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GENERAL LIMITATIONS AND EXCLUSIONS

GENERAL LIMITATIONS

Benefits provided under the DENCAP Dental Plan are subject to the following limitations:

EXAMINATIONS

• Initial, Comprehensive and Periodic Oral Evaluations are limited to 2 every 12 months.

PREVENTIVE

• Prophylaxis (teeth cleaning) is limited to 3 per 12 months (D1120-Pediatric) or 2 per 12 months (D1110-Adult). 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.
• Fluoride is covered 2 per 12 months, with no age limit. Under the age of 3, fluoride is covered 4 per 12 months.
• Sealants are covered for members between the ages of 5 and 15, for first and second permanent molars 1 sealant per 3 years. Sealants for members over the age of 15 are covered 1 per lifetime for an unrestored molar.
• Space Maintainers are covered for members under the age of 14, 1 space maintainer per 2 years per quadrant. Over the age of 14, 1 per quadrant per lifetime.

RADIOGRAPHS

• Full mouth images (FMX) and Panoramic radiographs are limited to 1 per 36 months.
• Bitewings, intraoral and/or periapical radiographs are covered as images are needed.

RESTORATIONS

• If a tooth can be restored (filled) with amalgam, composite, or other ADA recommended materials, these will be utilized in restoring the tooth. The judgment will be solely that of the dental professional providing the service and will be covered as needed.
• Crowns and onlays are covered 1 per 36 months per tooth or tooth space. A crown placed solely for the purpose of replacing an existing restoration will not be covered.
• When a crown or onlay is less than 36 months old no replacement will be provided under the program.
• The cost of repairs to a restorative appliance is not to exceed the cost of the replacement of said appliance.

ENDODONTICS

• Root canal therapy, root canal retreatment, and apicoectomy are covered 1 per lifetime of the tooth. Root canal therapy is a benefit only where otherwise sound teeth can be reasonably restored and the condition of the rest of the mouth supports this method of treatment.
• Retreatment of previous root canal therapy requires the removal of all previous root canal materials and the necessary preparation of the canals for new root canal filling materials. It includes all procedures necessary for complete root canal therapy and should be considered prior to performing an apicoectomy.

PEDIATRIC DENTISTRY

• Essential Health Benefits (**EHB**) are covered through the end of the month the insured turns 19 years old.
• EHB Annual Limitation on Cost Sharing (patient maximum out of pocket cost) is $375 per child, $750 for 2 or more children. DENCAP has no annual payment limit for EHB.
• Specialty services are provided for EHB with no waiting period. DENCAP recommends a referral from an in-network provider.

PERIODONTICS

• Debridement, irrigation, scaling and root planing (deep cleaning), and site-specific therapy is covered 1 per 24 months.
• Scaling and Root Planing (SRP) and other Periodontal Surgeries require Prior Authorization. All Prior Authorization requests must be submitted with the patient's current radiographs, periodontal charting, and periodontal treatment plan indicating the prognosis of the patient's condition. Prior Authorization requests are processed within 14 calendar days.
• Osseous surgery is covered 1 per 36 months.
• Other covered periodontal surgeries, including clinical crown lengthening are covered 1 per lifetime of the tooth.
• Periodontal maintenance is covered 4 per 12 months following scaling and root planing or osseous surgery.
• Services or supplies related to periodontal splinting are not covered.

ORAL SURGERY

• Extractions are covered 1 per lifetime of the tooth.
• Other oral surgery procedures are covered as determined by the dental professional.

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PROSTHODONTICS

• Dentures, partials, retainer crowns, or bridges are covered 1 per 36 months per arch. When a denture, partial, retainer crown, or bridge is less than 36 months old, no replacement will be provided under the program, unless such placement is needed due to the extraction of natural teeth.
• Prosthodontic appliances placed solely for the purpose of replacing an existing serviceable appliance will not be covered.
• The cost of repairs to a prosthodontic appliance is not to exceed the cost of the replacement of said appliance.

ORTHODONTICS

• Comprehensive Orthodontic Treatment (braces) will be provided when in the opinion of the Orthodontist, a satisfactory result can be achieved. Treatment is limited to Class I and II cases and 24 months of treatment.
• Cross bite in permanent dentition (teeth) will only be treated when, in the opinion of the Orthodontist, other conditions are present that would indicate orthodontic treatment is necessary.
• Interceptive Orthodontic Treatment discounts may be available at specific DENCAP provider locations. Contact DENCAP for assistance.

GENERAL EXCLUSIONS

The following treatments are not covered under the DENCAP Dental Plan:

• Dental services not appearing on the “Schedule of Benefits and Co-Payments”.
• Dental treatment for cosmetic purposes only. Cosmetic dentistry includes those procedures that improve the appearance of the dental structures such as dental implants, transplants, or grafts.
• Services needed solely in connection with non-covered treatment.
• Treatment for Temporal Mandibular Joint (TMJ) Disorder/Dysfunction.
• Root canal therapy where furcation pathology exists.
• Root canal therapy where teeth are deemed non-restorable.
• Retreatment of root canal therapy within five years of original root canal if final restoration has not been completed.
• Dental treatment performed by any dentist not under contract by DENCAP.
• Dental treatment performed by an unlicensed dentist at the time of service.
• Services that do not meet the generally accepted standards of dental treatment.
• Dental treatment performed in a hospital and/or any related hospital fee.