Benefits Summary
Prestige 1800
PS18

The below summary of the Prestige 1800 Plan Benefits is additional information to your Certificate of Coverage. If the information in this document is different from your Certificate of Coverage, this document applies. The percentages noted are applied to DENCAP's Dental allowance for each service and may vary based on your dentist's network participation.

Covered Services:
Annual Maximum: $1,800
Deductible: $50/$100 (Excludes Diagnostic & Preventive)
The DENCAP Prestige 1800 plan has no waiting periods.

	DENCAP DPOS Dentist	Out of Network Dentist†
Diagnostic & Preventive – Exams, Cleanings & X-Rays, Emergency Pain Relief		
Exams (including a second opinion)	**100%**	100%
Emergency Palliative Treatment	**100%**	100%
Brush Biopsy	**100%**	100%
Radiographs	**100%**	100%
Sealants	**100%**	100%
Basic Services – Fillings, Extractions, Root Canals, Denture Repair		
Minor Restorative Services (amalgam, plastic or similar materials and stainless steel-crowns)	**80%**	80%
Endodontic Services	**80%**	80%
Periodontic Service (including Gingivectomy or Gingivoplasty)	**80%**	80%
Oral Surgery Services	**80%**	80%
Other Basic Services	**80%**	80%
Relines and Repairs	**80%**	80%
Major Services – To Replace Missing Teeth, Crowns		
Major Restorative Services (Porcelain, Ceramic and Cast Metal Retainers for Resin Bonded Fixed Prosthesis)	**50%**	50%
Prosthodontic Services	**50%**	50%
EHB Services Include: Exams, Cleanings, Fillings, Sealants, Simple Extractions, Root Canals, and Crowns		

EHB ANNUAL LIMITATION ON COST SHARING (PATIENT MAXIMUM OUT OF POCKET COST) IS $400 PER CHILD, $800 FOR TWO OR MORE CHILDREN. DENCAP HAS NO ANNUAL PAYMENT LIMIT FOR EHB. APPLIES TO IN-NETWORK DENTISTS ONLY.
† DENCAP WILL PAY THE PERCENTAGES INDICATED IN THIS COLUMN TO NON-PARTICIPATING DENTISTS. YOU MAY BE RESPONSIBLE FOR THE BALANCE ABOVE THE APPROVED AMOUNT. FOR BEST SAVINGS, WE ENCOURAGE YOU TO SEE A DENCAP DPOS DENTIST. YOUR DENTIST MAY NOT ACCEPT YOUR INSURANCE.

FOR DENCAP CUSTOMER SERVICE or CLAIM STATUS

(844) 433-6227

DENTAL OFFICES, SUBMIT CLAIMS TO:

DENCAP Dental Plans
PO BOX 2548
Detroit, MI 48202

PAYOR ID:
DPLAN

LIMITATIONS:

Exams	2 every 12 months
Sealants	1 per tooth per 3 years for the first and second molars up to age 15. Over age 15, 1 per lifetime
Prophylaxis	Adults: 2 every 12 months; Children: 3 every 12 months
Full Mouth Debridement	1 every 24 months
Full Mouth X-ray / Panoramic X-ray	1 every 60 months
Bitewing X-ray	4 images every 12 months
Fillings	1 every 24 months per tooth
Crowns / Bridges	1 every 60 months per tooth
Dentures / Partials	1 every 60 months per arch
Periodontal Maintenance	4 every 12 months for 24 months following periodontal surgery; 3 every 12 months with documented history of periodontal disease
Scaling and Root Planning	1 every 24 months
Periodontal Surgery	1 per quadrant every 36 months
Fluoride	4 every 12 months up to age 3; 2 every 12 months up to age 15
Implants	1 every 10 years per tooth when allowed in plan design
Space Maintainers	1 per quadrant per 2 years up to age 15
Re-cementation of Prosthetic	1 per tooth / quad every year
Root Canal	1 per tooth per lifetime
Retreat Root Canal	1 per tooth per lifetime
Apicoectomy	1 per tooth per lifetime
Provisional Crowns	1 per tooth every 24 months up to age 19
Tissue Conditioning	1 per arch every 36 months
Relines / Rebases of Removable Prosthetics	1 per arch every 36 months
Occlusal Guard	1 every lifetime
Occlusal Adjustment	Complete: 1 every lifetime; Limited: 1 every year
Pediatric Dentistry Services	Up to the end of the month the insured turns 19;includes pulpotomy for primary teeth

