

**HEALTHCHOICE SMALL BUSINESS  
SCHEDULE OF BENEFITS AND FIXED CO-PAYS**

<b>ANNUAL MAXIMUMS (for each member)</b>		<b>\$1,000</b>
<b>Primary Care</b>		<b>Unlimited</b>
<b>Specialty Care</b>		<b>\$1,000</b>

code	description	co-pay
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<b>DIAGNOSTIC (Class I - Preventive)</b>		
0120	Periodic Oral Evaluation	\$0
0140	Limited Oral Evaluation - problem focused	\$20
0150	Comprehensive Oral Evaluation	\$0
0431	Prediagnostic Test	\$0
1110	Prophylaxis/Routine Cleaning - adult	\$0
1120	Prophylaxis/Routine Cleaning - child	\$0

<b>PREVENTIVE (Class I - Preventive)</b>		
1206	Topical Application of Flouride - varnish	\$0
1208	Topical Application of Flouride - excluding varnish	\$0
1330	Oral Hygiene Instructions	\$0
1351	Sealant - per tooth	\$15
1353	Sealant Repair - per tooth	\$10

<b>RADIOGRAPHS (Class I - Preventive)</b>		
0210	Intraoral - complete series	\$25
0220	Periapical - first radiographic image	\$0
0230	Periapical - each additional radiographic image	\$5
0240	Intraoral - occlusal radiographic image	\$0
0270	Bitewing - single radiographic image	\$0
0272	Bitewings - two radiographic images	\$10
0273	Bitewings - three radiographic images	\$15
0274	Bitewings - four radiographic images	\$20
0330	Panoramic Radiographic Image	\$25

<b>ADJUNCTIVE SERVICES (Class II - Basic)</b>		
0470	Diagnostic Casts (each)	\$53
1510	Fixed Space Maintainer - unilateral per quadrant	\$173
1520	Removable Space Maintainer - unilateral per quad	\$222
2940	Protective Restoration (sedative filling)	\$34
9110	Palliative (Emergency) Treatment	\$27
9215	Local Anesthesia	\$0
9930	Treatment of Complications, Post-Surgical	\$25

<b>RESTORATIVE (Class II - Basic)</b>		
2140	Amalgam Filling - one surface	\$57
2150	Amalgam Filling - two surfaces	\$68
2160	Amalgam Filling - three surfaces	\$78
2161	Amalgam Filling - four or more surfaces	\$87
2330	Composite Filling - one surface, anterior	\$71
2331	Composite Filling - two surfaces, anterior	\$85
2332	Composite Filling - three surfaces, anterior	\$101
2335	Composite Filling - four surfaces, anterior/incisal angle	\$164
2391	Composite Filling - one surface, posterior	\$78
2392	Composite Filling - two surfaces, posterior	\$93
2393	Composite Filling - three surfaces, posterior	\$109
2394	Composite Filling - four surfaces, posterior	\$184

<b>LAB WORK AND PRECIOUS METALS</b>
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.

<b>OFFICE VISIT CO-PAY</b>		
9430	Office Visit (for observation)	\$10
9999	Office Visit (regular hours)	\$10

code	description	co-pay
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<b>PROSTHETIC REPAIR (Class II - Basic)</b>		
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	\$32
5411	Adjustment to Complete Denture - lower	\$32
5421	Adjustment to Partial Denture - upper	\$32
5422	Adjustment to Partial Denture - lower	\$32
5520	Replace Missing/Broken Teeth - denture, per tooth	\$93
5630	Repair or Replace Broken Clasp - per tooth	\$111
5640	Replace Missing/Broken Teeth - partial, per tooth	\$94
5650	Add Tooth to Existing Partial Denture	\$90
5660	Add Clasp to Existing Partial Denture - per tooth	\$137
5730	Reline Complete Upper Denture - in office	\$158
5731	Reline Complete Lower Denture - in office	\$158
5740	Reline Partial Upper Denture - in office	\$160
5741	Reline Partial Lower Denture - in office	\$162
5750	Reline Complete Upper Denture - lab	\$238
5751	Reline Complete Lower Denture - lab	\$238
5760	Reline Partial Upper Denture - lab	\$236
5761	Reline Partial Lower Denture - lab	\$236
6930	Re-cement or Re-bond Fixed Partial Denture	\$32

