



IBC CHOICE DENTAL PLAN

Schedule of Benefits and Member Payments



CODE	DIAGNOSTIC AND PREVENTATIVE	MEMBER PAYS
9999	Office Visit (regular hours)	\$5.00
9999	Office Visit (regular hours - unscheduled)	\$20.00
0120	Periodic Oral Evaluation	\$22.00
0140	Limited Oral Evaluation - Problem Focused	\$38.00
0150	Comprehensive Oral Evaluation	\$22.00
0431	Prediagnostic Test	No Charge
1110*	Prophylaxis/Routine Cleaning - Adult	\$39.00
1120*	Prophylaxis/Routine Cleaning - Child	\$29.00
1203/4	Fluoride Treatment (up to age 19)	\$17.00
1330	Oral Hygiene Instructions	No Charge
9215	Local Anesthesia	No Charge

X-RAY COVERAGE

0210	Intraoral - Complete Series	\$52.00
0220	Periapical - First Film	\$13.00
0230	Periapical - Each Additional Film	\$10.00
0270	Bitewing - Single Film	\$13.00
0272	Bitewings - Two Films	\$19.00
0273	Bitewings - Three Films	\$24.00
0274	Bitewings - Four Films	\$28.00
0330	Panoramic Film	\$52.00

ADJUNCTIVE SERVICES

9999	Failed Appointment	\$10.00
1351	Sealant - per tooth	\$28.00
2940	Protective Restoration (Sedative Filling)	\$64.00
9110	Palliative (Emergency) Treatment (minor-reg. hrs.)	\$57.00
9310	Consultation (2nd opinion)	\$48.00
9430	Office Visit for Observation (no other treatment)	\$22.00
9440	Office Visit (after reg. scheduled hours)	\$55.00
9930	Treatment of Complications (post-surg. minor-per visit)	\$15.00
9940	Occlusal Guard, by report (night guard)	\$325.00

RESTORATIVE (fillings)

2140	Amalgam Filling - One Surface	\$57.00
2150	Amalgam Filling - Two Surfaces	\$73.00
2160	Amalgam Filling-Three Surfaces	\$88.00
2161	Amalgam Filling-Four or More Surfaces	\$109.00
2330	Composite Filling - One Surface (Anterior)	\$78.00
2331	Composite Filling - Two Surfaces (Anterior)	\$88.00
2332	Composite Filling - Three Surfaces (Anterior)	\$105.00
2335	Comp Filling-Four or More Surfaces/IA (Anterior)	\$140.00
2391	Composite Filling - One Surface (Posterior)	\$78.00
2392	Composite Filling - Two Surfaces (Posterior)	\$88.00
2393	Composite Filling-Three Surfaces (Posterior)	\$105.00
2394	Composite Filling - Four Surfaces (Posterior)	\$140.00

SPACE MAINTAINERS

1510	Unilateral - fixed	\$181.00
1515	Bilateral - fixed	\$218.00
1520	Unilateral - removable	\$238.00
1525	Bilateral - removable	\$276.00
1550	Re-cementation of Space Maintainer	\$34.00

* Second routine cleaning - \$50 for adults; \$40 for children
Additional routine cleanings - provider's usual & customary fees

Individual Benefits Company
313.972.1400
www.ibcchoicedental.com

CODE	CROWNS	MEMBER PAYS
2390	Resin-based Composite Crown, anterior	\$175.00
2751	Porcelain Fused to Pred. Base Metal	\$530.00
2752	Porcelain Fused to Noble Metal (per unit)	\$540.00
2781/91	3/4 / Full Cast Pred. Base Metal (per unit)	\$530.00
2782/92	3/4 / Full Cast Noble Metal (per unit)	\$540.00
2930/1/2/3	Prefabricated Stainless Steel-Resin Crown	\$170.00

OTHER FIXED DENTAL SERVICES

2952/6970	Cast Post and Core	\$240.00
2954/6972	Prefabricated Post and Core	\$215.00
2950/6973	Core Buildup (Including Any Pins)	\$185.00
2910	Recement Inlay, Onlay or Partial Cov. Rest.	\$60.00
2920	Recement Crown	\$60.00

ENDODONTICS (interior of tooth)

3310	Anterior Root Canal Therapy	\$390.00
3320	Bicuspid Root Canal Therapy	\$460.00
3330	Molar Root Canal Therapy	\$570.00
3430	Retrograde Filling (per root)	\$125.00
3220	Therapeutic Pulpotomy	\$88.00
3110/20	Pulp Cap (direct/indirect)	\$36.00
3346	Retreat of Previous RCT - anterior	\$455.00
3347	Retreat of Previous RCT - bicuspid	\$560.00
3348	Retreat of Previous RCT - molar	\$675.00

