

Delta Dental PPO *Plus Premier*



Schedule for Delta Dental PPO

www.deltadentalma.com

Delta Dental of Massachusetts

P.O. Box 9695
Boston, MA 02114
1-800-872-0500

JANUARY 1, 2010

DELTA DENTAL PPO

DENTAL EXPENSE BENEFITS FOR YOU AND YOUR FAMILY

MEMBER'S RIGHTS AND RESPONSIBILITIES

AS A DELTA DENTAL MEMBER, YOU HAVE THE RIGHT TO:

- file a grievance about Delta Dental or the participating providers
- be provided with appropriate information about Delta Dental and its benefits, providers and policies
- be informed of your diagnosis, treatment and prognosis by your dentist
- give informed consent before beginning any dental treatment, and be made aware of consequences of refusing treatment
- obtain a copy of your dental record, in accordance with the law
- be treated with respect and recognition of your dignity and need for privacy

YOU HAVE THE RESPONSIBILITY TO:

- ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by your dentist
- provide information to your dentist that is necessary to render care to you
- be familiar with Delta Dental benefits, policies and procedures, by reading the materials or calling customer service

GENERAL INFORMATION

When you or an eligible dependent receives dental care from a participating plan dentist, the fee that you are required to pay is listed in the Schedule of Dental Benefits under the column "Member Fee" which is the co-payment. Services that are listed with co-payments are provided to the member at the exact fee. There are no additional charges to the patient for any listed service up to the \$1,051.25 maximum each calendar year for each insured person, excluding orthodontia.

COVERED DENTAL SERVICES

In accordance with the Dental Schedule shown on the following pages, patient out of pocket expenses are listed for each dental service. This is the total fee you will be required to pay for each covered dental service.

MAXIMUM FUND PAYMENT

The Maximum Fund Payment of \$1,051.25 for each calendar year for each insured person excludes orthodontia. Any services provided after the \$1,051.25 maximum has been met are the responsibility of the member. For services provided after the \$1,051.25 maximum, the Delta Dental PPO dentist may charge regular and customary fees that are your responsibility. **However, you can ask your dentist to provide services at a discounted rate even after the \$1,051.25 maximum has been reached. It is worth asking to see if your dentist is willing to do so.**

SCHEDULE OF DENTAL BENEFITS

DELTA DENTAL PPO PLUS PREMIER

DELTA DENTAL PPO

IN NETWORK SERVICES

The following schedule lists the dental services covered by this plan and the members' co-payments for those services if received from a participating dentist. The members' co-payments are effective January 1, 2010.

