

# Welcome to DeltaCare

DeltaCare is an innovative dental plan that provides you with comprehensive care at a significantly lower cost than most other dental plans—which means great value for you. The plan is unique in its emphasis on preventive services, which are fully covered. DeltaCare works much like a dental HMO, in which you and your family receive all your care from a network of participating dentists. There are no waiting periods for any services. Your coverage begins immediately, so you get the care you need—when you need it.

## Using Your Dental Plan

### Choosing Your Primary Care Dentist

You and each member of your family covered under DeltaCare must select a Primary Care Dentist (PCD) from the DeltaCare directory.

Please indicate the name and provider number of the PCD in the designated area on your enrollment form. If you do not select a PCD, we will assign one located near your home. To select a PCD, check the **Directory of Participating Dentists** or our website at [www.deltadentalma.com](http://www.deltadentalma.com). You can also call the DeltaCare Unit at (800) 327-6277.

Shortly after your enrollment, each member of your family covered by DeltaCare will receive an ID card with his or her PCD's name and phone number on it. Coverage is effective for all dependents up to age 26.

To change your PCD, simply call our DeltaCare Unit by the 21<sup>st</sup> day of the month at (800) 327-6277 and let the representative know which DeltaCare dentist you would like as your PCD. The change will be effective at the beginning of the following month. We will send you a new ID card reflecting the change after it becomes effective.

### How Your Plan Works

There's never any paperwork for you to fill out when you visit your PCD or a specialist in the DeltaCare network. **Simply provide your dentist with the information that is printed on your ID card.** Your dentist will collect any applicable co-payments for services you receive and take care of all the paperwork for you.

When you are in need of specialty services, you may select a specialist from the DeltaCare network or ask your primary care dentist for a recommendation. However, to receive the maximum value from your benefits, you must receive services from a participating DeltaCare specialist.

### Out-of-Pocket Expenses

You will be responsible for the co-payments listed on your co-payment schedule, which you will pay directly to the dentist and, where noted, any additional lab fees associated with certain major restorative procedures. Most preventive and diagnostic services are covered at 100%, which means you won't have any additional out-of-pocket costs on these procedures. Please note there is a \$1,000 calendar year maximum on certain specialty services (oral surgery, endodontic services, and periodontic services). If you have reached the maximum amount allowed for these specialty services in a calendar year, the dentist may then charge you his/her usual fee for the services rendered.

### Out-of-Network Coverage

(See page 5 for out-of-network orthodontic information.)

DeltaCare provides coverage for out-of-network services; however, the benefits are lower than the coverage we offer when members receive care from a DeltaCare dentist. This means greater out-of-pocket expense for you if you receive services from a non-participating dentist.

**\$100 deductible:** Members who receive care from non-participating dentists must satisfy a \$100 annual deductible that applies to all services. Each member who receives care from a non-participating provider must satisfy the deductible before receiving benefits.

**Reduced benefits:** Coverage for out-of-network services is 20% lower than the co-insurance for an in-network DeltaCare panel dentist. This DeltaCare co-payment schedule does not apply to out-of-network services. Out-of-network benefits will be based on either the dentist's charge or the maximum allowable fee for the service, whichever is lower. Coverage is only available for those services covered by your DeltaCare plan, and it is subject to the same limitations and exclusions.

If you choose to receive care from an out-of-network dentist, you'll need to submit a claim form to: Delta Dental, Attn: DeltaCare Unit, PO Box 9695, Boston, MA 02114. We'll reimburse you directly, and you are responsible for making payment arrangements with your dentist. Claims must be submitted to DeltaCare no later than 12 months from the date of service in order to be considered for payment.

## Emergency Dental Care

If you need emergency care, contact your PCD immediately. He or she will arrange to get you the care you need. If you can't reasonably reach your PCD (if you are traveling or not in the area, for example) and need emergency care, you should see a local dentist for treatment. You should then contact your PCD to arrange for further care. DeltaCare will provide coverage for emergency services required to reduce swelling, relieve pain, and/or reduce the potential for infection until you can see your PCD for treatment.

## Orthodontic Care

We base orthodontic benefits on 24 months of comprehensive treatment. You'll be responsible for the co-payment associated with your treatment, which you'll pay directly to your orthodontist. It's up to you and your orthodontist to make payment arrangements for the patient co-payment.

### Out-of-Network Orthodontics

Any care you receive from a non-participating orthodontist will be reimbursed at 20% of the maximum allowable fee or the orthodontist- submitted charge, whichever is less. The \$100 deductible for out-of-network services will apply unless it has already been satisfied.

