dencap
DENTAL PLANS

Dental Health Management Organization (DHMO)

Group Dental Plan

Welcome!

DENCAP Dental Plans stands ready to serve your dental coverag

DENCAP Dental Plans has been providing high quality dental coverage at affordable rates to Michigan groups, individuals, and families since 1984. DENCAP's mission has always been to provide quality dental coverage, access to a large network of highly qualified dentists, and excellent customer care with transparency of pricing. 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: Schedule of Benefits, Exclusions, and Limitations are issued separately.

See: dencap.com/general-policies for more information

I. DENCAP DHMO 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.

DENCAP utilizes an enrollee's age at the time of policy issuance or renewal as the sole method to calculate an enrollee's age for rating and eligibility purposes.

This document is governed by the laws of the State of Michigan.

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

II. Selecting a Dentist

Your insurance plan requires you to choose an in-network dentist as your 'dental home.' You may choose from any dentist in the DENCAP Diamond or Emerald Network. Your out-of-pocket fixed co-payment costs only apply if you go to a network dentist. DENCAP DHMO dentists agree to accept payment according to the Schedule of Benefits, this results in a reduction of their fees.

IN-NETWORK GENERAL DENTIST

Co-payment amounts by dental procedure according to the Schedule of Benefits are considered full payments toward covered services. If the contracted amount is lower than the fee that they normally charge, the dentist cannot charge you the difference. **You are responsible for your co-payments, and/or lab fees for covered services.**

IN-NETWORK SPECIALIST DENTIST

You must be referred by your selected DHMO in-network general dentist to an in-network specialist for services to be covered. Refer to your Schedule of Benefits for a detailed breakdown of your coverage. You are responsible for your co-insurance amount for covered services. If eligible for EHB services, members can go to any pediatric dentist without a referral.

OUT-OF-NETWORK

If the dentist you select is not a DHMO in-network dentist, you will be charged the full amount of the dentist's fee for a service. **You are responsible for the full fee for all services.**

A list of in-network general dentists is on DENCAP's online dentist directory at dencap.com/find-a-dentist. Call 313.972.1400 or e-mail info@dencap.com for a printed directory.

III. Using Your Benefits

To use your plan, follow these steps:

1. Read this certificate and the Schedule of Benefits carefully so you are familiar with the benefits of your plan.
2. Choose a dentist from the DENCAP Diamond or Emerald DHMO network and inform DENCAP of your choice by calling 313.972.1400 or e-mailing at info@dencap.com.
3. Make an appointment with your dentist and tell them that you have dental coverage with DENCAP. If your dentist has questions about the plan, have them contact DENCAP by calling 313.972.1400.
4. After you receive your dental treatment, the dental office staff will inform you of your co-payment amount.

5.

IV. Identification Card

You will receive a DENCAP identification (ID) card and other materials that include information about your plan, effective date, and how to use your benefits.

Please present your ID card when visiting your dentist. Additional ID may be required to verify your identity and eligibility before treatment.

This card shall remain the property of DENCAP and is not transferable. Upon cancelation of the subscriber's policy, this card is void.

If this ID card is lost or stolen, please notify DENCAP right away, you will be issued a new dental ID card within 14 days.

V. Dental Plan Benefits

BENEFIT DETAILS

Your Schedule of Benefits details the dental coverage your employer selected. This summary includes fixed co-payment amounts for each covered procedure and your plan's annual maximums. If you have not received your Schedule of Benefits from your employer, you may request one from DENCAP at 313.972.1400 or info@dencap.com.

EMERGENCY SERVICES

Your DENCAP dental plan provides coverage 24 hours a day, 365 days a year. Should you have a dental emergency outside of your dentists' regular business hours, contact your regular dentist first. They have after-hours emergency services in place. If for any reason you are unable to contact your regular dental office, you may seek emergency services through a different in-network provider location.

If you are fifty miles or more away from the nearest in-network provider, you may seek emergency services from an out-of-network provider. Out-of-network emergency services are only to relieve severe pain. DENCAP will reimburse you for 50% of the approved services up to $100. For reimbursement, follow the instructions provided in section IX. Filing a Claim.

Be sure to complete any follow-up treatment to your emergency services at your regular dental office.

