**Comprehensive Dental Care Benefit Plan**

Campbell Family and Cosmetic Dentistry is now offering a Comprehensive Dental Care Benefit Plan to individuals and families who are not covered by traditional dental insurance. By enrolling in our benefit plan, you will receive dental services from Campbell Family and Cosmetic Dentistry at reduced fees that make sense for today’s economy.

**Who can enroll?**

Individuals, spouses and dependent children under the age of 19. We care about total dental health and we have made our plans affordable for individuals as well as families to enroll.

**How does a “Benefit Plan” work?**

Unlike traditional dental insurance companies, you do not pay premiums to a large corporation, who then in turn makes dental care decisions based on cost to the company rather than the best dental care possible for you as a patient.

When you enroll into our benefit plan, you are able to decide for yourself, along with our dental care team, what the best treatment is for you.

Traditional dental insurance only covers a certain dollar amount towards your care per year. Our benefit plans have no yearly maximums on the dental care you receive and cosmetic treatments are also included.

By enrolling in our benefit plan, an affordable yearly premium entitles you to $20 office visit co-pays and drastically reduced fees on most dental services. With your $20 co-pay, you will receive two complimentary simple prophylaxis, cavity detecting radiographs and periodic exams. We also provide a fee schedule to you, so that you know what you can expect to pay, rather than an insurance company dictating your financial responsibility based on percentages and loopholes in coverage.

**How much does membership enrollment cost?**

INDIVIDUAL PLAN~$149.00 PER YEAR

INDIVIDUAL + ONE DEPENDENT~$233.00 PER YEAR

INDIVIDUAL + TWO OR THREE DEPENDENTS~$317.00 PER YEAR

ADDITIONAL DEPENDENTS~$65 EACH PER YEAR

**Comprehensive Dental Care Benefit Plan Registration Form**

**INDIVIDUAL MEMBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INDIVIDUAL MEMBER BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INDIVIDUAL MEMBER SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHOTO ID: DRIVERS LICENSE STATE ID PASSPORT MILITARY ID**

**LIST COVERED DEPENDENTS AND BIRTHDATES:**

**PLEASE CIRCLE THE PLAN YOU WISH TO ENROLL:**

**INDIVIDUAL PLAN~$149.00 PER YEAR**

**INDIVIDUAL + ONE DEPENDENT~$233.00 PER YEAR**

**INDIVIDUAL + TWO OR THREE DEPENDENTS~$317.00 PER YEAR**

**ADDITIONAL DEPENDENTS~$65.00 EACH PER YEAR x \_\_\_\_\_\_\_\_\_\_**

**BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION I**

**HAVE PROVIDED IS TRUE AND ACCURATE, AND THAT I HAVE READ,**

**UNDERSTAND AND HAVE RECEIVED A COPY OF THE TERMS OF THIS**

**BENEFIT PLAN AND FEE SCHEDULE. I UNDERSTAND THAT THIS IS NOT**

**AN INSURANCE PLAN, BUT RATHER A MEMEBERSHIP PLAN.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INDIVIDUAL MEMBER SIGNATURE DATE**

**Comprehensive Dental Care Benefit Plan Terms and Conditions**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand the benefits,

limitations, exclusions and requirements of the Comprehensive Dental Care Benefit Plan

and I agree to the following: Fees for dental services are due as services are rendered.

Fees for prosthodontic and cast restoration services are due at the preparation/impression

visit. Failure to comply may result in my being charged usual and customary fees for

such services. I agree to pay any and all costs in collecting all charges, including but not

limited to attorney fees and court costs. I understand that if I default on my payment

terms for any reason, my account can be turned over to a collection agency and I will be

responsible for the associated fees. Coverage must be continuous. At no point are any

fees refundable. To terminate plan benefits after 12 months, I must notify Campbell

Family and Cosmetic Dentistry in writing prior to the first of the month to avoid

membership fees being charged. No refunds are given for partial months. I also

understand that this plan is not an insurance plan of any kind.

**DENTAL LIMITATIONS AND EXCLUSIONS**

1. Demonstrated non-compliance with recommended course of treatment

2. Services which in the opinion of the attending dentist are neither necessary nor recommended for

the patients dental health

3. Restorations, splints or other appliances used to increase vertical dimension or restore occlusion

4. Oral surgery requiring the setting of fractures or dislocations

5. Treatment of malignancies, cysts or neoplasms or congenital malformations, except congenital

anomaly of a tooth or teeth covered from birth

6. Dispensing of drugs not normally supplied in a dental office

7. Hospital benefits for any dental procedure

8. Loss or theft of dental appliances

9. Any procedures of implantation or experimental procedures

10. Services for injuries or conditions which are covered under worker’s compensation or employer’s

liability laws. Services which are provided without cost to the member by any municipality,

county or other political subdivision

11. General anesthesia

12. Services that cannot be performed because of the general health, physical or psychological

limitations of the patient

13. Periodontics, endodontics, or pedodontics requiring the services of a non participating dentist

14. Those procedures requiring appliances or restorations that are necessary for full mouth

rehabilitation, or to alter, restore or maintain occlusion, including without limitation treatment of

disturbances of the tempormandibular joint

15. Fluoride application is limited to dependents under age 19, twice per year

16. Diagnosis and treatment of myofacial disfunction syndrome

17. Procedures performed in the hospital

18. Orthodontics of any kind are not a covered benefit

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**INDIVIDUAL MEMBER SIGNATURE DATE**