### Termination of Coverage

You will be responsible for paying for any care you receive after your coverage terminates, and up to the submitted charge if you seek out-of-network treatment. It is up to you and your orthodontist to establish the terms and conditions of payment after coverage terminates. However, if you've started an orthodontic treatment plan and decide to continue to receive care from your DeltaCare orthodontist after your coverage terminates, your payments will be based on DeltaCare's discounted case fee.

### DeltaCare Orthodontic Exclusions

**Your plan does not cover the following:**

Replacement of lost, stolen, or broken orthodontic appliances; interceptive orthodontic treatment; retreatment of orthodontic cases; changes in treatment necessitated by an accident of any kind; surgical procedures incidental to orthodontic treatment; myofunctional therapy; surgical procedures related to cleft palate, micrognathia, macrognathia, or treatment related to temporomandibular joint dysfunctions and/or hormonal imbalance; malocclusions that are so severe they are not amenable to ideal orthodontic therapy; restorative work caused by orthodontic treatment; orthodontic examination and records unless you receive comprehensive treatment; tooth extraction solely for the purpose of orthodontics; **orthodontic treatment started before the effective date of your DeltaCare coverage may or may not be covered. Please refer to your Subscriber Certificate.**

## Frequency Limitations

Frequency limitations reflect the availability of coverage only. It is up to you and your dentist to determine the need and frequency of dental procedures.

The following contains the limitations for some common dental procedures. If you would like more information about limitations on services not included in this list, please contact our DeltaCare Unit at (800) 327-6277, for a copy of your Subscriber Certificate.

**Cleanings**—not to exceed two cleanings in any 12 consecutive months.

**Dentures and Partial Dentures**—up to one set per arch once every five years provided the existing set is no longer serviceable.

**Fixed Bridges, Crowns, and Other Cast Restorations**—up to one restoration per tooth or missing tooth space in a five-year period provided the existing restoration is no longer serviceable.

**Denture Relines**—up to once per denture in any 36 consecutive months beginning six months after delivery of the denture.

**Periodontal Treatments** (root planing/subgingival curettage)—up to once per quadrant in any 24 consecutive months.

**Bitewing X-rays**—based on need, up to one series of four films in any six-month period.

**Full-mouth X-rays**—based on need, up to one set every 24 consecutive months.

**Topical Fluoride Treatment**—once every six months for members under age 19.

**Space Maintainers**—(required due to the premature loss of teeth) for members under age 14 and not for the replacement of primary or permanent front teeth.

**Chlorhexidine Mouthrinse**—this is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing.

**Fluoride Toothpaste**—this is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.

**Sealants**—based on need, for unrestored permanent molars only, once per tooth for members under age 16.

Your DeltaCare provider is responsible for determining the best course of treatment for you. If more than one treatment option is appropriate, you can choose a more expensive option than your dentist recommends. In this case, you will be responsible for the difference in cost between the two options as well as the co-payment for the recommended treatment.

## Exclusions

1. General anesthesia and the services of a special anesthesiologist.
2. Cosmetic dental care.
3. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, country, or other subdivision.
4. Treatment required by reason of war.
5. Dental services performed in a hospital and related hospital fees.
6. Treatment of fractures and dislocations.
7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
9. Any service that is not specifically listed as a covered expense.
10. Congenital malformation.
11. Cysts and malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
14. Cases which in the professional judgment of the attending dentist determines a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
15. Dental services received from any dental office other than the assigned PCD's office, unless expressly authorized in writing from DeltaCare.
16. Prophylactic removal of impactions (asymptomatic nonpathological).
17. Specialist consultations for non-covered benefits.
18. Implant placement or removal, appliances placed on or services associated with implants.
19. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility with the DeltaCare program. Example: teeth prepared for crowns, root canals in progress, orthodontic treatment.
20. Occlusal guards for bruxism (grinding) or TMJ.
21. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly generally accepted method of treatment.
22. A service rendered by someone other than a licensed dentist or a hygienist that is employed by a licensed dentist.
23. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration, or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits.

24. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full-mouth reconstruction and are not a benefit of the DeltaCare program.
25. Tooth desensitization.
26. Interceptive orthodontic treatment.

## Member Rights and Responsibilities

As a Delta Dental member, you have the right to:

- Be provided with appropriate information about Delta Dental and its benefits, providers, and policies.
- Be informed of your diagnosis, the proposed treatment, and prognosis by your dentist.
- Give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment.
- Obtain a copy of your dental record, in accordance with the law.
- Be treated with respect and have your dignity and need for privacy recognized.

You have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers.
- Provide dentists with the information necessary to care for you.
- Be familiar with Delta Dental benefits, policies, and procedures by reading Delta Dental's written materials or calling the DeltaCare Unit.

## Where to Get More Information

If you have any question, please contact our DeltaCare Unit at (800) 327-6277.

