HALLMARK DENTAL (H)
SCHEDULE OF BENEFITS AND FIXED CO-PAYS

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

ANNUAL MAXIMUMS (for each member)	$3,300
Primary Care	$2,500
Specialty Care	$800

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)	$27
1351*	Sealant - per tooth	$0
1353*	Repair to Sealant - per tooth	$0
1510*	Fixed Space Maintainer - unilateral per quadrant	$118
1516*	Fixed Space Maintainer - bilateral, upper	$158
1517*	Fixed Space Maintainer - bilateral, lower	$158
1520*	Removable Space Maintainer - unilateral per quadrant	$158
1526*	Removable Space Maintainer - bilateral, upper	$174
1527*	Removable Space Maintainer - bilateral, lower	$174
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)	$25
9110*	Palliative (Emergency) Treatment - minor procedure	$7
9215	Local Anesthesia	$0
9230	Inhalation of Nitrous Oxide	$24
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)	$51
9910	Application of Desensitizing Medicament	$25
9930	Treatment of Complications, Post-Surgical - unusual	$18
9944	Hard Occlusal Guard (night guard) - full arch	$237
9945	Soft Occlusal Guard (night guard) - full arch	$237
9946	Hard Occlusal Guard (night guard) - partial arch	$237
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. A referral to an in-network provider is required.

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	$25
2150*	Amalgam Filling - two surfaces	$31
2160*	Amalgam Filling - three surfaces	$42
2161*	Amalgam Filling - four or more surfaces	$50
2330*	Composite Filling - one surface, anterior	$36
2331*	Composite Filling - two surfaces, anterior	$46
2332*	Composite Filling - three surfaces, anterior	$58
2335*	Composite Filling - four surfaces, anterior/incisal angle	$81
2391*	Composite Filling - one surface, posterior	$47
2392*	Composite Filling - two surfaces, posterior	$58
2393*	Composite Filling - three surfaces, posterior	$77
2394*	Composite Filling - four surfaces, posterior	$100
	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	$12
5411	Adjustment to Complete Denture - lower	$12
5421	Adjustment to Partial Denture - upper	$12
5422	Adjustment to Partial Denture - lower	$12
5511	Repair to Broken Complete Denture Base - lower	$76
5512	Repair to Broken Complete Denture Base - upper	$75
5520	Replace Missing/Broken Teeth - denture, per tooth	$60
5611	Repair Resin Partial Denture Base - lower	$73
5612	Repair Resin Partial Denture Base - upper	$75
5621	Repair Cast Partial Framework - lower	$85
5622	Repair Cast Partial Framework - upper	$85
5630	Repair or Replace Broken Clasp - per tooth	$84
5640	Replace Missing/Broken Teeth - partial, per tooth	$54
5650	Add Tooth to Existing Partial Denture	$73
5660	Add Clasp to Existing Partial Denture - per tooth	$102
5730	Reline Complete Upper Denture - in office	$127
5731	Reline Complete Lower Denture - in office	$127
5740	Reline Partial Upper Denture - in office	$128
5741	Reline Partial Lower Denture - in office	$130
5750	Reline Complete Upper Denture - lab	$182
5751	Reline Complete Lower Denture - lab	$182
5760	Reline Partial Upper Denture - lab	$180
5761	Reline Partial Lower Denture - lab	$180
6930	Re-cement or Re-bond Fixed Partial Denture	$25
	ENDODONTICS (Class III - Major)	
3110	Pulp Cap - direct	$25
3120	Pulp Cap - indirect	$25
3220*	Therapeutic Pulpotomy	$117
3310*	Root Canal Therapy - anterior tooth	$400
3320*	Root Canal Therapy - premolar tooth	$425
3330*	Root Canal Therapy - molar tooth	$450
3346	Retreat of Previous Root Canal Therapy - anterior tooth	$450
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	$266
3421	Apicoectomy Surgery - premolar tooth, first root	$289
3425	Apicoectomy Surgery - molar tooth, first root	$326
3426	Apicoectomy Surgery - each additional root	$117
3430	Retrograde Filling - per root	$76

