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. 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 21st 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 necessitatedby 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†	$ 12.00
Failed appointment without 24-hr notice per 15 min. of appointment time is		$ 10.00

† 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	$ 98.00
D1516	Space maintainer fixed - bilateral, maxillary	$ 165.00
D1517	Space maintainer - fixed - bilateral, mandibular	$ 165.00
D1520	Space maintainer - removable, unilateral - per quadrant	$ 68.00
D1526	Space maintainer - removable - bilateral, maxillary	$ 165.00
D1527	Space maintainer - removable - bilateral, mandibular	$ 165.00
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	$ 98.00

III. Minor Restorative Services — Type II

D2140	One surface silver filling, primary or permanent	$ 12.00
D2150	Two surfaces silver filling, primary or permanent	$ 14.00
D2160	Three surfaces silver filling, primary or permanent	$ 17.00
D2161	Four or more surfaces silver filling, primary or permanent	$ 20.00
D2330	One surface white filling: front tooth	$ 14.00
D2331	Two surfaces white filling: front tooth	$ 17.00
D2332	Three surfaces white filling: front tooth	$ 20.00
D2335	Four or more surfaces white filling: front teeth	$ 26.00
D2390	White crown, front	$ 26.00
D2391	One surface white filling: back tooth	$ 18.00
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	$ 323.00
D2543	Onlay - metallic - three surfaces	$ 290.00
D2544	Onlay - metallic - four or more surfaces	$ 339.00
D2642	Onlay - porcelain/ceramic- two surfaces	$ 299.00
D2643	Onlay - porcelain/ceramic- three surfaces	$ 316.00
D2644	Onlay - porcelain/ceramic- four or more surfaces	$ 353.00
D2710	Crown - resin-based white	$ 105.00
D2720	Crown - resin with high noble metal††	$ 315.00
D2721	Crown - resin with pred. base metal	$ 257.00
D2722	Crown - resin with noble metal	$ 274.00
D2740	Crown - porcelain/ceramic	$ 375.00*
D2750	Crown - porcelain and high noble metal††	$ 345.00*
D2751	Crown - porcelain and base metal	$ 313.00*
D2752	Crown - noble metal	$ 323.00*
D2753	Crown - porcelain fused to titanium or titanium alloy	$ 345.00*
D2780	Crown - ¾ cast high noble metal††	$ 345.00*
D2781	Crown - ¾ cast predominantly base metal	$ 343.00*
D2782	Crown - ¾ cast noble metal	$ 349.00*
D2783	Crown - ¾ porcelain/ceramic	OPT
D2790	Crown - high noble metal††	$ 359.00*

D2791	Crown - base metal	$ 313.00*	
D2792	Crown - full cast noble metal	$ 328.00*	
D2794	Crown - titanium and titanium alloy††	$ 435.00*	
D2910	Recement inlay, only or partial coverage restoration	$ 10.00	
D2915	Recement cast or prefabricated post and core	$ 9.00	(TII)
D2920	Recement crown	$ 10.00	(TII)
D2929	Prefabricated porcelain/ceramic crown, anterior primary tooth	$ 23.00	(TII)
D2930	Crown - stainless steel: baby tooth	$ 26.00	(TII)
D2931	Crown - stainless steel: permanent tooth	$ 26.00	(TII)
D2932	Crown - prefabricated resin	$ 30.00	(TII)
D2933	Crown - prefabricated stainless steel with resin window	$ 23.00	(TII)
D2940	Sedative filling	$ 10.00	(TII)
D2950	Core build-up, including any pins	$ 87.00	
D2951	Pin retention in addition to filling, per tooth	$ 5.00	(TII)
D2952	Post and core in addition to crown, indirectly fabricated	$ 120.00	
D2953	Each additional indirectly fabricated post - same tooth	$ 15.00	

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

D2954	Prefabricated post and core (in addition to crown)	$ 98.00	
D2957	Each additional prefab post - same tooth	$ 15.00	
D2971	Additional procedure to construct new crown under existing partial denture framework	$ 68.00	(TII)
D2980	Crown repair, by report	$ 20.00	(TII)
D2981	Inlay repair necessitated by restorative material failure	$ 20.00	(TII)
D2982	Onlay repair necessitated by restorative material failure	$ 20.00	(TII)
D2990	Resin infiltration of incipient smooth surface lesions	$ 0	(TII)

