DENCAP PPO

Our National Preferred Provider Organization (PPO)

Group Dental Plan

Welcome!

DENCAP Dental Plans stands ready to serve your dental coverage needs!

DENCAP Dental Plans has been providing high quality dental coverage at affordable rates to Michigan groups, individuals, and families since 1984. The mission of DENCAP has always been to provide quality dental coverage, access to a large network of highly qualified dentists, and excellent customer care to groups and individuals with transparency of pricing for dental services. Every facet of our company is shaped around this mission.

We encourage you to take advantage of the benefits included with your coverage to promote good oral health as part of your overall health.

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Note: Benefits Summary, Exclusions, and Limitations are issued separately.

I. DENCAP Dental PPO Certificate

DENCAP Dental Plans issues this Certificate to you, the Subscriber. It is an easy-to-read Benefits Summary. It reflects and is subject to the agreement between DENCAP Dental Plans and the Enrolling Group.

DENCAP Dental Plans agrees to provide dental benefits as described in this Certificate.

Note that we do not consider genetic testing for issuing, renewing or continuing the policy. We do not discriminate against genetic medical conditions. DENCAP will not ask for or collect genetic information for underwriting.

All the parts of this document and are governed by the laws of the State of Michigan.

Signed:
Joseph T. Lentine
President and CEO
DENCAP Dental Plans, Inc.

II. Selecting a Dentist

You may choose any Dentist in the United States. Your out-of-pocket costs are likely to be less if you go to a DENCAP Dental PPO Dentist. PPO Dentists agree to accept payment according to the PPO Dentist Schedule, and, in most cases, this results in a reduction of their fees. This plan is designed to save you the most money and to help reduce your out-of-pocket costs if you go to a PPO Dentist.

- **In-Network**

  Contracted Amounts by dental procedure according to the PPO Dentist Schedule are considered full payments toward Covered Services. If the Contracted Amount is lower than the fee that they submit, the dentist cannot charge you the difference. **You are only responsible for your Deductible, Copayments, and/or Coinsurance amounts for Covered Services.**

- **Out-of-Network**

  If the Dentist you select is not a PPO Dentist, you will be charged the difference of the Maximum Allowable Amount and the Dentists fee for a service. **You are only responsible for your Deductible, Copayments, and/or Coinsurance amounts as well as any fees above the Maximum Allowable Amount for Covered Services.**

A list of Participating Dentists will not be provided as it changes frequently and is accurate only as of the date it is printed. To verify that a Dentist is a Participating Dentist, you can use DENCAP Dental's online Dentist Directory at www.dencap.com or call (313) 972-1400.

III. Using Your Benefits

To use your Plan, follow these steps:

1. Please read this Certificate and the Benefits Summary carefully so you are familiar with the benefits of your Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits coverage with DENCAP Dental. If your Dentist is not familiar with your Plan or has questions about the Plan, have him or her contact DENCAP Dental by calling (313)972-1400.
3. After you receive your dental treatment, you or the dental office staff will file a claim form. For detailed instructions on filing a claim form, see the section called "Filing a Claim".

IV. Dental Plan Benefits

Your Benefits Summary gives you an explanation of the coverage level indicated on the plan your Group selected. This Summary includes the percentage coverage for each Class and the plan's annual maximums.

V. Coordination of Benefits

Coordination of Benefits (COB) is used to pay health care expenses when you are covered by more than one plan. The objective of coordination of benefits is to make sure the combined payments of the plans are no more than your actual bills.

When you or your family members are covered by more than one plan, DENCAP Dental follows the Michigan coordination of benefit rules to determine which plan is primary and which is secondary. You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

DENCAP Dental pays for dental care only when you follow its rules and procedures. If these rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

PLANS THAT DO NOT COORDINATE

DENCAP Dental will pay benefits without regard to benefits paid by the following kinds of coverage:

- Individual (not group) policies or contracts
- Medicaid
- Group hospital indemnity plans that pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

HOW DENCAP DENTAL PAYS AS PRIMARY PLAN

When DENCAP Dental is primary, it will pay the full benefit allowed by your contract as if you had no other coverage.

