Dental Health Management Organization (DHMO)



Group Dental Plan

Welcome!

DENCAP Dental Plans stand ready to serve your dental plan needs!

DENCAP Dental Plans has been offering dental plans 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 coverage included with your plan to promote good oral health as part of your overall health.

TABLE OF CONTENTS

Contents

I. INTRODUCTION 3

II. Selecting a Dentist 4

IN-NETWORK GENERAL DENTIST 4

OUT OF NETWORK 4

III. Using Your Benefits 5

IV. Identification Card 5

V. Dental Plan Benefits 6

BENEFIT DETAILS 6

EMERGENCY SERVICES 6

VI. Member Rights and Responsibilities 7

MEMBER RIGHTS 7

VII. Coordination of Benefits 8

PLANS THAT DO NOT COORDINATE 8

HOW DENCAP PAYS AS PRIMARY PLAN 8

HOW DENCAP PAYS AS SECONDARY PLAN 8

WHICH PLAN IS PRIMARY? 8

VIII. Filing a Claim 9

FILING A CLAIM FOR REIMBURSEMENT 9

IX. Specialty Claims Payment 10

PRE-SERVICE CLAIMS 10

DENIED CLAIMS 11

DENIED CLAIMS ADDITIONAL INFORMATION 11

X. Appeals, Complaints, Grievances 12

APPEALS 12

GRIEVANCE PROCESS 13

EXPEDITED REVIEW 14

RECORDS 15

XI. Cancelation of Coverage 15

SUBSCRIBER or GROUP CANCELATION 16

PAYMENT OF GROUP PREMIUMS 16

LOSS OF ELIGIBILITY DURING TREATMENT 16

XII. Continuation of Coverage 16

XIII. General Policies 17

XIV. Definitions 20

ADA 20

Note: Schedule of Benefits, Exclusions, and Limitations are issued separately. See: dencap.com/general-policies for more information

I. INTRODUCTION

This Certificate of Coverage (COC) describes the benefits available to Members covered under DENCAP Dental Plans policies.

Your coverage is guaranteed as described here.

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 uses a member's age at the time of policy issuance or renewal as the sole method to calculate their age for rating and eligibility purposes.

This certificate follows the laws of the State of Michigan.

DENCAP Dental Plans, Inc.

II. Selecting a Dentist

Your insurance plan requires you to choose an in-network dentist as your *dental home*.

Choosing a Dentist: You may pick any dentist from the DENCAP DHMO Network. A list of participating dentists is available online or by contacting Member Services.

Using your Coverage: You pay the co-pay listed in the Schedule of Benefits when you use a network dentist. Network dentists agree to accept DENCAP's set fees. This helps lower your cost and prevent surprise bills.

Changing Dentists: To change your selected dentist, notify DENCAP. Changes typically go into effect on the first day of the next month.

IN-NETWORK GENERAL DENTIST

When you use an in-network general dentist, you pay the co-pay in the *Schedule of Benefits*. The listed co-pay is full payment for the covered service. The dentist may not bill you for the difference between the contracted fee and their usual rate. You are responsible for co-pays and any applicable lab or enhancement fees that apply.

IN-NETWORK SPECIALIST DENTIST

Referral Requirement: To receive coverage for services by a specialist, you need a referral from your general dentist.

Coverage & Cost Sharing: See your *Schedule of Benefits* for details on co-insurance amounts and covered services. You are responsible for paying your co-insurance and any applicable lab fees.

Pediatric Dental Care: If your child is eligible for Essential Health Benefits (EHB), you may visit any pediatric dentist without a referral.

OUT OF NETWORK

If you see a dentist outside of the DENCAP Network, your plan will not cover the services. You are responsible for paying the full amount charged for any services received.

To find a dentist, visit dencap.com/find-a- dentist, call 313.972.1400 or e-mail info@dencap.com to ask for a printed copy of the provider directory.

III. Using Your Benefits

To get the most from your plan, please follow these steps:

1. **Review Your Plan**

   Read this Certificate of Coverage and your *Schedule of Benefits*. These explain what is covered, your co-pays, and any limits.

2. **Select a Dentist**

   Pick a dentist from the DENCAP Network. Call 313.972.1400 or email info@dencap.com to let us know your choice.

3. **Schedule an Appointment**

   Call your dentist to schedule an appointment. Tell them you have a DENCAP plan. If your dentist has questions, they can call us directly at 313.972.1400.

4. **Pay Your Co-Pay**

   After your visit, the dentist will let you know the co-pay due for your covered services, based on your plan.

IV. Identification Card

As a member, you will receive an identification (ID) card and coverage materials that include information about how to use your plan. Your dentist may ask for your ID card and another form of ID before treatment.