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	$625
5120*	Complete Lower Denture	$625
5130*	Immediate Upper Denture	$675
5140*	Immediate Lower Denture	$675
5211	Upper Partial Denture - resin base	$675
5212	Lower Partial Denture - resin base	$675
5213	Upper Partial Denture - cast metal framework with resin base, including clasps, rests, and teeth	$725
5214	Lower Partial Denture - cast metal framework with resin base, including clasps, rests and teeth	$725
5225	Upper Partial Denture - flexible base, including any clasps, rests and teeth	$725
5226	Lower Partial Denture - flexible base, including any clasps, rests and teeth	$725
5820	Interim Partial Denture - upper	$375
5821	Interim Partial Denture - lower	$375
5850	Tissue Conditioning - upper	$73
5851	Tissue Conditioning - lower	$73
6010	Endosteal Implant in Conjunction with Denture	$1,296
6012	Endosteal Implant in Conjunction with Denture	$1,135
6210	Pontic - cast high noble metal	$577
6211	Pontic - cast predominantly base metal	$474
6212	Pontic - cast noble metal	$447
6240	Pontic - porcelain fused to high noble metal	$541
6241	Pontic - porcelain fused to predominantly base metal	$431
6242	Pontic - porcelain fused to noble metal	$420
6245	Pontic - porcelain/ceramic	$662
6740	Retainer Crown - porcelain/ceramic	$662
6750	Retainer Crown - porcelain fused to high noble metal	$541
6751	Retainer Crown - porcelain fused to predominantly base metal	$421
6752	Retainer Crown - porcelain fused to noble metal	$420
6780	Retainer Crown - 3/4 cast high noble metal	$541
6781	Retainer Crown - 3/4 cast predominantly base metal	$410
6782	Retainer Crown - 3/4 cast noble metal	$421
6783	Retainer Crown - 3/4 porcelain/ceramic	$662
6790	Retainer Crown - full cast high noble metal	$588
6791*	Retainer Crown - full cast predominantly base metal	$471
6792*	Retainer Crown - full cast noble metal	$457
	PERIODONTICS (Class III - Major)	
0180	Comprehensive Periodontal Evaluation	$42
4210*	Gingivectomy/Gingivoplasty - 4+ teeth/spaces per quad	$194
4211*	Gingivectomy/Gingivoplasty - 1-3 teeth/spaces per quac	$172
4212	Gingivectomy/Gingivoplasty - access for restorative procedure, per tooth	$92
4240	Gingival Flap Procedure - 4+ teeth/spaces per quad	$268
4241	Gingival Flap Procedure - 1-3 teeth/spaces per quad	$237
4249	Clinical Crown Lengthening - hard tissue	$421
4260	Osseous Surgery - 4+ teeth/spaces per quad	$429
4261	Osseous Surgery - 1-3 teeth/spaces per quad	$300
4341*	Perio Scaling and Root Planning - 4+ teeth per quad	$73
4342*	Perio Scaling and Root Planning - 1-3 teeth per quad	$60
4355	Full Mouth Debridement	$48
4381	Site Specific Therapy, generic - per tooth	$45
4910	Periodontal Maintenance	$54
4921	Gingival Irrigation - per quad	$7

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, $1800 discount / Over age 19, $1200 discount (Lifetime benefit)

from usual and customary rate • 12 to 24 months standard braces

code	description	co-pay
	CROWNS (Class III - Major)	
2390	Crown - resin-based composite, anterior	$212
2542*	Onlay - metallic, two surfaces	$561
2543*	Onlay - metallic, three surfaces	$562
2544*	Onlay - metallic, four surfaces	$575
2642*	Onlay - porcelain/ceramic, two surfaces	$577
2643*	Onlay - porcelain/ceramic, three surfaces	$555
2644*	Onlay - porcelain/ceramic, four surfaces	$568
2662	Onlay - resin-based composite, two surfaces	$552
2663	Onlay - resin-based composite, three surfaces	$555
2664	Onlay - resin-based composite, four surfaces	$558
2740*	Crown - porcelain/ceramic	$840
2750	Crown - porcelain fused to high noble metal	$705
2751*	Crown - porcelain fused to predominantly base metal	$573
2752*	Crown - porcelain fused to noble metal	$575
2780	Crown - 3/4 cast high noble metal	$697
2781	Crown - 3/4 cast predominantly base metal	$570
2782	Crown - 3/4 cast noble metal	$584
2783	Crown - 3/4 porcelain/ceramic	$834
2790	Crown - full cast high noble metal	$817
2791*	Crown - full cast predominantly base metal	$593
2792*	Crown - full cast noble metal	$622
2799	Crown - interim	$189
2930*	Crown - prefabricated stainless steel, primary tooth	$179
2931*	Crown - prefabricated stainless steel, permanent tooth	$179
2932*	Crown - prefabricated resin	$191
2933*	Crown - prefabricated stainless steel with window	$180
2950	Core Buildup - including any pins	$90
2952	Post and Core in Addition to Crown	$132
2954	Prefabricated Post and Core in Addition to Crown	$132
	ORAL SURGERY (Class III - Major)	
7111*	Extraction - coronal remnants (primary tooth)	$36
7140*	Extraction - erupted tooth or exposed root	$36
7210	Surgical Removal of an Erupted Tooth	$77
7220	Removal of Impacted Tooth - soft tissue	$79
7230	Removal of Impacted Tooth - partially bony	$117
7240	Removal of Impacted Tooth - completely bony	$148
7241	Removal of Impacted Tooth - complicated	$194
7250	Surgical Removal of Residual Tooth Roots	$221
7280	Surgical Access of an Unerupted Tooth	$158
7285	Incisional Biopsy of Oral Tissue - hard	$387
7286	Incisional Biopsy of Oral Tissue - soft	$210
7287	Exfoliative Cytological Sample Collection	$71
7310	Alveoloplasty in Conjunction with Extractions - 4+ teeth/spaces per quad	$78
7311	Alveoloplasty in Conjunction with Extractions - 1-3 teeth/spaces per quad	$60
7320	Alveoloplasty not in Conjunction with Extractions - 4+ teeth/spaces	$109
7321	Alveoloplasty not in Conjunction with Extractions - 1-3 teeth/spaces	$85
7471	Removal of Lateral Exostosis	$225
7472	Removal of Torus Palatinus	$215
7473	Removal of Torus Mandibularis	$211
7510	Incision and Drainage of Abscess - intraoral soft tissue	$50

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

Note: Procedures marked with an asterisk (*) are EHB covered codes [Essential Health Benefits]

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 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	
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.