HOW DENCAP DENTAL PAYS AS SECONDARY PLAN

When DENCAP Dental is secondary, its payments will be based on the amount remaining after the primary plan has paid. DENCAP Dental will not pay more than that amount, and it will not pay more than it would have paid as primary.

- DENCAP Dental will pay only for expenses that are covered by DENCAP Dental.
- DENCAP Dental will pay only if you have followed all the procedural requirements.
- DENCAP Dental will pay no more than the "allowable expenses" for the health care involved. If the allowable expenses are lower than the primary plan's, DENCAP Dental will use the primary plan's allowable expenses. This may be less than the actual bill.

WHICH PLAN IS PRIMARY?

To decide which plan is primary, DENCAP Dental will consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another group plan that does not coordinate benefits, it will always be primary.

2. Employee

The plan that covers you as an employee (neither laid off nor retired) is always primary.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent's plan is primary. If a court decree gives joint custody and does not mention health care, DENCAP Dental follows the birthday rule.

If neither of those rules applies, the order will be determined in accordance with the Michigan Office of Financial and Insurance Services rule on Coordination of Benefits.

4. Children and the Birthday Rule

When your Children's health care expenses are involved, DENCAP Dental follows the "birthday rule." Under this rule, the plan of the parent with the first birthday in a calendar year is always primary for the Children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all your Children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" that says the father's plan is always primary), DENCAP Dental will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Michigan Office of Financial and Insurance Services rule on Coordination of Benefits.

VI. Claims Payment

DENCAP Dental will pay claims according to the Benefits Summary to the subscribers on the plan. If a claim is submitted by the dentist, DENCAP will reimburse the dentist directly. Should the subscriber pay for services and submit a claim with proof of payment, the subscriber will be reimbursed. The Subscriber will be responsible for any difference between DENCAP Dental's payment and the submitted amount or the non-participating dentist fee.

IN-NETWORK DENTIST

If the Dentist is a Participating Dentist, DENCAP Dental will base payment on the lesser of:

a. The Submitted Amount;

b. The Participating Dentist Schedule

OUT-OF-NETWORK DENTIST

If the Dentist does not participate in DENCAP Dental PPO, DENCAP Dental will base payment on the lesser of:

a. The Submitted Amount; or

b. The Nonparticipating Dentist Fee; or

c. The Maximum Allowable Amount

The Subscriber will be responsible for noncovered services.

DENIED CLAIMS

If your claim is denied, you will receive a letter from DENCAP called an adverse determination letter.

DENCAP will provide a letter indicating adverse determination within 45 days. If additional information is needed to process the claim, we will notify you or the provider within this 45-day period and assume a one-time extension not longer than 15 days.

Once you have received notice of the extension, you have 15 days to provide the needed information. DENCAP will determine the claim status within 15 days of receiving the needed information.

- If the claim meets plan benefit coverage, the claim will be approved and will be processed within 15 days from the date we approve the claim.
- If the claim is denied OR if the additional Information requested Is not received, the claim will not be paid.

You or the dental provider will be notified of approvals and denials by letter. An adverse determination will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures. If you believe that your claim should have been paid, you may appeal the decision. See Claims Appeal Procedure below for additional information.

VII. Filing a Claim

You or your dentist must file a claim for benefits within 12 months of the date that dental services were completed.

FILING A CLAIM FOR REIMBURSEMENT

It is necessary to complete a form which must include the following information:

a. Subscriber's full name and address

b. The Subscriber's Member ID number

c. The name and date of birth of the person receiving dental care

d. The name and address of the provider of the service(s), their tax ID, and NPI number.

e. Itemized bill which includes the ADA approved CDT codes or detailed description of each charge. If you have already paid for services, include all paid receipts.

f. When available, include radiographs, hospital or lab reports

g. A statement indicating whether you are or are not covered under another health or dental insurance plan or program. If you are enrolled for other coverage you must include the names of the other carriers.

