DELTA DENTAL®

Highlights of Delta Dental of Illinois DeltaCare® Program Plan 305

Office Visit Copay $0

Code	Procedure	Patient Pays
Diagnostic		
D0120	**Periodic oral evaluation**	$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
D0210	**Intraoral radiographs** complete series (including bitewings)	$0
D0220	**Intraoral:** Periapical first film	$0
D0230	**Intraoral:** Periapical each additional film	$0
D0240	**Intraoral:** Occlusal film	$0
D0270	**Bitewing:** Single film	$0
D0272	**Bitewings:** 2 films	$0
D0274	**Bitewings:** 4 films	$0
D0277	**Vertical bitewings:** 7 to 8 films	$0
D0330	**Panoramic film**	$0
D0460	**Pulp vitality tests**	$0
D0470	**Diagnostic casts**	$0
Preventive		
D1110	**Prophylaxis (cleaning):** Adult	$0
D1120	**Prophylaxis (cleaning):** Child (to age 19)	$0
D1208	**Topical application of fluoride** excluding varnish	$0
D1330	**Oral hygiene instructions**	$0
D1351	**Sealant** (per tooth, to age 15)	$14.00
D1510	**Space maintainer:** Fixed, unilateral	$79.00
D1516	**Space maintainer:** Fixed, bilateral, maxillary	$79.00
D1517	**Space maintainer:** Fixed, bilateral, mandibular	$79.00
D1520	**Space maintainer:** Removable, unilateral	$79.00
D1526	**Space maintainer:** Removable, bilateral, maxillary	$79.00
D1527	**Space maintainer:** Removable, bilateral, mandibular	$79.00
D1551	**Re-cement or re-bond bilateral space maintainer:** Maxillary	$11.00
D1552	**Re-cement or re-bond bilateral space maintainer:** Mandibular	$11.00
Diagnostic and preventive services may be subject to frequency limitations. See your booklet for details.		
Restorative		
D2140	**Amalgam:** Single surface (primary or permanent)	$24.00
D2150	**Amalgam:** 2 surfaces (primary or permanent)	$32.00
D2160	**Amalgam:** 3 surfaces (primary or permanent)	$46.00
D2161	**Amalgam:** 4 or more surfaces (primary or permanent)	$54.00
D2330	**Resin-based composite:** Single surface, anterior	$32.00
D2331	**Resin-based composite:** 2 surfaces, anterior	$37.00
D2332	**Resin-based composite:** 3 surfaces, anterior	$45.00

Code	Procedure	Patient Pays
Restorative (cont.)		
D2335	**Resin-based composite:** 4 or more surfaces or involving incisal angle (anterior)	$55.00
D2390	**Resin-based composite:** Crown, anterior	$142.00
D2391	**Resin-based composite:** Single surface, posterior	$24.00†
D2392	**Resin-based composite:** 2 surfaces, posterior	$32.00†
D2393	**Resin-based composite:** 3 surfaces, posterior	$46.00†
D2394	**Resin-based composite:** 4 or more surfaces, posterior	$54.00†
D2940	**Sedative filling**	$45.00
Crowns/Bridges		
D2710	**Crown:** Resin, indirect	$313.00
D2720	**Crown:** Resin with high noble metal*	$394.00
D2721	**Crown:** Resin with predominantly base metal	$394.00
D2722	**Crown:** Resin with noble metal	$394.00
D2740	**Crown:** Porcelain/ceramic substrate*	$394.00
D2750	**Crown:** Porcelain fused to high noble*	$394.00
D2751	**Crown:** Porcelain fused to predominantly base metal	$394.00
D2752	**Crown:** Porcelain fused to noble metal	$394.00
D2780	**Crown:** 3/4 cast high noble metal*	$394.00
D2781	**Crown:** 3/4 cast predominantly base metal	$394.00
D2782	**Crown:** 3/4 cast noble metal	$394.00
D2783	**Crown:** 3/4 porcelain/ceramic	$394.00
D2790	**Crown:** Full cast high noble metal*	$394.00
D2791	**Crown:** Full cast predominantly base metal	$394.00
D2792	**Crown:** Full cast noble metal	$394.00
D2794	**Crown:** Titanium	$394.00
D2910	**Recement inlay, onlay or partial coverage restoration**	$38.00
D2915	**Recement cast or prefabricated post and core**	$38.00
D2920	**Recement crown**	$38.00
D2930	**Prefabricated stainless steel crown:** Primary	$130.00
D2931	**Prefabricated stainless steel crown:** Permanent tooth	$130.00
D2932	**Prefabricated resin crown** (anterior teeth only)	$130.00
D2933	**Prefabricated stainless steel crown with resin window**	$130.00†
D2950	**Core buildup** (including any pins)	$111.00
D2951	**Pin retention** (per tooth, in addition to restoration)	$44.00
D2952	**Cast post and core in addition to crown***	$132.00
D2953	**Each additional cast post** (same tooth)*	$132.00
D2954	**Prefabricated post and core in addition to crown**	$112.00
D2957	**Each additional prefabricated post** (same tooth)	$112.00
D2971	**Additional procedures to construct new crown under existing partial denture framework**	$107.00
D6210	**Pontic:** Cast high noble metal*	$394.00
D6211	**Pontic:** Cast predominantly base metal	$394.00
D6240	**Pontic:** Porcelain fused to high noble metal*	$394.00

