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 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.

Emergency Dental Care
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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.
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.
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.

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 Velticle bitewing series (7 to 8 films) ....................................... $ 0
D0330 Panoramic x-ray ................................................................. $ 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, un 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
D1510 Space maintainer - fixed, unilateral .................................... $ 163.00
D1515 Space maintainer - fixed, bilateral ...................................... $ 275.00
D1520 Space maintainer - removable, unilateral ......................... $ 113.00
D1525 Space maintainer - removable, bilateral ......................... $ 263.00
D1550 Recementation of space maintainer .................................. $ 0
D1555 Removal of fixed space maintainer .................................. $ 0
D1575 Distal shoe space maintainer - fixed - unilateral - child to age 9 .............................................. $ 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* ................................... $ 630.00
D2721 Crown - resin with pred. base metal ................................ $ 513.00
D2722 Crown - resin with noble metal ........................................ $ 548.00
D2740 Crown - porcelain/ceramic substrate ..................................... $ 750.00
D2750 Crown - porcelain and high noble metal* ................................ $ 690.00
D2751 Crown - porcelain and base metal ................................ $ 614.00
D2752 Crown - noble metal .............................................................. $ 628.00
D2780 Crown - ¾ cast high noble metal* ......................................... $ 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* .................................................. $ 717.00
D2791 Crown - base metal .............................................................. $ 570.00
D2792 Crown - full cast noble metal .................................................. $ 639.00
D2794 Crown - titanium†† ............................................................... $ 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

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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 treatment: bicuspid  $ 255.00
D3330  Root canal treatment: molar  $ 315.00
D3346  Retreatment of previous root canal therapy - front  $ 254.00
D3347  Retreatment of previous root canal therapy - bicuspid  $ 285.00
D3348  Retreatment of previous root canal therapy - molar  $ 342.00
D3410  Surgical root canal treatment: front tooth  $ 225.00
D3421  Surgical root canal treatment: bicuspid (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

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.

D4355  Full-mouth debridement to enable comprehensive evaluation and diagnosis  $ 45.00
D4346  Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - I D1110, D1120 or D4346 per 6 month period  $ 0

D4910  Periodontal maintenance following active therapy  $ 20.00

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  Upper partial denture: resin base††  $ 554.00 (TII)
D5212  Lower partial denture: resin base††  $ 600.00 (TII)
D5213  Upper partial denture: metal††  $ 840.00*(TIII)
D5214  Lower partial denture: metal††  $ 840.00*(TIII)
D5221  Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)  $ 554.00
D5222  Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)  $ 600.00
D5223  Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  $ 840.00
D5224  Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  $ 840.00
D5225  Upper partial denture: flexible base††  $ 779.00 (TII)
D5226  Lower partial denture: flexible base††  $ 838.00 (TII)
D5281  Unilateral partial denture  $ 390.00*(TIII)
D5410  Adjust denture: complete, upper  $ 26.00
D5411  Adjust denture: complete, lower  $ 20.00
D5421  Adjust denture: partial, upper  $ 24.00
D5422  Adjust denture: partial, lower  $ 23.00
D5510  Repair broken complete denture base  $ 45.00
D5520  Replace missing or broken teeth: complete denture, per tooth  $ 41.00
D5610  Base repair: partial denture  $ 45.00
D5620  Cast framework repair  $ 62.00
D5630  Repair or replace broken clasps  $ 50.00
D5640  Replace partial denture tooth, per tooth  $ 42.00
D5650  Add tooth to existing partial denture  $ 51.00
D5660  Add clasps to existing partial denture  $ 56.00
D5670  Replace all teeth on upper denture  $ 270.00
D5671  Replace all teeth on lower denture  $ 270.00
D5710  Rebase denture: complete, upper  $ 146.00
D5711  Rebase denture: complete, lower  $ 146.00
D5720  Rebase denture: partial, upper  $ 146.00
D5721  Rebase denture: partial, lower  $ 146.00
D5730  Reline denture: complete, upper (chairside)  $ 89.00
D5731  Reline denture: complete, lower (chairside)  $ 90.00
D5740  Reline denture: partial, upper (chairside)  $ 71.00
D5741  Reline denture: partial, lower (chairside)  $ 82.00
D5750  Reline denture: complete, upper (laboratory)  $ 116.00
D5751  Reline denture: complete, lower (laboratory)  $ 117.00
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  $ 37.00
D5864  Overdenture — partial maxillary  $ 37.00
D5865  Overdenture — complete mandibular  $ 37.00
D5866  Overdenture — partial mandibular  $ 37.00

