dencap DENTAL PLANS

Wayne County Premier
SCHEDULE OF BENEFITS AND FIXED CO-PAYS

313-972-1400
888-98-TEETH
dencap.com

ANNUAL MAXIMUMS (for each member)	$4,500
Primary Care	$3,500
Specialty Care	$1,000

code	description	co-pay
	DIAGNOSTIC (Class I - Preventive)	
0120	Periodic Oral Evaluation	$0
0140	Limited Oral Evaluation - problem focused	$0
0150	Comprehensive Oral Evaluation	$0
0431	Prediagnostic Test	$0
1110	Prophylaxis/Routine Cleaning - adult	$0
1120	Prophylaxis/Routine Cleaning - child	$0
9995	Teledentistry - synchronous; billed with exam	$30
9996	Teledentistry - asynchronous; billed with exam	$30
	PREVENTIVE (Class I - Preventive)	
1206	Topical Application of Fluoride - varnish	$0
1208	Topical Application of Fluoride - excluding varnish	$0
1330	Oral Hygiene Instructions	$0
	RADIOGRAPHS (Class I - Preventive)	
0210	Intraoral - complete series	$0
0220	Periapical - first radiographic image	$0
0230	Periapical - each additional radiographic image	$0
0240	Intraoral - occlusal radiographic image	$0
0270	Bitewing - single radiographic image	$0
0272	Bitewings - two radiographic images	$0
0273	Bitewings - three radiographic images	$0
0274	Bitewings - four radiographic images	$0
0330	Panoramic Radiographic Image	$0
	ADJUNCTIVE SERVICES (Class II - Basic)	
0470	Diagnostic Casts (each)	$28
1351	Sealant - per tooth	$0
1353	Repair to Sealant - per tooth	$0
1510	Fixed Space Maintainer - unilateral per quadrant	$72
1516	Fixed Space Maintainer - bilateral, upper	$105
1517	Fixed Space Maintainer - bilateral, lower	$105
1520	Removable Space Maintainer - unilateral per quadrant	$95
1526	Removable Space Maintainer - bilateral, upper	$107
1527	Removable Space Maintainer - bilateral, lower	$107
1551	Re-cement or Re-bond Bilateral Space Maintainer - upper	$25
1552	Re-cement or Re-bond Bilateral Space Maintainer - lower	$25
1553	Re-cement or Re-bond Unilateral Space Maintainer - per quadrant	$25
2940	Protective Restoration (sedative filling)	$20
9110	Palliative (Emergency) Treatment - minor procedure	$7
9215	Local Anesthesia	$16
9230	Inhalation of Nitrous Oxide	$25
9239	IV Moderate (Conscious) Sedation/Analgesia - first 15 minute increment	50%
9243	IV Moderate (Conscious) Sedation/Analgesia - each subsequent 15 minute increment	50%
9310	Consultation (second opinion)	$62
9910	Application of Desensitizing Medicament	$26
9930	Treatment of Complications, Post-Surgical - unusual	$19
9944	Hard Occlusal Guard (night guard) - full arch	$200
9945	Soft Occlusal Guard (night guard) - full arch	$200
9946	Hard Occlusal Guard (night guard) - partial arch	$200
9951	Occlusal Adjustment - limited	$54

SPECIALTY CARE

- Endodontics - Oral Surgery - Periodontics - Pedodontics -

Approved referral from DENCAP is required

DENCAP pays 50% of our specialist's fees up to the Specialty Care Annual Maximum for covered services; you are responsible for the remaining balance.

OFFICE VISIT CO-PAY		
9430	Office Visit (for observation)	$15
9999	Office Visit (regular hours)	$15