*ADA Code	SERVICE DESCRIPTION	Member Fee
D0120	PERIODIC ORAL EVALUATION (TWICE PER CALENDAR YEAR)	\$0.00
D0140	LIMITED ORAL EVALUATION – PROBLEM FOCUSED	\$16.75
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	\$10.50
D0150	COMPREHENSIVE ORAL EVALUATION – NEW OR ESTABLISHED PATIENT	\$20.00
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION PROBLEM FOCUSED, BY REPORT	\$16.75
D0170	RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	\$16.75
D0180	COMPREHENSIVE PERIODONTAL EVALUATION – NEW OR ESTABLISHED PATIENT	\$20.00
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	\$31.00
D0220	INTRAORAL-PERIAPICAL FIRST FILM	\$4.25
D0230	INTRAORAL-PERIAPICAL EACH ADDITIONAL FILM	\$0.00
D0240	INTRAORAL-OCCLUSAL FILM	\$12.25
D0250	EXTRAORAL-FIRST FILM	\$0.00
D0260	EXTRAORAL-EACH ADDITIONAL FILM	\$0.00
D0270	BITEWING-SINGLE FILM	\$7.25
D0272	BITEWINGS-TWO FILMS	\$11.00
D0273	BITEWINGS-THREE FILMS	\$7.75
D0274	BITEWINGS-FOUR FILMS	\$2.75
D0277	VERTICAL BITEWING SERIES- 7 TO 8 FILMS	\$18.00
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY FILM	\$28.00
**D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	N/A
**D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	N/A
D0330	PANORAMIC FILM	\$18.00
**D0415	BACTERIOLOGICAL STUDIES FOR DETERMINATION OF PATHOLOGIC AGENTS	N/A
D0460	PULP VITALITY TESTS	\$5.00
D0470	DIAGNOSTIC CASTS	\$35.50
D1110	PROPHYLAXIS-ADULT (TWICE PER CALENDAR YEAR)	\$16.00
D1120	PROPHYLAXIS-CHILD (TWICE PER CALENDAR YEAR)	\$5.00
D1203	TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED)- CHILD	\$0.00
D1204	TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) – ADULT TO AGE 19	\$6.00
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENT	\$6.00
D1351	SEALANT-PER TOOTH (UNRESTORED PERMANENT MOLARS, ONCE PER TOOTH THROUGH AGE 15)	\$0.00
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	\$65.00
D1515	SPACE MAINTAINER-FIXED-BILATERAL	\$173.50
D1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	\$62.50
D1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	\$199.50
D1550	RECEMENTATION OF SPACE MAINTAINER	\$6.50
D1555	REMOVAL OF FIXED SPACE MAINTAINER	\$1.50
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	\$34.50
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	\$36.50
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	\$47.50
D2161	AMALGAM-FOUR SURFACES, PRIMARY OR PERMANENT	\$72.25

ADA Code	SERVICE DESCRIPTION	Member Fee
D2330	RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR	\$46.00
D2331	RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR	\$56.75
D2332	RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR	\$79.25
D2335	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$109.75
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	\$85.00
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	\$54.25
D2392	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	\$60.75
D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	\$82.25
D2394	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	\$93.00
D2542	ONLAY-METALLIC TWO SURFACES	\$432.00
D2543	ONLAY-METALLIC THREE SURFACES	\$443.00
D2544	ONLAY-METALLIC FOUR OR MORE SURFACES	\$453.00
D2642	ONLAY PORCELAIN/CERAMIC TWO SURFACES	\$431.75
D2643	ONLAY PORCELAIN/CERAMIC THREE SURFACES	\$477.25
D2644	ONLAY PORCELAIN/CERAMIC FOUR OR MORE SURFACES	\$507.75
D2662	ONLAY-RESIN-BASED COMPOSITE-TWO SURFACES	\$267.00
D2663	ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES	\$362.50
D2664	ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES	\$391.50
D2710	CROWN-RESIN (INDIRECT)	\$191.75
D2712	CROWN-RESIN BASED COMPOSITE (INDIRECT) NOT INCLUDING FACIAL VENEERS	\$191.75
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$447.50
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$377.50
D2722	CROWN-RESIN WITH NOBLE METAL	\$393.00
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	\$504.25
D2750	CROWN-PORCELAIN FUSED TO METAL	\$521.25
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$465.75
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$495.75
D2780	CROWN 3/4 CAST HIGH NOBLE METAL	\$521.25
D2781	CROWN 3/4 CAST PREDOMINANTLY BASE METAL	\$441.00
D2782	CROWN 3/4 CAST NOBLE METAL	\$471.00
D2783	CROWN 3/4 PORCELAIN/CERAMIC	\$507.75
D2790	CROWN-FULL CAST HIGH NOBLE METAL	\$521.25
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$489.50
D2792	CROWN-FULL CAST NOBLE METAL	\$505.75
D2794	CROWN TITANIUM	\$495.75
D2799	PROVISIONAL CROWN	\$116.75
D2910	RECEMENT INLAY	\$36.50
D2915	RECEMENT CAST OR PREFAB POST AND CORE	\$19.50
D2920	RECEMENT CROWN	\$28.50
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	\$129.00
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	\$119.75
D2932	PREFABRICATED RESIN CROWN	\$165.25
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH A RESIN WINDOW	\$121.50
D2934	PREFAB ESTHETIC COASTED SSC PRIMARY TOOTH	\$120.50
D2940	SEDATIVE FILLING	\$33.50
D2950	CROWN BUILD UP, INCLUDING ANY PINS	\$82.25
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION	\$18.50
D2952	CAST POST AND CORE-IN ADDITION TO CROWN	\$143.25
D2954	PREFABRICATED POST AND CORE-IN ADDITION TO CROWN	\$82.25
D2962	LABIAL VENEER (PORCELAIN LAMINATE)-LABORATORY	\$364.50
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK	\$99.25
D2980	CROWN REPAIR, BY REPORT	\$99.75

