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; 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 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 one per denture in any 12 consecutive months beginning six months after delivery of the denture.

- Periodontal Treatments (root planing/subgingival curettage)—up to once per quadrant in any 12 consecutive months.
- Bitewing X-rays—based on need, up to one series of four films in any six-month period.
- Full-mouth X-rays—based on need, up to one set every 24 consecutive months.
- Topical Fluoride Treatment—once every six months for members under age 19.
- Space Maintainers—(required due to the premature loss of teeth) for members under age 14 and not for the replacement of primary or permanent front teeth.
- Chlorhexidine Mouthrinse—this is a covered benefit only when administered and dispensed in the dentist’s office following scaling and root planing.
- Fluoride Toothpaste—this is a covered benefit only when administered and dispensed in the dentist’s office following periodontal surgery.
- Sealants—based on need, for unrestored permanent molars only, once per tooth for members under age 16.

Your DeltaCare provider is responsible for determining the best course of treatment for you. If more than one treatment option is appropriate, you can choose a more expensive option than your dentist recommends. In this case, you will be responsible for the difference in cost between the two options as well as the co-payment for the recommended treatment.

Exclusions

1. General anesthesia and the services of a special anesthesiologist.
2. Cosmetic dental care.
3. Dental conditions arising out of and due to enrollee’s employment or for which Worker’s Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, country, or other subdivision.
4. Treatment required by reason of war.
5. Dental services performed in a hospital and related hospital fees.
6. Treatment of fractures and dislocations.
7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
9. Any service that is not specifically listed as a covered expense.
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.
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

D0120 Periodic oral evaluation - established patient \$0

D0140 Limited oral evaluation problem focused \$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 Vertical bitewing series (7 to 8 films) \$0

D0230 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 \$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

D1110 Adult cleaning \$0

D1120 Child cleaning \$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 15, unrestored permanent molars, once per tooth \$0

D1352 Preventive resin restoration in permanent tooth for moderate to high caries risk patients \$0

D1510 Space maintainer - fixed, unilateral \$98.00

D1515 Space maintainer - fixed, bilateral \$165.00

D1520 Space maintainer - removable, unilateral \$68.00

D1525 Space maintainer - removable, bilateral \$158.00

D1550 Recementation of space maintainer \$0

D1555 Removal of fixed space maintainer \$0

III. MINOR RESTORATIVE SERVICES

D2140 One surface silver filling, primary or permanent \$12.00

D2150 Two surfaces silver filling, primary or permanent \$14.00

D2160 Three surfaces silver filling, primary or permanent \$17.00

D2161 Four or more surfaces silver filling, primary or permanent \$20.00

D2330 One surface white filling: front tooth \$14.00

D2331 Two surfaces white filling: front tooth \$17.00

D2332 Three surfaces white filling: front tooth \$20.00

D2335 Four or more surfaces white filling: front teeth \$26.00

D2390 White crown, front \$26.00

D2391 One surface white filling: back tooth \$18.00

D2392 Two surfaces white filling: back tooth \$OP

D2393 Three surfaces white filling: back tooth \$OP

D2394 Four or more surfaces white filling: back teeth \$OP

D2410 Gold foil - one surface \$OP

D2420 Gold foil - two surfaces \$OP

D2430 Gold foil - three surfaces \$OP

IV. MAJOR RESTORATIVE SERVICES

D2542 Onlay - metallic - two surfaces \$323.00

D2543 Onlay - metallic - three surfaces \$290.00

D2544 Onlay - metallic - four or more surfaces \$339.00

D2642 Onlay - porcelain/ceramic - two surfaces \$299.00

D2643 Onlay - porcelain/ceramic - three surfaces \$316.00

D2644 Onlay - porcelain/ceramic - four or more surfaces \$353.00

D2710 Crown - resin-based white \$105.00

D2720 Crown - resin with high noble metal†† \$315.00

D2721 Crown - resin with pred. base metal \$274.00

D2722 Crown - resin with noble metal \$274.00

D2740 Crown - porcelain/ceramic substrate \$375.00*††

D2750 Crown - porcelain and high noble metal†† \$345.00*

D2751 Crown - porcelain and base metal \$313.00*

D2752 Crown - noble metal \$323.00*

D2780 Crown - \(\frac{1}{2}\) cast high noble metal†† \$345.00*

D2781 Crown - \(\frac{1}{2}\) cast predominantly base metal \$343.00*

D2782 Crown - \(\frac{1}{2}\) cast noble metal \$349.00*

D2783 Crown - \(\frac{1}{2}\) porcelain/ceramic \$OP

D2790 Crown - high noble metal†† \$359.00*

D2791 Crown - base metal \$313.00*

D2792 Crown - full cast noble metal \$328.00*

D2794 Crown - titanium†† \$435.00*

D2910 Recement inlay, onlay or partial coverage restoration \$10.00

D2915 Recement cast or prefabricated post and core \$9.00

D2920 Recement crown \$10.00

D2929 Prefabricated porcelain/ceramic crown, anterior primary tooth \$23.00

D2930 Crown - stainless steel: baby tooth \$26.00

D2931 Crown - stainless steel: permanent tooth \$26.00

D2932 Crown - prefabricated resin \$30.00

D2933 Crown - prefabricated stainless steel with resin window \$23.00

D2940 Sedative filling \$10.00

D2950 Core build-up, including any pins \$87.00

D2951 Pin retention in addition to filling, per tooth \$5.00

D2952 Post and core in addition to crown, indirectly fabricated \$120.00

* Includes co-payment and lab fee for this procedure.
appropriate care for this condition, yet an alternative procedure can also be applied