If you would like a reimbursement form or help completing that form, call DENCAP at (313) 972-1400.

Subscribers may mail the completed form to:

Claims Department
DENCAP Dental Plans
45 E. Milwaukee Street
Detroit, MI 48202
-or-
Fax number: (313) 972-4662

Providers may submit claims through electronic data transfer using PAYOR code: "DPLAN." Providers can also mail claims to DENCAP Dental Plans, P.O. Box 2548, Detroit, MI 48202.

Prior approval is not required for claims. A claim filed after 12 months of the date of dental services may be denied.

VIII. Appeals, Complaints, Grievances

APPEAL PROCEDURE

If you disagree with the decision that DENCAP made about your claim, you can appeal the decision. You must notify DENCAP in writing that you want to appeal.

DENCAP's Dental Director or another qualified person(s) will review your claim appeal. The person who reviews the appeal will not be the same as, or work for, the person(s) who originally decided your claim status. He/she will assess the information, including any additional information that you have provided, as if he/she were deciding on the claim for the first time.

Upon request and free of charge, you have the right to copies of all documents, records, and other information relevant to your claim for benefits.

The Dental Director or qualified person(s) will make their decision within 60 days of receiving your request for the review of our original decision. If the claim appeal is approved, we will send you a letter indicating that the claim will be paid, and the claim will be processed. If the claim appeal decision is denied (in whole or in part) you will be notified in writing. The notice of the adverse determination by the Dental Director or qualified person(s) will:

a. Inform you of the specific reason(s) for the denial.

b. List the reason(s)

c. Contain a description of any additional information or material that is needed to decide on the claim and an explanation why such information is needed.

d. Reference any internal rule, guideline, or protocol that was relied on in making the decision.

e. Contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the denied claim.

Submit your appeal to:
Appeals
DENCAP Dental Plans
45 E. Milwaukee Street
Detroit, MI 48202
-or-
Fax number: (313) 972-4662

Filing time period

A Subscriber has 60 days from the date of notice of adverse benefit determination to file an appeal with DENCAP. You may request a reasonable extension if required.

EXTERNAL REVIEW PROCESS

Subscribers are informed of their right to file for an External Review of a grievance or adverse determination once the DENCAP processes described here have been exhausted.

The Subscriber has the right to a review of a grievance or an adverse determination by the Director of the Department of Insurance and Financial Services (DIFS) or their designee or by an Independent Review Organization under the Patient's Right to Independent Review Act.

DENCAP will provide the address and phone number for filing a Grievance at the State of Michigan level if your appeal is denied. It is:

Department of Insurance and Financial Services
Office of General Counsel / Health Care Appeals Section
PO Box 30220
Lansing, Michigan 48909-7720
Phone: 1.877.999.6442

A Subscriber has the right to submit additional information along with the forms used to process an External Review.

Forms needed to start the External Grievance Procedure are also available through the website of https://difs.state.mi.us/Complaints/ExternalReview.aspx or through their toll-free number of 1.877.999.6442.

Filing time period

A Subscriber has 127 days from the date of notice of adverse benefit determination to file an appeal with the State of Michigan.

COMPLAINTS AND GRIEVANCES

DENCAP and your dental provider wants you to feel satisfied with your care.

If you are unhappy with your dentist or dental care, please discuss your concern with your provider. You may also contact DENCAP.

If you are unhappy with DENCAP, please let us know! We strive to provide excellent customer care and will do our best to address your concern.

If you feel that a provider or DENCAP has not resolved your concern or complaint, you may file a grievance. A grievance should be written and mailed to:

Member Grievance
DENCAP Dental Plans
45 E. Milwaukee Street
Detroit, MI 48202
-or-
Fax number: (313) 972-4662

Once we receive your written grievance, we will let you know we received it and will address your concern within 30 days. If an extension is required by either DENCAP, the provider, or the subscriber, a timeframe no longer than ten (10) days will be granted.