ADA Code	SERVICE DESCRIPTION	Member Fee
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	\$80.25
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH	\$49.00
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS – PERMANENT TOOTH WITH INCOMPLETE ROOT – DEVELOPMENT	\$80.25
D3230	PULPAL THERAPY – ANTERIOR PRIMARY TOOTH	\$115.25
D3240	PULPAL THERAPY-POST PRIMARY TOOTH	\$100.00
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	\$314.50
D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	\$317.75
D3330	MOLAR (EXCLUDING FINAL RESTORATION)	\$404.75
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	\$166.75
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY- ANTERIOR	\$325.25
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	\$370.50
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	\$515.75
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS ROOT RESORPTION, ETC.)	\$56.75
D3352	APEXIFICATION-INTERIM	\$39.75
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	\$274.25
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)	\$318.50
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT)	\$315.25
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)	\$111.75
D3430	RETROGRADE FILLING-PER ROOT	\$50.25
D3450	ROOT AMPUTATION-PER ROOT	\$173.25
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	\$139.75
D4210	GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$246.25
D4211	GINGIVECTOMY OR GINGIVOPLASTY-ONE TO THREE TEETH, PER QUADRANT	\$123.75
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANNING FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$232.50
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING ONE TO THREE TEETH, PER QUAD	\$158.50
D4249	CLINICAL CROWN LENGTHENING, HARD TISSUE	\$320.25
D4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$356.00
D4261	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) ONE TO THREE TEETH, PER QUADRANT	\$439.75
D4263	BONE REPLACEMENT GRAFT-FIRST SITE IN QUADRANT	\$54.25
D4264	BONE REPLACEMENT GRAFT EACH ADDITIONAL SITE IN QUADRANT	\$0.00
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	\$7.75
D4266	GUIDED TISSUE REGENERATION- RESORBABLE BARRIER, PER SITE	\$193.25
D4267	GUIDED TISSUE REGENERATION – NON RESORBABLE BARRIER PER SITE	\$190.75
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$302.75
D4271	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)	\$330.25
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES	\$454.00
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	\$306.25
D4275	SOFT TISSUE ALLOGRAFT	\$449.25
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT	\$453.25
D4341	PERIODONTAL SCALING AND ROOT PLANING – FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$92.00
D4342	PERIODONTAL SCALING AND ROOT PLANING ONE TO THREE TEETH, PER QUADRANT	\$55.25
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	\$19.50
D4381	LOCALIZED DELIVERY OF CHEMOTHERAPEUTIC AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE PER TOOTH, BY REPORT	\$1.25