V. ENDONTOIC SERVICES

D3110 Pulp cap: direct .......................... $ 7.00
D3120 Pulp cap: indirect ......................... $ 7.00
D3122 Pulp removal on baby tooth ............. $16.00
D3221 Pulpal debridement primary and permanent teeth ......................... $ 19.00
D3230 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development .................. $ 16.00
D3240 Pulpal therapy (resorbable filling) - front, primary tooth (excl. final restoration) .......................... $ 12.00
D3310 Root canal treatment: front tooth ........ $ 74.00
D3320 Root canal treatment: bicuspids ......... $ 85.00
D3330 Root canal treatment: molar ............ $105.00
D3346 Retreatment of previous root canal therapy - front ......................... $ 85.00
D3347 Retreatment of previous root canal therapy - bicuspids ................... $ 95.00
D3348 Retreatment of previous root therapy - molar ............................... $125.00
D3410 Surgical root canal treatment: front tooth ................................. $ 75.00
D3421 Surgical root canal treatment: bicuspids (first root) ...................... $ 60.00
D3425 Surgical root canal treatment: molar (first root) .......................... $ 87.00
D3426 Surgical root canal treatment: each additional root ...................... $ 51.00
D3430 Retrograde filling - per root ......................... $ 16.00

VI. PERIODONTIC SERVICES

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant ............ $ 42.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant ............... $ 30.00
D4240 Gingival flap procedures, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant ......................... $ 84.00
D4241 Gingival flap procedures, including root planing, one to three contiguous teeth or bounded teeth spaces per quadrant ......................... $ 53.00
D4245 Apically positioned flap ........................................ $ 130.00
D4249 Crown lengthening - hard tissue .................................... $ 87.00
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant ......................... $112.00

D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant ......................... $ 85.00
D4341 Periodontal scaling and root planing - four or more teeth, per quadrant ......................... $ 23.00
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant ......................... $ 16.00
D4355 Full-mouth debridement to enable comprehensive evaluation and diagnosis ......................... $ 40.00
D4910 Periodontal maintenance following active therapy .......................... $ 7.00

VII. REMOVABLE PROSTHODONTICS

D5110 Complete denture, upper†† ................ $ 390.00*
D5120 Complete denture, lower†† ................ $ 388.00*
D5130 Immediate denture, upper†† ............... $ 420.00*
D5140 Immediate denture, lower†† ............... $ 434.00*
D5211 Upper partial denture: resin base†† ...... $ 277.00
D5212 Lower partial denture: resin base†† ...... $ 300.00
D5213 Upper partial denture: metal†† .......... $ 420.00*
D5214 Lower partial denture: metal†† .......... $ 420.00*
D5225 Upper partial denture: flexible base†† ... $ 390.00
D5226 Lower partial denture: flexible base†† ... $ 419.00
D5231 Unilateral partial denture .................. $ 195.00
D5410 Adjust denture: complete, upper ........ $ 9.00
D5411 Adjust denture: complete, lower ......... $ 7.00
D5421 Adjust denture: partial, upper .......... $ 8.00
D5422 Adjust denture: partial, lower .......... $ 8.00
D5510 Repair broken complete denture base ........ $ 15.00
D5520 Replace missing or broken teeth:
  complete denture, per tooth ....................... $ 14.00
  base repair: partial denture ....................... $ 15.00
D5610 Cast framework repair ....................... $ 21.00
D5630 Repair or replace broken clasp ........... $ 17.00
D5640 Replace partial denture tooth, per tooth .... $ 14.00
D5650 Add tooth to existing partial denture .......... $ 17.00
D5660 Add clasp to existing partial denture .......... $ 19.00
D5670 Replace all teeth on upper denture ........ $ 135.00
D5671 Replace all teeth on lower denture ........ $ 135.00
D5710 Rebase denture: complete, upper ........ $ 42.00
D5711 Rebase denture: complete, lower ......... $ 40.00
D5720 Rebase denture: partial, upper .......... $ 45.00
D5721 Rebase denture: partial, lower .......... $ 40.00
D5730 Reline denture: complete, upper (chairsde) ... $ 30.00
D5731 Reline denture: complete, lower (chairsde) ... $ 30.00
D5740 Reline denture: partial, upper (chairsde) ... $ 24.00
D5741 Reline denture: partial, lower (chairsde) ... $ 27.00
D5750 Reline denture: complete, upper (laboratory) ... $ 39.00
D5751 Reline denture: complete, lower (laboratory) ... $ 39.00
D5760 Reline denture: partial, upper (laboratory) ... $ 37.00
D5761 Reline denture: partial, lower (laboratory) ... $ 35.00
D5820 Temp partial denture, upper .................. $149.00
D5821 Temp partial denture, lower .................. $140.00
D5830 Tissue conditioning: upper .................. $ 15.00
D5831 Tissue conditioning: lower .................. $ 19.00
D5863 Overdenture – complete maxillary ........ OPT
D5864 Overdenture – partial maxillary ........ OPT
D5865 Overdenture – complete mandibular .... OPT
D5866 Overdenture – partial mandibular .... OPT