VI. Member Rights and Responsibilities

As a member of DENCAP, you have rights and responsibilities. Understanding these rights and responsibilities helps you get the most out of your dental benefits.

MEMBER RIGHTS

Member rights will be honored by all DENCAP staff and affiliated providers. You have the right to:

- Understand information about your dental benefits
- Get required care as described in this document and your Schedule of Benefits
- Be treated with dignity and respect
- Privacy of your health care information as outlined in this document
- Fully join in making decisions about your health care
- Refuse to accept treatment
- Review your dental records and ask that they be corrected or amended
- Request to receive the credentials of providers in the DENCAP network
- Receive all written notices in a culturally and linguistically appropriate manner

MEMBER RESPONSIBILITIES

You have the responsibility to:

- Know your DENCAP Certificate and all other provided materials
- Call Customer Service with any questions
- Seek services for all non-emergency care through your primary care dentist
- Make and keep appointments with your primary care dentist
- Contact your dentist's office if you need to cancel an appointment
- Pay member co-payment amounts when required, and pay for non-covered benefits
- Notify your dentist of other dental insurance you have in addition to your DENCAP insurance
- Be involved in decisions regarding your health
- Behave in a proper, considerate, and truthful manner to providers, their staff, other patients and DENCAP staff
- Tell your employer of address changes, and any changes for your dependent coverage
- Follow your dentist's instructions regarding your care
- Cooperate with DENCAP when coordination is needed between DENCAP and another insurance carrier

VII. 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. You are responsible for notifying your provider about all applicable insurance before receiving services to ensure coverage and coordinated benefits.

When you or your family members are covered by more than one plan, DENCAP 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 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

The following kinds of coverage will not affect DENCAP benefit payments:

- 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 PAYS AS PRIMARY PLAN

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

HOW DENCAP PAYS AS SECONDARY PLAN

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

- DENCAP will only cover services listed on your Schedule of Benefits
- DENCAP will pay only if you have followed all the requirements

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

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

4. Children and the Birthday Rule

When your Children's health care expenses are involved, DENCAP 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 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 Department of Insurance and Financial Services rule on Coordination of Benefits. If the plans cannot agree on the order of benefits within 30 calendar days after receiving all information needed to pay the claim, the plans will pay in equal parts and determine their responsibilities following payment. Neither plan will be responsible for more than it would have paid if it were the primary plan.

VIII. Specialty Claims Payment

DENCAP will pay claims for specialty care treatment according to the Schedule of Benefits. If the dentist submits a claim, DENCAP will pay 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's payment and the maximum approved amount.

You are responsible for the following:

- Your co-payments and/or co-insurance amounts for covered services
- All non-covered services

DENIED CLAIMS

If your claim is denied, you will receive a letter from DENCAP called an Adverse Determination Notice by mail.

An Adverse Determination letter will:

- Explain the reason for denial
- Refer to the part of the plan on which the denial is based
- Provide the claim appeal procedure

DENCAP will provide this notice within 45 days of the claim denial. If you believe that your claim should have been paid, you may appeal the decision. See "Appeals" section for additional information.

If your claim cannot be processed and additional information is needed, we will notify you and/or the provider within 45 days and assume a one-time extension not longer than 15 days.

Once you have received notice, 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.

IX. Filing a Claim

You or your dentist must file a claim for benefits within one (1) year 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. The 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), and their 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 x-rays, 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 & Providers may mail the completed form to:
Claims Department
DENCAP Dental Plans
45 E. Milwaukee Ave
Detroit, MI 48202
-or-
Fax number: 313.972.4662

X. Appeals, Complaints, Grievances

DENCAP ensures member satisfaction through a Quality Assurance (QA) Committee. QA members review member dental care to ensure all members receive quality care and all appropriate dental standards are applied. This committee will review all Appeals and Grievances.

If you disagree with the decision that DENCAP has made about your claim, you can appeal the decision by following the appeal process.

APPEALS

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 review all 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 a copy 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 processed and paid. If the claim appeal decision is denied (in whole or in part) you will be notified in writing. The notice of the adverse determination 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 or guideline 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 the information relevant to the denied claim

Submit your appeal to:
Appeals
DENCAP Dental Plans
45 E. Milwaukee Ave.
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.

