DELTA DENTAL®

The Delta Dental Premier Voluntary Enhanced Table Plan

The Delta Dental Premier Voluntary Enhanced Table Plan is an employee-paid dental plan that will enable you and your family to enjoy the benefits of quality, affordable dental care.

How the Plan Works

The Delta Dental Premier Voluntary Enhanced Table Plan is easy to use and understand. There are no deductibles, and each member is eligible to receive up to $1,000 in benefits each year.

It provides coverage for the services listed in the following Table of Allowance. When you visit a Delta Dental Premier dentist (or a dentist whose office is located outside of Massachusetts), we will provide reimbursement up to the amount listed on the Table of Allowance.

To use your dental benefits, simply provide your dentist with the information that is printed on your ID card. The dentist will complete and submit your claim for you. If you have a patient responsibility, Delta Dental will send you an Explanation of Benefits (EOB) detailing what Delta Dental paid the dentist under your plan's coverage and your remaining patient balance, which you pay directly to the dentist.

Coverage is effective for all dependents up to age 26, or for two years past the loss of dependent status, whichever occurs first.

When You Visit a Delta Dental Premier Dentist

The Delta Dental Premier Voluntary Enhanced Table Plan utilizes our Delta Dental Premier network of more than 7,100 dentist locations in Massachusetts. To find out if your dentist is part of this network, simply ask your dentist, visit our Web site at www.deltadentalma.com, or contact Delta Dental's Customer Service department at 1-800-872-0500. Because our dentists generally agree to accept reduced fees from Delta Dental members, your out-of-pocket costs will generally be lower when visiting a Delta Dental Premier dentist.

All diagnostic and preventive services are covered at 100%, which means you have no out-of-pocket costs when you visit a participating dentist. Other services require a co-payment. For example, assume your Delta Dental Premier dentist typically charges $75 for a one surface silver filling. However, his/her contract fee with Delta Dental is $65, which means that he/she will accept $65 as payment in full. Delta Dental will pay $31 (code D2140 on the table of allowance) toward the filling, and your co-payment will be $34.

If you receive a treatment that is not covered under your plan, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate. **Also, if you receive a treatment after you have exhausted your maximum or if you receive a treatment which will cause you to exceed your maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.** To avoid any unexpected out-of-pocket expenses, we recommend that you visit Delta Dental's Web site at www.deltadentalma.com or call Customer Service at 1-800-872-0500 to determine your remaining benefits.

When You Visit an Out-of-Network Dentist

When you visit a non-participating Massachusetts dentist, you will be responsible for any difference between Delta Dental's payment and the dentist's submitted charge for diagnostic and preventive services. For all other services, we will provide up to 80% of the amount listed on the Table of Allowance. For example, for a one surface filling (code D2140) we will pay $25.00 if provided by a non-participating dentist—that is 80% of the $31.00 payment you would receive if you visited a Delta Dental Premier dentist.

If you receive dental care from a dentist located outside of Massachusetts, you will be responsible for any difference between Delta Dental's payment and the dentist's submitted charge for diagnostic and preventive services. For all other services we will pay up to the amount listed on the Table of Allowance.

In these cases, you will be responsible for the difference between your dentist's full charge and the amount Delta Dental pays. In addition, you may have to pay the dentist at the time of your visit and submit a claim to us at: Delta Dental, P.O. Box 9695, Boston, MA 02114.

Identification Card

Two Delta Dental identification cards will be mailed to your home shortly after your enrollment. Both cards are issued in the subscriber's name, but can be used by any family member covered by the Delta Dental Premier Voluntary Enhanced Table Plan.

More About Claims

- All claims must be submitted within one year.
- You may want to ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will enable us to help you estimate any out-of-pocket expenses you may incur.
- If a claim is denied you can request an appeal by writing to Delta Dental within 180 days of receiving notice on the claim. Appeals should be sent to Delta Dental, P.O. Box 9695, Boston, MA 02114.
- Under your plan's subrogation clause you may be required to reimburse Delta Dental for claim payments if you also receive payment from a third party who is held liable for an injury that required the dental care.

