

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

OFFICE VISIT CO-PAY		
9430	Office Visit (for observation)	\$15
9999	Office Visit (regular hours)	\$15

code description co-pay

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

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

PREVENTIVE (Class I - Preventive)		
1206	Topical Application of Fluoride - varnish	\$0
1208	Topical Application of Fluoride - excluding varnish	\$0
1330	Oral Hygiene Instructions	\$0

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

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

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

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.

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.		

code	description	co-pay	code	description	co-pay
<b>PROSTHODONTICS (Class III - Major)</b>			<b>CROWNS (Class III - Major)</b>		
5110	Complete Upper Denture	\$625	2390	Crown - resin-based composite, anterior	\$212
5120	Complete Lower Denture	\$625	2542	Onlay - metallic, two surfaces	\$561
5130	Immediate Upper Denture	\$675	2543	Onlay - metallic, three surfaces	\$562
5140	Immediate Lower Denture	\$675	2544	Onlay - metallic, four surfaces	\$575
5211	Upper Partial Denture - resin base	\$675	2642	Onlay - porcelain/ceramic, two surfaces	\$577
5212	Lower Partial Denture - resin base	\$675	2643	Onlay - porcelain/ceramic, three surfaces	\$555
5213	Upper Partial Denture - cast metal framework with resin base, including clasps, rests, and teeth	\$725	2644	Onlay - porcelain/ceramic, four surfaces	\$568
5214	Lower Partial Denture - cast metal framework with resin base, including clasps, rests and teeth	\$725	2662	Onlay - resin-based composite, two surfaces	\$552
5225	Upper Partial Denture - flexible base, including any clasps, rests and teeth	\$725	2663	Onlay - resin-based composite, three surfaces	\$555
5226	Lower Partial Denture - flexible base, including any clasps, rests and teeth	\$725	2664	Onlay - resin-based composite, four surfaces	\$558
5820	Interim Partial Denture - upper	\$375	2740	Crown - porcelain/ceramic	\$840
5821	Interim Partial Denture - lower	\$375	2750	Crown - porcelain fused to high noble metal	\$705
5850	Tissue Conditioning - upper	\$73	2751	Crown - porcelain fused to predominantly base metal	\$573
5851	Tissue Conditioning - lower	\$73	2752	Crown - porcelain fused to noble metal	\$575
6010	Endosteal Implant in Conjunction with Denture	\$1,296	2780	Crown - 3/4 cast high noble metal	\$697
6011	Surgical Access to an Implant Body	\$414	2781	Crown - 3/4 cast predominantly base metal	\$570
6012	Endosteal Implant in Conjunction with Denture	\$1,135	2782	Crown - 3/4 cast noble metal	\$584
6210	Pontic - cast high noble metal	\$577	2783	Crown - 3/4 porcelain/ceramic	\$834
6211	Pontic - cast predominantly base metal	\$474	2790	Crown - full cast high noble metal	\$817
6212	Pontic - cast noble metal	\$447	2791	Crown - full cast predominantly base metal	\$593
6240	Pontic - porcelain fused to high noble metal	\$541	2792	Crown - full cast noble metal	\$622
6241	Pontic - porcelain fused to predominantly base metal	\$431	2799	Crown - interim	\$189
6242	Pontic - porcelain fused to noble metal	\$420	2930	Crown - prefabricated stainless steel, primary tooth	\$179
6245	Pontic - porcelain/ceramic	\$662	2931	Crown - prefabricated stainless steel, permanent tooth	\$179
6740	Retainer Crown - porcelain/ceramic	\$662	2932	Crown - prefabricated resin	\$191
6750	Retainer Crown - porcelain fused to high noble metal	\$541	2933	Crown - prefabricated stainless steel with window	\$180
6751	Retainer Crown - porcelain fused to predominantly base metal	\$421	2950	Core Buildup - including any pins	\$90
6752	Retainer Crown - porcelain fused to noble metal	\$420	2952	Post and Core in Addition to Crown	\$132
6780	Retainer Crown - 3/4 cast high noble metal	\$541	2954	Prefabricated Post and Core in Addition to Crown	\$132
6781	Retainer Crown - 3/4 cast predominantly base metal	\$410	<b>ORAL SURGERY (Class III - Major)</b>		
6782	Retainer Crown - 3/4 cast noble metal	\$421	7111	Extraction - coronal remnants (primary tooth)	\$36
6783	Retainer Crown - 3/4 porcelain/ceramic	\$662	7140	Extraction - erupted tooth or exposed root	\$36
6790	Retainer Crown - full cast high noble metal	\$588	7210	Surgical Removal of an Erupted Tooth	\$77
6791	Retainer Crown - full cast predominantly base metal	\$471	7220	Removal of Impacted Tooth - soft tissue	\$79
6792	Retainer Crown - full cast noble metal	\$457	7230	Removal of Impacted Tooth - partially bony	\$117
<b>PERIODONTICS (Class III - Major)</b>			7240	Removal of Impacted Tooth - completely bony	\$148
0180	Comprehensive Periodontal Evaluation	\$42	7241	Removal of Impacted Tooth - complicated	\$194
4210	Gingivectomy/Gingivoplasty - 4+ teeth/spaces per quad	\$194	7250	Surgical Removal of Residual Tooth Roots	\$221
4211	Gingivectomy/Gingivoplasty - 1-3 teeth/spaces per quad	\$172	7280	Surgical Access of an Unerupted Tooth	\$158
4212	Gingivectomy/Gingivoplasty - access for restorative procedure, per tooth	\$92	7285	Incisional Biopsy of Oral Tissue - hard	\$387
4240	Gingival Flap Procedure - 4+ teeth/spaces per quad	\$268	7286	Incisional Biopsy of Oral Tissue - soft	\$210
4241	Gingival Flap Procedure - 1-3 teeth/spaces per quad	\$237	7287	Exfoliative Cytological Sample Collection	\$71
4249	Clinical Crown Lengthening - hard tissue	\$421	7310	Alveoloplasty in Conjunction with Extractions - 4+ teeth/spaces per quad	\$78
4260	Osseous Surgery - 4+ teeth/spaces per quad	\$429	7311	Alveoloplasty in Conjunction with Extractions - 1-3 teeth/spaces per quad	\$60
4261	Osseous Surgery - 1-3 teeth/spaces per quad	\$300	7320	Alveoloplasty not in Conjunction with Extractions - 4+ teeth/spaces	\$109
4341	Perio Scaling and Root Planning - 4+ teeth per quad	\$73	7321	Alveoloplasty not in Conjunction with Extractions - 1-3 teeth/spaces	\$85
4342	Perio Scaling and Root Planning - 1-3 teeth per quad	\$60	7471	Removal of Lateral Exostosis	\$225
4355	Full Mouth Debridement	\$48	7472	Removal of Torus Palatinus	\$215
4381	Site Specific Therapy, generic - per tooth	\$45	7473	Removal of Torus Mandibularis	\$211
4910	Periodontal Maintenance	\$54	7510	Incision and Drainage of Abscess - intraoral soft tissue	\$50
4921	Gingival Irrigation - per quad	\$7	<i>Benefits are subject to change. Limitations and Exclusions found at: dencap.com/general-policies</i>		

**ORTHODONTICS (Class IV - Orthodontics)**

Approved referral from DENCAP to an in-network Orthodontist is required

Up to Age 19, \$1800 benefit / Over age 19, \$1200 benefit (Lifetime benefit)

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**

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	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.