GRIEVANCE PROCESS

If you are not satisfied with the care received from your provider and you have been unable to resolve the concern by contacting your dentist directly, please contact DENCAP customer service by calling 844.919.1601 or writing to info@dencap.com to submit an Internal Informal Grievance. If we are unable to resolve your concern to your satisfaction, you have the right to submit a Formal Grievance by following the steps listed below. A subscriber has 180 days from the date of discovery of the incident to file a grievance.

Submit in writing to DENCAP a detailed account of your concern, any supporting documentation, and a proposed resolution. Your grievance must include the Subscriber's name and member ID number. Send notice to DENCAP at:

Member Grievance
DENCAP Dental Plans, Inc.
45 E. Milwaukee Street
Detroit, MI 48202

Upon receipt of your grievance, the DENCAP QA committee will promptly and fully review the matter and address your concerns. Within seven (7) business days DENCAP will provide written acknowledgement of receipt of the Grievance. You can ask to present your grievance in person. If you would like to present your grievance in person, you must indicate that in your written request and DENCAP will contact you to set up a meeting date and time. A decision will be made within 30 business days, and DENCAP will provide you with written notice.

If DENCAP requires additional information from you or the dental provider to make a final decision, an extension of not more than 10 business days may be added to the time in which DENCAP has to respond. If after 10 business days the additional information is not provided, DENCAP will make a final determination to close the grievance.

You have a right to request a review of an adverse determination by 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 (PRIRA) within 127 days after receipt of the determination.

The address and phone number for filing a grievance due to adverse determination at the State of Michigan is:

Department of Insurance and Financial Services
Office of General Counsel / Health Care Appeals Section
P.O. Box 30220
Lansing, Michigan 48909-7720

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 , by email at DIFSComplaints@michigan.gov, or through their toll-free number of 877.999.6442

PROMPT RESOLUTION

If the nature of the grievance requires prompt resolution, or related to a dental emergency, you should call or email DENCAP immediately.

Your grievance will be expedited, and a determination will be made by DENCAP not later than 72 hours after receipt.

RECORDS

DENCAP shall keep all information and dental records confidential. Information and records shall be maintained to the extent and degree professionally required. Grievance and appeal case records are retained for a period of no less than two (2) years, kept on file electronically at DENCAP. Records can be made available upon request by the appropriate parties. Grievance and appeal case files are summarized, reviewed, and are reported in our quarterly Quality Assurance Grievance Committee minutes (QAGC). QAGC minutes are filed with the director annually.

We will make a subscriber or enrolled dependent's records available for inspection and review by you and those persons you authorize. 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 DENCAP: 313.972.1400, or by email at info@dencap.com.

XI. Cancelation of Coverage

Your coverage is guaranteed to be renewable. However, DENCAP reserves the right to reject reinstatement of coverage for any of the reasons noted below.
Your DENCAP coverage may be automatically canceled:

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

DENCAP will not continue eligibility for any person covered under this plan beyond the eligibility cancelation date requested by the enrolling group. A person whose eligibility is canceled may not continue 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 XII.

In the case of cancelation due to fraud or misrepresentation (recission), DENCAP will issue a notice of cancellation to the enrolling group 30 days prior to ending coverage.

SUBSCRIBER or GROUP CANCELATION

A group or agent must submit cancelations to DENCAP by the 10th of the month if the group or a subscriber of the group cancels coverage. All cancelations must be submitted to DENCAP in writing via e-mail, fax, or mail. Retroactive cancelations are allowed for up to 90 days. The subscriber is responsible for paying for any dental services he/she receives during a period of inactive coverage.

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 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 premium payment from the group after the expiration of the grace period, up to 60 days post cancellation date with no lapse in coverage.

LOSS OF ELIGIBILITY DURING TREATMENT

If a person loses eligibility while receiving dental treatment, only services received while that person was covered under the plan will be covered.

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

XII. Continuation of Coverage

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that you, and/or your eligible dependents have the right in certain circumstances to continue in the dental plan, at your expense, beyond the time coverage would normally end.
If you believe you are entitled to continue coverage, you should contact your employer to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 (ERISA).

