

# 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.

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## Using Your Dental Plan

### CHOOSE YOUR PC D

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 **DELTA CARE DENTIST** or our website at [www.deltadentalma.com](http://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

## 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.

### O - N O

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.

### T C

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.

### D C O E Y :

Replacement of lost, stolen, or broken orthodontic appliances; interceptive orthodontic treatment; 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;

3 3 D C 3  
3 3 . P 3 S  
C 3 .

## 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.

C 3 —not to exceed two cleanings in any 12 consecutive months.

D 3 P 3 D —up to one set per arch once every five years provided the existing set is no longer serviceable.

F B , C , 3 O C 3 R 3 —up to one restoration per tooth or missing tooth space in a five-year period provided the existing restoration is no longer serviceable.

D R —up to once per denture in any 36 consecutive months beginning six months after delivery of the denture.

P 3 T 3 (root planing/subgingival curettage)—up to once per quadrant in any 24 consecutive months.

B - 3 —based on need, up to one series of four films in any six-month period.

F - - 3 —based on need, up to one set every 24 consecutive months.

T 3 F T 3 —once every six months for members under age 19.

S 3 M 3 —(required due to the premature loss of teeth) for members under age 14 and not for the replacement of primary or permanent front teeth.

C M —this is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing.

F T 3 —this is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.

S 3 3 —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.
10. Congenital malformation.
11. Cysts and malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
14. Cases which in the professional judgment of the attending dentist determines a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
15. Dental services received from any dental office other than the assigned PCD's office, unless expressly authorized in writing from DeltaCare.
16. Prophylactic removal of impactions (asymptomatic nonpathological).
17. Specialist consultations for non-covered benefits.
18. Implant placement or removal, appliances placed on or services associated with implants.
19. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility with the DeltaCare program. Example: teeth prepared for crowns, root canals in progress, orthodontic treatment.
20. Occlusal guards for bruxism (grinding) or TMJ.
21. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly generally accepted method of treatment.
22. A service rendered by someone other than a licensed dentist or a hygienist that is employed by a licensed dentist.
23. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration, or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits.

24. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full-mouth reconstruction and are not a benefit of the DeltaCare program.
25. Tooth desensitization.
26. Interceptive orthodontic treatment.

## Member Rights and Responsibilities

As a Delta Dental member, you have the right to:

- ✓ Be provided with appropriate information about Delta Dental and its benefits, providers, and policies.
- ✓ Be informed of your diagnosis, the proposed treatment, and prognosis by your dentist.
- ✓ Give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment.
- ✓ Obtain a copy of your dental record, in accordance with the law.
- ✓ Be treated with respect and have your dignity and need for privacy recognized.

You have the responsibility to:

- ✓ Ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers.
- ✓ Provide dentists with the information necessary to care for you.
- ✓ Be familiar with Delta Dental benefits, policies, and procedures by reading Delta Dental's written materials or calling the DeltaCare Unit.

## Where to Get More Information

If you have any question, please contact our DeltaCare Unit at (800) 327-6277.

This information should be used only as a guide for your dental plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, please see the Subscriber Certificate. Copies of the Subscriber Certificate are available through your benefits administrator.

## Member Co-payments for DeltaCare

As a DeltaCare member, you are responsible for the following co-payments when you receive care from your PCD or a DeltaCare participating specialist. All co-payments should be made directly to the treating dentist. Your DeltaCare plan provides coverage for only those procedures listed in this co-payment schedule.

**I. D 3**      **S**      — Type I  
D0120

|       |  |                |
|-------|--|----------------|
| D2791 | Crown - base metal . . . . .   | \$ 313.00*     |
| D2792 | Crown - full cast noble metal . . . . .                                    | \$ 328.00*     |
| D2794 | Crown - titanium and titanium alloy <sup>††</sup> . . . . .                | \$ 435.00*     |
| D2910 | Recement inlay, only or partial coverage<br>restoration . . . . .          | \$ 10.00       |
| D2915 | Recement cast or prefabricated<br>post and core . . . . .                  | \$ 9.00 (TII)  |
| D2920 | Recement crown . . . . .   | \$ 10.00 (TII) |
| D2929 | Prefabricated porcelain/ceramic crown,<br>anterior primary tooth . . . . . | \$ 23.00 (TII) |
| D2930 | Crown - stainless steel: baby tooth . . . . .                              | \$ 26.00 (TII) |
| D2931 | TJ0.26 Tc -0.538 Tw /Span/ActualText                                       |                |

D331x(TII)Tj0.03 Tw -27.201 -1.2 Td(D29)10 (20)TJs)10 (s s)10 R020E00ot canal t2E0020ea ..... p-6(TII)D29207.82E04FEFF00092E00200r prima  
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**I . O 3 3 M 3 3 S — Type II**

|       |   |          |
|-------|---|----------|
| D7111 | Extraction, coronal remnants - baby tooth.....  | \$ 10.00 |
| D7140 | Extraction, erupted tooth or exposed root; includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary..... | \$ 14.00 |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated .....     | \$ 27.00 |
| D7220 | Impacted tooth removal: soft tissue.....  | \$ 32.00 |
| D7230 | Impacted tooth removal: partially bony ..   | \$ 42.00 |
| D7240 | Impacted tooth removal: completely bony   | \$ 50.00 |
| D7241 | Removal of impacted tooth: completely bony with unusual surgical complications  | \$ 60.00 |
| D7250 | Removal of residual tooth roots (cutting procedure) .....   | \$ 27.00 |
| D7286 | Biopsy of soft tissue .....   | \$ 35.00 |
| D7310 | Alveoloplasty in conjunction with extractions, four or more teeth or tooth spaces - per quadrant.....   | \$ 21.00 |
| D7311 | Bone recontouring (done with extractions) - one to three teeth or tooth spaces, per quadrant .....  | \$ 25.00 |
| D7320 | Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per quadrant.....   | \$ 30.00 |
| D7321 | Bone recontouring (done without extractions) - one to three teeth or tooth spaces, per quadrant.....  | \$ 23.00 |
| D7471 | Excision - bone tissue.....   | \$ 34.00 |
| D7472 | Removal of torus palatinus.....   | \$ 69.00 |
| D7473 | Removal of torus mandibularis .....   | \$ 55.00 |
| D7510 | Incision and drainage of abscess.....   | \$ 20.00 |
| D7960 | Frenulectomy (frenectomy or frenotomy)  | \$ 50.00 |

**I . O S — Type IV**

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

## NONDISCRIMINATION NOTICE

Delta Dental of Massachusetts complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Delta Dental of Massachusetts does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Delta Dental of Massachusetts:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, visit: <http://www.deltadentalma.com> or call the number on your member ID card.

If you believe that Delta Dental of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu  
Civil Rights Coordinator  
Compliance Department  
465 Medford Street  
Boston, MA 02129  
Fax: 617-886-1390  
Phone: 617-886-1683  
Email: [FairTreatment@greatdentalplans.com](mailto:FairTreatment@greatdentalplans.com)  
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

View our Notice of Privacy Practices at <http://bit.ly/ddmanpp>

Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc.  
Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered DSM Massachusetts Insurance Company, Inc.





Your Plan is Administered by:

**Delta Dental of Massachusetts**

(800) 327-6277

[www.deltadentalma.com](http://www.deltadentalma.com)

465 Medford Street  
Boston, MA 02129

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