EXCLUSIONS:

1. Procedures done only for cosmetic reasons or for asymptomatic teeth, unless specified in the plan design
2. Tooth whitening is not a covered benefit unless specified in the plan design
3. Services for which you would not be required to pay in the absence of dental insurance
4. Services for trauma caused by an automobile accident
5. Conditions arising from employment or work-related injuries or illnesses
6. Treatment for any condition for which benefits of any nature are recovered or found to be recoverable; whether by adjudication or settlement under any Workers Compensation or Occupational Disease Law, even though the Subscriber fails to claim the right to such benefits, provided that his/her exclusion shall only apply to the extent that such benefits are payable through such other plans
7. Care or treatment obtained from or for which payment is made by any Federal, State, County, Municipal or other government agency, including any foreign government or conditions arising from war
8. Conditions arising as the result of willful criminal activity
9. Replacement of lost, stolen or missing prosthetic appliance(s), and those for replacement due to abuse, misuse, or neglect (i.e., orthodontic retainer, occlusal guard, denture)
10. Replacement of complete or partial dentures, fixed bridgework, or crowns if damage or breakage was directly related to provider error.
11. Decoration, embellishment, or personalization of any dental work such as crown, partial or denture
12. Precision attachments
13. Replacement or Restoration of teeth beyond the normal complement of 32
14. Prescription drugs
15. Services deemed to be medical services
    a. treatment of fractures, dislocation or other injury to the jaw or face.
    b. hospital charges
    c. treatment to correct congenital malformation
    d. treatment of cysts, lesions, or malignancies other than biopsy collection for initial diagnosis
16. Treatment performed outside of the United States other than for emergency treatment. Emergency treatment outside the United States is reimbursable up to $100.00
17. Payment for:
    a. travel time
    b. travel expenses
    c. completion of forms
    d. missed appointment fees
    e. duplication of radiographs
    f. phone consultations
    g. oral hygiene instruction
    h. smoking cessation instruction
    i. diet or nutritional instruction
    j. infection control
18. Treatment, which is temporary, transitional, or interim in nature
19. Services started prior to coverage effective date
20. Treatment started during coverage and not completed within 30 days of termination of coverage.
21. Prosthetic delivery must be completed within 30 days of loss of coverage and is only payable if impressions were taken during active coverage
22. Any service not specifically listed on the covered services
23. Specialist consultations for non-covered services
24. Diagnosis and Treatment of TMD/TMJ, including occlusal guards used specifically to treat TMD/TMJ
25. Occlusal guards except if prescribed to control habitual grinding
26. Occlusal guards or safety appliances for sports-related activities or to enhance performance during sports-related activities
27. General Anesthesia administered by an anesthesiologist (specialist)
28. General Anesthesia for any reason other than surgical procedures
29. Hospital or Operating Room fees for dental care
30. Services performed by anyone other than a licensed hygienist or licensed dentist
31. Personal care supplies, including but not limited to, toothbrushes, flossing devices, or water picks
32. Alternate treatment, or experimental treatment, not widely accepted or deemed to meet ADA standard of care.
33. Acupuncture, acupressure, and other forms of alternative treatment, whether or not used as anesthesia
34. Replacement or repair of a restoration is the provider's responsibility for the first two (2) years following its placement. This applies to all restorations.
35. Tooth preparation, temporary crowns, bases, impressions, anesthesia, or other services which are part of the complete dental procedure. These services are considered components of and included in the fee for the complete procedure. Separate fees may not be charged.