code	description	co-pay
	RESTORATIVE (Class II - Basic)	
2140	Amalgam Filling - one surface	$30
2150	Amalgam Filling - two surfaces	$40
2160	Amalgam Filling - three surfaces	$48
2161	Amalgam Filling - four or more surfaces	$60
2330	Composite Filling - one surface, anterior	$40
2331	Composite Filling - two surfaces, anterior	$50
2332	Composite Filling - three surfaces, anterior	$53
2335	Composite Filling - four surfaces, anterior/incisal angle	$85
2391	Composite Filling - one surface, posterior	$50
2392	Composite Filling - two surfaces, posterior	$65
2393	Composite Filling - three surfaces, posterior	$80
2394	Composite Filling - four surfaces, posterior	$90
	PROSTHETIC REPAIR (Class II - Basic)	
2910	Re-cement Partial Coverage Restoration	$25
2915	Re-cement Indirectly Fabricated or Prefab Post and Core	$25
2920	Re-cement or Re-bond crown	$25
5410	Adjustment to Complete Denture - upper	$25
5411	Adjustment to Complete Denture - lower	$25
5421	Adjustment to Partial Denture - upper	$25
5422	Adjustment to Partial Denture - lower	$25
5511	Repair to Broken Complete Denture Base - lower	$50
5512	Repair to Broken Complete Denture Base - upper	$49
5520	Replace Missing/Broken Teeth - denture, per tooth	$35
5611	Repair Resin Partial Denture Base - lower	$48
5612	Repair Resin Partial Denture Base - upper	$49
5621	Repair Cast Partial Framework - lower	$90
5622	Repair Cast Partial Framework - upper	$90
5630	Repair or Replace Broken Clasp - per tooth	$90
5640	Replace Missing/Broken Teeth - partial, per tooth	$32
5650	Add Tooth to Existing Partial Denture	$53
5660	Add Clasp to Existing Partial Denture - per tooth	$66
5730	Reline Complete Upper Denture - in office	$90
5731	Reline Complete Lower Denture - in office	$90
5740	Reline Partial Upper Denture - in office	$91
5741	Reline Partial Lower Denture - in office	$92
5750	Reline Complete Upper Denture - lab	$136
5751	Reline Complete Lower Denture - lab	$136
5760	Reline Partial Upper Denture - lab	$135
5761	Reline Partial Lower Denture - lab	$135
6930	Re-cement or Re-bond Fixed Partial Denture	$27
	ENDODONTICS (Class III - Major)	
3110	Pulp Cap - direct	$20
3120	Pulp Cap - indirect	$20
3220	Therapeutic Pulpotomy	$65
3310	Root Canal Therapy - anterior tooth	$260
3320	Root Canal Therapy - premolar tooth	$290
3330	Root Canal Therapy - molar tooth	$350
3346	Retreat of Previous Root Canal Therapy - anterior tooth	$280
3347	Retreat of Previous Root Canal Therapy - premolar tooth	$320
3348	Retreat of Previous Root Canal Therapy - molar tooth	$380
3410	Apicoectomy Surgery - anterior tooth	$150
3421	Apicoectomy Surgery - premolar tooth, first root	$149
3425	Apicoectomy Surgery - molar tooth, first root	$150
3426	Apicoectomy Surgery - each additional root	$80
3430	Retrograde Filling - per root	$50

LAB WORK AND PRECIOUS METALS

Additional charges may apply for lab work and precious metals for procedures involving crowns, bridges, prosthodontics, space maintainers, appliances and any repairs to such items.

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code	description	co-pay
	PROSTHODONTICS (Class III - Major)	
5110	Complete Upper Denture	$330
5120	Complete Lower Denture	$330
5130	Immediate Upper Denture	$407
5140	Immediate Lower Denture	$410
5211	Upper Partial Denture - resin base	$369
5212	Lower Partial Denture - resin base	$368
5213	Upper Partial Denture - cast metal framework with resin base, including clasps, rests, and teeth	$444
5214	Lower Partial Denture - cast metal framework with resin base, including clasps, rests and teeth	$447
5225	Upper Partial Denture - flexible base, including any clasps, rests and teeth	$447
5226	Lower Partial Denture - flexible base, including any clasps, rests and teeth	$447
5820	Interim Partial Denture - upper	$247
5821	Interim Partial Denture - lower	$247
5850	Tissue Conditioning - upper	$42
5851	Tissue Conditioning - lower	$42
6010	Endosteal Implant in Conjunction with Denture	$1,400
6012	Endosteal Implant in Conjunction with Denture	$800
6210	Pontic - cast high noble metal	$260
6211	Pontic - cast predominantly base metal	$250
6212	Pontic - cast noble metal	$250
6240	Pontic - porcelain fused to high noble metal	$331
6241	Pontic - porcelain fused to predominantly base metal	$300
6242	Pontic - porcelain fused to noble metal	$250
6245	Pontic - porcelain/ceramic	$300
6740	Retainer Crown - porcelain/ceramic	$300
6750	Retainer Crown - porcelain fused to high noble metal	$360
6751	Retainer Crown - porcelain fused to predominantly base metal	$205
6752	Retainer Crown - porcelain fused to noble metal	$250
6780	Retainer Crown - 3/4 cast high noble metal	$310
6781	Retainer Crown - 3/4 cast predominantly base metal	$350
6782	Retainer Crown - 3/4 cast noble metal	$280
6783	Retainer Crown - 3/4 porcelain/ceramic	$300
6790	Retainer Crown - full cast high noble metal	$295
6791	Retainer Crown - full cast predominantly base metal	$154
6792	Retainer Crown - full cast noble metal	$205
	PERIODONTICS (Class III - Major)	
0180	Comprehensive Periodontal Evaluation	$27
4210	Gingivectomy/Gingivoplasty - 4+ teeth/spaces per quad	$123
4211	Gingivectomy/Gingivoplasty - 1-3 teeth/spaces per quad	$108
4212	Gingivectomy/Gingivoplasty - access for restorative procedure, per tooth	$81
4240	Gingival Flap Procedure - 4+ teeth/spaces per quad	$221
4241	Gingival Flap Procedure - 1-3 teeth/spaces per quad	$174
4249	Clinical Crown Lengthening - hard tissue	$368
4260	Osseous Surgery - 4+ teeth/spaces per quad	$268
4261	Osseous Surgery - 1-3 teeth/spaces per quad	$221
4341	Perio Scaling and Root Planning - 4+ teeth per quad	$58
4342	Perio Scaling and Root Planning - 1-3 teeth per quad	$48
4355	Full Mouth Debridement	$37
4381	Site Specific Therapy, generic - per tooth	$45
4910	Periodontal Maintenance	$42
4921	Gingival Irrigation - per quad	$6