You may also file a complaint with the Department of Insurance and Financial Services. Please see the section called "External Review Process" for details.

Filing time period

For a grievance, a Subscriber has 180 days from the date of discovery to file a Grievance. An extension is allowed when the Subscriber can show conclusively that circumstances required a longer period prior to filing the Grievance.

PROMPT RESOLUTION

If the nature of the Grievance requires a Prompt Resolution, telephone or email the DENCAP Dental Director immediately. Normally, a Prompt Resolution is required when a Dentist indicates that a subscriber's life or ability to regain maximum function could be at risk.

A determination will be made by DENCAP not later than seventy-two (72) hours after receipt of an expedited Grievance. Within ten (10) days after receipt of a determination, the Subscriber may request an independent review of our determination under the Patient's Right to Independent Review Act.

RECORDS

DENCAP shall keep all information and dental records confidential. Information and records shall be maintained to the extent and degree professionally required.

We will make a subscriber or enrolled dependent's records available for inspection and review by the Subscribers and those persons authorized by the Subscribers. Copies shall be made available for inspection and review to the extent legally and professionally ethical.

DENCAP protects patient health information according to HIPAA legislation. A copy of the DENCAP Dental Plans Notice of Privacy Practices is available by contacting the DENCAP administrative offices: 313-972-1400, or by email at info@dencap.com.

IX. Termination of Coverage

Your DENCAP Dental coverage may be automatically terminated:

- When your employer or organization advises DENCAP Dental to terminate your coverage.
- The employer or organization terminates coverage with DENCAP Dental.
- Your employer or organization has failed to pay DENCAP Dental.
- If DENCAP learns of any fraud or misrepresentation by the subscriber, agent or the group.

DENCAP Dental will not continue eligibility for any person covered under this program beyond the eligibility termination date requested by the Enrolling Group. A person whose eligibility is terminated may not continue Group coverage under this Contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or comparable, non-preempted state law. See Continuation of Coverage, Section X.

In the case of termination due to fraud or misrepresentation, DENCAP will issue a notice of cancellation to the subscriber thirty (30) days prior to ending coverage.

Your coverage is guaranteed to be renewable. However, DENCAP reserves the right to reject reinstatement of coverage for any of the reasons noted above.

SUBSCRIBER or GROUP TERMINATION

The enrolling group or agent must inform DENCAP if the group or a subscriber of the group terminates coverage. If the group or agent terminates coverage prior to the 10th day of the month, then the end date of coverage will be the prior month. The group will not be held responsible for the Monthly Premiums for the current month.

If the Group terminates Coverage after the 10th of the month, then the end date of coverage will be the current month. The group will be held responsible for the premium for that month.

All terminations must be submitted to DENCAP in writing via e-mail, fax or mail.

The subscriber is responsible for any dental services he/she receives in the month following termination.

PAYMENT OF GROUP PREMIUMS

The group or agent will make payments on behalf of the subscriber. Premiums are payable monthly in advance of coverage. A fourteen (14) day grace period will be allowed during which the coverage will remain in place. If a group or agent fails to make payment, the insurance will terminate at the end of the grace period with notice to the Group. DENCAP will accept payment of Premiums from the Group after the expiration of the grace period up to 60 days post cancelation date with no lapse in coverage.

LOSS OF ELIGIBILITY DURING TREATMENT

If an eligible person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under the Plan will be payable.

Certain services which began before the loss of eligibility may be covered if they are completed within a 60-day period measured from the date of termination. In those cases, DENCAP Dental evaluates those services in progress to determine what portion may be paid by DENCAP Dental.

Any balance of the total fee not paid by DENCAP Dental is your responsibility.

X. Continuation of Coverage

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that you and/or your covered Eligible Dependents have the right under certain circumstances to continue coverage in the medical and dental plans, at your expense, beyond the time coverage would normally end.

If you believe you are entitled to continuation coverage, you should contact your employer to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 (ERISA).

