# Delta Dental PPO *Plus Premier*

www.deltadentalma.com

**Delta Dental of Massachusetts**
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Milwaukee, WI 53201-2907
1-800-872-0500

**JANUARY 1, 2024**

# DELTA DENTAL PPO PLUS PREMIER

## 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, provider 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 of 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, and policies and procedures, by reading the materials or call customer service.

## GENERAL INFORMATION

The Maximum Fund payment each calendar year is $1,052.00 for each insured person, excluding Type I, orthodontia, and dental implants.

The following schedule lists the covered dental services and the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund payment for those services. The same Maximum Fund Payment applies to services received from dentists in either of the Delta Dental networks or a non-participating dentist.

## COVERED DENTAL SERVCIES

Benefits are payable only for services as shown in the schedule of benefits. No other benefits or services are covered. The payment schedule is subject to change on a periodic basis at the Trustee's discretion. This schedule is effective January 1, 2024.

## MAXIMUM FUND PAYMENT

The Maximum Fund Payment of $1,052.00 for each calendar year for each insured person excludes all Type I Service, orthodontia, and dental implants. Any service provided after the $1,052.00 maximum has been met are the responsibility of the member.

## DELTA DENTAL IDENTIFICATION CARDS

Two identification cards from Delta Dental are mailed to all member's homes. Both cards are issued in the member's name but can be used by everyone covered under your plan. You must provide your dentist with the information that is printed on your ID card, so they know you are now a Delta Dental *PPO Plus Premier* member.

If you did not receive your card or need replacement cards, contact Delta Dental at 1-800-872-0500.

## PRE-TREATMENT ESTIMATES

If your dentist expects that dental treatment will involve a series of covered services, he or she should file a copy of the treatment plan with Delta Dental BEFORE these services are rendered to you or your dependents. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service. Pre-treatment estimates are recommended for any services that are $300.00 or more but are not mandatory.

Upon receipt of the treatment plan Delta Dental will notify you and your dentist about the maximum extent of your benefits for the services reported. If your dentist does not file a treatment plan for a pre-treatment estimate, Delta Dental will decide the extent of your benefit based on a review of those services using standards that are generally considered as accepted dental practices.

## DO YOU PARTICIPATE IN A FLEXAIBLE SPENDING PLAN?

A Flexible Spending Plan is a program that allows you to have a designated dollar amount of your paycheck put aside and held in an account until you need to use it for out-of-pocket healthcare expenses. The money is deducted before taxes are paid, allowing you to apply 100 percent of the money you earn and put aside toward eligible expenses.

Out-of-Pocket dental costs that are not covered by your dental insurance are an eligible expense under a Flexible Spending Plan. Some examples are Crowns/Bridges, Dental x-rays, Dentures, Exams/teeth cleaning, Extractions, Fillings, Gum treatment, Oral surgery, Orthodontia. For additional information call The Group Insurance Commission Health Care Spending Account Administrator at 1-866-862-2422.

## CONTACT THE NAGE FUND OFFICE

If you have any questions or need any additional information concerning the enclosed dental schedule, please feel free to contact the NAGE Fund Office at 1-800-641-0700 or 617-773-8947 or email us at **fundoffice@nage.org** .

A full description of all Trust Fund benefits and all claim forms can be found on the NAGE web site **www.nage.org**

## Procedure Time Limitations/Qualifications

**Diagnostic:**

Comprehensive Evaluation – Once every 60 months per dentist
Periodic Oral Exam – Twice per calendar year
Full Mouth X-rays – Once every 36 months
Bitewing X-rays – Twice per calendar year
Single Tooth X-rays – As needed.

**Preventative:**

Teeth Cleaning – Twice per calendar year
Fluoride Treatments – Twice per calendar year for members under age 19
Space Maintainers (required due to premature loss of teeth) – For members under age 14 and not for the replacement of primary or permanent anterior teeth
Sealants – Unrestored permanent molars, once per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who have had a recent cavity and are at risk for decay
Chlorhexidine Mouth rinse – This is a covered benefit only when administered and dispensed in your dentist' office following scaling and root planning
Fluoride Toothpaste – This is a covered benefits only when administered and dispensed in your dentist office following periodontal surgery

**Restorative:**

White Fillings – Once every 24 months per surface per tooth
Temporary Fillings – Once per tooth
Stainless Steel Crowns – Once every 24 months per tooth

**Oral Surgery:**

Simple Extractions – once per tooth
Surgical Extractions - once per tooth

**Periodontics:**

Periodontal Surgery - Once every 36 months, per quadrant
Scaling and Root Planing – Once in 24 months, per quadrant. No more than two quadrants are allowed of the same date of service
Periodontal Cleaning – Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings

**Endodontics:**

Root Canal Treatment – Once per tooth
Vital Pulpotomy – Limited to deciduous teeth

**Prosthetic Maintenance:**

Bridge or Denture Repair – Once within 12 months, same repair
Rebase or Reline of Dentures – Once within 36 months
Recements of Crown 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 Crown (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 Implants – Once within 60 months per implant per tooth

**Orthodontics:**

Reimbursement for Orthodontics treatment up to 50% of the orthodontists' charges to a separate LIFETIME maximum of $2000 for each insured member

# SCHEDULE OF DENTAL BENEFITS

**DELTA DENTAL PPO *PLUS PREMIER***

**Dental Plan Maximums**

| | |
|---|---|
| Annual Plan Maximum | $1,052.00 |
| Orthodontia Benefit Lifetime Maximum | $2,000.00 |
| Annual Maximum Dental Implants | $1,000.00 |

**DENTAL SERVICES**
The maximum payment each calendar year is $1,052.00 for each insured person, excluding Type I Services, orthodontia and dental implants.