Coordination of Benefits

Many people have dental coverage under more than one plan. If you and your family are covered by more than one dental plan (or a medical plan that offers dental coverage), Delta Dental will coordinate benefits with the other carrier. In determining coverage, total payments from both carriers cannot exceed the allowable charge for the service. If you have a question about Coordination of Benefits (COB), please contact our Customer Service department at 1-800-872-0500.

Premiums and Rates

All premiums will be automatically deducted from your paycheck. Once you enroll, you must remain on the Delta Dental Premier Voluntary Enhanced Table Plan for one year. Rates for the Delta Dental Premier Voluntary Enhanced Table Plan are reviewed each year and may be subject to change effective in July.

Rollover Max

Rollover Max is a new benefit feature that allows you to roll over a portion of your unused spending to increase your maximum benefit limit next year, and beyond. To qualify, you must receive at least one cleaning or one oral exam in the plan year, and your total yearly claims cannot exceed $500. *Rollover Max* will then allow you to roll over $350 to use the next year and beyond. For more details, see www.deltadentalma.com/pdf/07/rollovermax.pdf.

The following is a list of common procedures covered under the Delta Dental Premier Voluntary Enhanced Table Plan. The amounts listed are the maximum amounts Delta Dental will pay for these procedures.

Delta Dental Premier Voluntary Enhanced Table Plan

Table of Allowance

DIAGNOSTIC SERVICES

D0120	Periodic oral examination	Covered at 100%
D0140	Limited oral evaluation problem focused	Covered at 100%
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Covered at 100%
D0150	Comprehensive oral evaluation	Covered at 100%
D0160	Detailed and extensive oral evaluation - problem focused	Covered at 100%
D0170	Re-Evaluation - limited problem focused	Covered at 100%
D0180	Comprehensive periodontal evaluation - new or established patient	Covered at 100%
D0210	Full-mouth x-ray series	Covered at 100%
D0220	Single x-ray	Covered at 100%
D0230	Additional x-ray	Covered at 100%
D0270	Single bitewing x-ray	Covered at 100%
D0272	Two bitewing x-rays	Covered at 100%
D0273	Three bitewing x-rays	Covered at 100%
D0274	Four bitewing x-rays	Covered at 100%
D0277	Vertical bitewing series (7 to 8 films)	Covered at 100%
D0330	Panoramic x-ray	Covered at 100%
D0999	Unspecified diagnostic procedure, by report**	Covered at 100%

*** This code may be used for reimbursing Chlorhexidine and prescription strength toothpaste only when administered and dispensed in the dental office.*

PREVENTIVE SERVICES

D1110	Adult cleaning	Covered at 100%
D1120	Child cleaning	Covered at 100%
D1203	Fluoride excluding cleaning - child	Covered at 100%
D1351	Sealant application	Covered at 100%
D1510	Space maintainer - fixed, unilateral	Covered at 100%
D1515	Space maintainer - fixed, bilateral	Covered at 100%
D1520	Space maintainer - removable, unilateral	Covered at 100%
D1525	Space maintainer - removable, bilateral	Covered at 100%
D4910	Periodontal cleaning	Covered at 100%

MINOR RESTORATIVE SERVICES

D2140	One surface silver filling: permanent tooth	$ 31.00
D2150	Two surface silver filling: permanent tooth	$ 40.00
D2160	Three surface silver filling: permanent tooth	$ 46.00
D2161	Four or five surface silver filling: permanent tooth	$ 58.00
D2330	One surface white filling: front tooth	$ 36.00
D2331	Two surface white filling: front tooth	$ 47.00
D2332	Three surface white filling: front tooth	$ 57.00
D2335	Four or five surface white filling: front tooth	$ 76.00
D2391	One surface white filling: back tooth	$ 36.00