code	description	co-pay
	CROWNS (Class III - Major)	
2390	Crown - resin-based composite, anterior	$134
2542	Onlay - metallic, two surfaces	$318
2543	Onlay - metallic, three surfaces	$305
2544	Onlay - metallic, four surfaces	$331
2642	Onlay - porcelain/ceramic, two surfaces	$302
2643	Onlay - porcelain/ceramic, three surfaces	$310
2644	Onlay - porcelain/ceramic, four surfaces	$348
2662	Onlay - resin-based composite, two surfaces	$301
2663	Onlay - resin-based composite, three surfaces	$312
2664	Onlay - resin-based composite, four surfaces	$318
2740	Crown - porcelain/ceramic	$490
2750	Crown - porcelain fused to high noble metal	$450
2751	Crown - porcelain fused to predominantly base metal	$350
2752	Crown - porcelain fused to noble metal	$355
2780	Crown - 3/4 cast high noble metal	$420
2781	Crown - 3/4 cast predominantly base metal	$440
2782	Crown - 3/4 cast noble metal	$440
2783	Crown - 3/4 porcelain/ceramic	$490
2790	Crown - full cast high noble metal	$440
2791	Crown - full cast predominantly base metal	$340
2792	Crown - full cast noble metal	$406
2799	Crown - interim	$180
2930	Crown - prefabricated stainless steel, primary tooth	$100
2931	Crown - prefabricated stainless steel, permanent tooth	$100
2932	Crown - prefabricated resin	$100
2933	Crown - prefabricated stainless steel with window	$100
2950	Core Buildup - including any pins	$100
2952	Post and Core in Addition to Crown	$110
2954	Prefabricated Post and Core in Addition to Crown	$110
	ORAL SURGERY (Class III - Major)	
7111	Extraction - coronal remnants (primary tooth)	$38
7140	Extraction - erupted tooth or exposed root	$25
7210	Surgical Removal of an Erupted Tooth	$67
7220	Removal of Impacted Tooth - soft tissue	$89
7230	Removal of Impacted Tooth - partially bony	$124
7240	Removal of Impacted Tooth - completely bony	$191
7241	Removal of Impacted Tooth - complicated	$284
7250	Surgical Removal of Residual Tooth Roots	$106
7280	Surgical Access of an Unerupted Tooth	$252
7285	Incisional Biopsy of Oral Tissue - hard	$407
7286	Incisional Biopsy of Oral Tissue - soft	$235
7287	Exfoliative Cytological Sample Collection	$84
7310	Alveoloplasty in Conjunction with Extractions - 4+ teeth/spaces per quad	$54
7311	Alveoloplasty in Conjunction with Extractions - 1-3 teeth/spaces per quad	$45
7320	Alveoloplasty not in Conjunction with Extractions - 4+ teeth/spaces	$95
7321	Alveoloplasty not in Conjunction with Extractions - 1-3 teeth/spaces	$95
7471	Removal of Lateral Exostosis	$189
7472	Removal of Torus Palatinus	$181
7473	Removal of Torus Mandibularis	$177
7510	Incision and Drainage of Abscess - intraoral soft tissue	$53

ORTHODONTICS (Class IV - Orthodontics)

Approved referral from DENCAP to an in-network Orthodontist is required

Continuous coverage is required for the duration of the treatment

Up to Age 19, $2000 benefit / Over age 19, $1200 benefit (Lifetime benefit)

• 12 to 24 months standard orthodontic treatment; Interceptive Ortho is not covered

Benefits are subject to change.