The following schedule lists the dental services and the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund maximum payment for those services. The same Maximum Fund Payment applies to services received from dentists in either of the Delta Dental Networks. This schedule is effective January 1, 2024.

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| *D0120 | PERIODIC ORAL EXAMINATION | 100% |
| *D0140 | LIMITED ORAL EVALUATION – PROBLEM FOCUSED | 100% |
| *D0145 | ORAL EVALUATION FOR PATIENTS UNDER THREE YEARS OF AGE | 100% |
| *D0150 | COMPREHENSIVE ORAL EVALUATION – NEW OR ESTABLISHED PATIENT | 100% |
| *D0160 | DETAILED AND EXTENSIVE ORAL EVALUATON PROBLEM FOCUSED BY REPORT | 100% |
| *D0170 | RE-EVLUATION – LIMITED PROBLEM (ESTABLISHED PATIENT: NOT POST-OPERATIVE VISIT) | 100% |
| *D0180 | COMPREHENSIVE PERIODONTAL EVALUATION – NEW OR ESTABLISHED PATIENT | 100% |
| *D0210 | FULL MOUTH XRAYS | 100% |
| *D0220 | INTRAORAL-PERIAPICAL FIRST FILM | 100% |
| *D0230 | INTRAORAL-PERIAPICAL EACH ADDITIONAL FILM | 100% |
| *D0240 | INTRORAL-OCCLUSAL FILM | 100% |
| *D0250 | EXTRAORAL-FIRST FILM | 100% |
| *D0251 | EXTRAORAL – ORAL POSTERIOR DENTAL RADIOGRAPH IMAGE | 100% |
| *D0270 | BITEWING-SINGLE FILM | 100% |
| *D0272 | BITEWINGS-TWO FILMS | 100% |
| *D0273 | BITEWINGS-THREE FILMS | 100% |
| *D0274 | BITEWINGS-FOUR FILMS | 100% |
| *D0277 | VERTICAL BITEWING SERIES -7 TO 8 FILMS | 100% |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| *D0320 | TEMPOROMANDIBULAR JOINT ARTHROGRAM | 100% |
| *D0321 | OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT | 100% |
| *D0330 | PANORAMIC FILM | 100% |
| *D0414 | LAB PROCESSING FOR MICROBIAL SPECIMAN | 100% |
| *D0415 | COLLECTION OF MICROORGANISMS FOR CULTURE & SENSITIVITY | 100% |
| *D0460 | PULP VITALITY TESTS | 100% |
| *D0470 | DIAGNOSTIC CASTS | 100% |
| *D1110 | PROPHYLAXIS-ADULT (TWICE PER CALANDER YEAR) | 100% |
| *D1120 | PROPHYLAXIS-CHILD (TWICE PER CALANDER YEAR) | 100% |
| *D1206 | TOPICAL FLUORIDE VARNISH: THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENT | 100% |
| *D1208 | TOPICAL APPLICATION OF FLUORIDE | 100% |
| *D1351 | SEALANT-PER TOOTH (UNRESTORED PERMANENT MOLARS, ONCE PER TOOTH THROUGH AGE 15) | 100% |
| *D1352 | PREVENTATIVE RESIN RESTORATION | 100% |
| *D1510 | SPACE MAINTAINER – FIXED – UNILATERAL | 100% |
| *D1516 | SPACE MAINTAINER-FIXED -BILATERAL, MAXILLARY | 100% |
| *D1517 | SPACE MAINTAINER-FIXED-BILATERAL, MANDIBULAR | 100% |
| *D1520 | SPACE MAINTAINER-REMOVABLE-UNILATERAL | 100% |
| *D1526 | SPACE MAINTAINER-REMOVABLE-BILATERAL MAXILLARY | 100% |
| *D1527 | SPACE MAINTAINER-REMOVALE-BILATERAL MANDIBULAR | 100% |
| *D1551 | RE-CEMENT OR RE-BOND SPACE MAINTAINER-MAXILLARY | 100% |
| *D1552 | RE-CEMNT TO RE-BOND SPACE MAINTAINER-MANDIBULAR | 100% |
| *D1553 | RE-CEMENT OR RE-BOND SPACE MAINTAINER-PER QUADRANT | 100% |
| *D1556 | REMOVAL OF UNILATERAL FIXED BILATERAL SPACE MAINTAINER – PER QUADRANT | 100% |
| *D1557 | REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXILLARY | 100% |
| *D1558 | REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIBULAR | 100% |
| *D1575 | DISTAL SHOE SPACE MAINTAINER – FIXED UNILATERAL (FOR FIRST MOLARS ONLY FOR PREMATURE LOSS OF SECOND PRIMARY MOLARS: A, J,K OR T) | 100% |
| D2140 | AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT | $47.50 |
| D2150 | AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT | $62.50 |
| D2160 | AMALGAM-THREE SURFACES, PRIMARY OR PERMNENT | $74.50 |
| D2161 | AMALGAM FOUR OR MORE SURFACE PERM OR PRIMARY | $73.75 |
| D2330 | RESIN-BASED COMPOSITE/ONE SURFACE, ANTERIOR | $49.00 |
| D2331 | RESIN-BASED COMPOSITE-TWO SURFACE, ANTERIOR | $65.25 |
| D2332 | RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR | $65.75 |
| D2335 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGEL (ANTERIOR) | $66.25 |
| D2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR | $91.00 |
| D2391 | RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR | $46.75 |
| D2392 | RESIN-2 SURFACE POSTIER | $104.25 |
| D2393 | RESIN-3 SURFACES POSTERIOR | $105.75 |
| D2394 | RESIN-4 OR MORE SURFACES POSTERIOR | $116.00 |
| D2510 | INLAY-METALLIC-ONE SURFACE | $221.50 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D2520 | INLAY-METALLIC-TWO SURFACES | $221.50 |
| D2530 | INLAY-METALLIC-THREE OR MORE SURFACES | $221.50 |
| D2542 | ONLAY-METALLIC TWO SURFACES | $340.00 |
| D2543 | ONLAY-METALLIC THREE SURFACES | $340.00 |
| D2544 | ONLAY-METALLIC FOUR OR MORE SURFACES | $340.00 |
| D2610 | INLAY-PORCELAIN/CERAMIC-ONE SURFACE | $221.50 |
| D2620 | INLAY-PORCELAIN/CERAMIC-TWO SURFACES | $221.50 |
| D2630 | INLAY-PORCELAIN/CERAMIC-THREE SURFACES | $221.50 |
| D2642 | ONLAY PROCELAIN/CERAMIC TWO SURFACES | $315.25 |
