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. Services from a provider who does not participate in the DeltaCare network are not covered except in some cases for an emergency. In addition, with prior approval, DeltaCare may allow your DeltaCare primary care dentist to authorize a referral to a non-participating dentist when DeltaCare has determined that it does not have in its network a specialist with the professional training and expertise to treat a particular condition or disease.

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.

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.

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.
- 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.

Delta Dental of Massachusetts
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.
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation problem focused</td>
<td>$0</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for patient under three years of age</td>
<td>$0</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report</td>
<td>$0</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused, by report (established patient; not post-operative visit)</td>
<td>$0</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0190</td>
<td>Screening of a patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0191</td>
<td>Assessment of a patient</td>
<td>$0</td>
</tr>
<tr>
<td>D0210</td>
<td>Full-mouth x-ray series</td>
<td>$0</td>
</tr>
<tr>
<td>D0220</td>
<td>Single x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>D0230</td>
<td>Additional x-ray(s)</td>
<td>$0</td>
</tr>
<tr>
<td>D0240</td>
<td>Occlusal x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>D0270</td>
<td>Single bitewing x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>D0272</td>
<td>Two bitewing x-rays</td>
<td>$0</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three films</td>
<td>$0</td>
</tr>
<tr>
<td>D0274</td>
<td>Four bitewing x-rays</td>
<td>$0</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewing series (7 to 8 films)</td>
<td>$0</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>D0460</td>
<td>Nerve vitality test</td>
<td>$0</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>$0</td>
</tr>
<tr>
<td>D0999</td>
<td>Unspecified diagnostic procedure, by report</td>
<td>$12.00</td>
</tr>
</tbody>
</table>

Note: 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period</td>
<td>$0</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period</td>
<td>$0</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish; therapeutic application for moderate to high caries risk patients</td>
<td>$0</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride - child</td>
<td>$0</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instruction</td>
<td>$0</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant application - through age 25, unrestored permanent molars, once per month</td>
<td>$0</td>
</tr>
<tr>
<td>D1352</td>
<td>Preventive resin restoration in permanent tooth for moderate to high caries risk patients</td>
<td>$0</td>
</tr>
<tr>
<td>D1353</td>
<td>Sealant repair, per tooth</td>
<td>$0</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed, unilateral</td>
<td>$163.00</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed, bilateral</td>
<td>$275.00</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer - removable, unilateral</td>
<td>$113.00</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer - removable, bilateral</td>
<td>$263.00</td>
</tr>
<tr>
<td>D1550</td>
<td>Recementation of space maintainer</td>
<td>$0</td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
<td>$0</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer - fixed - unilateral - child to age 9</td>
<td>$163.00</td>
</tr>
</tbody>
</table>