Limitations and Exclusions found at: dencap.com/general-policies

GENERAL LIMITATIONS & EXCLUSIONS	
DIAGNOSTIC: EXAMS	
Periodic, Limited or Comprehensive Oral Evaluation **Comprehensive Periodontal Evaluation** **Assessment of a Patient** **Consultation/Second Opinion**	**TWO EXAMS EVERY 12 MONTHS**
DIAGNOSTIC: X-RAYS	
Full Mouth Radiographs **Panoramic Radiograph**	**ONCE EVERY 5 YEARS**
Periapical Radiographs	**NO MORE THAN 12 IMAGES PER 12 MONTHS**
Bitewing Radiographs	**NO MORE THAN 4 IMAGES, ONCE EVERY 6 MONTHS**
PREVENTIVE	
Prophylaxis (Cleaning) - Adult	**TWO EVERY 12 MONTHS** Two additional cleanings may be allowed every 12 months for patients that are pregnant, diabetic, or otherwise medically compromised, at the recommendation of a licensed dental professional.
Prophylaxis (Cleaning) - Child	**THREE EVERY 12 MONTHS**
Debridement	**ONCE EVERY 2 YEARS**
Topical Application of Flouride Varnish/Non-Varnish	**TWO EVERY 12 MONTHS** Under the age of 3, flouride is covered 4 every 12 months
Space Maintainers	**ONCE PER 2 YEARS, PER QUADRANT - COVERED UP TO AGE 14** **ONCE PER LIFETIME, PER QUADRANT - OVER THE AGE 14** (Primary Teeth Only)
Sealant	**ONCE EVERY 3 YEARS, PER TOOTH; AGES 5-15** **ONCE PER LIFETIME, PER TOOTH; AGES 16-19** **F**irst and second unrestored molars only
RESTORATIONS: MINOR	
Amalgam Fillings	**ONE FILLING PER SURFACE, PER TOOTH EVERY 2 YEARS**
Composite Fillings	**ONE FILLING PER SURFACE, PER TOOTH EVERY 2 YEARS**
RESTORATIONS: CROWNS	
Onlays, Porcelain and Non-Porcelain Crowns	**ONCE EVERY 5 YEARS, PER TOOTH**
Stainless Steel Crown	**ONCE EVERY 5 YEARS, PER TOOTH; COVERED UP TO AGE 21**
CROWN REPAIR	
Recement Restoration	**ONCE EVERY 6 MONTHS, PER TOOTH**
Protective Restoration **Pulp Cap**	**ONCE PER LIFETIME, PER TOOTH; COVERED UP TO AGE 21**
Core Buildup **Post and Core in addition to Crown**	**ONCE EVERY 5 YEARS, PER TOOTH**
Pin Retention	**ONCE EVERY 2 YEARS, PER TOOTH**
ENDODONTICS	
Pulpotomy	**ONCE PER LIFETIME, PER TOOTH - COVERED UP TO AGE 21**
Root Canals	**ONCE PER LIFETIME, PER TOOTH** Molar root canal therapy is not a covered benefit for third molars (1,16, 17, 32).
Retreatment of Root Canal	**ONCE PER LIFETIME, PER TOOTH** Retreatment of molars is not a covered benefit for third molars (1,16, 17, 32).
Apicoectomy	**ONCE PER LIFETIME, PER TOOTH; COVERED UP TO AGE 21**
PERIODONTICS	
Peridontal Scaling and Root Planing	**ONCE EVERY TWO YEARS, PER QUADRANT** Covered when probing depths are greater than or equal to 4mm. The expected prognosis of the teeth must be more than one year.
Clinical Crown Lengthening	**ONCE PER LIFETIME, PER TOOTH**
Gingivectomy/Gingivoplasty	**ONCE PER LIFETIME, PER TOOTH OR QUADRANT**
Osseous Surgery	**ONCE EVERY 3 YEARS**
Full Mouth Debridement	**ONCE EVERY 2 YEARS**
Periodontal Maintenance	**4 VISITS EVERY 12 MONTHS** Following Scaling and Root Planing or other periodontal treatment
PROSTHODONTICS	
Complete or Immediate Upper/Lower Denture **Upper/Lower Partial Denture - Resin or Flexible base** **Upper/Lower Partial Denture - Cast Metal frame**	**ONCE EVERY 5 YEARS**
Occlusal Guard	**ONCE PER LIFETIME**