†† Includes any adjustments for six months.

VIII. FIXED PROSTHODONTICS

D6210 Pontic: cast high noble metal††† ............ $ 338.00*
D6211 Pontic: predominantly base metal ........ $ 308.00*

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

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.
**IX. ORAL AND MAXILLOFACIAL SURGERY**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6212</td>
<td>Pontic: cast noble metal</td>
<td>$323.00*</td>
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<tr>
<td>D6240</td>
<td>Pontic: porcelain fused to high noble metal†††</td>
<td>$342.00*</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic: porcelain fused to pred. base metal</td>
<td>$308.00*</td>
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<tr>
<td>D6242</td>
<td>Pontic: porcelain fused to noble metal</td>
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<td>D6250</td>
<td>Pontic: resin with high noble metal†††††</td>
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<tr>
<td>D6251</td>
<td>Pontic: resin with pred. base metal</td>
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<tr>
<td>D6252</td>
<td>Pontic: resin with noble metal</td>
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<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
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<tr>
<td>D6602</td>
<td>Inlay - cast high noble metal, two surfaces††††</td>
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<tr>
<td>D6603</td>
<td>Inlay - cast high noble metal, three or more surfaces††††</td>
<td>$277.00</td>
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<td>D6604</td>
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<td>Inlay - cast predominantly base metal, three or more surfaces†††</td>
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<td>Inlay - cast noble metal, two surfaces</td>
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<td>D6607</td>
<td>Inlay - cast noble metal, three or more surfaces</td>
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<td>Onlay - cast high noble metal, two surfaces††††</td>
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<td>D6611</td>
<td>Onlay - cast high noble metal, three or more surfaces††††</td>
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<tr>
<td>D6612</td>
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<td>D6613</td>
<td>Onlay - cast predominantly base metal, three or more surfaces</td>
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<td>Onlay - cast noble metal, two surfaces</td>
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<td>D6615</td>
<td>Onlay - cast noble metal, three or more surfaces</td>
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<td>D6720</td>
<td>Crown - resin with high noble metal†††</td>
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<td>D6721</td>
<td>Crown - resin with pred. base metal</td>
<td>$240.00</td>
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<tr>
<td>D6722</td>
<td>Crown - resin with noble metal</td>
<td>$240.00</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown - porcelain fused to high noble metal†††† &amp; ††††</td>
<td>$345.00*</td>
</tr>
<tr>
<td>D6751</td>
<td>Crown - porcelain fused to predominantly base metal†††† &amp; ††††</td>
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<tr>
<td>D6752</td>
<td>Crown - porcelain fused to noble metal†††††</td>
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<td>D6780</td>
<td>Crown - 1/2 cast high noble metal†††</td>
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<td>D6781</td>
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<tr>
<td>D6791</td>
<td>Crown - cast base metal</td>
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<tr>
<td>D6792</td>
<td>Crown - cast noble metal</td>
<td>$328.00*</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement fixed partial denture (bridge)</td>
<td>$14.00</td>
</tr>
</tbody>
</table>

†††† Porcelain on molars is considered optional treatment.

**X. ORTHODONTIC SERVICES**

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 | $3350.00
Adults and covered dependents over age 19 Comprehensive care up to 24 months | $3550.00

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-reports), 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Emergency treatment for relief of pain</td>
<td>$10.00</td>
</tr>
<tr>
<td>D9211</td>
<td>Regional block anesthesia</td>
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<td>D9212</td>
<td>Trigeminal division block anesthesia</td>
<td>$0</td>
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<tr>
<td>D9215</td>
<td>Local anesthesia</td>
<td>$0</td>
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<tr>
<td>D9310</td>
<td>Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>$8.00</td>
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<tr>
<td>D9440</td>
<td>After-hours office visit</td>
<td>$25.00</td>
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<tr>
<td>D9999</td>
<td>Unspecified diagnostic procedure, by report</td>
<td>$10.00</td>
</tr>
</tbody>
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*Includes co-payment and lab fee for this procedure.
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 questions, 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.