This information should be used only as a guide for your dental plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, please see the Subscriber Certificate. Copies of the Subscriber Certificate are available through your benefits administrator.

# Member Co-payments for DeltaCare

As a DeltaCare member, you are responsible for the following co-payments when you receive care from your PCD or a DeltaCare participating specialist. All co-payments should be made directly to the treating dentist. Your DeltaCare plan provides coverage for only those procedures listed in this co-payment schedule.

## I. Diagnostic Services — Type I

|       |  |    |       |
|-------|--|----|-------|
| D0120 | Periodic oral evaluation - established patient   | \$ | 0     |
| D0140 | Limited oral evaluation problem focused  | \$ | 0     |
| D0145 | Oral evaluation for patient under three years of age                                     | \$ | 0     |
| D0150 | Comprehensive oral evaluation - new or established patient                               | \$ | 0     |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report                      | \$ | 0     |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | \$ | 0     |
| D0180 | Comprehensive periodontal evaluation - new or established patient                        | \$ | 0     |
| D0190 | Screening of a patient   | \$ | 0     |
| D0191 | Assessment of a patient  | \$ | 0     |
| D0210 | Full-mouth x-ray series  | \$ | 0     |
| D0220 | Single x-ray   | \$ | 0     |
| D0230 | Additional x-ray(s)  | \$ | 0     |
| D0240 | Occlusal x-ray   | \$ | 0     |
| D0270 | Single bitewing x-ray  | \$ | 0     |
| D0272 | Two bitewing x-rays  | \$ | 0     |
| D0273 | Bitewings - three films  | \$ | 0     |
| D0274 | Four bitewing x-rays   | \$ | 0     |
| D0277 | Verticle bitewing series (7 to 8 films)  | \$ | 0     |
| D0330 | Panoramic x-ray  | \$ | 0     |
| D0419 | Assessment of salivary flow by measurement   | \$ | 0     |
| D0460 | Nerve vitality test  | \$ | 0     |
| D0470 | Diagnostic casts   | \$ | 0     |
| D0999 | Unspecified diagnostic procedure, by report <sup>†</sup>                                 | \$ | 12.00 |
|       | Failed appointment without 24-hr notice per 15 min. of appointment time is               | \$ | 10.00 |

<sup>†</sup> This code may be used for reimbursing Chlorhexidine and prescription strength fluoride toothpaste only when dispensed in the office by a dentist.

## II. Preventive Services — Type I

|       |   |    |        |
|-------|---|----|--------|
| D1110 | Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period                           | \$ | 0      |
| D1120 | Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period                           | \$ | 0      |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.        | \$ | 0      |
| D1208 | Topical application of fluoride - child   | \$ | 0      |
| D1330 | Oral hygiene instruction  | \$ | 0      |
| D1351 | Sealant application - through age 25, unrestored permanent molars, once per month                   | \$ | 0      |
| D1352 | Preventive resin restoration in permanent tooth for moderate to high caries risk patients.          | \$ | 0      |
| D1353 | Sealant repair, per tooth   | \$ | 0      |
| D1354 | Interim caries arresting medicament application - per tooth - child to age 19; 1 per 6 month period | \$ | 0      |
| D1510 | Space maintainer - fixed, unilateral - per quadrant   | \$ | 163.00 |
| D1516 | Space maintainer fixed - bilateral, maxillary   | \$ | 275.00 |
| D1517 | Space maintainer - fixed - bilateral, mandibular  | \$ | 275.00 |
| D1520 | Space maintainer - removable, unilateral - per quadrant   | \$ | 113.00 |
| D1526 | Space maintainer - removable - bilateral, maxillary   | \$ | 275.00 |
| D1527 | Space maintainer - removable - bilateral, mandibular  | \$ | 275.00 |

|       |  |    |        |
|-------|--|----|--------|
| D1551 | Re-cement or re-bond bilateral space maintainer - maxillary      | \$ | 0      |
| D1552 | Re-cement or re-bond bilateral space maintainer - mandibular     | \$ | 0      |
| D1553 | Re-cement or re-bond unilateral space maintainer - per quadrant  | \$ | 0      |
| D1556 | Removal of fixed unilateral space maintainer - per quadrant      | \$ | 0      |
| D1557 | Removal of fixed bilateral space maintainer - maxillary          | \$ | 0      |
| D1558 | Removal of fixed bilateral space maintainer - mandibular         | \$ | 0      |
| D1575 | Distal shoe space maintainer - fixed - unilateral - per quadrant | \$ | 163.00 |

