charge you for additional lists.
- **Right to Inspect and Copy.** You have the right to inspect and receive an electronic or paper copy of health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to the Privacy Official at the address listed previously. The Fund must provide the requested information within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline and if the Fund provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.
- **Right to Request Amendment.** You have a right to request that the Fund amend your health information that you believe is incorrect or incomplete. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. The Fund is not required to change your health information. If the Fund denies your request in whole or in part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information. To request an amendment, you must make your request in writing to Privacy Officer at the address listed previously.
- **Right to Accounting of Disclosures.** You have the right to receive a list or “accounting of disclosures” of your health information made by us in the past six years, except that we do not have to account for disclosures made for purposes of payment functions, carrying out treatment or health care operations, disclosures made to you, or disclosures made before the privacy rule compliance date. To request this accounting of disclosures, you must submit your request in writing to Privacy Officer at the address listed previously. The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The Fund will provide one list per 12 month period free of charge; we may charge you for additional lists.

Your Right to a Copy. You have a right to receive a paper copy of the Notice of Privacy Practices at any time. This right applies even if you have agreed to receive the Notice electronically. You may obtain a copy of this Notice at our web site, www.mpefund.org. To obtain a paper copy of the Notice, send your written request to Privacy Officer at the address listed previously.

- **Right to be Notified of a Breach.** You will be notified in the event of a breach of your unsecured protected health information.

You may exercise any of the above rights through a personal representative. Your personal representative will be required to produce satisfactory evidence of authority to act on your behalf before the personal representative will be given access to your Protected Health Information or be allowed to take any action for you.

Changes to this Notice and Distribution

The Fund reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. If material changes are made, the revised Notice will be posted on the Fund’s website at: www.mpefund.org. It will be posted not later than the effective date of the revision and thereafter sent by first class mail to all named participants in the Fund’s next annual mailing.

Material changes are changes to (1) the uses or disclosures of Protected Health Information, (2) your individual rights, (3) the duties of the Fund, or (4) other privacy practices stated in this Notice.
Member Appeal Process

If your dental claim is denied or partly denied, you will receive written notice of the denial (referred to as an Explanation of Benefits, or EOB) directly from the Fund’s third-party administrator (Delta Dental of Massachusetts) with a description of the process available to appeal the determination. If your vision claim is denied or partly denied, you will receive written notice of the denial directly from Davis Vision with a description of the process to appeal the determination.

Delta Dental is retained as a third-party administrator, responsible for processing and paying claims as per the Fund’s policies and procedures. Delta Dental is not able to approve any appeal regarding the application of Fund policy. Any appeal involving Fund policies may be sent directly to the MPE Fund office.

If your appeal involves the quality or other concern about the care delivered by a dental provider, a copy of your treatment records may be requested from the dental office and may be reviewed by a Dental Consultant and/or Analyst. Please note that the dental provider is solely responsible for the delivery of quality care. As per the Fund’s Legal Rights and Obligations, the Fund does not have any responsibility for the failure of a provider to fulfill these obligations.

Provided that you have exhausted all appeals available to you with Delta Dental of Massachusetts or Davis Vision, respectively, you or, if applicable, your beneficiary can request a review of your claim by the Fund.

This request for review should be sent to:

Board of Trustees
c/o Executive Director
Massachusetts Public Employees Fund
PO Box 3319
Peabody, MA 01961-3319

This request must be postmarked within sixty (60) days after you or, if applicable, your beneficiary received notice of the review of the claim.

When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deem appropriate, including but not limited to:

- Member’s name and Subscriber Identification Number;
- Description of the problem, including relevant dates;
- Names of providers or others involved.

The Fund will investigate the problem and reply within forty-five (45) days. The Fund will do its best to resolve your appeal more quickly for services you are either receiving now or planning to receive.

The decision of the Board of Trustees, or the Executive Director acting on their behalf, on the disposition of the appealed claim is final.

Any appeal received after the required time limitations will not be considered for review.

Frequently Asked Questions

Q: I never received a Plan Booklet or enrollment form when I first became eligible for the Fund’s vision and dental health plan. I now need services but my dentist does not participate in the MPE Exclusive Provider Network (EPN) Plan. Can I change my plan?

A: All members are sent eligibility information approximately two months prior to their effective date of coverage so that they have time to enroll dependents and select a dental plan. If the enrollment form is not returned by the effective date of coverage, members are automatically enrolled in the MPE EPN Plan. You may add eligible dependents any time during the year. However, you will have to wait until the Fund’s Open Enrollment period to change your dental plan.

Q: I recently called your office and was told my coverage is under the MPE Fund plan. I thought I had a Delta Dental Plan, which my dentist accepts. What’s the difference?

A: Your dental benefits are with the Massachusetts Public Employees Fund. The Fund retains Delta Dental of MA, a third-party administrator, to process and pay dental claims according to all the policies and guidelines established by the Trustees of the MPE Fund. The MPE Exclusive Provider Network (EPN) is a unique network of dentists that participate in the MPE Fund plan. They may, or may not, also participate in a Delta Dental plan. In the Fund’s Indemnity Plan, you may go to any dentist you choose. Please read this booklet carefully to ensure you are enrolled in the correct plan to receive coverage.

Q: I am enrolled in the MPE Exclusive Provider Network (EPN) Plan and I went to a dentist that apparently does not participate in the MPE EPN Plan. Can I submit the claims for reimbursement?