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Crowns/Bridges (cont.)		
D6241	**Pontic:** Porcelain fused to predominantly base metal	$394.00
D6242	**Pontic:** Porcelain fused to noble metal	$394.00
D6250	**Pontic:** Resin with high noble metal*	$394.00
D6251	**Pontic:** Resin with predominantly base metal	$394.00
D6252	**Pontic:** Resin with noble metal	$394.00
D6750	**Crown:** Porcelain fused to high noble metal*	$394.00
D6790	**Crown:** Full cast high noble metal*	$394.00
D6930	**Recement fixed partial denture**	$66.00
Endodontics		
D3110	**Pulp cap:** Direct (excluding final restoration)	$22.00
D3120	**Pulp cap:** Indirect (excluding final restoration)	$12.00
D3220	**Therapeutic pulpotomy** (excluding final restoration) removal of pulp coronal to dentinocemental junction and application of medicament	$58.00
D3221	**Pulpal debridement** (primary and permanent teeth)	$58.00
D3230	**Pulpal therapy** (resorbable filling): Anterior, primary tooth (excluding final restoration)	$40.00
D3240	**Pulpal therapy** (resorbable filling): Posterior, primary tooth (excluding final restoration)	$40.00
D3310	**[Root canal]:** Anterior (excluding final restoration)	$102.00
D3320	**[Root canal]:** Bicuspid (excluding final restoration)	$125.00
D3330	**[Root canal]:** Molar (excluding final restoration)	$289.00
D3346	**Retreatment of previous root canal therapy:** Anterior	$305.00
D3347	**Retreatment of previous root canal therapy:** Bicuspid	$383.00
D3348	**Retreatment of previous root canal therapy:** Molar	$488.00
D3410	**Apicoectomy/periradicular surgery:** Anterior	$273.00
D3421	**Apicoectomy/periradicular surgery:** Bicuspid (first root)	$273.00
D3425	**Apicoectomy/periradicular surgery:** Molar (first root)	$273.00
D3426	**Apicoectomy/periradicular surgery** (each additional root)	$92.00
D3430	**Retrograde filling** (per root)	$68.00
Periodontics		
D4210	**Gingivectomy or gingivoplasty:** 4 or more contiguous teeth or bounded teeth spaces, per quadrant	$255.00
D4211	**Gingivectomy or gingivoplasty:** 1 to 3 contiguous teeth, per quadrant	$255.00
D4260	**Osseous surgery** (including flap entry and closure): 4 or more contiguous teeth or bounded teeth spaces, per quadrant	$387.00
D4261	**Osseous surgery** (including flap entry and closure): 1 to 3 contiguous teeth, per quadrant	$368.00
D4341	**Periodontal scaling/root planing:** 4 or more, per quadrant	$47.00
D4342	**Periodontal scaling/root planing:** 1 to 3 teeth, per quadrant	$45.00
D4355	**Full mouth debridement to enable comprehensive evaluation and diagnosis**	$31.00