ADA Code	SERVICE DESCRIPTION	Member Fee
D4910	PERIODONTAL MAINTENANCE	\$43.50
D5110	COMPLETE DENTURE - MAXILLARY	\$678.25
D5120	COMPLETE DENTURE - MANDIBULAR	\$678.25
D5130	IMMEDIATE DENTURE - MAXILLARY	\$698.25
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$698.75
D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$487.75
D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$487.75
D5213	AXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$800.25
D5214	MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$800.25
D5225	MAXILLARY PARTIAL DENTURE FLEXIBLE BASE	\$789.75
D5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE	\$789.75
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)	\$277.00
D5410	ADJUST COMPLETE DENTURE-MAXILLARY	\$29.25
D5411	ADJUST COMPLETE DENTURE-MANDIBULAR	\$29.25
D5421	ADJUST PARTIAL DENTURE-MAXILLARY	\$29.25
D5422	ADJUST PARTIAL DENTURE-MANDIBULAR	\$29.25
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$82.00
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)	\$77.50
D5610	REPAIR RESIN DENTURE BASE	\$63.75
D5620	REPAIR CAST FRAMEWORK	\$81.50
D5630	REPAIR OR REPLACE BROKEN CLASP	\$79.75
D5640	REPLACE BROKEN TEETH-PER TOOTH	\$58.75
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$93.50
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	\$118.25
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	\$317.75
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	\$317.75
D5710	REBASE COMPLETE MAXILLARY DENTURE	\$206.50
D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$206.50
D5720	REBASE MAXILLARY PARTIAL DENTURE	\$178.50
D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$178.50
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	\$60.50
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	\$60.50
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	\$36.50
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	\$36.50
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	\$178.00
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	\$178.00
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	\$142.50
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	\$142.50
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	\$193.50
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	\$193.50
D5850	TISSUE CONDITIONING, MAXILLARY	\$60.50
D5851	TISSUE CONDITIONING, MANDIBULAR	\$66.50
D6010	SURGICAL – ENDOSTEAL IMPLANT	\$987.00
D6053	IMPLANT/ABUTMENT REMOVABLE DENTURE	\$1,104.75
D6054	IMPLANT/ABUTMENT REMOVABLE DENTURE	\$1,104.75
D6056	PREFAB ABUTMENT	\$309.50
D6057	CUSTOM ABUTMENT	\$370.00
D6058	IMPLANT ABUTMENT CROWN	\$881.25

ADA Code	SERVICE DESCRIPTION	Member Fee
D6059	IMPLANT ABUTMENT CROWN	\$881.25
D6060	IMPLANT ABUTMENT CROWN	\$779.75
D6061	IMPLANT ABUTMENT CROWN	\$775.75
D6062	IMPLANT ABUTMENT CROWN	\$881.25
D6063	IMPLANT ABUTMENT CROWN	\$778.75
D6064	IMPLANT ABUTMENT CROWN	\$778.75
D6065	IMPLANT ABUTMENT CROWN	\$881.00
D6066	IMPLANT ABUTMENT CROWN	\$881.00
D6067	IMPLANT ABUTMENT CROWN	\$881.00
D6069	ABUTMENT SUPPORTED RETAINER FPD	\$881.00
D6070	ABUTMENT SUPPORTED RETAINER FPD	\$712.75
D6071	ABUTMENT SUPPORTED RETAINER FPD	\$775.75
D6072	ABUTMENT SUPPORTED RETAINER FPD	\$881.00
D6073	ABUTMENT SUPPORTED RETAINER FPD	\$712.75
D6074	ABUTMENT SUPPORTED RETAINER FPD	\$775.75
D6076	IMPLANT SUPPORTED RETAINER FPD	\$881.25
D6077	IMPLANT SUPPORTED RETAINER FPD	\$881.25
D6078	IMPLANT/ABUTMENT SUPPORTED DENTURE	\$1,267.00
D6079	IMPLANT/ABUTMENT SUPPORTED DENTURE	\$1,267.00
D6090	REPAIR IMPLANT PROSTHESIS	\$72.00
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN	\$34.00
D6093	RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$49.75
D6094	ABUTMENT SUPPORTED CROWN – TITANIUM	\$881.25
D6194	IMPLANT RETAINER TITANIUM	\$881.25
D6205	PONTIC-INDIRECT RESIN BASED COMPOSITE	\$0.00
D6210	PONTIC-CAST HIGH NOBLE METAL	\$521.25
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	\$465.25
D6212	PONTIC-CAST NOBLE METAL	\$495.75
D6214	PONTIC-TITANIUM	\$495.75
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	\$521.25
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$465.25
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	\$495.75
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL	\$521.25
D6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL	\$473.25
D6252	PONTIC-RESIN WITH NOBLE METAL	\$495.75
D6253	PROVISIONAL PONTIC	\$135.75
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	\$195.75
D6602	INLAY-CAST HIGH NOBLE METAL, TWO SURFACES	\$443.00
D6603	INLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES	\$387.75
D6604	INLAY-CAST PREDOMINANTLY BASE METAL, TWO SURFACES	\$395.50
D6605	INLAY-CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES	\$381.75
D6606	INLAY-CAST NOBLE METAL, TWO SURFACES	\$438.00
D6607	INLAY-CAST NOBLE METAL, THREE OR MORE SURFACES	\$381.75
D6610	ONLAY-CAST HIGH NOBLE METAL, TWO SURFACES	\$402.50
D6611	ONLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES	\$453.00
D6612	ONLAY-CAST PREDOMINANTLY BASE METAL, TWO SURFACES	\$294.50
D6613	ONLAY-CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES	\$404.50
D6614	ONLAY-CAST NOBLE METAL, TWO SURFACES	\$294.50
D6615	ONLAY-CAST NOBLE METAL, THREE OR MORE SURFACES	\$417.50
D6624	INLAY-TITANIUM	\$347.00
D6634	ONLAY-TITANIUM	\$404.00
D6710	CROWN-INDIRECT RESIN-BASED COMPOSITE	\$0.00
D6720	CROWN-RESIN WITH HIGH NOBLE METAL	\$521.25
D6721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$465.25