## III. Minor Restorative Services — Type II

|       |  |     |       |
|-------|--|-----|-------|
| D2140 | One surface silver filling, primary or permanent           | \$  | 35.00 |
| D2150 | Two surfaces silver filling, primary or permanent          | \$  | 42.00 |
| D2160 | Three surfaces silver filling, primary or permanent        | \$  | 51.00 |
| D2161 | Four or more surfaces silver filling, primary or permanent | \$  | 61.00 |
| D2330 | One surface white filling: front tooth                     | \$  | 41.00 |
| D2331 | Two surfaces white filling: front tooth                    | \$  | 50.00 |
| D2332 | Three surfaces white filling: front tooth                  | \$  | 60.00 |
| D2335 | Four or more surfaces white filling: front teeth           | \$  | 77.00 |
| D2390 | White crown, front   | \$  | 78.00 |
| D2391 | One surface white filling: back tooth                      | \$  | 46.00 |
| D2392 | Two surfaces white filling: back tooth                     | OPT |       |
| D2393 | Three surfaces white filling: back tooth                   | OPT |       |
| D2394 | Four or more surfaces white filling: back teeth            | OPT |       |
| D2410 | Gold foil - one surface                                    | OPT |       |
| D2420 | Gold foil - two surfaces                                   | OPT |       |
| D2430 | Gold foil - three surfaces                                 | OPT |       |

## IV. Major Restorative Services — Type III, except when noted as (TII) for Type II

|       |   |     |         |
|-------|---|-----|---------|
| D2542 | Onlay - metallic - two surfaces                       | \$  | 646.00  |
| D2543 | Onlay - metallic - three surfaces                     | \$  | 579.00  |
| D2544 | Onlay - metallic - four or more surfaces              | \$  | 678.00  |
| D2642 | Onlay - porcelain/ceramic- two surfaces               | \$  | 599.00  |
| D2643 | Onlay - porcelain/ceramic- three surfaces             | \$  | 632.00  |
| D2644 | Onlay - porcelain/ceramic- four or more surfaces      | \$  | 705.00  |
| D2710 | Crown - resin-based white                             | \$  | 210.00  |
| D2720 | Crown - resin with high noble metal <sup>††</sup>     | \$  | 630.00  |
| D2721 | Crown - resin with pred. base metal                   | \$  | 513.00  |
| D2722 | Crown - resin with noble metal                        | \$  | 548.00  |
| D2740 | Crown - porcelain/ceramic                             | \$  | 750.00* |
| D2750 | Crown - porcelain and high noble metal <sup>††</sup>  | \$  | 690.00* |
| D2751 | Crown - porcelain and base metal                      | \$  | 614.00* |
| D2752 | Crown - noble metal                                   | \$  | 628.00* |
| D2753 | Crown - porcelain fused to titanium or titanium alloy | \$  | 690.00* |
| D2780 | Crown - ¾ cast high noble metal <sup>††</sup>         | \$  | 690.00* |
| D2781 | Crown - ¾ cast predominantly base metal               | \$  | 557.00* |
| D2782 | Crown - ¾ cast noble metal                            | \$  | 698.00* |
| D2783 | Crown - ¾ porcelain/ceramic                           | OPT |         |
| D2790 | Crown - high noble metal <sup>††</sup>                | \$  | 717.00* |
| D2791 | Crown - base metal                                    | \$  | 570.00* |

|       |   |            |       |
|-------|---|------------|-------|
| D2792 | Crown - full cast noble metal                                 | \$ 639.00* |       |
| D2794 | Crown - titanium and titanium alloy**                         | \$ 800.00* |       |
| D2910 | Recement inlay, only or partial coverage restoration          | \$ 30.00   |       |
| D2915 | Recement cast or prefabricated post and core                  | \$ 28.00   | (TII) |
| D2920 | Recement crown  | \$ 29.00   | (TII) |
| D2929 | Prefabricated porcelain/ceramic crown, anterior primary tooth | \$ 69.00   | (TII) |
| D2930 | Crown - stainless steel: baby tooth                           | \$ 77.00   | (TII) |
| D2931 | Crown - stainless steel: permanent tooth                      | \$ 79.00   | (TII) |
| D2932 | Crown - prefabricated resin                                   | \$ 90.00   | (TII) |
| D2933 | Crown - prefabricated stainless steel with resin window       | \$ 69.00   | (TII) |
| D2940 | Sedative filling  | \$ 30.00   | (TII) |
| D2950 | Core build-up, including any pins                             | \$ 153.00  |       |
| D2951 | Pin retention in addition to filling, per tooth               | \$ 14.00   | (TII) |
| D2952 | Post and core in addition to crown, indirectly fabricated     | \$ 240.00  |       |
| D2953 | Each additional indirectly fabricated post - same tooth       | \$ 20.00   |       |

\* Includes co-payment and lab fee for this procedure.