| D2643 | ONLAY PORCELAIN/CERAMIC THREE SURFACES | $315.75 |
| D2644 | ONLAY PORCELAIN/CERAMIC FOUR OR MORE SURFACES | $316.25 |
| D2650 | INLAY-COMP/RESIN-1 SURFACE | $221.50 |
| D2651 | INLAY-COMP/RESIN-2 SURFACES | $221.50 |
| D2652 | INLAY-COMP/RESIN-3 OR MORE SURFACES | $221.50 |
| D2662 | ONLAY-RESIN-BASED COMPOSITE-TWO SURFACES | $338.00 |
| D2663 | ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES | $339.50 |
| D2664 | ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES | $339.50 |
| D2710 | CROWN-RESIN (INDIRECT) | $102.25 |
| D2712 | CROWN ¾ RESIN BASED COMPOSITE (INDIRECT) | $102.25 |
| D2720 | CROWN-RESIN WITH HIGH NOBLE METAL | $320.50 |
| D2721 | CROWN-RESIN WITH PREDOMINANTLY BASE METAL | $282.50 |
| D2722 | CROWN-RESIN WITH NOBLE METAL | $303.00 |
| D2740 | CROWN-PORCELAIN/CERAMIC SUBSTRATE | $345.75 |
| D2750 | CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL | $328.75 |
| D2751 | CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | $328.25 |
| D2752 | CROWN-PORCELAIN FUSED TO NOBLE METAL | $328.25 |
| D2753 | CROWN – PORCELAIN FUSED TO TITANIUM ALLOYS | $328.25 |
| D2780 | CROWN 3/4 CAST HIGH NOBLE METAL | $328.75 |
| D2781 | CROWN 3/4 CAST PREDOMINANTLY BASE METAL | $353.00 |
| D2782 | CROWN 3/4 CAST NOBLE METAL | $353.00 |
| D2783 | CROWN 3/4 PORCELAIN/CERAMIC | $316.25 |
| D2790 | CROWN-FULL CAST HIGH NOBLE | $328.75 |
| D2791 | CROWN-FULL CAST PREDOMINANTLY BASE METAL | $304.50 |
| D2792 | CROWN-FULL CAST NOBLE METAL | $318.25 |
| D2794 | CROWN TITANIUM | $328.25 |
| D2799 | PROVISIONAL CROWN | $64.25 |
| D2910 | RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION | $29.50 |
| D2915 | RECEMENT CAST OR PREFAB POST AND CORE | $29.50 |
| D2920 | RECEMENT CROWN | $29.50 |
| D2930 | PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH | $60.00 |
| D2931 | PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH | $76.25 |
| D2932 | PREFABRICATED RESIN CROWN | $81.75 |
| D2933 | PREFABRICATED STAINLESS STEEL CROWN WITH A RESIN WINDOW | $82.50 |
| D2934 | PREFABRICATED ESTHETIC COATED STAINELESS STEEL CROWN PRIMARY TOOTH | $82.50 |
| D2940 | SEDATIVE FILLING | $24.50 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D2941 | INTERIM THERAPEUTIC RESTOATION (PRIMAY TOOTH) | $24.50 |
| D2950 | CROWN BUILDUP, INCLUDING PINS | $75.75 |
| D2951 | PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION | $19.50 |
| D2952 | POST AND CORE-IN ADDITION TO CROWN | $114.75 |
| D2954 | PREFABRICATED POST AND CORE-IN ADDITION TO CROWN | $113.75 |
| D2962 | LABIAL VENEER (PORCELAIN LAMINATE)-LABORATORY | $228.50 |
| D2971 | ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK | $65.75 |
| D2976 | BAND STABILIZATION – PER TOOTH – PER LIFETIME | $76.25 |
| D2980 | CROWN REPAIR | $86.25 |
| D3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) | $33.75 |
| D3221 | PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH | $30.00 |
| D3222 | PARTIAL PULPOTANY FOR APEXOGENSIS-PERMANENT TOOTH WITH INCOMPLETE ROOT – DEVELOPMENT | $33.75 |
| D3230 | PULPAL THERAPY (RESORBABLE RILLING) - ANTERIOR, PRIMARY TOOTH | $155.75 |
| D3240 | PULPAL THERAPY (RESORBABLE FILLING) – POSTERIOR, PRIMAY TOOTH | $135.00 |
| D3310 | ENDOONTIC THERAPY, ANTEIOR TOOTH | $303.50 |
| D3320 | ENDONTIC THERAPY, BICUSPID TOOTH | $414.25 |
| D3330 | ENDONTIC THERAPY, MOLAR | $543.25 |
| D3333 | INTERNAL ROOT REPAIR OR 1 PERFORATION DEFECTS | $60.25 |
| D3346 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY- ANTERIOR | $385.25 |
| D3347 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID | $450.50 |
| D3348 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR | $493.25 |
| D3351 | APEXIFICATION/RECALCIFICATION-INITIAL VISIT | $58.75 |
| D3352 | APEXIFCATION/RECALCIFCATION – INTERM MEDICATION REPLACEMEMT | $58.25 |
| D3410 | APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR | $244.75 |
| D3421 | APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT) | $317.50 |
| D3425 | APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT) | $343.75 |
| D3426 | APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT) | $120.25 |
| D3430 | RETROGRADE FILLING-PER ROOT | $61.75 |
| D3450 | ROOT AMPUTATION-PER ROOT | $161.75 |
| D3920 | HEMISECTION (INCLUDING ANY ROOT REMOVAL) | $158.75 |
| D4210 | GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | $194.75 |
| D4211 | GINGIVECTOMY OR GINGIVOPLASTY – ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | $69.25 |
| D4240 | GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANNING FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | $318.50 |
| D4241 | GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING ONE TO THREE TEETH, PER QUADRANT | $191.50 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D4249 | CLINICAL CROWN LENGTHENING, HARD TISSUE | $312.75 |