MAJOR RESTORATIVE SERVICES

D2542	Onlay - metallic, two surfaces	$ 303.00
D2543	Onlay - metallic, three surfaces	$ 303.00
D2544	Onlay - metallic, four or more surfaces	$ 303.00
D2642	Onlay - porcelain/ceramic, two surfaces	$ 303.00
D2643	Onlay - porcelain/ceramic, three surfaces	$ 303.00
D2644	Onlay - porcelain/ceramic, four or more surfaces	$ 303.00
D2662	Onlay - white/resin, two surfaces (laboratory processed)	$ 303.00
D2663	Onlay - white/resin, three surfaces (laboratory processed)	$ 303.00
D2664	Onlay - white/resin, four or more surfaces (laboratory processed)	$ 303.00
D2740	Crown - porcelain/ceramic substrate	$ 331.00
D2750	Crown - porcelain and high noble metal	$ 315.00
D2751	Crown - porcelain and base metal	$ 278.00
D2752	Crown - noble metal	$ 290.00
D2780	Crown - ¾ cast high noble metal	$ 315.00
D2781	Crown - ¾ cast predominately base metal	$ 315.00
D2782	Crown - ¾ cast noble metal	$ 315.00
D2783	Crown - ¾ porcelain/ceramic	$ 303.00
D2790	Crown - high noble metal	$ 315.00
D2791	Crown - base metal	$ 278.00
D2792	Crown - noble metal	$ 290.00
D2794	Crown - titanium	$ 315.00
D2910	Recement inlay	$ 28.00
D2915	Recement cast or prefabricated post and core	$ 28.00
D2920	Recement crown	$ 28.00
D2930	Crown - stainless steel: baby tooth	$ 83.00
D2931	Crown - stainless steel: permanent tooth	$ 91.00
D2932	Crown - prefabricated resin	$ 76.00
D2940	Sedative filling (temporary)	$ 28.00
D2950	Crown build-up	$ 88.00
D2951	Pin retention in addition to filling	$ 22.00
D2952	Cast post and core	$ 121.00
D2954	Prefabricated post and core	$ 107.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$ 64.00

ENDODONTIC SERVICES

D3220	Pulp removal on baby tooth	$ 44.00
D3221	Gross pulpal debridement primary and permanent teeth	$ 28.00
D3310	Root canal treatment: front tooth	$ 200.00
D3320	Root canal treatment: bicuspid tooth	$ 233.00
D3330	Root canal treatment: molar tooth	$ 333.00
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	$ 87.00
D3410	Surgical root canal treatment: front tooth	$ 168.00
D3426	Surgical root canal treatment: each additional tooth	$ 167.00

PERIODONTIC SERVICES

D4210	Gum surgery: gingivectomy, per quadrant	$ 182.00
D4211	Gum surgery: gingivectomy, per tooth	$ 46.00
D4240	Gum surgery: flap procedure	$ 254.00
D4241	Gingival flap procedures, including root planing, one to three teeth, per quadrant	$ 153.00
D4260	Bone surgery	$ 358.00
D4273	Subepithelial connective tissue graft procedure	$ 254.00
D4274	Distal or proximal wedge procedure	$ 179.00
D4341	Periodontal scaling and root planing, per quadrant	$ 65.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$ 39.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$ 56.00
D4381	Non-surgical gum therapy	$ 23.00

Table of Allowance (continued...)

REMOVABLE PROSTHODONTICS

D5110	Complete denture, upper	$ 315.00
D5120	Complete denture, lower	$ 315.00
D5130	Immediate denture, upper	$ 315.00
D5140	Immediate denture, lower	$ 315.00
D5211	Upper partial denture: resin	$ 290.00
D5212	Lower partial denture: resin	$ 290.00
D5213	Upper partial denture: metal	$ 338.00
D5214	Lower partial denture: metal	$ 338.00
D5225	Upper partial denture - flexible base (including any clasps, rests and teeth)	$ 338.00
D5226	Lower partial denture - flexible base (including any clasps, rests and teeth)	$ 338.00
D5281	Partial denture: one tooth, one side	$ 194.00
D5410	Adjust denture: complete, upper	$ 24.00
D5411	Adjust denture: complete, lower	$ 24.00
D5510	Repair broken complete denture base	$ 56.00
D5520	Replace missing or broken teeth: complete denture, per tooth	$ 36.00
D5610	Base repair: partial denture	$ 43.00
D5620	Cast framework repair	$ 64.00
D5630	Repair or replace broken clasp	$ 43.00
D5640	Replace partial denture tooth, per tooth	$ 37.00
D5650	Add tooth to existing partial denture	$ 46.00
D5660	Add clasp to existing partial denture	$ 55.00
D5670	Replace all teeth and acrylic on cast metal framework (upper)	$ 202.00
D5671	Replace all teeth and acrylic on cast metal framework (lower)	$ 202.00
D5730	Reline denture: complete, upper (chairside)	$ 76.00
D5731	Reline denture: complete, lower (chairside)	$ 76.00
D5740	Reline denture: partial, upper (chairside)	$ 76.00
D5741	Reline denture: partial, lower (chairside)	$ 76.00
D5750	Reline denture: complete, upper (laboratory)	$ 116.00
D5751	Reline denture: complete, lower (laboratory)	$ 116.00
D5760	Reline denture: partial, upper (laboratory)	$ 107.00
D5761	Reline denture: partial, lower (laboratory)	$ 107.00