PERIODONTICS (gums and supporting tissue)

0180	Comprehensive Periodontal Evaluation	\$52.00
4355	Full Mouth Debridement	\$100.00
4910	Periodontal Maintenance	\$87.00
4341	Perio Scaling/Root Planing (>=4)	\$148.00
4342	Perio Scaling/Root Planing (<=3)	\$120.00
4381	Site Specific Therapy (per tooth)	\$75.00
4260	Osseous Surgery (>=4 or bounded)	\$680.00
4261	Osseous Surgery (<=3 or bounded)	\$560.00
9951	Occlusal Adjustment (limited)	\$78.00

PROSTHODONTICS (removables)

5110/20	Complete Denture (upper/lower)	\$780.00
5130/40	Immediate Denture (upper/lower)	\$850.00
5211/12	Partial Denture (upper/lower - resin base)	\$770.00
5213/14	Partial Denture (u/l cast frame, resin base)	\$880.00
54XX+	Denture/Partial Adjustment (existing)	\$48.00

Repairs

5510	Repair broken complete denture base	\$90.00
5520	Replace missing/broken denture teeth (each)	\$75.00
5610	Repair partial resin denture base	\$98.00
5620	Repair partial cast framework	\$111.00
5630	Repair or replace broken clasp	\$125.00
5640	Replace broken teeth on partial (per tooth)	\$78.00
5650	Add tooth to existing partial denture	\$103.00
5660	Add clasp to existing partial denture	\$130.00

+ 2930, 2931, 2932, 2933
++ 5410, 5411, 5421, 5422

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

Benefits and Member Payments are subject to change.

CODE	Rebase and Reline	MEMBER PAYS
5710/11	Rebase complete denture (upper/lower)	\$300.00
5720/21	Rebase partial denture (upper/lower)	\$300.00
5730/31	Reline complete denture (upper/lower - office)	\$170.00
5740/41	Reline partial denture (upper/lower - office)	\$161.00
5750/51	Reline complete denture (upper/lower - lab)	\$229.00
5760/61	Reline partial denture (upper/lower - lab)	\$229.00
5850/51	Tissue conditioning (per arch)	\$73.00

PROSTHODONTICS (fixed)

6211	Pontic - cast predominantly base metal	\$520.00
6212	Pontic - cast noble metal	\$530.00
6241	Pontic - porcelain fused-pred. base metal	\$490.00
6242	Pontic - porcelain fused to noble metal	\$540.00
6751	Crown - porcelain fused-pred. base metal	\$560.00
6752	Crown - porcelain fused to noble metal	\$570.00
6791	Crown - full cast predominantly base metal	\$550.00
6792	Crown - full cast noble metal	\$560.00
6930	Recement fixed partial denture	\$50.00

ORAL SURGERY

Extractions		
7111	Simple extraction of primary tooth	\$75.00
7140	Simple extraction of single tooth	\$75.00

Surgical Extractions

7210	Surgical removal of an erupted tooth	\$135.00
7220	Removal impacted tooth- soft tissue	\$172.00
7230	Removal impacted tooth- partially bony	\$229.00
7240	Removal impacted tooth- completely bony	\$263.00
7241	Removal Impacted Tooth- completely bony (diff.)	\$310.00
7250	Surgical removal of residual tooth roots	\$148.00
7471/72/73	Removal of exostosis (per site)	\$326.00
7510	Incision & drainage of abscess (intraoral soft tiss.)	\$95.00
7970	Excision of hyperplastic tissue (per arch)	\$250.00
9230	Inhalation of nitrous oxide	\$15.00

ANNUAL MAXIMUM for Primary Care Dentistry

\$2,000.00

Dentist's usual and customary fees less the co-payments listed on this Schedule consumes the annual maximum.

IBC CHOICE ORTHODONTIC BENEFITS

(Approved referral from DENCAP required for all Orthodontic Care)

IBC Choice Members may receive orthodontic care (braces) at DENCAP authorized Orthodontic Treatment Centers for reduced rates. Contact DENCAP for more information: 313.972.1400

SPECIALTY CARE

There is no specialty care coverage with your IBC Choice Dental Plan.
For possible savings on specialty care costs, contact DENCAP/ IBC prior to treatment for more information: 313.972.1400.

LAB WORK AND PRECIOUS METALS

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