| D4260 | OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | $550.00 |
| D4261 | OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) ONE TO THREE TEETH, PER QUADRANT 1 | $188.25 |
| D4263 | BONE REPLACEMENT GRAFT-FIRST SITE IN QUADRANT | $182.75 |
| D4264 | BONE REPLACEMENT GRAFT EACH ADDITIONAL SITE IN QUADRANT | $202.00 |
| D4265 | BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION | $182.25 |
| D4266 | GUIDED TISSUE REGENERATION- RESORBABLE BARRIER, PER SITE | $218.75 |
| D4267 | GUIDED TISSUE REGENERATION – NON RESORBABLE BARRIER PER SITE | $221.25 |
| D4270 | PEDICLE SOFT TISSUE GRAFT PROCEDURE | $330.25 |
| D4273 | SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES PER TOOTH | $349.00 |
| D4274 | DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA) | $84.75 |
| D4275 | SOFT TISSUE ALLOGRAFT | $349.75 |
| D4276 | COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT PER TOOTH | $349.75 |
| D4277 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT | $369.29 |
| D4278 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOURS TOOTH POSTION IN SAME GRAFT SITE | $186.94 |
| D4283 | AUTOGENOUS CONNECTIVE TISSURE GRAFT PROCEDURE EACH ADDITIONAL CONTIGUOUS TOOTH, TWO SOFT TISSUE GRAFTS PER 36 MONTHS PER QUADRANTT | $209.40 |
| D2485 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT EACH ADDITIONAL CONTIGUOUS TOOTH, POSITION IN SAME GRAFT SITE. TWO SOFT TISSURE GRAFTS PER 36 MONTHS PER QUADRANT | $209.85 |
| D4341 | PERIODONTAL SCALING & ROOT PLANING – FOUR OR MORE TEETH PER QUADRANT. ONLY TWO QUADRANTS ARE ALLOWED PER DATE OF SERVICE, ADDITIONAL QUADRANTS WILL DENY | $88.00 |
| D4342 | PERIODONTAL SCALING & ROOT PLANING ONE TO THREE TEETH, PER QUADRANT | $52.75 |
| *D4346 | SCALING IN THE PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION-FULL MOUTH AFTER ORAL EVALUATION | 100% |
| *D4355 | FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS | 100% |
| D4381 | LOCALIZED DELIVERY OF ANTIMOCROBIAL AGENTS | $50.75 |
| *D4910 | PERIODONTAL MAINTENANCE. FOUR PER CALDENAR YEAR | 100% |
| D5110 | COMPLETE DENTURE - MAXILLARY | $330.75 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D5120 | COMPLETE DENTURE - MANDIBULAR | $330.75 |
| D5130 | IMMEDIATE DENTURE - MAXILLARY | $331.75 |
| D5140 | IMMEDIATE DENTURE - MANDIBULAR | $331.75 |
| D5211 | MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $328.25 |
| D5212 | MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $328.25 |
| D5213 | MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $332.75 |
| D5214 | MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $332.75 |
| D5221 | IMMEDIATE MAXILLARY PARTIAL DENTURE- RESIN BASE | $338.10 |
| D5222 | IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE | $338.10 |
| D5223 | IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTUE BASES | $342.22 |
| D5224 | IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES | $342.22 |
| D5225 | MAXILLARY PARTIAL DENTURE FLEXIBLE BASE | $322.25 |
| D5226 | MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE | $322.25 |
| D5227 | IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE | $322.25 |
| D5228 | IMMEDIATE MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE | $322.25 |
| D5282 | REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH) MAXILLARY | $227.00 |
| D5283 | REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH), MANIBULAR | $227.00 |
| D5284 | PARTIAL DENTURE-REMOVABLE UNILATERAL ONE-PIECE FLEXIBLE BASE (INCLUDING CLASPS AND TEETH) PER QUADRANT | $227.00 |
| D5286 | PARTIAL DENTURE-REMOVABLE UNILATERAL ONE-PIECE RESIN (INCLUDING CLASPS AND TEETH) PER QUADRANT | $227.00 |
| D5410 | ADJUST COMPLETE DENTURE-MAXILLARY | $20.75 |
| D5411 | ADJUST COMPLETE DENTURE-MANDIBULAR | $20.75 |
| D5421 | ADJUST PARTIAL DENTURE-MAXILLARY | $20.75 |
| D5422 | ADJUST PARTIAL DENTURE-MANDIBULAR | $20.75 |
| D5511 | REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR (LOWER ARCH). ONCE PER 12 MONTHS (AFTER 6 MONTHS FROM INSERTION) | $40.00 |
| D5512 | REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY (UPPER ARCH). ONCE PER 12 MONTHS (AFTER 6 MONTHS FROM INSERTION) | $40.00 |
| D5611 | REPAIR RESIN PARTIAL DENTURE BASE, MANDIBUALR (LOWER ARCH). ONCE PER 12 MONTHS (AFTER 6 MONTHS REOM INSERTION) | $39.25 |
| D5612 | REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY (UPPER ARCH) ONCE PER 12 MONTHS (AFTER 6 MONTHS FROM INSERTION) | $39.25 |
| D5621 | REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR (LOWER ARCH). ONCE PER 12 MONTHS (AFTER 6 MONTHS FROM INSERTION | $56.50 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D5622 | REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY (UPPER ARCH). ONCE PER 12 MONTHS (AFTER 6 MONTHS FROM INSERTION) | $56.50 |