Code	Procedure	Patient Pays
Prosthodontics — Removable*		
D5110	**Complete denture:** Maxillary**	$603.00
D5211	**Maxillary partial denture:** Resin base (including any conventional clasps, rests and teeth)**	$603.00
D5213	**Maxillary partial denture:** Cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	$793.00
D5225	**Maxillary partial denture:** Flexible base (including any clasps, rests and teeth)	$793.00†
D5226	**Mandibular partial denture:** Flexible base (including any clasps, rests and teeth)	$793.00†
D5410	**Adjust complete denture:** Maxillary	$20.00
D5421	**Adjust partial denture:** Maxillary	$20.00
Repairs to Prosthetics		
D5511	**Repair broken complete denture base:** Mandibular	$92.00
D5512	**Repair broken complete denture base:** Maxillary	$92.00
D5520	**Replace missing or broken teeth:** Complete denture (each tooth)	$67.00
D5611	**Repair resin partial denture base:** Mandibular	$93.00
D5612	**Repair resin partial denture base:** Maxillary	$93.00
D5630	**Repair or replace broken clasp**	$101.00
D5640	**Replace broken teeth** (per tooth)	$75.00
D5650	**Add tooth to existing partial denture**	$87.00
D5660	**Add clasp to existing partial denture**	$115.00
D5710	**Rebase complete maxillary denture**	$218.00
D5720	**Rebase maxillary partial denture**	$218.00
D5730	**Reline complete maxillary denture** (chairside)	$222.00
D5740	**Reline maxillary partial denture** (chairside)	$222.00
D5750	**Reline complete maxillary denture** (laboratory)	$233.00
D5760	**Reline maxillary partial denture** (laboratory)	$233.00
Oral Surgery		
D7111	**Extraction, coronal remnants:** Deciduous tooth	$30.00
D7140	**Extraction, erupted tooth or exposed root** (elevation and/or forceps removal); includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	$30.00
D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, minor smoothing of socket bone closure**	$68.00
D7220	**Removal of impacted tooth:** Soft tissue	$89.00
D7230	**Removal of impacted tooth**: Partially bony	$126.00
D7240	**Removal of impacted tooth:** Completely bony	$152.00
D7241	**Removal of impacted tooth:** Completely bony, with unusual surgical complications	$152.00
D7250	**Surgical removal of residual tooth roots** (cutting procedure)	$68.00
D7310	**Alveoloplasty in conjunction with extractions** (per quadrant)	$86.00
D7320	**Alveoloplasty not in conjunction with extractions** (per quadrant)	$129.00
D7321	**Alveoloplasty not in conjunction with extractions:** 1 to 3 teeth or tooth spaces, per quadrant	$129.00
D7960	**Frenulectomy (frenectomy or frenotomy):** Separate procedure	$179.00

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Other (Adjunctive) Services		
D9110	**Palliative (emergency) treatment of dental pain:** Minor procedure	$25.00
D9215	**Local anesthesia**	$0
D9310	**Consultation** (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$25.00
D9450	**Case presentation, detailed and extensive treatment**	$0

Code	Procedure	Patient Pays
Orthodontics		
D8080	**Comprehensive orthodontic treatment of the adolescent dentition****	$2,235.00
D8090	**Comprehensive orthodontic treatment of the adult dentition****	$2,760.00
D8660	**Pre-orthodontic treatment visit** (applied to treatment fee if patient proceeds with treatment)	$30.00

"Patient Pays" applies to those procedures provided by the member's primary care dentist or approved specialty dentist.

* All charges for crown and bridge are per unit. There will be an additional patient charge for the actual cost for gold/high noble metal including any upgrade in materials such as porcelain.

** Includes any adjustments for 6 months.

*** Plan benefits are for active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 2 years. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to an office visit fee, not to exceed $75 per month. Additional charges may apply for records, post records and retention.

† These procedures are specialized and considered a limited benefit. For these procedures, the patient pays the listed copayment plus the difference between the dentist's usual fees for the applicable covered benefit and the dentist's usual fees for the specialized treatment. For example, for a maxillary partial denture with a flexible base (D5225), the patient would pay the copay plus the difference between the dentist's usual fee for this procedure and the usual fee for the covered benefit, a maxillary partial denture resin base (D5213).