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>D6210</td>
<td>Pontic: cast high noble metal</td>
<td>$675.00*</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic: predominantly base metal</td>
<td>$510.00*</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic: cast noble metal</td>
<td>$555.00*</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic: porcelain fused to high noble metal</td>
<td>$684.00*</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic: porcelain fused to pred. base metal</td>
<td>$585.00*</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic: porcelain fused to noble metal</td>
<td>$615.00*</td>
</tr>
<tr>
<td>D6250</td>
<td>Pontic: resin with high noble metal</td>
<td>$621.00</td>
</tr>
<tr>
<td>D6251</td>
<td>Pontic: resin with pred. base metal</td>
<td>$447.00</td>
</tr>
<tr>
<td>D6252</td>
<td>Pontic: resin with noble metal</td>
<td>$510.00</td>
</tr>
<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
<td>$240.00</td>
</tr>
<tr>
<td>D6549</td>
<td>Resin retainer for resin-bonded fixed prosthesis</td>
<td>$240.00</td>
</tr>
<tr>
<td>D6602</td>
<td>Retainer inlay - cast high noble metal, two surfaces</td>
<td>$570.00</td>
</tr>
<tr>
<td>D6603</td>
<td>Retainer inlay - cast high noble metal, three or more surfaces</td>
<td>$554.00</td>
</tr>
<tr>
<td>D6604</td>
<td>Retainer inlay - cast predominantly base metal, two surfaces</td>
<td>$487.00</td>
</tr>
<tr>
<td>D6605</td>
<td>Retainer inlay - cast predominantly base metal, three or more surfaces</td>
<td>$550.00</td>
</tr>
<tr>
<td>D6606</td>
<td>Retainer inlay - cast noble metal, two surfaces</td>
<td>$636.00</td>
</tr>
<tr>
<td>D6607</td>
<td>Retainer inlay - cast noble metal, three or more surfaces</td>
<td>$550.00</td>
</tr>
<tr>
<td>D6610</td>
<td>Retainer inlay - cast high noble metal, two surfaces</td>
<td>$583.00</td>
</tr>
<tr>
<td>D6611</td>
<td>Retainer inlay - cast high noble metal, three or more surfaces</td>
<td>$630.00</td>
</tr>
<tr>
<td>D6612</td>
<td>Retainer inlay - cast predominantly base metal, two surfaces</td>
<td>$583.00</td>
</tr>
<tr>
<td>D6613</td>
<td>Retainer inlay - cast predominantly base metal, three or more surfaces</td>
<td>$583.00</td>
</tr>
<tr>
<td>D6614</td>
<td>Retainer inlay - cast noble metal, two surfaces</td>
<td>$583.00</td>
</tr>
<tr>
<td>D6615</td>
<td>Retainer inlay - cast noble metal, three or more surfaces</td>
<td>$735.00</td>
</tr>
<tr>
<td>D6720</td>
<td>Retainer crown - resin with high noble metal</td>
<td>$270.00</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer crown - resin with pre. base metal</td>
<td>$480.00</td>
</tr>
<tr>
<td>D6722</td>
<td>Retainer crown - resin with noble metal</td>
<td>$480.00</td>
</tr>
<tr>
<td>D6750</td>
<td>Retainer crown - porcelain fused to high noble metal</td>
<td>$690.00*</td>
</tr>
<tr>
<td>D6751</td>
<td>Retainer crown - porcelain fused to predominantly base metal</td>
<td>$690.00*</td>
</tr>
<tr>
<td>D6752</td>
<td>Retainer crown - porcelain fused to noble metal</td>
<td>$585.00*</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown - 1/4 cast high noble metal</td>
<td>$630.00*</td>
</tr>
<tr>
<td>D6781</td>
<td>Retainer crown - 1/4 cast predominantly base metal</td>
<td>$570.00*</td>
</tr>
<tr>
<td>D6782</td>
<td>Retainer crown - 1/4 cast noble metal</td>
<td>$578.00*</td>
</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - cast high noble metal</td>
<td>$660.00*</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer crown - cast base metal</td>
<td>$614.00*</td>
</tr>
<tr>
<td>D6792</td>
<td>Retainer crown - cast noble metal</td>
<td>$633.00*</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement fixed partial denture (bridge)</td>
<td>$410.00 (TI)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - baby tooth</td>
<td>$30.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root; includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary</td>
<td>$43.00</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>$80.00</td>
</tr>
<tr>
<td>D7220</td>
<td>Impacted tooth removal: soft tissue</td>
<td>$95.00</td>
</tr>
<tr>
<td>D7230</td>
<td>Impacted tooth removal: partially bony</td>
<td>$125.00</td>
</tr>
<tr>
<td>D7240</td>
<td>Impacted tooth removal: completely bony</td>
<td>$150.00</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth: completely bony with unusual surgical complications</td>
<td>$180.00</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
<td>$90.00</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of soft tissue</td>
<td>$105.00</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions, four or more teeth or tooth spaces - per quadrant</td>
<td>$63.00</td>
</tr>
<tr>
<td>D7311</td>
<td>Bone recontouring (done with extractions) - one to three teeth or tooth spaces, per quadrant</td>
<td>$75.00</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per quadrant</td>
<td>$90.00</td>
</tr>
<tr>
<td>D7471</td>
<td>Excision - bone tissue</td>
<td>$68.00</td>
</tr>
<tr>
<td>D7472</td>
<td>Removal of torus palatinus</td>
<td>$103.00</td>
</tr>
<tr>
<td>D7473</td>
<td>Removal of torus mandibularis</td>
<td>$206.00</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess</td>
<td>$60.00</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenulectomy (frenectomy or frenotomy)</td>
<td>$149.00</td>
</tr>
</tbody>
</table>