ADA Code	SERVICE DESCRIPTION	Member Fee
D6722	CROWN-RESIN WITH NOBLE METAL	\$495.75
D6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$521.25
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$465.25
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$495.75
D6780	CROWN- 3/4 CAST HIGH NOBLE METAL	\$521.25
D6781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	\$440.50
D6782	CROWN-3/4 CAST NOBLE METAL	\$471.00
D6790	CROWN-FULL CAST HIGH NOBLE METAL	\$521.25
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$409.25
D6792	CROWN-FULL CAST NOBLE METAL	\$495.75
D6793	PROVISIONAL RETAINER CROWN	\$118.25
D6794	CROWN-TITANIUM	\$521.25
D6930	RECEMENT FIXED PARTIAL DENTURE	\$63.25
D6970	CAST POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER	\$152.25
D6972	PREFABRICATED POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER	\$92.25
D6973	CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS	\$89.25
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$141.75
D7111	CORONAL REMNANTS-DECIDUOUS TOOTH	\$25.25
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	\$46.75
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH.	\$142.50
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$214.25
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	\$228.25
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$287.00
D7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY WITH UNUSUAL SURGICAL COMPLICATIONS	\$213.00
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	\$100.50
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	\$163.00
D7280	SURGICAL ACCESS OF IMPACTED OR UNERUPTED TOOTH	\$243.25
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	\$0.00
D7285	BIOPSY OF ORAL TISSUE-HARD (BONE, TOOTH)	\$132.75
D7286	BIOPSY OF ORAL TISSUE-SOFT (ALL OTHERS)	\$132.75
D7287	CYTOLOGY SAMPLE COLLECTION	\$50.75
D7288	BRUSH BIOPSY-TRANSEPITHELIAL SAMPLE COLLECTION	\$50.75
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY BY REPORT	\$50.50
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS PER QUADRANT	\$74.00
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS 1 TO 3 TEETH OR TOOTH SPACES PER QUADRANT	\$48.50
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS PER QUADRANT	\$128.25
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS 1 TO 3 TEETH OR TOOTH SPACES PER QUADRANT	\$78.25
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	\$85.00
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	\$115.50
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM	\$163.00
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	\$113.00
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM	\$88.00
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	\$127.75
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	\$202.25
D7472	REMOVAL OF TORUS PALATINUS	\$202.25
D7473	REMOVAL OF TORUS MANDIBULARIS	\$202.25
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	\$50.50
D7511	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE COMPLICATED	\$50.50
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	\$90.00