| D5630 | REPAIR OR REPLACE BROKEN CLASP | $65.25 |
| D5640 | REPLACE BROKEN TEETH-PER TOOTH | $39.25 |
| D5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE | $27.50 |
| D5660 | ADD CLASP TO EXISTING PARTIAL DENTURE | $33.75 |
| D5670 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY) | $197.25 |
| D5671 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR) | $197.25 |
| D5710 | REBASE COMPLETE MAXILLARY DENTURE | $131.50 |
| D5711 | REBASE COMPLETE MANDIBULAR DENTURE | $131.50 |
| D5720 | REBASE MAXILLARY PARTIAL DENTURE | $130.50 |
| D5721 | REBASE MANDIBULAR PARTIAL DENTURE | $130.50 |
| D5725 | REBASE HYBRID PROTHESIS | $130.50 |
| D5730 | RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE) | $130.50 |
| D5731 | RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE) | $130.50 |
| D5740 | RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE) | $130.50 |
| D5741 | RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE) | $130.50 |
| D5750 | RELINE COMPLETE MAXILLARY DENTURE (LABORATORY) | $131.00 |
| D5751 | RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY) | $131.00 |
| D5760 | RELINE MAXILLARY PARTIAL DENTURE (LABORATORY) | $130.50 |
| D5761 | RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY) | $130.50 |
| D5765 | SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE-INDIRECT | $130.50 |
| D5820 | INTERIM PARTIAL DENTURE (MAXILLARY) | $110.50 |
| D5821 | INTERIM PARTIAL DENTURE (MANDIBULAR) | $110.50 |
| D5850 | TISSURE CONDITIONING MAXILLARY – UPPER DENTURE | $36.50 |
| D5851 | TISSUE CONDITIONING, MANDIBULAR – LOWER DENTURE | $36.50 |
| **D6010 | SURGICAL-ENDOSTEAL IMPLANT | $785.00 |
| **D6013 | MINI-IMPLANT | $392.50 |
| D6056 | PREFAB ABUTMENT | $226.50 |
| D6057 | CUSTOM ABUTMENT | $300.00 |
| D6058 | IMPLANT ABUTMENT SUPPORTED PORCELAIN/CERMAIC CROWN | $333.75 |
| D6059 | IMPLANT ABUTMENT SUPPORTED TO HIGH NOBLE METAL CROWN | $333.75 |
| D6060 | IMPLANT ABUTMENT SUPPORTED PORCELAIN FUSED TO PREDOMINANTLY BASE METAL CROWN | $332.25 |
| D6061 | IMPLANT ABUTMENT SUPPORTED PROCELAIN FUSED TO NOBLE METAL CROWN | $332.25 |
| D6062 | IMPLANT ABUTMENT SUPPORTED HIGH NOBLE CAST METAL CROWN | $333.75 |
| D6063 | IMPLANT ABUTMENT SUPPORTED PREDOMINANTLY BASE METAL CROWN | $333.25 |
| D6064 | IMPLANT ABUTMENT SUPPORTED CAST NOBLE METAL CROWN | $333.25 |
| D6065 | IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | $334.00 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D6066 | IMPLANT SUPPORTED PROCELAIN FUSED TO HIGH NOBLE METAL CROWN | $334.00 |
| D6067 | IMPLANT SUPPORTED HIGH NOBLE METAL CROWN | $334.00 |
| D6069 | IMPLANT ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD | $334.00 |
| D6070 | IMPLANT ABUTMENT SUPPORTED RETAINER FOR PORCELAN FUSED TO PREDOMINANTLY BASE METAL FPD | $331.25 |
| D6071 | IMPLANT ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO NOBLE METAL FPD | $332.25 |
| D6072 | IMPLANT ABUTMENT SUPPORTED RETAINER FOR CAST HIGH NOBLE METAL FPD | $334.00 |
| D6073 | IMPLANT ABUTMENT SUPPORED RETAINER FOR PREDOMINANTLY BASE CAST METAL FPD | $331.25 |
| D6074 | IMPLANT ABUTMENT SUPPORTED RETAINER FOR CAST NOBLE METAL FOR FPD | $332.25 |
| D6076 | IMPLANT SUPPORTED RETAINER FOR PRCLAIN FUSED TO HIGH NOBLE METAL FPD | $333.75 |
| D6077 | IMPLANT SUPPORTED RETAINER FOR CAST HIGH NOBLE METAL FOR FPD | $333.75 |
| D6082 | IMPLANT SUPPORTED CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | $333.75 |
| D6083 | IMPLANT SUPPORTED CROWN-PORCELAIN FUSED TO NOBLE ALLOYS | $333.75 |
| D6084 | IMPLANT SUPPORTED CORWN – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | $333.75 |
| D6085 | PROVISIONAL IMPLANT CROWN | $64.50 |
| D6086 | IMPLANT SUPPORTED CROWN-PREDOMINANTLEY BASE ALLOYS | $333.75 |
| D6087 | IMPLANT SUPPORTED CROWN- NOBLE ALLOYS | $333.75 |
| D6088 | IMPLANT SUPPORTED CROWN-TITANIUM AND TITANIUM ALLOYS | $333.75 |
| D6089 | ACCESSING & RESTORING LOOSE IMPLANTS SCREW-PER SCREW – 1x IN 24 MONTHS – 6 MONTHS AFTER INSERTION | $46.75 |
| D6090 | REPAIR IMPLANT SUPPORTED PROSTHESIS | $57.00 |
| D6092 | RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN | $24.00 |
| D6093 | RECEMENT IMPLANT/ABUTMNENT SUPPORTED FIXED PARTIAL DENTURE | $37.25 |
| D6094 | ABUTMENT SUPPORTED CROWN – TITANIUM | $333.75 |
| D6097 | ABUTMENT SUPPORTED CROWN-PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | $332.25 |
| D6098 | IMPLANT SUPPORTED RETAINER-PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | $331.25 |
| D6099 | IMPLANT SUPPORTED RETAINER FOR FPD – PORCELAINE FUSED TO NOBLE ALLOYS | $333.75 |
| D6100 | SURGICAL REMOVAL OF IMPLANT BODY | $58.50 |
| D6105 | REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL OR FLAP ELEVATION | $50.25 |