|       |  |           |       |
|-------|--|-----------|-------|
| D2954 | Prefabricated post and core (in addition to crown)                                   | \$ 190.00 |       |
| D2957 | Each additional prefab post - same tooth   | \$ 20.00  |       |
| D2971 | Additional procedure to construct new crown under existing partial denture framework | \$ 110.00 | (TII) |
| D2980 | Crown repair, by report  | \$ 60.00  | (TII) |
| D2981 | Inlay repair necessitated by restorative material failure                            | \$ 60.00  | (TII) |
| D2982 | Onlay repair necessitated by restorative material failure                            | \$ 60.00  | (TII) |
| D2990 | Resin infiltration of incipient smooth surface lesions                               | \$ 0      | (TII) |

#### V. Endodontic Services — Type II

|       |   |           |  |
|-------|---|-----------|--|
| D3110 | Pulp cap: direct  | \$ 20.00  |  |
| D3120 | Pulp cap: indirect  | \$ 21.00  |  |
| D3220 | Pulp removal on baby tooth  | \$ 48.00  |  |
| D3221 | Pulpal debridement primary and permanent teeth  | \$ 56.00  |  |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | \$ 48.00  |  |
| D3230 | Pulpal therapy (resorbable filling) - front, primary tooth (excl. final restoration)  | \$ 37.00  |  |
| D3240 | Pulpal therapy (resorbable filling) - back, primary tooth (excl. final restoration)   | \$ 37.00  |  |
| D3310 | Root canal treatment: front tooth   | \$ 221.00 |  |
| D3320 | Root canal - endodontic therapy, premolar tooth (excluding final restoration)         | \$ 255.00 |  |
| D3330 | Root canal - endodontic therapy, molar tooth (excluding final restoration)            | \$ 315.00 |  |
| D3346 | Retreatment of previous root canal therapy - front                                    | \$ 254.00 |  |
| D3347 | Retreatment of previous root canal therapy - premolar                                 | \$ 285.00 |  |
| D3348 | Retreatment of previous root canal therapy - molar                                    | \$ 342.00 |  |
| D3410 | Surgical root canal treatment: front tooth  | \$ 225.00 |  |
| D3421 | Apicoectomy - premolar (first root)   | \$ 180.00 |  |
| D3425 | Surgical root canal treatment: molar (first root)                                     | \$ 260.00 |  |
| D3426 | Surgical root canal treatment: each additional root                                   | \$ 153.00 |  |
| D3430 | Retrograde filling - per root   | \$ 48.00  |  |

#### VI. Periodontic Services — Type II

|       |  |           |  |
|-------|--|-----------|--|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant   | \$ 127.00 |  |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant   | \$ 90.00  |  |
| D4240 | Gingival flap procedures, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant   | \$ 252.00 |  |
| D4241 | Gingival flap procedures, including root planing, one to three contiguous teeth or bounded teeth spaces per quadrant   | \$ 160.00 |  |
| D4245 | Apically positioned flap   | \$ 150.00 |  |
| D4249 | Crown lengthening - hard tissue  | \$ 260.00 |  |
| D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant                                      | \$ 336.00 |  |
| D4261 | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant                                      | \$ 256.00 |  |
| D4341 | Periodontal scaling and root planing - four or more teeth, per quadrant  | \$ 69.00  |  |
| D4342 | Periodontal scaling and root planing - one to three teeth, per quadrant  | \$ 48.00  |  |
| D4355 | Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit   | \$ 45.00  |  |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 1 D1110, D1120 or D4346 per 6 month period | \$ 0      |  |
| D4910 | Periodontal maintenance following active therapy   | \$ 20.00  |  |

OPT = An alternative benefit. Your plan covers the least expensive method of appropriate care for this condition, yet an alternative procedure can also be applied at the discretion of you and your dentist at a higher out-of-pocket cost to you.

#### VII. Removable Prosthodontics — Type II, except when noted as (TIII) for Type III

|       |   |            |        |
|-------|---|------------|--------|
| D5110 | Complete denture, upper**   | \$ 780.00* | (TIII) |
| D5120 | Complete denture, lower**   | \$ 776.00* | (TIII) |
| D5130 | Immediate denture, upper**  | \$ 840.00* | (TIII) |
| D5140 | Immediate denture, lower**  | \$ 868.00* | (TIII) |
| D5211 | Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)**  | \$ 554.00  | (TIII) |
| D5212 | Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)**   | \$ 600.00  | (TIII) |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)**         | \$ 840.00* | (TIII) |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)**        | \$ 840.00* | (TIII) |
| D5221 | Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)                                    | \$ 554.00  |        |
| D5222 | Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)                                   | \$ 600.00  |        |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$ 840.00  |        |