### 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 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Emergency treatment for relief of pain</td>
<td>$29.00</td>
</tr>
<tr>
<td>D9210</td>
<td>Regional block anesthesia</td>
<td>$0</td>
</tr>
<tr>
<td>D9211</td>
<td>Trigeminal division block anesthesia</td>
<td>$0</td>
</tr>
<tr>
<td>D9215</td>
<td>Local anesthesia</td>
<td>$0</td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>$24.00 (TI)</td>
</tr>
<tr>
<td>D9440</td>
<td>After-hours office visit</td>
<td>$25.00 (TI)</td>
</tr>
</tbody>
</table>

---

**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.**
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Delta Dental of Massachusetts:
• 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
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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At your request, interpreter and translation services related to administrative procedures are available to you or a covered family member.

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.


Sëvis Entèpré ak TradiskyonSi w mande sëvis entèpré ak tradiskyon pou prosede administratif, nap mete yo a dispozisyon ou.

Les services de traduction et d’interprétariat sont disponibles pour les procédures administratives.

在您的要求下，我们为您提供与行政程序相关的口译和翻译服务。

Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

Informacje na temat języka polskiego, comawiez o językach obcych i traduktora, wysyłane na żądanie, dostępne dla osób, które potrzebują pomocy językowej.

Your Plan is Administered by:
Delta Dental of Massachusetts
(800) 327-6277
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

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