FIXED PROSTHODONTICS

D6010	Surgical placement of implant body: endosteal implant	$ 315.00
D6056	Prefabricated abutment (includes placement)	$ 107.00
D6057	Custom abutment (includes placement)	$ 121.00
D6058	Abutment supported porcelain/ceramic crown	$ 331.00
D6059	Abutment supported porcelain fused to metal crown (high noble)	$ 315.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$ 290.00
D6065	Implant supported porcelain/ceramic crown	$ 331.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$ 315.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$ 315.00
D6094	Abutment supported crown - (titanium)	$ 315.00
D6095	Repair implant abutment, by report	$ 121.00
D6100	Implant removal, by report	$ 110.00
D6194	Abutment supported retainer crown for FPD - (titanium)	$ 315.00
D6205	Pontic - indirect resin based white	$ 283.00
D6210	Bridge pontic: high noble metal	$ 315.00
D6211	Bridge pontic: base metal	$ 278.00
D6212	Bridge pontic: noble metal	$ 290.00
D6214	Pontic - titanium	$ 315.00
D6240	Bridge pontic: porcelain with high noble metal	$ 315.00
D6241	Bridge pontic: porcelain with base metal	$ 278.00
D6242	Bridge pontic: porcelain with noble metal	$ 290.00
D6545	Retainer - cast metal for acid etch bridge	$ 121.00
D6611	Onlay - cast high noble metal, three or more surfaces	$ 303.00
D6612	Onlay - cast predominantly base metal, two surfaces	$ 303.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	$ 303.00
D6615	Onlay - cast noble metal, three or more surfaces	$ 303.00
D6624	Inlay - titanium	$ 303.00
D6634	Onlay - titanium	$ 303.00
D6710	Crown - indirect resin based white	$ 315.00
D6750	Crown - porcelain with high noble metal	$ 315.00
D6751	Crown - porcelain with base metal	$ 278.00
D6752	Crown - porcelain with noble metal	$ 290.00
D6780	Crown - ¾ cast high noble metal	$ 315.00
D6781	Crown - ¾ cast predominately base metal	$ 315.00
D6782	Crown - ¾ cast noble metal	$ 315.00
D6790	Crown - cast high noble metal	$ 315.00
D6791	Crown - cast base metal	$ 278.00
D6792	Crown - cast noble metal	$ 290.00
D6794	Crown - titanium	$ 315.00
D6930	Recement bridge	$ 36.00
D6970	Cast post and core in addition to bridge retainer	$ 121.00
D6972	Prefabricated post and core in addition to bridge retainer	$ 107.00
D6973	Core build-up for retainer, including any pins	$ 88.00

ORAL AND MAXILLOFACIAL SURGERY

D7111	Coronal remnants - deciduous (baby) tooth	$ 19.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 36.00
D7210	Surgical tooth removal	$ 73.00
D7220	Impacted tooth removal: soft tissue	$ 91.00
D7230	Impacted tooth removal: partially bony	$ 121.00
D7240	Impacted tooth removal: completely bony	$ 167.00
D7250	Root recovery	$ 61.00
D7285	Biopsy of hard tissue	$ 147.00
D7286	Biopsy of soft tissue	$ 147.00
D7287	Oral Exfoliative Cytology (brush biopsy)	$ 61.00
D7288	Brush biopsy - transepithelial sample collection	$ 61.00
D7310	Bone recontouring (done with extractions)	$ 77.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$ 77.00
D7320	Bone recontouring (done without extractions)	$ 112.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$ 112.00
D7471	Excision - bone tissue	$ 197.00
D7472	Removal of torus palatinus	$ 197.00
D7473	Removal of torus mandibularis	$ 197.00
D7510	Incision and drainage of abscess	$ 46.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$ 46.00
D7960	Frenulectomy (frenectomy or frenotomy)	$ 136.00
D7963	Frenuloplasty	$ 136.00