| D6106 | GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER IMPLANT | $218.75 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D6107 | GUIDED TISSUE REGENERATION – NON-RESORBABLE BARRIER, PER IMPLANT | $221.25 |
| D6110 | IMPLANT/ABUTMENT COMPLETE DENTRUE-REMOVABLE UPPER ARCH | $337.25 |
| D6111 | IMPLANT/ABUTMENT COMPLETE DENTURE – REMOVALBLE LOWE ARCH | $337.25 |
| D6112 | IMPANT/ABUTMANT PARTIAL DENTURE – REMOVALBEL UPPER ARCH | $337.25 |
| D6113 | IMPLANT/ABUTMENT PARTIAL DENTURE – REMOVABLE LOWE ARCH | $337.25 |
| D6114 | IMPLANT/ABUTMENT COMPLETE DENTURE - FIXED UPPER ARCH | $340.00 |
| D6115 | IMPLANT/ABUTMENT COMPLETE DENTURE – FIXED LOWE ARCH | $340.00 |
| D6116 | IMPLANT/ABUTMENT PARTIAL DENTURE – FIXED UPPER ARCH | $340.00 |
| D6117 | IMPLANT/ABUTMENT PARTIAL DENTURE- FIXED LOWER ARCH | $340.00 |
| D6120 | IMPLANT SUPPORTED RETAINER – PORCELAINE FUSED TO TITANIUM AND TITANMIUM ALLOYS | $333.75 |
| D6121 | IMPLANT SUPPORTED RETAINER FOR METAL FPD – PREDOMINANTLY BASE ALLOYS | $333.75 |
| D6122 | IMPLANT SUPPORTED RETAINER FOR METAL FPD – NOBLE ALLOYS | $333.75 |
| D6123 | IMPLANT SUPPORTED RETAINER FOR METAL FPD – TITANIUM AND TITANMIUM ALLOYS | $333.75 |
| D6194 | IMPLANT RETAINER TITANMUM | $333.75 |
| D6195 | ABUTMENT SUPPORTED RETAINER – PORCELAINE FUSED TO TITANIUM AND TITANMIUM ALLOYS | $331.25 |
| D6197 | REPLACEMENT OF RESTORATIVE MATERIAL USED TO CLOSE AN ACCESS OPENING OF A SCREW-RETAINED IMPLANT SUPPORTED PROSTHESIS, PER IMPLANT | $46.75 |
| D6205 | PONTIC-INDIRECT RESIN BASED COMPOSITE | $316.25 |
| D6210 | PONTIC-CAST HIGH NOBLE METAL | $328.75 |
| D6211 | PONTIC-CAST PREDOMINANTLY BASE METAL | $327.75 |
| D6212 | PONTIC-CAST NOBLE METAL | $328.25 |
| D6214 | PONTIC-TITANIUM | $328.25 |
| D6240 | PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL | $328.75 |
| D6241 | PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | $327.75 |
| D6242 | PONTIC-PORCELAIN FUSED TO NOBLE METAL | $328.25 |
| D6243 | PONTIC-PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | $327.75 |
| D6245 | PONTIC-PORCELAIN CERAMIC SUBSTRATE | $328.75 |
| D6250 | PONTIC-RESIN WITH HIGH NOBLE METAL | $328.75 |
| D6251 | PONTIC-RESIN WITH PREDOMINANTLY BASE METAL | $319.75 |
| D6252 | PONTIC-RESIN WITH NOBLE METAL | $328.25 |
| D6253 | PROVISIONAL PONTIC | $67.25 |
| D6545 | RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS | $128.25 |
| D6549 | RESIN RETAINER FOR RESIN BONDED FIXED PROSTHESIS, ONE PER TOOTH EVERY 5 YEARS | $316.25 |
| D6602 | INLAY-CAST HIGH NOBLE METAL, TWO SURFACES | $217.00 |
| D6603 | INLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES | $277.25 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D6604 | INLAY-CAST PREDOMINANTLY BASE METAL, TWO SURFACES | $216.50 |
| D6605 | INLAY-CAST PREDOMINANTLY BASE METAL, THREE SURFACES | $277.25 |
| D6606 | INLAY-CAST NOBLE METAL, TWO SURFACES | $217.00 |
| D6607 | INLAY-CAST NOBLE METAL, THREE OR MORE SURFACES | $277.25 |
| D6610 | ONLAY-CAST HIGH NOBLE METAL, TWO SURFACES | $339.50 |
| D6611 | ONLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES | $340.00 |
| D6612 | ONLAY-CAST PREDOMINANTLY BASE METAL, TWO SURFACES | $337.50 |
| D6613 | ONLAY-CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES | $339.50 |
| D6614 | ONLAY-CAST NOBLE METAL, TWO SURFACES | $337.50 |
| D6615 | ONLAY-CAST NOBLE METAL, THREE OR MORE SURFACES | $339.50 |
| D6624 | INLAY-TITANIUM | $339.00 |
| D6634 | ONLAY-TITANIUM | $340.00 |
| D6710 | CROWN-INDIRECT RESIN-BASED COMPOSITE | $275.00 |
| D6720 | CROWN-RESIN WITH HIGH NOBLE METAL | $328.75 |
| D6721 | CROWN-RESIN WITH PREDOMINANTLY BASE METAL | $327.75 |
| D6722 | CROWN-RESIN WITH NOBLE METAL | $328.25 |
| D6740 | RETAINER CROWN-PROCELAIN/CERAMIC | $328.75 |
| D6750 | CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL | $328.75 |
| D6751 | CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | $327.75 |
| D6752 | CROWN-PORCELAIN FUSED TO NOBLE METAL | $328.25 |
| D6753 | RETAINER CROWN-PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | $327.75 |
| D6780 | CROWN- 3/4 CAST HIGH NOBLE METAL | $328.75 |
| D6781 | CROWN – 3/4 CAST PREDOMINANTLY BASE METAL | $352.50 |
| D6782 | CROWN-3/4 CAST NOBLE METAL | $353.00 |
| D6784 | RETAINER CROWN ¾ - TITANIUM AND TITANIUM ALLOYS | $352.50 |
| D6790 | CROWN-FULL CAST HIGH NOBLE METAL | $328.75 |
| D6791 | CROWN-FULL CAST PREDOMINANTLY BASE METAL | $326.75 |
| D6792 | CROWN-FULL CAST NOBLE METAL | $328.25 |
| D6793 | PROVISIONAL RETAINER CROWN | $63.75 |
| D6794 | CROWN-TITANIUM | $328.75 |
| D6930 | RECEMENT FIXED PARTIAL DENTURE | $30.75 |
| D6980 | FIXED PARTIAL DENTURE REPAIR, BY REPORT | $34.25 |
| D7111 | CORONAL REMNANTS-DECIDUOUS TOOTH | $23.75 |
| D7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) | $50.25 |