ADA Code	SERVICE DESCRIPTION	Member Fee
D7521	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE COMPLICATED	\$90.00
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	\$19.50
D7911	COMPLICATED SUTURE – UP TO 5CM	\$40.25
D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY)-SEPARATE PROCEDURE	\$187.75
D7963	FRENUOPLASTY	\$187.75
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	\$64.75
D7971	EXCISION OF PERICORONAL GINGIVA	\$42.75
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN- MINOR PROCEDURE	\$42.50
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 30 MINUTES	\$114.00
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	\$63.00
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA-FIRST 30 MINUTES	\$114.00
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA EACH ADDITIONAL 15 MINUTES	\$63.00
D9310	CONSULTATION (DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN PRACTITIONER PROVIDING TREATMENT)	\$35.75
D9910	APPLICATION OF DESENSITIZING MEDICAMENTS	\$17.25
D9930	TREATMENT OF COMPLICATIONS (POST SURGICAL)-UNUSUAL CIRCUMSTANCES, BY REPORT	\$35.50
D9940	OCCLUSAL GUARDS-BY REPORT	\$0.00
**D9941	FABRICATION ATHLETIC MOUTHGUARD	N/A
D9942	REPAIR AND OR RELINE OF AN OCCLUSAL GUARD	\$60.00
**D9952	OCCLUSAL ADJUSTMENT-COMPLETE	N/A

***Current Dental Terminology ©2009 American Dental Association.**

****Procedure not covered under the Delta Dental schedule. Please contact the NAGE Fund Office regarding claim submission information.**

ALTERNATE PROCEDURES

ADA Code	SERVICE DESCRIPTION	Maximum Fund Payment
***D2510	INLAY-METALLIC-ONE SURFACE	\$221.50
***D2520	INLAY-METALLIC-TWO SURFACES	\$221.50
***D2530	INLAY-METALLIC-THREE OR MORE SURFACES	\$221.50
***D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	\$221.50
***D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	\$221.50
***D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	\$221.50
***D2650	INLAY-COMP/RESIN-1 SURFACE LAB PROCESS	\$221.50
***D2651	INLAY-COMP/RESIN-2 SURFACES LAB PROCESS	\$221.50
***D2652	INLAY-COMP/RESIN-3 OR MORE SURFACES LAB PROCESS	\$221.50

*****PLEASE NOTE THAT THE AMOUNTS SHOWN IN THIS SECTION ARE THE MAXIMUM FUND PAYMENTS; THEY ARE NOT MEMBER FEES. ANY REMAINING BALANCE PAYABLE TO THE PROVIDER FOR THESE SERVICES IS THE RESPONSIBILITY OF THE MEMBER.**

ORTHODONTICS: *Reimbursement for orthodontic procedures up to 50% of the orthodontist's charges to a lifetime maximum of \$1,650.00 for each insured person.*

NOTE: Procedures not shown are not covered by the dental plan. Member co-payments shall be based on the payment schedule in effect on the date the procedure is finished. The payment schedule is subject to change on a periodic basis at the Trustees' discretion.

BENEFIT PAYMENTS FOR SERVICES PROVIDED BY NON-PANEL PROVIDERS

When covered services are furnished by non-panel providers, such as for emergency care, for services outside of Massachusetts, or by non-participating dentists, benefits are payable according to the Schedule of Dental Benefits set by the Fund, up to the maximum amount payable to a Delta PPO provider for the covered service. Any remaining balance payable to the non-panel provider is the member's responsibility. You must contact the NAGE Fund Office at 1-800-641-0700 or 617-773-8947 or by writing 159 Burgin Parkway, First Floor, Quincy, MA. 02169-4213 after treatment by a non-participating dentist has been received.

FILING A CLAIM

1. EXPLANATION OF BENEFITS

Each time a claim is processed for you under this Plan, a written notice will be sent to you called an Explanation of Benefits (EOB), which will explain your benefits for that claim. This notice will tell you how Delta Dental paid the claim or the reason it was denied.

