DETROIT MEDICAL CENTER
Dental Program: DMC
Schedule of Benefits and Co-payments

(313) 972-1400

DENCAP dental plans

CODE	DIAGNOSTIC AND PREVENTIVE	MEMBER PAYS
9999	Office Visit (regular hours)	$5.00
0120	Periodic Oral Evaluation	No Charge
0140	Limited Oral Evaluation - Problem Focused	No Charge
0150	Comprehensive Oral Evaluation	No Charge
1110	Prophylaxis/Routine Cleaning - Adult	No Charge
1120	Prophylaxis/Routine Cleaning - Child	No Charge
1330	Oral Hygiene Instructions	No Charge
9215	Local Anesthesia	No Charge
1203	Flouride Treatment - Child	No Charge
1351	Sealant - per tooth	$10.00
	X-RAY COVERAGE	
0210	Intraoral - Complete Series	No Charge
0220	Periapical - First Film	No Charge
0230	Periapical - Each Additional Film	No Charge
0240	Intraoral oclusal film	No Charge
0270/2/3/4	Bitewing(s)	No Charge
0330	Panoramic Film	No Charge
	ADJUNCTIVE SERVICES ++	
9110	Palliative (Emergency) Treatment (minor-reg. hrs.)	$20.00
9999	Office Visit (reg. hrs. - unscheduled)	$20.00
2910	Recement inlay, onlay or partial cov. Rest	$30.00
2920	Recement Crown	$20.00
6930	Recement Bridge (fixed partial denture)	$40.00
2940	Sedative Filling	No Charge
2950	Core Buildup (Including Any Pins)	$90.00
6973	Core Buildup for Bridge/Ret. (incl. any pins)	$55.00
0470	Diagnostic casts (each)	$15.00
	RESTORATIVE (fillings)	
2140	Amalgam Filling - One Surface	$10.00
2150	Amalgam Filling - Two Surfaces	$20.00
2160	Amalgam Filling-Three Surfaces	$30.00
2161	Amalgam Filling-Four or More Surfaces	$45.00
2330	Composite Filling - One Surface (Anterior)	$20.00
2331	Composite Filling - Two Surfaces (Anterior)	$30.00
2332	Composite Filling - Three Surfaces (Anterior)	$40.00
2335	Comp Filling-Four or More Surfaces/IA (Anterior)	$55.00
2391	Composite Filling - One Surface (Posterior)	$30.00
2392	Composite Filling - Two Surfaces (Posterior)	$40.00
2393	Composite Filling - Three Surfaces (Posterior)	$50.00
2394	Comp Filling-Four or More Surfaces/IA (Posterior)	$60.00
	SPACE MAINTAINERS	
1510	Unilateral - fixed	$80.00
1515	Bilateral - fixed	$110.00
1525	Bilateral - removable	$120.00
1550	Re-cementation of Space Maintainer	$15.00
9940	Occlusal guard (night guard)	$225.00

CODE	CROWN AND BRIDGE ++	MEMBER PAYS
2791	Full cast predominantly base metal (per unit)	$230.00
2751	Crown - Porcelain Fused to Pred. Base Metal	$230.00
2752	Porcelain fused to pred. base metal (per unit)	$240.00
2781	3/4 cast predominantly bvase metal (per unit)	$230.00
27,67XX/6212	Cast noble metal (per unit)	$240.00
2930	Prefabricated stainless steel crown	$90.00
2931	Prefab. Stainless Steel Crown (Permanent)	$90.00
6211/6791	Cast predominantly base metal (per unit)	$225.00
6241/6751	Porcelain fused- pred. base metal (per unit)	$230.00
6242/6752	Porcelain fused to noble metal (per unit)	$230.00
2390	Resin-based composite crown, anterior	$135.00
2952/6970	Cast post and core	$90.00/$70.00
2954/6972	Prefabricated post and core	$90.00/$65.00
	ENDODONTICS (interior of tooth)	
3310	Anterior Root Canal Therapy	$150.00
3320	Bicuspid Root Canal Therapy	$195.00
3330	Molar Root Canal Therapy	$270.00
3410/21/25	Apicoectomy- separate procedure (per root)	$240.00
3426	Apicoectomy- each additional root	$60.00
3430	Retrograde filling (per root)	$65.00
3220	Therapeutic Pulpotomy	$45.00
3110/20	Pulp Cap (direct/indirect)	$20.00
	PERIODONTICS (gums and supporting tissue)	
0180	Comprehensive Periodontal Evaluation	No Charge
4355	Full Mouth Debridement	$50.00
4910	Periodontal Maintenance	$30.00
4341	Perio Scaling/Root Planing (>=4)	$70.00
4342	Perio Scaling/Root Planing (<=3)	$40.00
4210	Gingivectomy/Gingivoplasty (>=4 or bounded)	$210.00
4211	Gingivectomy/Gingivoplasty (<=3 or bounded)	$180.00
4240	Gingival Flap Procedure (>=4 or bounded)	$270.00
4241	Gingival Flap Procedure (<=3 or bounded)	$255.00
4260	Osseous Surgery (>=4 or bounded)	$330.00
4261	Osseous Surgery (<=3 or bounded)	$265.00
	PROSTHODONTICS (removables) ++	
5110	Complete Upper Denture	$350.00
5120	Complete Lower Denture	$350.00
5130	Immediate Upper Denture	$395.00
5140	Immediate Lower Denture	$395.00
5213/14	Partial U/L Denture- cast metal framework with resin bases (inc. regular clasps, rests & teeth)	$365.00
5820/21	Partial Denture (interim)	$275.00
5850/51	Tissue Conditioning (per arch)	$40.00
54XX+	Denture/Partial adjustment (existing)	$20.00