| D7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH. | $58.50 |
| D7220 | REMOVAL OF IMPACTED TOOTH-SOFT TISSUE | $83.75 |
| D7230 | REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY | $123.75 |
| D7240 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY | $149.00 |
| D7241 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY WITH UNUSUAL SURGICAL COMPLICATIONS | $244.00 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | $95.50 |
| D7270 | TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH | $120.00 |
| D7280 | SURGICAL ACCESS OF UNERUPTED TOOTH | $218.75 |
| D7283 | PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH | $180.00 |
| D7284 | EXCISIONAL BIOPSY OF MINOR SALIVORY GLANDS – 1X PER LIFETIME | $174.25 |
| D7285 | BIOPSY OF ORAL TISSUE-HARD (BONE, TOOTH) | $174.25 |
| D7286 | BIOPSY OF ORAL TISSUE-SOFT (ALL OTHERS) | $174.25 |
| D7287 | CYTOLOGY SAMPLE COLLECTION | $37.25 |
| D7288 | BRUSH BIOPSY-TRANSEPITHELILAL SAMPLE COLLECTION | $37.25 |
| D7291 | TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY BY REPORT | $31.50 |
| D7296 | CORTICOMY-ONE TO THREE THETH SPACES PER QUADRANT – ONCE PER LIFETIME PER QUADRANT. SUBJECT TO ORTHODONTIA MAXIMUM | $191.50 |
| D7297 | CORTCOMY-FOUR OR MORE TEETH SPACES PER QUADRANT. ONCE PER LIFETIME PER QUADRANT. SUBMECT TO ORTHODONTIA MAXIMUM | $318.50 |
| D7310 | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS, FOUR OR MORE TEETH PER QUADANT | $106.00 |
| D7311 | ALEVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS 1 TO 3 TEETH OR TOOTH SPACES PER QUADRANT | $106.50 |
| D7320 | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS PER QUADRANT | $171.75 |
| D7321 | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS 1 TO 3 TEETH OR TOOTH SPACES PER QUADRANT | $170.75 |
| D7410 | EXCISION OF BENIGN LESION UP TO 1.25 CM | $95.00 |
| D7411 | EXCISION OF BENIGN LESION GREATER THAN 1.25 CM | $179.50 |
| D7450 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM | $130.00 |
| D7451 | REMOVALOF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25CM | $182.00 |
| D7460 | REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM | $118.00 |
| D7461 | REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM | $204.25 |
| D7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) | $253.75 |
| D7472 | REMOVAL OF TORUS PALATINUS | $253.75 |
| D7473 | REMOVAL OF TORUS MANDIBULARIS | $253.75 |
| D7509 | MARSUPIALIZATION OF ODONTOGENIC CYST | $182.00 |
| D7510 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE | $73.50 |
| D7511 | INCISION AND DRAINAGE OF ABCESS INTRAORAL SOFT TISSUE COMPLICATED | $73.50 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D7520 | INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE | $118.00 |
| D7521 | INCISION AND DRAINAGE OF ABCESS EXTRAORAL SOFT TISSUE COMPLICATED | $118.00 |
| D7910 | SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM | $32.50 |
| D7911 | COMPLICATED SUTURE – UP TO 5CM | $55.75 |
| D7950 | OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF MANDIBLE OR MAXILLA-AUTOGENOUS. ONCE PER 60 MONTHS | $582.08 |
| D7952 | SINUS AUGMENTATION VIA A VERTICAL APPROACH. ONCE PER 60 MONTHS | $850.16 |
| D7953 | BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION, PER SITE, ONCE PER 60 MONTHS | $182.77 |
| D7956 | GUIDED TISSURE REGENERATION. EDENTULOUS AREA – RESORBABLE BARRIER, PER SITE | $218.75 |
| D7957 | GUIDED TISSUE REGENERATION, EDENTULOUS AREA – NON-RESORBABLE BARRIER, PER SITE | $221.25 |
| D7961 | BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY) – TWO PER LIFETIME FOR PATIENTS OVER AGE 6 | $190.25 |
| D7962 | LINGUAL FRENECTOMY (FRENULECTOMY) – ONCE PER LIFETIME PER ARCH FOR PATIENTS OVER AGE 6 | $190.25 |
| D7963 | FRENUOPLASTY | $190.25 |
| D7970 | EXCISION OF HYPERPLASTIC TISSUE-PER ARCH | $105.25 |
| D7971 | EXCISION OF PERICORONAL GINGIVA | $64.25 |
| D8695 | REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT. ONCE PER LIFETIME, PER QUADRANT. SUBJECT TO ORTHDONTIA LIFETIME MAXIMUM | $52.32 |
| D9110 | PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN | $29.50 |
| D9222 | DEEP SEDATION/GENERAL ANESTHESIA – FIRST 15 MINUTES (PRE-SET UP TIME). COVERD IN CONJUNCTION WITH IMPACTED TEETH ONLY UP TO ONE HOUR | $45.25 |
| D9223 | DEEP SEDATION/GENERAL ANESTHESIA – EACH 15 MINUTES INCREMENTS | $45.25 |
| D9224 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA – EACH 15 MONUTE INCREMENTS | $45.25 |
| D9239 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATON/ANTHESIA – FIRST 15 MINUTES (PRE-SET UP TIME) COVERED IN CONJUNCTION WITH IMPACTED TEETH ONLY (UP TO ONE HOUR) | $45.25 |
| D9310 | CONSULTATION | $46.25 |
| D9910 | APPLICATION OF DESENSITIZING MEDICAMENTS | $18.75 |
| D9930 | TREATMENT OF COMPLICATIONS | $31.50 |