V. Endodontic Services — Type II

D3110	Pulp cap: direct	$ 7.00	
D3120	Pulp cap: indirect	$ 7.00	
D3220	Pulp removal on baby tooth	$ 16.00	
D3221	Pulpal debridement primary and permanent teeth	$ 19.00	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$ 16.00	
D3230	Pulpal therapy (resorbable filling) - front, primary tooth (excl. final restoration)	$ 12.00	
D3240	Pulpal therapy (resorbable filling) - back, primary tooth (excl. final restoration)	$ 12.00	
D3310	Root canal treatment: front tooth	$ 74.00	
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	$ 85.00	
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	$ 105.00	
D3346	Retreatment of previous root canal therapy - front	$ 85.00	
D3347	Retreatment of previous root canal therapy - premolar.	$ 95.00	
D3348	Retreatment of previous root canal therapy - molar	$ 125.00	
D3410	Surgical root canal treatment: front tooth	$ 75.00	
D3421	Surgical root canal treatment: premolar (first root)	$ 60.00	
D3425	Surgical root canal treatment: molar (first root)	$ 87.00	
D3426	Surgical root canal treatment: each additional root	$ 51.00	
D3430	Retrograde filling - per root	$ 16.00	

VI. Periodontic Services — Type II

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$ 42.00	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 30.00	
D4240	Gingival flap procedures, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant	$ 84.00	
D4241	Gingival flap procedures, including root planing, one to three contiguous teeth or bounded teeth spaces per quadrant	$ 53.00	
D4245	Apically positioned flap	$ 130.00	
D4249	Crown lengthening - hard tissue	$ 87.00	
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quandrant	$ 112.00	
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quandrant	$ 85.00	
D4341	Periodontal scaling and root planing - four or more teeth, per quadrant	$ 23.00	
D4342	Periodontal scaling and root planning – one to three teeth, per quadrant	$ 16.00	
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	
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit	$ 40.00	
D4910	Periodontal maintenance following active therapy	$ 7.00	

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††	$ 390.00*	(TIII)
D5120	Complete denture, lower††	$ 388.00*	(TIII)
D5130	Immediate denture, upper††	$ 420.00*	(TIII)
D5140	Immediate denture, lower††	$ 434.00*	(TIII)
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)††	$ 277.00	(TIII)
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)††	$ 300.00	(TIII)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)††	$ 420.00*	(TIII)
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$ 420.00*	(TIII)
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$ 277.00	
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth).	$ 300.00	
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$ 420.00	

D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$	420.00	
D5225	Upper partial denture: flexible base[††]	$	390.00	(TIII)
D5226	Lower partial denture: flexible base[††]	$	419.00	(TIII)
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	$	195.00*	(TIII)
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	$	195.00*	(TIII)
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) - per quadrant	$	195.00*	(TIII)
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) - per quadrant	$	195.00*	(TIII)
D5410	Adjust denture: complete, upper	$	9.00	
D5411	Adjust denture: complete, lower	$	7.00	
D5421	Adjust denture: partial, upper	$	8.00	
D5422	Adjust denture: partial, lower	$	8.00	
D5511	Repair broken complete denture base, mandibular	$	15.00	
D5512	Repair broken complete denture base, maxillary	$	15.00	
D5520	Replace missing or broken teeth: complete denture, per tooth	$	14.00	
D5611	Repair resin partial denture base, mandibular	$	15.00	
D5612	Repair resin partial denture base, maxillary	$	15.00	
D5621	Repair cast partial framework, mandibular	$	21.00	
D5622	Repair cast partial framework, maxillary	$	21.00	
D5630	Repair or replace broken retentive clasping materials - per tooth	$	17.00	
D5640	Replace partial denture tooth, per tooth	$	14.00	
D5650	Add tooth to existing partial denture	$	17.00	
D5660	Add clasp to existing partial denture	$	19.00	
D5670	Replace all teeth on upper denture	$	135.00	
D5671	Replace all teeth on lower denture	$	135.00	
D5710	Rebase denture: complete, upper	$	42.00	
D5711	Rebase denture: complete, lower	$	40.00	
D5720	Rebase denture: partial, upper	$	45.00	
D5721	Rebase denture: partial, lower	$	40.00	
D5730	Reline denture: complete, upper (chairside)	$	30.00	
D5731	Reline denture: complete, lower (chairside)	$	30.00	
D5740	Reline denture: partial, upper (chairside)	$	24.00	
D5741	Reline denture: partial, lower (chairside)	$	27.00	
D5750	Reline denture: complete, upper (laboratory)	$	39.00	
D5751	Reline denture: complete, lower (laboratory)	$	39.00	
D5760	Reline denture: partial, upper (laboratory)	$	37.00	
D5761	Reline denture: partial, lower (laboratory)	$	35.00	
D5820	Temp partial denture, upper	$	149.00	
D5821	Temp partial denture, lower	$	140.00	(TII)
D5850	Tissue conditioning: upper	$	15.00	(TII)
D5851	Tissue conditioning: lower	$	19.00	
D5863	Overdenture — complete maxillary		OPT	
D5864	Overdenture — partial maxillary		OPT	
D5865	Overdenture — complete mandibular		OPT	
D5866	Overdenture — partial mandibular		OPT	