**Comprehensive Dental Care Benefit Package Reduced Fee Schedule**

**Code Description Regular Fee Member Fee**

***Examinations***

D0120 Periodic Oral Evaluation $52 No Charge

D0140 Limited Oral Evaluation $69 No Charge

D0150 Complete Oral Evaluation $87 No Charge

D0180 Comprehensive Perio Evaluation $93 No Charge

***Xrays***

D0210 Intraoral Complete Series $141 No Charge

D0220 Intraoral Periapical $36 No Charge

D0272 Bitewings- two films $49 No Charge

D0274 Bitewings- four films $65 No Charge

D0330 Panoramic Film $118 No Charge

***Diagnostics***

D0431 VelScope Cancer Screening $37 $28

D0470 Diagnostic Casts $226 $180

***Simple Cleanings/Preventatives***

D1110 Prophylaxis- adult $95 No Charge

D1120 Prophylaxis- child $74 No Charge

D1208 Fluoride $62 No Charge

D1330 Oral Hygiene Instruction $69 No Charge

D1351 Sealant- per tooth $58 $40

***Periodontics***

D4341 Periodontal Scaling 4+ teeth per quad $283 $227

D4342 Periodontal Scaling 1-3 teeth per quad $176 $141

D4355 Full Mouth Debridement $183 $147

D4381 Local Delivery of Antimicrobals $25 $20

D4910 Periodontal Maintenance Cleaning $154 No Charge

D4211 Gingivectomy $337 $270

***Restoratives/Fillings***

D0510 Space Maintainer $394 $316

D2140 Amalgam- 1 surface $170 $136

D2150 Amalgam- 2 surface $207 $166

D2160 Amalgam- 3 surface $256 $205

D2161 Amalgam- 4+ surface $310 $248

D2330 Resin- 1 surface, anterior $170 $136

D2331 Resin- 2 surface, anterior $197 $158

D2332 Resin- 3 surface, anterior $239 $192

D2335 Resin- 4+ surface, anterior $281 $225

D2391 Resin- 1 surface, posterior $181 $145

D2392 Resin- 2 surface, posterior $228 $183

D2393 Resin- 3 surface, posterior $290 $232

D2394 Resin- 4+ surface, posterior $354 $283

D2940 Sedative Filling $120 $96

**Comprehensive Dental Care Benefit Package Reduced Fee Schedule Continued**

**Code Description Regular Fee Member Fee**

***Restoratives/Crowns&Bridges***

D2950 Core Buildup $301 $241

D2954 Prefab Post & Core Buildup $363 $291

D2740 Crown- all porcelain/ceramic $1,144 $915

D2750 Crown- porcelain fused to metal $1,150 $920

D2790 Crown- full cast high noble metal $1,150 $920

D2930 Stainless Steel Crown- baby tooth $317 $253

D2932 Prefab Resin Crown- baby tooth $345 $254

D2920 Recement Crown $110 $88

D6740 Retainer Crown for Bridge $1,149 $919

D6245 Pontic Crown for Bridge $1,149 $919

***Root Canal Treatments***

D3110 Direct Pulp Cap $87 $70

D3120 Indirect Pulp Cap $71 $57

D3220 Therapeutic Pulpotomy $206 $165

D3310 Root Canal- anterior tooth $694 $555

D3320 Root Canal- biscupid tooth $840 $672

D3330 Root Canal- molor tooth $1,048 $839

***Extractions***

D7140 Simple Extraction $192 $153

D7210 Surgical Extraction $250 $200

D7220 Soft Tissue Impacted Extraction $315 $252

D7230 Partially Bony Extraction $421 $336

D7240 Completely Bony Extraction $560 $448

D7250 Surgical Root Removal $260 $208

***Dentures/Partials***

D5110 Complete Denture Maxillary $1,780 $1,424

D5120 Complete Denture Mandibular $1,780 $1,424

D5130 Immediate Denture Maxillary $1,890 $1,512

D5140 Immediate Denture Mandibular $1,890 $1,512

D5211 Temporary Resin Based Partial $1,460 $1,168

D5213 Metal Based Partial Maxillary $1,905 $1,524

D5214 Metal Based Partial Mandibular $1,905 $1,524

D5225 Flex Based Partial Maxillary $1,276 $1,021

D5226 Flex Based Partial Mandibular $1,276 $1,021

***Cosmetic Treatment***

D9972 Take Home Whitening $75 $175

D9975 Whitening Syringe Refill-each $20 $16

D2962 Veneer- Porcelain, Lab Crafted $1,144 $915

***Other Services***

D9110 Emergency Treatment, Palliative $110 $82

D9310 Consultation $227 No Charge

D9215 Local Anesthesia $55 No Charge

D9230 Nitrous Oxide Analgesia $57 $45