XI. General Conditions

CHANGE OF STATUS

You must notify the Enrolling Group of any event that changes the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

ASSIGNMENT

Services and/or benefit payments to eligible people are for the personal benefit of those people and cannot be transferred or assigned.

SUBROGATION

A legal right held by DENCAP to legally pursue a third party to recover a claim paid to the subscriber.

REIMBURSEMENT

If you or your Eligible Dependent recovers damages from any party or through any coverage named above, you must reimburse DENCAP Dental from that recovery to the extent of payments made under the Plan.

GENERAL PROVISIONS

Entire Policy

The Policy issued to the Enrolling Group, including the Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber shall be deemed to be true at the time of their submission.

Limitation of Action

You do not have the right to bring any legal proceeding or action against DENCAP without first completing the complaint procedure found in the Section entitled Appeals, Complaints, Grievances. If you do not bring legal proceeding or action against DENCAP within 3 years of the date DENCAP notified you of its final decision; you give up your rights to bring any action against DENCAP.

Term of Agreement and Renewal

The term of agreement is twelve (12) months from the group effective date unless otherwise specified. The agreement shall automatically renew month to month. Either the group or DENCAP can terminate coverage by giving at least thirty (30) days written notice.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by DENCAP. No change will be made to the Policy unless it is made by an Amendment or by a Rider that is signed by an officer of DENCAP. No agent has authority to change the Policy or to waive any of its parts.

Relationship Between Parties

The relationships between DENCAP and its providers and the relationship between DENCAP and its Enrolling Groups, are solely contractual relationships between independent contractors. Providers and Enrolling Groups are not agents or employees of DENCAP. DENCAP or any employee of DENCAP are not agents or employees of providers or Enrolling Groups.

The relationship between a provider and any Subscriber is that of provider and patient. The provider is solely responsible for the services provided to any Subscriber.

The relationship between the Enrolling Group and Subscribers is that of employer and employee, Dependent or other Coverage classification as defined in the Policy. The Enrolling Group is solely responsible for:

- enrollment
- coverage classification changes
- termination of a Subscriber's Coverage
- timely payment for the Policy
- notifying Subscribers of the termination of the Policy

Assignment
Either party may assign this contract with thirty (30) days written notice to the other party.

Records
You must furnish DENCAP with all reasonable information and proofs regarding any matters pertaining to the Policy.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you, to furnish DENCAP all information and records or copies of records relating to the services provided to you. DENCAP has the right to request this information at any reasonable time. This applies to all Subscribers, including Enrolled Dependents whether they have signed the Subscriber's enrollment form or not.

DENCAP agrees that such information and records will be considered confidential. DENCAP has the right to release all records concerning dental care services which are necessary to administer the terms of the Policy or for appropriate review or quality assessment.

DENCAP is permitted to charge you reasonable fees to cover costs for completing requested dental records or forms that you have requested.

In some cases, DENCAP will designate other persons or entities to request records or information from or related to you and to release those records as necessary. DENCAP's designees have the same rights to this information, as does DENCAP.

During and after the term of the Policy, DENCAP and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

ERISA
When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., DENCAP is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Examination of Subscribers
In the event of a question or dispute concerning Coverage for Dental Services, DENCAP may reasonably require that a Dentist acceptable to DENCAP examine you at DENCAP's expense.

Clerical Error
If a clerical error or other mistake occurs, that error shall not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

Notice
When DENCAP provides written notice of the Policy to an agent or authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Subscribers.

Workers' Compensation Not Affected
The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Statute Compliance

Any part of the Policy which, on its effective date, conflicts with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Non-Liability

A Subscriber may, for personal or religious reasons, refuse to accept procedures or treatment recommended as Medically Necessary by his or her Dentist. In some situations, such refusal may be regarded as a barrier to the Dentist-patient relationship or to the delivery of the appropriate care.

The Subscriber will be advised if the Dentist believes that no acceptable alternative treatment exists. If the Subscriber continues to refuse the treatment or procedure, the Dentist is relieved of further responsibility to provide care for the condition which requires treatment. Further, DENCAP will have no obligation to provide Coverage for treatment of the condition.