|       |  |            |        |       |   |                |
|-------|--|------------|--------|-------|---|----------------|
| D5224 | Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) . . . . . | \$ 840.00  |        | D6242 | Pontic: porcelain fused to noble metal ..   | \$ 615.00*     |
| D5225 | Upper partial denture: flexible base <sup>††</sup> . . . . .   | \$ 779.00  | (TIII) | D6243 | Pontic: porcelain fused to titanium or titanium alloys . . . . .                                | \$ 615.00*     |
| D5226 | Lower partial denture: flexible base <sup>††</sup> . . . . .   | \$ 838.00  | (TIII) | D6250 | Pontic: resin with high noble metal <sup>†††</sup> . . .  | \$ 621.00      |
| D5282 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary . . . . .  | \$ 390.00* | (TIII) | D6251 | Pontic: resin with pred. base metal . . . . .   | \$ 447.00      |
| D5283 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular . . . . .   | \$ 390.00* | (TIII) | D6252 | Pontic: resin with noble metal . . . . .  | \$ 510.00      |
| D5284 | Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant . . . . .                                     | \$ 390.00* | (TIII) | D6545 | Retainer - cast metal for resin bonded fixed prosthesis . . . . .                               | \$ 240.00      |
| D5286 | Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant . . . . .   | \$ 390.00* | (TIII) | D6549 | Resin retainer for resin-bonded fixed prosthesis . . . . .                                      | \$ 240.00      |
| D5410 | Adjust denture: complete, upper . . . . .  | \$ 26.00   |        | D6602 | Retainer inlay - cast high noble metal, two surfaces <sup>†††</sup> . . . . .                   | \$ 570.00      |
| D5411 | Adjust denture: complete, lower . . . . .  | \$ 20.00   |        | D6603 | Retainer inlay - cast high noble metal, three or more surfaces <sup>†††</sup> . . . . .         | \$ 554.00      |
| D5421 | Adjust denture: partial, upper . . . . .   | \$ 24.00   |        | D6604 | Retainer inlay - cast predominantly base metal, two surfaces . . . . .                          | \$ 487.00      |
| D5422 | Adjust denture: partial, lower . . . . .   | \$ 23.00   |        | D6605 | Retainer inlay - cast predominantly base metal, three or more surfaces . . . . .                | \$ 550.00      |
| D5511 | Repair broken complete denture base, mandibular . . . . .  | \$ 45.00   |        | D6606 | Retainer inlay - cast noble metal, two surfaces . . . . .                                       | \$ 636.00      |
| D5512 | Repair broken complete denture base, maxillary . . . . .   | \$ 45.00   |        | D6607 | Retainer inlay - cast noble metal, three or more surfaces . . . . .                             | \$ 550.00      |
| D5520 | Replace missing or broken teeth: complete denture, per tooth . . . . .   | \$ 41.00   |        | D6610 | Retainer onlay - cast high noble metal, two surfaces <sup>†††</sup> . . . . .                   | \$ 583.00      |
| D5611 | Repair resin partial denture base, mandibular  | \$ 45.00   |        | D6611 | Retainer onlay - cast high noble metal, three or more surfaces <sup>†††</sup> . . . . .         | \$ 630.00      |
| D5612 | Repair resin partial denture base, maxillary   | \$ 45.00   |        | D6612 | Retainer onlay - cast predominantly base metal, two surfaces . . . . .                          | \$ 583.00      |
| D5621 | Repair cast partial framework, mandibular  | \$ 62.00   |        | D6613 | Retainer onlay - cast predominantly base metal, three or more surfaces . . . . .                | \$ 366.00      |
| D5622 | Repair cast partial framework, maxillary .   | \$ 62.00   |        | D6614 | Retainer onlay - cast noble metal, two surfaces . . . . .                                       | \$ 583.00      |