<b>ENDODONTICS (Class III - Major)</b>		
3110	Pulp Cap - direct	\$38
3120	Pulp Cap - indirect	\$38
3220	Therapeutic Pulpotomy	\$153
3310	Root Canal Therapy - anterior tooth	\$400
3320	Root Canal Therapy - premolar tooth	\$450
3330	Root Canal Therapy - molar tooth	\$500
3346	Retreat of Previous Root Canal Therapy - anterior tooth	\$425
3347	Retreat of Previous Root Canal Therapy - premolar tooth	\$525
3348	Retreat of Previous Root Canal Therapy - molar tooth	\$600
3410	Apicoectomy Surgery - anterior tooth	\$390
3421	Apicoectomy Surgery - premolar tooth, first root	\$441
3425	Apicoectomy Surgery - molar tooth, first root	\$505
3426	Apicoectomy Surgery - each additional root	\$204
3430	Retrograde Filling - per root	\$79

<b>SPECIALTY CARE</b>
- Endodontics - Oral Surgery - Periodontics - Pedodontics -
Approved referral from DENCAP is required
Benefits are available after six (6) consecutive months of coverage. DENCAP pays 35% of our specialist's fees up to the Specialty Care Annual Maximum for covered services; you are responsible for the remaining balance.

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code	description	co-pay	code	description	co-pay
<b>PROSTHODONTICS (Class III - Major)</b>			<b>CROWNS (Class III - Major)</b>		
5110	Complete Upper Denture	\$700	2390	Crown - resin-based composite, anterior	\$244
5120	Complete Lower Denture	\$700	2751	Crown - porcelain fused to predominantly base metal	\$643
5211	Upper Partial Denture - resin base	\$750	2752	Crown - porcelain fused to noble metal	\$680
5212	Lower Partial Denture - resin base	\$750	2781	Crown - 3/4 cast predominantly base metal	\$649
5213	Upper Partial Denture - cast metal framework with resin base, including clasps, rests, and teeth	\$800	2782	Crown - 3/4 cast noble metal	\$689
5214	Lower Partial Denture - cast metal framework with resin base, including clasps, rests, and teeth	\$800	2790	Crown - full cast high noble metal	\$919
5850	Tissue Conditioning - upper	\$95	2791	Crown - full cast predominantly base metal	\$680
5851	Tissue Conditioning - lower	\$95	2792	Crown - full cast noble metal	\$739
6010	Surgical Placement of Endosteal Implant Body	\$1,241	2799	Crown - interim	\$219
6011	Surgical Access to an Implant Body	\$525	2930	Crown - prefabricated stainless steel, primary tooth	\$190
6012	Surgical Placement of Interim Endosteal Implant Body for Transitional Prosthesis	\$1,187	2931	Crown - prefabricated stainless steel, permanent tooth	\$189
6211	Pontic - cast predominantly base metal	\$565	2932	Crown - prefabricated resin	\$202
6212	Pontic - cast noble metal	\$559	2933	Crown - prefabricated stainless steel with window	\$190
6241	Pontic - porcelain fused to predominantly base metal	\$501	2950	Core Buildup - including any pins	\$135
6242	Pontic - porcelain fused to noble metal	\$525	2952	Post and Core in Addition to Crown	\$200
6751	Retainer Crown - porcelain fused to predominantly base metal	\$510	2954	Prefabricated Post and Core in Addition to Crown	\$160
6752	Retainer Crown - porcelain fused to noble metal	\$540	<b>ORAL SURGERY (Class III - Major)</b>		
6781	Retainer Crown - 3/4 cast predominantly base metal	\$590	7111	Extraction - coronal remnants (primary tooth)	\$53
6782	Retainer Crown - 3/4 cast noble metal	\$526	7140	Extraction - erupted tooth or exposed root	\$53
6791	Retainer Crown - full cast predominantly base metal	\$561	7210	Surgical Removal of an Erupted Tooth	\$107
6792	Retainer Crown - full cast noble metal	\$571	7220	Removal of Impacted Tooth - soft tissue	\$114
<b>PERIODONTICS (Class III - Major)</b>			7230	Removal of Impacted Tooth - partially bony	\$146
0180	Comprehensive Periodontal Evaluation	\$51	7240	Removal of Impacted Tooth - completely bony	\$191
4210	Gingivectomy/Gingivoplasty - 4+ teeth/spaces per quad	\$315	7241	Removal of Impacted Tooth - complicated	\$284
4211	Gingivectomy/Gingivoplasty - 1-3 teeth/spaces per quad	\$165	7250	Surgical Removal of Residual Tooth Roots	\$195
4240	Gingival Flap Procedure - 4+ teeth/spaces per quad	\$368	7280	Surgical Access of an Unerupted Tooth	\$252
4241	Gingival Flap Procedure - 1-3 teeth/spaces per quad	\$315	7310	Alveoloplasty in Conjunction with Extractions - 4+ teeth/spaces per quad	\$135
4260	Osseous Surgery - 4+ teeth/spaces per quad	\$499	7311	Alveoloplasty in Conjunction with Extractions - 1-3 teeth/spaces per quad	\$135
4261	Osseous Surgery - 1-3 teeth/spaces per quad	\$410	7320	Alveoloplasty not in Conjunction with Extractions - 4+ teeth/spaces	\$175
4341	Perio Scaling and Root Planning - 4+ teeth per quad	\$95	7321	Alveoloplasty not in Conjunction with Extractions - 1-3 teeth/spaces	\$175
4342	Perio Scaling and Root Planning - 1-3 teeth per quad	\$72	7471	Removal of Lateral Exostosis	\$276
4355	Full Mouth Debridement	\$64	7472	Removal of Torus Palatinus	\$264
4381	Site Specific Therapy, generic - per tooth	\$45	7473	Removal of Torus Mandibularis	\$259
4910	Periodontal Maintenance	\$63	7510	Incision and Drainage of Abscess - intraoral soft tissue	\$60

