(313) 972-1400

SENIOR VALUE
DENTAL PLAN: S-5
Schedule of Benefits and Co-payments

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	Fluoride Treatment (up to age 19)	No Charge
1204	Adult Fluoride Treatment (over age 19)	$15.00
1351	Sealant - per tooth	$9.00
	X-RAY COVERAGE	
0210	Intraoral - Complete Series	No Charge
0220	Periapical - First Film	No Charge
0230	Periapical - Each Additional Film	No Charge
0240	Intraoral - Occlusal Film	No Charge
0270	Bitewing - Single Film	No Charge
0272	Bitewings - Two Films	No Charge
0273	Bitewings - Three Films	No Charge
0274	Bitewings - Four Films	No Charge
0330	Panoramic Film	No Charge
	ADJUNCTIVE SERVICES ++	
0470	Diagnostic casts (each)	$20.00
9110	Palliative (Emergency) Treatment (minor-reg. hrs.)	$20.00
9430	Office Visit for Observation (no other treatment)	$5.00
9999	Office visit-unscheduled appt. (reg. hours)	$20.00
2910	Recement Inlay, Onlay or Partial Cov. Rest.	$10.00
2920	Recement Crown	$10.00
6930	Recement fixed partial denture	$20.00
9310	Consultation (2nd opinion)	$48.00
9440	Office Visit (after reg. scheduled hours)	$55.00
9930	Treatment of Complications (post-surg. minor-per visit)	$15.00
2940	Sedative Filling	$15.00
2950	Core Buildup (Including Any Pins)	$85.00
6973	Core Buildup for Bridge/Ret. (incl. any pins)	$85.00
	RESTORATIVE (fillings)	
2140	Amalgam Filling - One Surface	$15.00
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)	$35.00
2332	Composite Filling - Three Surfaces (Anterior)	$50.00
2335	Comp Filling-Four or More Surfaces/IA (Anterior)	$65.00
2391	Composite Filling - One Surface (Posterior)	$35.00
2392	Composite Filling - Two Surfaces (Posterior)	$50.00
2393	Composite Filling-Three Surfaces (Posterior)	$65.00
2394	Composite Filling-Four Surfaces (Posterior)	$75.00
	SPACE MAINTAINERS	
1510	Space Maintainer - Fixed - Unilateral	$100.00
1515	Space Maintainer - Fixed - Bilateral	$130.00
1520	Space Maintainer - Removable - Unilateral	$130.00
1525	Space Maintainer - Removable - Bilateral	$145.00
1550	Re-cementation of Space Maintainer	$15.00
9940	Occlusal guard (night guard)	$200.00

CODE	CROWN AND BRIDGE++	MEMBER PAYS
2791	Full cast predominantly base metal (per unit)	$325.00
2751	Crown - Porcelain Fused to Pred. Base Metal	$325.00
2752	Porcelain Fused to Noble Metal (per unit)	$340.00
2781/6781	3/4 Cast Pred. Base Metal (per unit)	$295.00
27,67XX/6212	Cast noble metal (per unit)	$340.00
2930/1/2/3	Prefabricated Stainless Steel-Resin Crown	$110.00
6211/6791	Cast predominantly base metal (per unit)	$320.00
6241/6751	Porcelain fused- pred. base metal (per unit)	$350.00
6242/6752	Porcelain fused to noble metal (per unit)	$365.00
6781	Crown- 3/4 cast pred. base metal (per unit)	$295.00
2390	Resin-based Composite Crown, anterior	$210.00
2799	Provisional Crown	$100.00
2952/6970	Cast Post and Core	$120.00
2954/6972	Prefabricated Post and Core	$110.00
	ENDODONTICS (interior of tooth)	
3310	Anterior Root Canal Therapy	$250.00
3320	Bicuspid Root Canal Therapy	$285.00
3330	Molar Root Canal Therapy	$350.00
3410	Apicoectomy/Periradicular surg.- anterior	$275.00
3421	Apicoectomy/Per. Surgery-bicuspid (first root)	$350.00
3425	Apicoectomy/Per. surg.- molar (first root)	$400.00
3426	Apicoectomy/Per. Surgery (ea. additional root)	$150.00
3430	Retrograde Filling (per root)	$50.00
3220	Therapeutic Pulpotomy	$40.00
3110/20	Pulp Cap (direct/indirect)	$15.00
	PERIODONTICS (gums and supporting tissue)	
0180	Comprehensive Periodontal Evaluation	$25.00
4355	Full Mouth Debridement	$30.00
4910	Periodontal Maintenance	$35.00
4341	Perio Scaling/Root Planing (>=4)	$50.00
4342	Perio Scaling/Root Planing (<=3)	$45.00
4381	Site Specific Therapy (per tooth)	$50.00
4210	Gingivectomy/Gingivoplasty (>=4)	$235.00
4211	Gingivectomy/Gingivoplasty (<=3)	$195.00
4240	Gingival Flap Procedure (>=4 or bounded)	$290.00
4241	Gingival Flap Procedure (<=3 or bounded)	$260.00
4260	Osseous Surgery (>=4 or bounded)	$385.00
4261	Osseous Surgery (<=3 or bounded)	$320.00
9951	Occlusal Adjustment (limited)	$30.00
	PROSTHODONTICS (removables) ++	
5110/20	Complete Denture (upper/lower)	$350.00
5130/40	Immediate Denture (upper/lower)	$375.00
5211/12	Partial Denture (upper/lower - resin base)	$310.00
5213/14	Partial Denture (u/l cast frame, resin base)	$450.00
5850/51	Tissue Conditioning (per arch)	$40.00
54XX+	Denture/Partial Adjustment (existing)	$15.00

XX = 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

DENCAP Members are responsible for 100% of any Dental Prescriptions.

CODE	REPAIR OF PROSTHESIS++	MEMBER PAYS
5510/5610	Repair denture/partial (resin base)	$60.00
5520/5640	Replace missing/broken tooth on denture/partial	$35.00
5630	Repair or replace broken clasp	$105.00
5650	Add tooth to existing partial denture	$50.00
5660	Add clasp to existing partial denture	$120.00
57XX+++	Reline complete or partial denture (office)	$110.00
57XX++++	Reline complete or partial denture (lab)	$175.00
	ORAL SURGERY	
7140	Simple extraction of single tooth	$25.00
7210	Surgical removal of an erupted tooth	$50.00
7220	Removal impacted tooth- soft tissue	$70.00
7230	Removal impacted tooth- partially bony	$110.00
7240	Removal impacted tooth- completely bony	$170.00
7241	Removal Impacted Tooth- completely bony (diff.)	$225.00
7250	Surgical removal of residual tooth roots	$95.00
7280	Surgical access of an unerupted tooth	$200.00
7310	Alveoloplasty in conj. w/exts. (4+ teeth or spaces)	$40.00
7311	Alveoloplasty in conj. w/exts. (1-3 teeth or spaces)	$35.00
7320	Alveoloplasty not in conj. w/exts. (4+ teeth or spaces)	$75.00
7321	Alveoloplasty not in conj. w/exts. (1-3 teeth or spaces)	$70.00
7471/2/3	Removal of exostosis (per site)	$140.00
7510	Incision & drainage of abscess (intraoral soft tiss.)	$35.00
9241/42	IV analgesia - first 30/+15 min (3+ surg. extractions)	50%

ANNUAL MAXIMUM for Primary Care Dentistry $2,500.00

ORTHODONTIC BENEFITS

(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. No extractions by Specialists for Orthodontics.

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**).
There is a six month waiting period for new enrollees.

ANNUAL MAXIMUM for Specialty Care……$500

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 10/2008