| D5630 | Repair or replace broken retentive clasping materials - per tooth . . . . .  | \$ 50.00   |        | D6615 | Retainer onlay - cast noble metal, three or more surfaces . . . . .                             | \$ 735.00      |
| D5640 | Replace partial denture tooth, per tooth   | \$ 42.00   |        | D6720 | Retainer crown - resin with high noble metal <sup>†††</sup> . . . . .                           | \$ 270.00      |
| D5650 | Add tooth to existing partial denture . . .  | \$ 51.00   |        | D6721 | Retainer crown - resin with pre. base metal   | \$ 480.00      |
| D5660 | Add clasp to existing partial denture . . . .  | \$ 56.00   |        | D6722 | Retainer crown - resin with noble metal .   | \$ 480.00      |
| D5670 | Replace all teeth on upper denture . . . . .   | \$ 270.00  |        | D6750 | Retainer crown - porcelain fused to high noble metal <sup>†††</sup> & <sup>††††</sup> . . . . . | \$ 690.00*     |
| D5671 | Replace all teeth on lower denture . . . . .   | \$ 270.00  |        | D6751 | Retainer crown- porcelain fused to predominantly base metal <sup>††††</sup> . . . . .           | \$ 585.00*     |
| D5710 | Rebase denture: complete, upper . . . . .  | \$ 146.00  |        | D6752 | Retainer crown - porcelain fused to noble metal <sup>††††</sup> . . . . .                       | \$ 630.00*     |
| D5711 | Rebase denture: complete, lower . . . . .  | \$ 146.00  |        | D6753 | Retainer crown - porcelain fused to titanium or titanium alloys . . . . .                       | \$ 690.00*     |
| D5720 | Rebase denture: partial, upper . . . . .   | \$ 146.00  |        | D6780 | Retainer crown - ¾ cast high noble metal <sup>†††</sup> . . . . .                               | \$ 570.00*     |
| D5721 | Rebase denture: partial, lower . . . . .   | \$ 146.00  |        | D6781 | Retainer crown - ¾ cast predominantly base metal . . . . .                                      | \$ 578.00*     |
| D5730 | Reline denture: complete, upper (chairside)  | \$ 89.00   |        | D6782 | Retainer crown - ¾ cast noble metal . . . .   | \$ 591.00*     |
| D5731 | Reline denture: complete, lower (chairside)  | \$ 90.00   |        | D6784 | Retainer crown ¾ - titanium and titanium alloys . . . . .                                       | \$ 660.00*     |
| D5740 | Reline denture: partial, upper (chairside).  | \$ 71.00   |        | D6790 | Retainer crown - cast high noble metal <sup>†††</sup>   | \$ 660.00*     |
| D5741 | Reline denture: partial, lower (chairside) .   | \$ 82.00   |        | D6791 | Retainer crown - cast base metal . . . . .  | \$ 614.00*     |
| D5750 | Reline denture: complete, upper (laboratory)   | \$ 116.00  |        | D6792 | Retainer crown - cast noble metal . . . . .   | \$ 633.00*     |
| D5751 | Reline denture: complete, lower (laboratory)   | \$ 117.00  |        | D6930 | Recement fixed partial denture (bridge)   | \$ 41.00 (TII) |
| D5760 | Reline denture: partial, upper (laboratory)  | \$ 111.00  |        |       |   |                |
| D5761 | Reline denture: partial, lower (laboratory)  | \$ 106.00  |        |       |   |                |
| D5820 | Temp partial denture, upper . . . . .  | \$ 295.00  |        |       |   |                |
| D5821 | Temp partial denture, lower . . . . .  | \$ 279.00  | (TII)  |       |   |                |
| D5850 | Tissue conditioning: upper . . . . .   | \$ 45.00   | (TII)  |       |   |                |
| D5851 | Tissue conditioning: lower . . . . .   | \$ 56.00   |        |       |   |                |
| D5863 | Overdenture - complete maxillary . . . . .   | OPT        |        |       |   |                |
| D5864 | Overdenture - partial maxillary . . . . .  | OPT        |        |       |   |                |
| D5865 | Overdenture - complete mandibular . . . .  | OPT        |        |       |   |                |
| D5866 | Overdenture - partial mandibular . . . . .   | OPT        |        |       |   |                |