2. WHO FILES A CLAIM?

Panel Providers: When the Delta Dental I.D. Card is presented to the Panel Provider they will file claims directly to Delta Dental for the services covered by this program. Delta Dental will make benefit payments to them.

NECESSARY AND APPROPRIATE CHARGES

Benefits will not be covered that are not necessary and appropriate. Necessary and appropriate means consistent with the prevention of oral disease or with the diagnosis and treatment on (a.) those teeth that are decayed or fractured or (b.) those teeth where supporting periodontium is weakened by disease; in accordance with standards of good dental practice; not solely for your convenience or the convenience of your dentist. The determination of what is necessary and appropriate, under the terms of the schedule is made by Delta Dental based on a review of dental records describing your condition and treatment. Delta Dental may decide a service is not necessary and appropriate under the terms of this schedule even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

EXCEPTIONS AND LIMITATIONS

THIS PLAN DOES NOT COVER:

1. Services not listed in this booklet.
2. Hospitalization for any dental procedure.
3. Services that are rendered due to the requirements of a third party, such as an employer or school.
4. Travel time and related expenses.
5. An illness or injury that Delta Dental determines arose out of or in the course of your employment.
6. A service for which you are not required to pay, or for which you would not be required to pay if you did not have this benefit.
7. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
8. A separate fee for services rendered by interns, residents and fellows.
9. A service rendered by someone other than a licensed dentist or a hygienist that is employed by a licensed dentist.
10. A service to treat disorders of the joints of the jaw (temporomandibular joint-TMJ) includes consultations.
11. A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
Occlusion is the contact that teeth have when you bite down. Occlusion can be impaired/changed due to periodontal disease or problems with the jaw (TMJ).
12. Occlusal guard for the treatment of disorders of the joints of the jaw.
13. Services that are meant primarily to change or improve your appearance.

14. Lost or stolen dentures, bridges, space maintainers or periodontic appliances.
15. Lab exams.
16. Photographs.
17. Laminate veneers, which is bonding on the facial surface of teeth.
18. Duplicate dentures and bridges.
19. Services related to congenital anomalies. This exclusion does not apply to orthodontic services.
20. An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have this benefit. A government program refers to dental coverage a member may have access to via the military or federal assistance program for low-income families.
21. Appointments with your dentist that you fail to keep. Some dentists, at their discretion, will require payment for broken appointments.
22. Consultations. Consultations are when a member may go to any number of dentists to assess and estimate potential services. This kind of consultation is different from a regular scheduled appointment.
23. Restoration for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
24. Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting. Periodontal splinting is the tying and/or attaching of a loose tooth to permanent teeth. This is a temporary fix and may loosen other permanent teeth.
25. Temporary complete dentures and temporary fixed bridges or crowns.
26. Cast restorations, copings and attachments for installing overdentures.

NOTE: All limitations and exclusions are subject to policies set by the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund.

WHEN YOUR PANEL PROVIDER MAY CHARGE YOU MORE

1. If you or your eligible dependent has reached the \$1,051.25 calendar maximum.
2. If you and your dentist decide to use services that are more expensive than those customarily furnished by most dentists, benefits will be provided toward the service with the lower fee.
3. If you receive payment from another person or his or her insurance company for injuries he or she caused.
4. If you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned course of treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all their services.

ACCESS TO YOUR DENTAL RECORDS

You agree that when you claim benefits under Delta Dental PPO, you give Delta Dental the right to obtain all dental records and/or other related information that they need from any source. This information will be kept confidential. If you receive services from a dentist who practices and treats you outside Massachusetts, you must help them obtain all dental records or other related information they need. Delta Dental will not pay the dentist for providing this information. If the dentist does not provide the required information, Delta Dental may not provide benefits for his or her services.

Delta Dental PPO *Plus Premier*



Schedule for Delta Dental PPO

www.deltadentalma.com

DELTA DENTAL OF MASSACHUSETTS

P.O. BOX 9695

BOSTON, MA 02114

1-800-872-0500