ADJUSTMENTS TO DENTURES/PARTIALS	
Adjust or repair Complete Upper/Lower Denture or Partial	**ONCE EVERY 3 YEARS** Adjustment is not payable on same date of service as a Reline.
Reline complete Upper/Lower Denture or Partial	**ONCE EVERY 3 YEARS** Adjustment is not payable on same date of service as a Reline.
Replace missing/broken teeth or Add Tooth to Denture or Partial	**ONCE EVERY 12 MONTHS, PER TOOTH**
Repair or replace broken clasp	**ONCE EVERY 12 MONTHS**
Rebase complete upper/lower denture or partial	**ONCE EVERY TWO YEARS** Reline is not payable on same date of service as an adjustment.
Recement or Re-bond fixed partial denture	**ONCE EVERY 12 MONTHS**
ORAL SURGERY	
Extractions - Surgical and Non-Surgical	**ONCE PER LIFETIME, PER TOOTH**
Removal of Lateral Exostosis - Upper/Lower **Oroantula Fistula Closure**	**ONCE PER LIFETIME**
Primary Closure of Sinus Perforation **Alveoloplasty with extractions**	**ONCE PER LIFETIME, PER QUADRANT**
Alveoloplasty without extractions	**ONCE PER FIVE YEARS, PER QUADRANT**
Tooth Reimplantation	**ONCE PER LIFETIME, PER TOOTH - COVERED UP TO AGE 22**

PEDODONTICS

Pediatric dental services are available for members under the age of six (6). These services are considered specialty care and are covered under your specialty care benefit, if applicable. To ensure coverage and minimize out-of-pocket costs, DENCAP recommends obtaining a referral from an in-network general dentist before scheduling an appointment.

GENERAL EXCLUSIONS (Non-Covered Benefits)

Dental Services not listed on the "Schedule of Benefits and Fixed Co-Pays" is not a covered benefit

Dental treatment for cosmetic purposes, or treatment rendered for the explicit purpose of improving appearance, such as implants, transplants or grafts.

Treatment for Temporal Mandibular Joint (TMJ) Disorder

Lab fees billed in conjunction with covered dental treatment is not a covered benefit.

Dental treatment performed in a hospital and/or any related hospital fees are not a covered benefit.

Dental insurance claims submitted due to an auto accident should be processed through an automobile insurance carrier, and are not a covered benefit.

Extraction of asymptomatic teeth is not a covered benefit

Root canal therapy where furcation involved teeth exists, or where teeth are deemed non-restorable is not covered.

Retreatment of root canal therapy within five years of the original root canal if the final restoration has not been completed, is not a covered benefit.

Treatment of cleft palate, anodontia, and mandibular prognathism is not a covered benefit.

Replacement of lost, missing, or stolen appliances are not a covered benefit.

Behavior management fees for covered persons requiring additional or unusual efforts to complete a dental procedure is not covered.

Experimental, investigational or temporary procedures and/or appliances is not a covered benefit.

Dental treatment started before a covered person's policy became effective, or services rendered after the termination of benefits will not be covered.

Porcelain, porcelain substrate, and cast restorations on primary teeth is not a covered benefit.

Missed appointments, duplication of radiographs, and oral hygiene instruction procedures are non-covered benefits.

ORTHODONTIC EXCLUSIONS

Retreatment of prior orthodontic services, unless provided under this policy is not a covered benefit.

Orthodontic treatment that would not render satisfactory results and/or the overall prognosis is poor is not covered.

Orthodontic treatment during a period of ineligibility is not covered

Repair or replacement of a lost or broken orthodontic appliance is not a covered benefit.

Interceptive Orthodontic treatment is not a covered benefit.

Surgical procedures indicental to orthodontic treatment is not covered.

Active treatment extending more than 24 months from the banding date due to lack of patient cooperation and/or deviation from the treatment plan is not covered.

After initial banding, transfers to another Orthodontic Provider is not covered.

WAITING PERIODS

Refer to the plan Schedule of Benefits and Co-Payments for applicable benefit waiting periods.