XII. Definitions

ADA

An abbreviation for the American Dental Association.

ADVERSE DETERMINATION

A decision made by the Insurance company that a treatment or service is not a covered benefit based on the information provided. It can also mean that a claim was not submitted in a timely manner.

ANNUAL MAXIMUM

The maximum dollar amount DENCAP Dental will pay in any benefit year for covered dental services. (See the Benefits Summary.)

APPEAL

A subscriber's written disagreement with the payment your Insurance made to a provider for services or treatment.

BENEFITS SUMMARY

A description of the specific parts of your group dental Plan. The Benefits Summary is included with this Certificate of Coverage. If the information in the Benefits Summary is different from your Certificate of Coverage, the Benefits Summary applies.

CDT

An abbreviation for Current Dental Terminology

CERTIFICATE

This document. DENCAP Dental will provide dental benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Plan.

CLEAN CLAIMS

Clean claims include all the information that an Insurance company requires to pay a provider for treatment/services. The claim does not have any errors when it is submitted.

COMPLETION DATES

Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates
- For crowns and bridgework, on the cementation dates
- For root canals and gum disease treatment, on the date of the final procedure that completes treatment.

CO-PAYMENT

As provided by your Plan, the percentage of the charge, if any, that you will have to pay for Covered Services.

COVERED SERVICES/COVERAGE

The unique benefits selected in your Plan. The Benefits Summary provided with this

Certificate lists the Covered Services provided by your Plan.

DEDUCTIBLE
The amount a person and/or a family must pay toward Covered Services before DENCAP Dental begins paying for services. The Benefits Summary lists the Deductible that applies to you, if any.

DENCAP DENTAL
DENCAP Dental Plans, a state-licensed dental insurance company that provides dental service benefits.

DENTIST
A person licensed to practice dentistry in the state or country in which dental services are provided.

- **DENCAP Dental PPO Dentist (PPO Dentist) or Participating Dentist**
  A Dentist who has agreed to participate in the DENCAP Dental PPO. PPO Dentists agree to accept DENCAP Dental's fee as payment in full for Covered Services.

- **Out-of-Network Dentist**
  A Dentist who has not agreed to participate in DENCAP Dental PPO. The dentist may charge you directly for services received.

ELIGIBLE DEPENDENT
Your legal dependent as determined by the Enrolling Group. Contact the Group for specific information about your plan's rules for dependent eligibility.

ENROLLING GROUP
Your employer or organization.

GRIEVANCE
A complaint about your care.

MAXIMUM ALLOWABLE AMOUNT
The amount that DENCAP will pay for a service or treatment. A fee meets Maximum Allowable Amount if it is the lowest of:
- The Submitted Amount.
- The Contracted Amount.
- The lowest fee regularly charged by an individual Dentist.
- The maximum fee that the local DENCAP Dental Plan approves for a given procedure in each region and/or specialty, under normal circumstances. DENCAP Dental may also approve a fee under unusual circumstances.

  Participating Dentists are not allowed to charge more than the Maximum Allowable Amount for the Covered Service. In all cases, DENCAP Dental will make the final determination about what is the Maximum Allowable Amount for the Covered Service.

OUT-OF-NETWORK DENTIST FEE
The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

POLICY
The benefit that DENCAP is providing. The Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber shall be assumed true at the time of their submission.

PPO DENTIST SCHEDULE
A list of procedures that include the maximum Allowable Amount per procedure for services.

PPO NETWORK
A provider network that is contracted to accept lower costs for dental care. These lower costs save you money when you see an in-network, PPO Dentist.

SUBMITTED AMOUNT OR SUBMITTED FEE
The fee a Dentist bills to DENCAP Dental for a specific treatment.

SUBSCRIBER
You, when your employer or organization notifies DENCAP Dental that you are eligible to receive dental benefits under your employer's or organization's Plan.