*Benefits are subject to change.  
Limitations and Exclusions found at:  
dencap.com/general-policies*

**ORTHODONTICS (Class IV - Orthodontics)**

Member must have twelve (12) months of continuous enrollment to be eligible for the orthodontic benefit.

Members are referred to an in-network Orthodontist  
Up to Age 19, \$1800 discount / Over age 19, \$1200 discount  
from usual and customary rate • 12 to 24 months standard braces

**GENERAL LIMITATIONS & EXCLUSIONS****DIAGNOSTIC: EXAMS**

Periodic, Limited or Comprehensive Oral Evaluation	
Comprehensive Periodontal Evaluation	TWO EXAMS EVERY 12 MONTHS
Assessment of a Patient	
Consultation/Second Opinion	

**DIAGNOSTIC: X-RAYS**

Full Mouth Radiographs	ONCE EVERY 5 YEARS
Panoramic Radiograph	
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 Fluoride Varnish/Non-Varnish	TWO EVERY 12 MONTHS Under the age of 3, fluoride 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 First 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**

Periodontal 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	ONCE EVERY 5 YEARS
Upper/Lower Partial Denture - Cast Metal frame	
Occlusal Guard	ONCE PER LIFETIME

**ADJUSTMENTS TO DENTURES/PARTIALS**

<b>Adjust or repair Complete Upper/Lower Denture or Partial</b>	<b>ONCE EVERY 3 YEARS</b> Adjustment is not payable on same date of service as a Reline.
<b>Reline complete Upper/Lower Denture or Partial</b>	<b>ONCE EVERY 3 YEARS</b> Adjustment is not payable on same date of service as a Reline.
<b>Replace missing/broken teeth or Add Tooth to Denture or Partial</b>	<b>ONCE EVERY 12 MONTHS, PER TOOTH</b>
<b>Repair or replace broken clasp</b>	<b>ONCE EVERY 12 MONTHS</b>
<b>Rebase complete upper/lower denture or partial</b>	<b>ONCE EVERY TWO YEARS</b> Reline is not payable on same date of service as an adjustment.
<b>Recement or Re-bond fixed partial denture</b>	<b>ONCE EVERY 12 MONTHS</b>

**ORAL SURGERY**

<b>Extractions - Surgical and Non-Surgical</b>	<b>ONCE PER LIFETIME, PER TOOTH</b>
<b>Removal of Lateral Exostosis - Upper/Lower</b>	<b>ONCE PER LIFETIME</b>
<b>Oroantula Fistula Closure</b>	<b>ONCE PER LIFETIME, PER QUADRANT</b>
<b>Primary Closure of Sinus Perforation</b>	<b>ONCE PER LIFETIME, PER QUADRANT</b>
<b>Alveoloplasty with extractions</b>	<b>ONCE PER FIVE YEARS, PER QUADRANT</b>
<b>Alveoloplasty without extractions</b>	<b>ONCE PER FIVE YEARS, PER QUADRANT</b>
<b>Tooth Reimplantation</b>	<b>ONCE PER LIFETIME, PER TOOTH - COVERED UP TO AGE 22</b>

**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 incidental 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.