| ADA Code | SERVICE DESCRIPTION | Maximum Payment |
|---|---|---|
| D9941 | FABRICATION ATHLETIC MOUTHGUARD | $74.19 |
| D9942 | REPAIR AND OR RELINE OF AN OCCLUSAL GUARD | $100.00 |
| D9944 | OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH | $296.75 |
| D9945 | OCCLUSAL GUARD – SOFT APPLICANCE, FULL ARCH | $74.19 |
| D9946 | OCCLUSAL GUARD – HARD APPLICANCE, PARTIAL ARCH | $118.70 |
| D9952 | OCCLUSAL ADJUSTMENT-COMPLETE | $95.00 |

***Maximum Fund Payment For All Type I Services is not deducted from Annual Plan Maximum.**

****Maximum Fund Payment is deducted from Annual Implant Maximum (not from Annual Plan Maximum).**

**ORTHODONTIA BENEFIT LIFETIME MAXIMUM: $2,000.00**

*Reimbursement for orthodontic procedures up to 50% of the orthodontist's charges up to a lifetime maximum of $2,000.00 for each insured person. Orthodontic treatment must be administered/supervised by a licensed dentist. Mail order orthodontic kits are not covered under this plan.*

## BENEFIT PAYMENTS FOR SERVICES PROVIDED BY NON-PANEL PROVIDERS

When covered services are furnished by a non-panel provider, such as for emergency care, services by non-participating dentist, you will be balanced billed for difference between the regular charge and the maximum payment made by the Fund. Any remaining balance payable to the non-panel provider is the member's responsibility.

## 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 Plan 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 is 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

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.

If you receive payment from another person or his or her insurance company for injuries, he or she caused.

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 *PPO Plus Premier*, 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 to provide this information. If the dentist does not provide the required information, Delta Dental may not provide benefits for his or her services.