ADJUNCTIVE GENERAL SERVICES

D9110	Emergency treatment for the relief of pain	$ 28.00
D9220	General anesthesia: up to 30 minutes	$ 95.00
D9221	General anesthesia: each additional 15 minutes	$ 8.00
D9241	Intravenous sedation: up to 30 minutes	$ 95.00
D9242	Intravenous sedation: each additional 15 minutes	$ 8.00

Delta Dental Premier Voluntary Enhanced Table Plan

Limitations

DIAGNOSTIC:
Comprehensive Evaluation – Once every 60 months per dentist
Periodic Oral Exams – Once every 6 months
Full-mouth X-rays – Once every 60 months
Bitewing X-rays – Once every 6 months when oral conditions indicate need
Single Tooth X-rays – As needed

PREVENTIVE:
Teeth Cleaning – Once every 6 months
Fluoride Treatments – Once every 6 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
Sealants – Once per tooth per 48 months on the occlusal surface of permanent first and second molars for patients up to age 16. Sealants are also covered for patients age 16 to 19 on molars for those who have had a recent cavity and are at risk for decay
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

RESTORATIVE:
Silver Fillings – Once every 24 months per surface per tooth
White Fillings – Once every 24 months per surface per tooth on front teeth; single surface only on back teeth
Temporary Fillings – Once per tooth
Stainless Steel Crowns (baby teeth only) – Once every 24 months per tooth

ORAL SURGERY:
Simple Extractions – Oral surgical benefits not provided when rendered in a surgical day care or hospital setting
Surgical Extractions – Oral surgical benefits not provided when rendered in a surgical day care or hospital setting

PERIODONTICS:
Periodontal Surgery – Periodontal benefits not provided when rendered in a surgical day care or hospital setting
Scaling and Root Planing – Once in 24 months, per quadrant
Periodontal Cleaning – Once every 3 months following active periodontal treatment, not to exceed 2 in a calendar year if combined with preventive cleanings

ENDODONTICS:
Root Canal Treatment – Once per tooth
Vital Pulpotomy – Limited to deciduous (baby) teeth for members under age 14

PROSTHETIC MAINTENANCE:
Bridge or Denture Repair – Once within 12 months, same repair
Rebase or Reline of Dentures – Once within 36 months
Recement of Crowns and Onlays – Once per tooth

EMERGENCY DENTAL CARE:
Minor Treatment for Pain Relief – Three occurrences in 12 months
General Anesthesia – Allowed with covered surgical services only

PROSTHODONTICS:
Dentures – Once within 60 months
Fixed Bridges and Crowns (when part of a bridge) – Once within 60 months

MAJOR RESTORATIVE:
Crowns (when teeth cannot be restored with regular fillings) – Once within 60 months per tooth
Endosteal (single tooth) Implants – Covered to replace one missing tooth (in lieu of a three unit bridge, and when the adjacent teeth do not require crowns.) Once per 60 months per implant.

For More Information

This information should be used only as a guideline for your dental benefits 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. If you have further questions, please contact Delta Dental's Customer Service department.

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

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

អ្នកបកប្រែ ឬកិច្ចការបកប្រែ
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翻譯服務
如果您提出要求，我們可以為您提供相關的行政程序的翻譯服務。

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 TradiksyonSi 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.

ບໍລິການແປພາສາ ແລະ ນາຍພາສາ
ຕາມທີ່ທ່ານຂໍມາ, ພວກເຮົາມີບໍລິການນາຍ ແປພາສາ ແລະ
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Serviços de tradutor(a)/intérprete Se assim o solicitar, estão disponíveis serviços de tradução e interpretação 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.

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500

DELTA DENTAL®

Delta Dental of Massachusetts
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1-800-872-0500 • www.deltadentalma.com

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