III. Minor Restorative Services — Type II

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>One surface silver filling, primary or permanent</td>
<td>$35.00</td>
</tr>
<tr>
<td>D2150</td>
<td>Two surfaces silver filling, primary or permanent</td>
<td>$42.00</td>
</tr>
<tr>
<td>D2160</td>
<td>Three surfaces silver filling, primary or permanent</td>
<td>$51.00</td>
</tr>
<tr>
<td>D2161</td>
<td>Four or more surfaces silver filling, primary or permanent</td>
<td>$61.00</td>
</tr>
<tr>
<td>D2330</td>
<td>One surface white filling: front tooth</td>
<td>$41.00</td>
</tr>
<tr>
<td>D2331</td>
<td>Two surfaces white filling: front tooth</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2332</td>
<td>Three surfaces white filling: front tooth</td>
<td>$60.00</td>
</tr>
<tr>
<td>D2335</td>
<td>Four or more surfaces white filling: front teeth</td>
<td>$77.00</td>
</tr>
<tr>
<td>D2390</td>
<td>White crown, front</td>
<td>$78.00</td>
</tr>
<tr>
<td>D2391</td>
<td>One surface white filling: back tooth</td>
<td>$46.00</td>
</tr>
<tr>
<td>D2392</td>
<td>Two surfaces white filling: back tooth</td>
<td>OPT</td>
</tr>
<tr>
<td>D2393</td>
<td>Three surfaces white filling: back tooth</td>
<td>OPT</td>
</tr>
<tr>
<td>D2394</td>
<td>Four or more surfaces white filling: back teeth</td>
<td>OPT</td>
</tr>
<tr>
<td>D2410</td>
<td>Gold foil - one surface</td>
<td>OPT</td>
</tr>
<tr>
<td>D2420</td>
<td>Gold foil - two surfaces</td>
<td>OPT</td>
</tr>
<tr>
<td>D2430</td>
<td>Gold foil - three surfaces</td>
<td>OPT</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2542</td>
<td>Onlay - metallic - two surfaces</td>
<td>$646.00</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay - metallic - three surfaces</td>
<td>$579.00</td>
</tr>
<tr>
<td>D2544</td>
<td>Onlay - metallic - four or more surfaces</td>
<td>$678.00</td>
</tr>
<tr>
<td>D2642</td>
<td>Onlay - porcelain/ceramic- two surfaces</td>
<td>$599.00</td>
</tr>
<tr>
<td>D2643</td>
<td>Onlay - porcelain/ceramic- three surfaces</td>
<td>$632.00</td>
</tr>
<tr>
<td>D2644</td>
<td>Onlay - porcelain/ceramic- four or more surfaces</td>
<td>$705.00</td>
</tr>
<tr>
<td>D2710</td>
<td>Crown - resin-based white</td>
<td>$210.00</td>
</tr>
<tr>
<td>D2720</td>
<td>Crown - resin with high noble metal‡</td>
<td>$630.00</td>
</tr>
<tr>
<td>D2721</td>
<td>Crown - resin with pred. base metal</td>
<td>$513.00</td>
</tr>
<tr>
<td>D2722</td>
<td>Crown - resin with noble metal</td>
<td>$548.00</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
<td>$750.00*</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain and high noble metal‡</td>
<td>$690.00*</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain and base metal</td>
<td>$614.00*</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - noble metal</td>
<td>$624.00*</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - ¾ cast high noble metal‡</td>
<td>$690.00*</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown - ¾ cast predominantly base metal</td>
<td>$557.00*</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown - ¾ cast noble metal</td>
<td>$698.00*</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - ¾ porcelain/ceramic</td>
<td>OPT</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - high noble metal‡</td>
<td>$717.00*</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown - base metal</td>
<td>$570.00*</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown - full cast noble metal</td>
<td>$639.00*</td>
</tr>
<tr>
<td>D2794</td>
<td>Crown - titanium‡</td>
<td>$800.00*</td>
</tr>
<tr>
<td>D2910</td>
<td>Recement inlay, only or partial coverage restoration</td>
<td>$30.00</td>
</tr>
<tr>
<td>D2915</td>
<td>Recement cast or prefabricated post and core</td>
<td>$28.00 (TII)</td>
</tr>
<tr>
<td>D2920</td>
<td>Recement crown</td>
<td>$29.00 (TII)</td>
</tr>
<tr>
<td>D2929</td>
<td>Prefabricated porcelain/ceramic crown, anterior primary tooth</td>
<td>$69.00 (TII)</td>
</tr>
<tr>
<td>D2930</td>
<td>Crown - stainless steal: baby tooth</td>
<td>$77.00 (TII)</td>
</tr>
<tr>
<td>D2931</td>
<td>Crown - stainless steal: permanent tooth</td>
<td>$79.00 (TII)</td>
</tr>
<tr>
<td>D2932</td>
<td>Crown - prefabricated resin</td>
<td>$90.00 (TII)</td>
</tr>
<tr>
<td>D2933</td>
<td>Crown - prefabricated stainless steel with resin window</td>
<td>$69.00 (TII)</td>
</tr>
<tr>
<td>D2940</td>
<td>Sedative filling</td>
<td>$30.00 (TII)</td>
</tr>
<tr>
<td>D2950</td>
<td>Core build-up, including any pins</td>
<td>$153.00</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention in addition to filling, per tooth</td>
<td>$14.00 (TII)</td>
</tr>
<tr>
<td>D2952</td>
<td>Post and core in addition to crown, indirectly fabricated</td>
<td>$240.00</td>
</tr>
<tr>
<td>D2953</td>
<td>Each additional indirectly fabricated post - same tooth</td>
<td>$20.00</td>
</tr>
</tbody>
</table>
D2954 Prefabricated post and core (in addition to crown) $ 190.00