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

D6210	Pontic: cast high noble metal[†††]	$	338.00*	
D6211	Pontic: predominantly base metal	$	308.00*	
D6212	Pontic: cast noble metal	$	323.00*	
D6240	Pontic: porcelain fused to high noble metal[†††]	$	342.00*	
D6241	Pontic: porcelain fused to pred. base metal	$	308.00*	
D6242	Pontic: porcelain fused to noble metal	$	318.00*	
D6243	Pontic: porcelain fused to titanium or titanium alloys	$	318.00*	
D6250	Pontic: resin with high noble metal[†††]	$	311.00	
D6251	Pontic: resin with pred. base metal	$	224.00	
D6252	Pontic: resin with noble metal	$	255.00	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$	120.00	
D6549	Resin retainer for resin-bonded fixed prosthesis	$	120.00	
D6602	Retainer Inlay - cast high noble metal, two surfaces[†††]	$	285.00	
D6603	Retainer Inlay - cast high noble metal, three or more surfaces[†††]	$	277.00	
D6604	Retainer Inlay - cast predominantly base metal, two surfaces	$	244.00	
D6605	Retainer Inlay - cast predominantly base metal, three or more surfaces	$	275.00	
D6606	Retainer Inlay - cast noble metal, two surfaces	$	450.00	
D6607	Retainer Inlay - cast noble metal, three or more surfaces	$	275.00	
D6610	Retainer onlay - cast high noble metal, two surfaces[†††]	$	292.00	
D6611	Retainer onlay - cast high noble metal, three or more surfaces[†††]	$	315.00	
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$	292.00	
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$	183.00	
D6614	Retainer onlay - cast noble metal, two surfaces	$	292.00	
D6615	Retainer onlay - cast noble metal, three or more surfaces	$	413.00	
D6720	Retainer crown - resin with high noble metal[†††]	$	180.00	
D6721	Retainer crown - resin with pred. base metal	$	240.00	
D6722	Retainer crown - resin with noble metal	$	240.00	
D6750	Retainer crown - porcelain fused to high noble metal[†††] & [††††]	$	345.00*	
D6751	Retainer crown - porcelain fused to predominantly base metal[††††]	$	313.00*	
D6752	Retainer crown - porcelain fused to noble metal[††††]	$	313.00*	
D6753	Retainer crown - porcelain fused to titanium or titanium alloys	$	345.00*	
D6780	Retainer crown - ¾ cast high noble metal[†††]	$	343.00*	
D6781	Retainer crown - ¾ cast predominantly base metal	$	343.00*	
D6782	Retainer crown - ¾ cast noble metal	$	343.00*	
D6784	Retainer crown ¾ – titanium and titanium alloys	$	336.00*	
D6790	Retainer crown - cast high noble metal[†††]	$	336.00*	
D6791	Retainer crown - cast base metal	$	313.00*	
D6792	Retainer crown - cast noble metal	$	328.00*	
D6930	Recement fixed partial denture (bridge)	$	14.00	(TII)

*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.