A: There is no out-of-network coverage. You must read Your Dental Health Plan Options section of your annual plan booklet to understand your responsibilities before receiving treatment.

Q: My family is enrolled in the MPE Exclusive Provider Network (EPN) Plan. My son is undergoing orthodontic treatment. Will he still receive coverage if we switch to the Indemnity Plan during Open Enrollment but before his treatment is completed?

A: There will be no additional benefits payable if you change your plan if the Fund has already made payments that exceed the orthodontic benefit under the Indemnity Plan, which is $1,200.

Q: I left my job and never received a Continuation Coverage Election Form. Can I request coverage now?

A: You are eligible to elect continuation coverage only if 60 days has not lapsed from your termination date or the date the form was sent to you by the Fund to the address we have on file, whichever is later. If you have left your job recently, or have another “qualifying event” as described on page 6, you should contact the Fund office to ensure that your eligibility is up-to-date.
The Fund’s Legal Rights and Obligations

Each Fund member selects the Vision Plan and the Dental Plan which best serves their needs. The vision and dental care providers you select are solely responsible for the delivery of quality vision and dental health care. The Fund does not have any responsibility for the failure of a vision or dental care provider to fulfill these obligations. The inclusion of a provider in the MPE Exclusive Provider Network (EPN) or Wellness Exclusive Provider Network (WEPN) is not an endorsement or recommendation of that provider.

The Fund, by a vote of a majority of its Trustees, may amend, modify, or terminate all or part of any or all of the Fund’s Vision and Dental Health Plans whenever, in their sole judgement, such an amendment, modification or termination shall be necessary or expedient.

The Fund’s Board of Trustees, or the Executive Director acting on their behalf, has the final authority to delegate and/or determine any question arising in connection with the administration, interpretation and application of any or all of these Plans, including any question regarding eligibility for benefits and the right to participate in a Plan. Either the Board’s or the Director’s determination concerning the administration, application and interpretation of the Plans shall be conclusive and binding on all persons subject to the provisions of these Plans.

The Trustees may transfer a member from the MPE EPN or WEPN Plan to the Indemnity Plan, or terminate a member from dental and vision coverage, if the Trustees, in their sole discretion, determine it is in the best interest of the Fund to do so.

The Fund may, at its sole discretion, require additional and/or supporting documentation as it deems appropriate to confirm eligibility or enrollment information.

It is illegal for a Fund member to willfully misrepresent any fact, including misrepresenting an individual as their dependent, for the purpose of securing benefits. Any member who is found by the Fund to have committed such misrepresentation shall immediately become ineligible for Fund benefits and will be required to reimburse the Fund for any benefits obtained. The Fund will cooperate fully with law enforcement agencies investigating and prosecuting criminal complaints, including potential cases of fraud or larceny, as they relate to Fund assets.
Massachusetts Public Employees Fund

Vision and Dental Health Plans

For benefits effective
July 1, 2019

Do you have questions?

The Fund Office: 800.325.5214 mpefund.org
- You have questions about your eligibility for benefits
- You want to verify your dental plan enrollment
- You need an Enrollment Form to add your eligible dependents
  (you may also download a form from mpefund.org)
- You need a Student Verification Form
  (you may also download a form from mpefund.org)
- You need to inform the Fund of a change in dependent status

MPE Dental Unit: 800.553.6277
- You need a MPE dental plan identification card
- You need to locate a MPE Exclusive Provider Network dentist in your area
  (you may also visit mpefund.org for a current listing)
- You have questions about which dental procedures are covered under this program

Alliance Dental Center, LLC: 617.984.5300 mpefund.org/adc
- You want to learn more about our new MPE Member Only office
- You want to make an appointment for dental care

Vision Care Processing Unit: 800.406.1656 davisvision.com
- You need to confirm the date on which you are eligible to receive vision services
- You are using the Davis Vision Provider Network and need to locate a provider in your area
- You are not using the Davis Vision Provider Network and need a Claim Form
- You wish to access the Laser Vision Correction Discount program
- You need a vision plan identification card

EPIC Hearing: 844.246.0544 epichearing.com/davisvision
- You want to learn more about the discount hearing aid benefit

Massachusetts Public Employees Fund
PO Box 3319
Peabody, Massachusetts 01961-3319
Phone: 800.325.5214
Fax: 617.426.4411
mpefund.org
July 1, 2019

Dear Fund Member:

July 1, 2019 marks the beginning of the Massachusetts Public Employees Fund’s thirty-fifth year of providing vision and dental benefits to public workers in Massachusetts. Because the Fund is purchasing these benefits on behalf of its over 34,000 members, you can obtain quality vision and dental services at significant cost savings.

The Fund’s Board of Trustees is committed to the development of a model program for delivering quality vision and dental health plans.

Please review this booklet carefully and select the benefit plan options which best meet your needs and the needs of your family. We hope you will take advantage of these valuable benefit programs.

Sincerely,

Union Trustees
Mr. Mark Bernard
AFSCME Council 93

Mr. Michael Grunko
SEIU Local 509

Mr. Edward Hunter
State Police Association of
Massachusetts (SPAM)

Mr. Antonio Nunes
SEIU Local 888

Management Trustees
Mr. Matthew Hale
Human Resource Division
Office of Employee Relations

Ms. Maryellen Lyons
Massachusetts Department of
Transportation

Mr. Michael Murray
Department of Higher Education

Ms. Catherine Starr
Executive Office of Health & Human
Services

Executive Director
Susan M. Fournier