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

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
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 comprehensive evaluation and diagnosis $ 45.00

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

D5100 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 (TIII)
D5212 Lower partial denture: resin base†† $ 600.00 (TIII)
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 (TIII)
D5226 Lower partial denture: flexible base†† $ 838.00 (TIII)
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 clasp $ 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, per tooth $ 56.00
D5670 Replace all teeth on upper denture $ 270.00
D5671 Replace all teeth on lower denture $ 270.00
D5710 Rebake denture: complete, upper $ 146.00
D5711 Rebake denture: complete, lower $ 146.00
D5720 Rebake denture: partial, upper $ 146.00
D5721 Rebake denture: partial, lower $ 146.00
D5730 Reline denture: complete, upper (chairsides) $ 89.00
D5731 Reline denture: complete, lower (chairsides) $ 90.00
D5740 Reline denture: partial, upper (chairsides) $ 71.00
D5741 Reline denture: partial, lower (chairsides) $ 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
VII. Fixed Prosthodontics — Type III, except when noted as (TII) for Type II

D6210 Pontic: cast high noble metal†‡‡‡‡ $675.00*

D6211 Pontic: predominantly base metal $510.00*

D6212 Pontic: cast noble metal $555.00*

D6240 Pontic: porcelain fused to high noble metal†‡‡‡‡ $684.00*

D6241 Pontic: porcelain fused to pred. base metal $585.00*

D6242 Pontic: porcelain fused to noble metal, two surfaces†‡‡‡‡ $615.00*

D6250 Pontic: resin with high noble metal†‡‡‡‡ $621.00

D6251 Pontic: resin with pred. base metal $447.00

D6252 Pontic: resin with noble metal $510.00

D6545 Retainer - cast metal for resin bonded fixed prosthesis $240.00

D6549 Resin retainer for resin-bonded fixed prosthesis $240.00

D6602 Retainer inlay - cast high noble metal, two surfaces†‡‡‡‡ $570.00

D6603 Retainer inlay - cast high noble metal, three or more surfaces†‡‡‡‡ $554.00

D6604 Retainer inlay - cast predominantly base metal, two surfaces $487.00

D6605 Retainer inlay - cast predominantly base metal, three or more surfaces $550.00

D6606 Retainer inlay - cast noble metal, two surfaces $636.00

D6607 Retainer inlay - cast noble metal, three or more surfaces $550.00

D6610 Retainer onlay - cast high noble metal, two surfaces†‡‡‡‡ $583.00

D6611 Retainer onlay - cast high noble metal, three or more surfaces†‡‡‡‡ $630.00

D6612 Retainer onlay - cast predominantly base metal, two surfaces $583.00

D6613 Retainer onlay - cast predominantly base metal, three or more surfaces $366.00

D6614 Retainer onlay - cast noble metal, two surfaces $583.00

D6615 Retainer onlay - cast noble metal, three or more surfaces $735.00

D6720 Retainer crown - resin with high noble metal†‡‡‡‡ $270.00

D6721 Retainer crown - resin with pre. base metal $480.00

D6722 Retainer crown - resin with noble metal $480.00

D6750 Retainer crown - porcelain fused to high noble metal†‡‡‡‡ $690.00*

D6751 Retainer crown - porcelain fused to predominantly base metal †‡‡‡‡ $585.00*

D6752 Retainer crown - porcelain fused to noble metal †‡‡‡‡ $630.00*

D6780 Retainer crown - ⅓ cast high noble metal †‡‡‡‡ $570.00*

D6781 Retainer crown - ⅓ cast predominantly base metal $578.00*

D6782 Retainer crown - ⅓ cast noble metal $591.00*

D6790 Retainer crown - high noble metal †‡‡‡‡ $660.00*

D6791 Retainer crown - cast base metal $614.00*

D6792 Retainer crown - cast noble metal $633.00*

D6930 Recement fixed partial denture (bridge) .. $ 41.00 (TII)

† 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 posts and cores.

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

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 Alveoplasty 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 Alveoplasty 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

XI. Additional Procedures — Type II, except when noted as (TII) 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)
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465 Medford Street
Boston, MA 02129
Fax: 617-886-1390
Phone: 617-886-1683
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TTY: 711

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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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