XIII. General Policies

Change of Status
You must notify your Employer 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
Subscriber: Services and/or benefit payments to eligible people are for the personal benefit of those people and cannot be transferred or assigned.
Enrolling Group: Either party may assign this contract with 30 days written notice to the other party.

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 from that recovery to the extent of payments made under the plan.

Entire Policy
The policy issued to the enrolling group, including the Certificate of Coverage, the enrollment 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 proceedings or action against DENCAP within 3 years of the date DENCAP notified you of its final decision; you give up your right to bring any action against DENCAP.

Term of Agreement and Renewal
The term of agreement is 12 months from the group's effective date unless otherwise specified. The agreement shall automatically be renewed month to month. Either the Employer or DENCAP can cancel coverage by giving at least 30 days written notice.

Amendments and Alterations
Amendments to the policy are effective upon 30 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 dentist and patient. The provider is solely responsible for the services rendered 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
- Cancelation of a Subscriber's coverage
- Timely payment for the Policy
- Notifying Subscribers of the cancelation of the Policy

Records

You must furnish DENCAP with all reasonable information and proof 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 is 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 providing 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 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, it 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.

XIV. Definitions

ADA
An abbreviation for the American Dental Association.

ADVERSE DETERMINATION
A decision made by the insurance company to deny, reduce, or refuse to pay (in whole or in part) a benefit. Decisions may be based on eligibility, plan limitations and exclusions, medical necessity, or utilization review.

ANNUAL MAXIMUM
The maximum dollar amount DENCAP will pay for care in a 12-month period. (See the Schedule of Benefits.)

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

BALANCE BILLING
When a dental provider bills an employee for the difference between their charge and the carrier's regional discounted rate.

BENEFIT
The amount a plan pays for a dental procedure or service.

CDT
An abbreviation for Current Dental Terminology.

CERTIFICATE
This document. DENCAP will provide dental benefits as described in this certificate. Any changes to this certificate will be based on changes to the plan.

COBRA
Federal legislation regarding the continuation of health benefits for all types of employee benefits plans provided by the employer.

CO-INSURANCE
As provided by your plan, the percentage of the charge, if any, that you will have to pay for covered services.

CO-PAYMENT
As provided by your plan, a fixed dollar amount that an employee must pay at the time service is rendered.

COVERED SERVICES/COVERAGE
The unique benefits selected in your plan. The Schedule of Benefits lists the covered services provided by your plan.

DENCAP
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 DHMO Dentist

A dentist who has agreed to participate in the DENCAP DHMO. DHMO dentists agree to accept your co-payment as payment in full for covered services.

- Out-of-Network Dentist

A dentist who has not agreed to participate in DENCAP DHMO. The dentist will charge you in full for services received.

- General Dentist

A dentist who performs most dental services and serves as a member's 'dental home.'

- Specialist Dentist

A dentist who has a special license to perform dental care beyond that of a general dentist.

DHMO NETWORK
A provider network that is contracted to accept lower costs for dental care.

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

ENROLLING GROUP
Your employer or organization.

(EHB) ESSENTIAL HEALTH BENEFITS
A set of services health insurance plans must cover under the Affordable Care Act.

EXCLUSIONS
Specific conditions, services, or treatments for which a plan will not provide coverage. They can be found at dencap.com/general-policies.

HIPAA
Health Insurance Portability and Accountability Act.

GRIEVANCE
A complaint about your care.

MAXIMUM APPROVED AMOUNT
The amount that DENCAP will pay for a service or treatment.
Participating dentists cannot charge more than the maximum approved amount for the covered service.
In all cases, DENCAP will make the final determination about what is the maximum approved amount for the covered service.

MEDICALLY NECESSARY / MEDICAL NECESSITY
Services that are appropriate to the Member's diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Services must be based on accepted medical or scientific evidence, and consistent with generally accepted practice standards. This excludes cosmetic procedures.

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.

PREMIUM
Monthly amount due to DENCAP to maintain coverage.

PROVIDER
The dentist, the employer of the dentist, and employees who assist in providing dental services.

SCHEDULE OF BENEFITS
A detailed list of all the covered services provided by your plan. If the information in the Schedule of Benefits is different from your Certificate of Coverage, the Schedule of Benefits applies.

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