\*Includes co-payment and lab fee for this procedure.

††† For members who reside outside of Massachusetts, if precious and semi-precious metals are used, they will be charged to the enrollee at the additional cost of the metal. This applies to crowns, bridges, and cast post and cores.

†††† Porcelain on molars is considered optional treatment.

## VII. Fixed Prosthodontics — Type III, except when noted as (TII) for Type II

|       |  |            |
|-------|--|------------|
| D6210 | Pontic: cast high noble metal <sup>†††</sup> . . . . .               | \$ 675.00* |
| D6211 | Pontic: predominantly base metal . . . . .                           | \$ 510.00* |
| D6212 | Pontic: cast noble metal . . . . .                                   | \$ 555.00* |
| D6240 | Pontic: porcelain fused to high noble metal <sup>†††</sup> . . . . . | \$ 684.00* |
| D6241 | Pontic: porcelain fused to pred. base metal . . . . .                | \$ 585.00* |

**IX. Oral and Maxillofacial Surgery — Type II**

|       |  |           |
|-------|--|-----------|
| D7111 | Extraction, coronal remnants - baby tooth  | \$ 30.00  |
| D7140 | Extraction, erupted tooth or exposed root; includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary | \$ 43.00  |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated      | \$ 80.00  |
| D7220 | Impacted tooth removal: soft tissue  | \$ 95.00  |
| D7230 | Impacted tooth removal: partially bony   | \$ 125.00 |
| D7240 | Impacted tooth removal: completely bony  | \$ 150.00 |
| D7241 | Removal of impacted tooth: completely bony with unusual surgical complications   | \$ 180.00 |
| D7250 | Removal of residual tooth roots (cutting procedure)  | \$ 80.00  |
| D7286 | Biopsy of soft tissue  | \$ 105.00 |
| D7310 | Alveoloplasty in conjunction with extractions, four or more teeth or tooth spaces - per quadrant   | \$ 63.00  |
| D7311 | Bone recontouring (done with extractions) - one to three teeth or tooth spaces, per quadrant   | \$ 75.00  |
| D7320 | Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per quadrant   | \$ 90.00  |
| D7321 | Bone recontouring (done without extractions) - one to three teeth or tooth spaces, per quadrant  | \$ 68.00  |
| D7471 | Excision - bone tissue   | \$ 103.00 |
| D7472 | Removal of torus palatinus   | \$ 206.00 |
| D7473 | Removal of torus mandibularis  | \$ 165.00 |
| D7510 | Incision and drainage of abscess   | \$ 60.00  |
| D7960 | Frenulectomy (frenectomy or frenotomy)   | \$ 149.00 |

**IX. Orthodontic Services — Type IV**

Please contact your local DeltaCare Service Team using the phone number listed on the back side of your ID card for a detailed breakdown of the following all-inclusive orthodontic fees.

|   |             |
|---|-------------|
| Pre-orthodontic treatment visit (applied to treatment fee if patient proceeds with treatment)         | \$ 25.00    |
| Pre-orthodontic records (applied to treatment fee if patient proceeds with treatment) <sup>****</sup> | \$ 200.00   |
| Dependent children to age 19  |             |
| <i>Comprehensive care up to 24 months</i>   | \$ 3,350.00 |
| Adults and covered dependents over age 19   |             |
| <i>Comprehensive care up to 24 months</i>   | \$ 3,550.00 |

This comprehensive orthodontic treatment includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers, and office visits for a maximum of two years after the completion of active treatment. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee, not to exceed \$75/month.

<sup>\*\*\*\*</sup> This fee is built into the all-inclusive orthodontic fees listed, but will be a separate co-payment if you choose not to continue treatment with this dentist. The fee includes: records solely for the purpose of orthodontics (pre-records), intraoral-complete series (including bitewings), cephalometric film, panoramic film, tomographic survey, oral/facial images (includes intra and extra oral images), diagnostic casts.

**XI. Additional Procedures — Type II, except when noted as (TI) for Type I**

|       |   |          |      |
|-------|---|----------|------|
| D9110 | Emergency treatment for relief of pain  | \$ 29.00 |      |
| D9211 | Regional block anesthesia   | \$ 0     |      |
| D9212 | Trigeminal division block anesthesia  | \$ 0     |      |
| D9215 | Local anesthesia  | \$ 0     |      |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | \$ 24.00 | (TI) |
| D9440 | After-hours office visit  | \$ 25.00 | (TI) |
| D9990 | Certified translation or sign language services - per visit   | \$ 0     |      |
| D9995 | Teledentistry - synchronous; real-time encounter  | \$ 0     |      |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review               | \$ 0     |      |

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- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, visit: <http://www.deltadentalma.com> or call the number on your member ID card.

If you believe that Delta Dental of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu  
Civil Rights Coordinator  
Compliance Department  
465 Medford Street  
Boston, MA 02129  
Fax: 617-886-1390  
Phone: 617-886-1683  
Email: [FairTreatment@greatdentalplans.com](mailto:FairTreatment@greatdentalplans.com)  
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-872-0500 (TTY: 1-844-233-4524).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-872-0500 (TTY: 1-844-233-4524).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-872-0500 (TTY: 1-844-233-4524)。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-872-0500 (TTY: 1-844-233-4524).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-872-0500 (TTY: 1-844-233-4524).

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مُؤرَب لَصْتَا: اناجملاب لفل رفاوتت ةيوعلل اءعاسمال تامءخ ناف، ةءلل ارلءا ءءءت ءنءك اذا: ءظوءلم 1-800-872-0500 (ءلءبل او ءصلل اءءاء ءؤر) (1-844-233-4524).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្លូវភាសា ដោយមិនគិតលុយនូវ គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-872-0500 (TTY: 1-844-233-4524)។

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-872-0500 (ATS: 1-844-233-4524).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-872-0500 (TTY: 1-844-233-4524).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-872-0500 (TTY: 1-844-233-4524). 번으로 전화해 주십시오.

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