XX = 2782 2782, 2792, 6212, 6782, 6792
\+ 5410, 5411, 5421, 5422
++ Additional charges may apply for lab work and/or for gold/precious metals
+++ 5730, 5731, 5740, 5741
++++ 5750, 5751, 5760, 5761

CODE	REPAIR OF PROSTHESIS ++	MEMBER PAYS
5510	Repair denture/partial (resin base)	$60.00
5520	Replace missing/broken tooth on denture/partial	$60.00
5630	Repair or replace broken clasp	$85.00
5650	Add tooth to existing partial denture	$50.00
5660	Add clasp to existing partial denture	$90.00
57XX+++	Reline complete or partial denture (office)	$100.00
57XX++++	Reline complete or partial denture (lab)	$125.00
	ORAL SURGERY	
7140	Simple extraction of single tooth	No Charge
7210	Surgical removal of an erupted tooth	$37.00
7220	Removal impacted tooth- soft tissue	$40.00
7230	Removal impacted tooth- partially bony	$55.00
7240	Removal impacted tooth- completely bony	$65.00
7241	Removal Impacted Tooth- completely bony (diff.)	$80.00
7250	Surgical removal of residual tooth roots	$55.00
7310	Alveoloplasty in conj. w/exts. (4+ teeth or spaces)	$90.00
7311	Alveoloplasty in conj. w/exts. (1-3 teeth or spaces)	$70.00
7320	Alveoloplasty not in conj. w/exts. (4+ teeth or spaces)	$90.00
7321	Alveoloplasty not in conj. w/exts. (1-3 teeth or spaces)	$70.00
7471/2/3	Removal of exostosis (per site)	$85.00
7510	Incision & drainage of abscess (intraoral soft tiss.)	$20.00
9241	IV anesthesia- first 30 min. (3+ surg. extractions)	40%
9242	IV anesthesia- ea. addt'l. 15 min. (3+ surg. extractions)	40%
9430	Office visit for observation (no other treatment)	$10.00
9930	Treatment of complications (post-surg. minor-per visit)	$10.00

ANNUAL MAXIMUM for Primary Care Dentistry **UNLIMITED**

ORTHODONTICS
(Approved referral from DENCAP required for all Orthodontic Care)
DENCAP covers up to $1500 of the fee at authorized locations for members under age 19. Over age 19, DENCAP covers up to $500 of the fee.

SPECIALTY CARE
(Approved referral from DENCAP required for all Specialty Care)
Members referred to another DENCAP Dentist for Specialty Care are responsible for 50% of the fee for covered treatment, including evaluations and x-rays (see NOTE).

ANNUAL MAXIMUM for Specialty Care **$1,000.00**

TEETH WHITENING
DENCAP Members may receive Zoom!® in-office teeth whitening at DENCAP participating offices for reduced rates. Contact DENCAP for a participating location.

NOTE: Having x-rays sent from the Primary Care Dentist to the Specialist may be cost effective.

Benefits and Co-payments subject to change. EFFECTIVE 12/2008