This is a brief description of your DeltaCare dental plan. Please consult your Certificate of Coverage for the complete Schedule of Dental Benefits, as well as the terms and conditions of coverage and any limitations and exclusions. Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment Delta Dental is required to make.

Your DeltaCare dental HMO plan is designed to make dental care affordable and convenient for you and your family. Under this plan, you pay only the patient copayment amount listed in the Schedule of Dental Benefits. There are no deductibles, no annual benefit maximums and no claim forms to complete.

How DeltaCare Works
The panel dentist you select when you enroll in this DeltaCare plan will provide all routine dental care for you and your family. If specialty care is required, your panel dentist will refer you to a specialist who is also a member of the DeltaCare network. You will need a written referral in order to visit a specialist. You may select a new panel dentist at any time; however, you must notify the DeltaCare administrator. Change requests received prior to the 20th of the month become effective on the first day of the following month.

Emergency Treatment
If you require emergency treatment and you are more than 35 miles from your panel dentist's office or you are unable to schedule an appointment with your panel dentist within 24 hours, you may go to any licensed dentist. Upon submission of the dentist's statement and your proof of payment, Delta Dental will reimburse you up to $50 (less any copayment amount) in any year for the cost of emergency treatment.

About the Procedures
The procedures listed below are performed as needed and deemed necessary by the DeltaCare network dentist and are subject to the limitations and exclusions of the program. Please refer to those sections for further clarification of benefits. These procedures are specialized and considered a limited benefit. For these procedures, the patient pays the listed copayment plus the difference between the dentist's usual fees for the applicable covered benefit and the dentist's usual fees for the specialized treatment. For example, for a maxillary partial denture with a flexible base (D5225), the patient would pay the copay plus the difference between the dentist's usual fee for this procedure and the usual fee for the covered benefit, a maxillary partial denture resin base (D5213).

Missed appointments without 24 hour notice are subject to a $10 charge per 15 minutes of appointment time.

Any procedure not listed is available on a fee-for-service basis.

If you have questions, contact Delta Dental of Illinois at 800-942-3772.

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Exclusions of Benefits

1. General anesthesia, IV sedation and nitrous oxide and the services of a special anesthesiologist.
2. Dental procedures performed for purely cosmetic purposes.
3. Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.
4. Treatment required by reason of war, declared or undeclared.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities.
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 or dental expenses incurred in connection with any dental procedure started prior to Enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment.
9. Any service that is not specifically listed as a covered expense.
10. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function. This exclusion does not apply to newly born children.
11. Cysts and malignancies.
12. Prescription drugs.
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 in which, in the professional judgment of the attending Dentist, 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 dental office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Treatment."
16. Prophylactic removal of impactions (asymptomatic, nonpathological).
17. "Consultations" for noncovered benefits.
18. Implant placement or removal, appliances placed on or services associated with implants including but not limited to prophylaxis and periodontal treatment.
19. Placement of a crown where there is sufficient tooth structure to retain a standard filling.
20. Porcelain crowns and porcelain fused to metal crowns on all molars.
21. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
22. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The patient must pay the difference in cost between the Dentist's usual fees for the covered benefit and optional treatment, plus any coinsurance for the covered benefit.
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).
24. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction).
25. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants and appliances associated therewith), personalization and characterization.
26. Soft tissue management (irrigation, infusion, special toothbrush).
27. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.
28. Restorative work caused by orthodontic treatment.
29. Extractions solely for the purpose of orthodontics.

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
2. Retreatment of orthodontic cases.
3. Changes in treatment necessitated by accident of any kind and/or lack of patient cooperation.
4. Surgical procedures incidental to orthodontic treatment.
5. Myofunctional therapy.
6. Surgical procedures related to cleft palate, micrognathia or macrognathia.
7. Treatment related to temporomandibular joint disturbances.
8. Supplemental appliances not routinely utilized in typical Phase II orthodontics.
9. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month.
10. Restorative work caused by orthodontic treatment.
11. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion.
12. Extractions solely for the purpose of orthodontics.
13. Treatment in progress at inception of eligibility.
14. Transfer after banding has been initiated.
15. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

*Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.