IX. Oral and Maxillofacial Surgery — Type II

D7111	Extraction, coronal remnants - baby tooth	$	10.00
D7140	Extraction, erupted tooth or exposed root; includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	$	14.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$	27.00
D7220	Impacted tooth removal: soft tissue	$	32.00
D7230	Impacted tooth removal: partially bony	$	42.00
D7240	Impacted tooth removal: completely bony	$	50.00
D7241	Removal of impacted tooth: completely bony with unusual surgical complications	$	60.00
D7250	Removal of residual tooth roots (cutting procedure)	$	27.00
D7286	Biopsy of soft tissue	$	35.00
D7310	Alveoloplasty in conjunction with extractions, four or more teeth or tooth spaces - per quadrant	$	21.00
D7311	Bone recontouring (done with extractions) - one to three teeth or tooth spaces, per quadrant	$	25.00
D7320	Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per qaudrant	$	30.00
D7321	Bone recontouring (done without extractions) - one to three teeth or tooth spaces, per quadrant	$	23.00
D7471	Excision - bone tissue	$	34.00
D7472	Removal of torus palatinus	$	69.00
D7473	Removal of torus mandibularis	$	55.00
D7510	Incision and drainage of abscess	$	20.00
D7960	Frenulectomy (frenectomy or frenotomy)	$	50.00

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)†††††	$	200.00
Dependent children to age 19 *Comprehensive care up to 24 months*	$	3,350.00
Adults and covered dependents over age 19 *Comprehensive care up to 24 months*	$	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.

††††† This fee is built into the all-inclusive orthodontic fees listed, but will be a separate co-payment if you choose not to continue treatement 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	$	10.00	
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	$	8.00	(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	

NONDISCRIMINATION NOTICE

Delta Dental of Massachusetts complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Delta Dental of Massachusetts does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Delta Dental of Massachusetts:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, and accessible electronic formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, visit: 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
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)

View our Notice of Privacy Practices at http://bit.ly/ddmanpp

Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc.
Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered DSM Massachusetts Insurance Company, Inc.

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

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

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

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

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

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-872-0500 (телетайп: TTY: 1-844-233-4524).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-872-0500 (رقم هاتف الصم والبكم: 1-844-233-4524).

បរយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-872-0500 (TTY: 1-844-233-4524).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-872-0500 (TTY: 1-844-233-4524).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-872-0500 (TTY: 1-844-233-4524). पर कॉल करें।

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-872-0500 (TTY: 1-844-233-4524).

At your request, Interpreter and translation services related to administrative procedures are available to you or a covered family member.

خدمات ترجمة فورية/ترجمة
فى حالة طلبكم نقوم بتوفير مترجمين وخدمات ترجمة تتعلق بالإجراءات الإدارية.

អ្នកបកប្រែ ឬកិច្ចការបកប្រែ
បើអ្នកស្នើឱ្យមានអ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង
វិធីចាត់ចែងការ យើងមានផ្តល់ជូន ។

翻譯服務
如果您提出要求,我們可以為您提供相關的行政禮節的翻譯服務。

Services de traduction et d'interprétariat.
Les services de traduction et d'interprétariat en connexion avec les procédures administratives sont disponibles sur demande.

Услуги устного/письменного перевода.
По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами.

Sèvis Entèprèt ak TradiskyonSi w mande sèvis entèprèt ak tradiksyon pou prosede administratif, nap mete yo a dispozisyon ou.

Servizi di interpretariato e traduzioneA richiesta, sono disponibili servizi di interpretariato e traduzione relazionati con pratiche amministrative.

บริการแปลภาษา และ บายภาษา
ตามที่ท่านขอมา, พวกเราเรามีบริการบบาย แปลภาษา และ
การแปลภาษาที่ร่วมกับขั้นตอนการบริหารให้ท่านและ สมาชิกในครอบครัวของท่าน

Servicos de tradutor(a)/interprete Se assim o solicitar, estao disponiveis servicos de traducao e interpretacao para os procedimentos administrativos.

Υπηρεσίες Διερμηνέα/Μεταφραστή
Μετά από αίτησή σας, υπηρεσίες διερμηνέα και μεταφραστή σχετικά με διοικητικές διαδικασίες είναι στη διάθεσή σας.

Servicios de interpretación/traducción Si usted lo solicita, se encuentran a su disposición servicios de interpretación y traducción para asistirle en procedimientos administrativos.

DELTA DENTAL®

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Delta Dental of Massachusetts
(800) 327-6277
www.deltadentalma.com

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