This card remains the property of DENCAP and is not transferable. Upon cancelation of the policy, this card is no longer valid. If your ID card is lost or stolen, tell DENCAP right away. We will send a new card within 14 business days.

V. Dental Plan Benefits

BENEFIT DETAILS

Your Schedule of Benefits lists what is covered, co-pay amounts, and any yearly limits. If you need a copy, you may request one by calling DENCAP at 313.972.1400 or emailinginfo@dencap.com.

EMERGENCY SERVICES

Your plan provides coverage **24 hours a day, 365 days a year**.

Contacting Your Dentist: If you have a dental emergency outside of regular business hours, contact your regular general dentist first. Most have after-hours emergency procedures in place.

In-Network Emergency Care: If you cannot reach your regular dentist, you may seek emergency care from another in-network provider.

Out-of-Network Emergency Care: If you are 50 miles or more from the nearest in-network provider, you may get emergency treatment from an out-of-network dentist.

- Out-of-network coverage is limited to relief of severe pain only.
- You will be reimbursed for 50% of the approved charges, up to $100.
- To receive reimbursement, follow the claim submission instructions in Section IX: Filing a Claim.

Important: All follow-up care after an emergency visit must be completed with your regular DENCAP dentist.

ORTHODONTIC COVERAGE

You or a covered family member may qualify for continued orthodontic coverage if treatment began under another dental plan. This may also apply when changing DENCAP plans.

To determine eligibility for continued orthodontic coverage, a **Continuous Orthodontic Coverage Form** must be completed and submitted to DENCAP for review.

Review Process

- All submitted requests are reviewed to assess eligibility for continuation of benefits.
- The review process typically takes up to **45 days** from the date all required documentation is received.
- You will be notified once a determination has been made.

How to Submit

Forms are available on our website: **dencap.com/general-policies**

Need Help?

If you need assistance completing the form, please contact our Customer Service Department at: **(313) 972-1400**

VI. Member Rights and Responsibilities

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

MEMBER RIGHTS

DENCAP staff and its providers must honor these member rights. You have the right to:

- Receive clear 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
- Take part in decisions about your health care
- Refuse to accept treatment you do not want
- Review your dental records and ask for corrections
- Ask for credentials of providers in the network
- Receive notices in a language and format you can understand

MEMBER RESPONSIBILITIES

You have the responsibility to:

- Choose an In-Network Provider and assign them as your "dental home"
- Read your Certificate and all other plan materials
- Call Customer Service if you have any questions
- Use your primary dentist for all non-emergency care
- Keep appointments and cancel in advance if needed
- Follow your dentist's instructions about your care
- Be involved in decisions about your health
- Pay co-pays when required, and costs for non-covered services
- Tell your dentist of other dental insurance you may have
- Work with DENCAP if another insurance carrier is involved
- Be respectful to providers, staff, other patients, and DENCAP staff
- Tell your employer about address changes or dependent plan changes

VII. Coordination of Benefits

Coordination of Benefits (COB) applies when you are covered by more than one insurance plan. Coordination of benefits rules make sure the plans do not pay more than your actual bill. Tell your provider about all other insurance coverage before you receive care.

If you or your family have 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 coverage as if you had no other plan. 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 the plan rules. If the rules conflict with another plan, you may not be able to use both plans. You may need to choose which plan to use.

PLANS THAT DO NOT COORDINATE

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

- 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 plan.

HOW DENCAP PAYS AS SECONDARY PLAN

When DENCAP is secondary, its coverage will be based on the amount remaining after the primary plan has been 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 the 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 reviews the other plan's coordination rules and the family member named in the claim. The primary plan will be determined by the first of the following rules that apply:

1. Non-coordinating Plan

If you have another group plan that does not coordinate coverage, 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 Michigan's Coordination of Benefits Act.

4. Children and the Birthday Rule

DENCAP uses the Birthday Rule for a child's dental expenses. The plan of the parent whose birthday comes first in the calendar year pays first. 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 DENCAP will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of coverage will be determined in accordance with the State of Michigan's 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. Filing a Claim

You or your dentist must file a claim within one (1) year of the date that dental services are completed.

FILING A CLAIM FOR REIMBURSEMENT

To request reimbursement, you must complete a Claim Reimbursement Form and include the following information:

a. Policyholder's full name and address
b. Policyholder's Member ID number
c. Name and date of birth of the patient receiving dental care
d. Provider's name, address, Tax ID, and NPI number
e. An itemized bill that includes the CDT codes or detailed description of each charge. If you have already paid for services, include all paid receipts.
f. If you are enrolled in another plan, you must include the names of the other carrier(s).

If you would like a form or help to complete it, call DENCAP at 313.972.1400.

Completed forms may be submitted to:

Claims Department
DENCAP Dental Plans 45
E. Milwaukee Ave Detroit,
MI 48202
Fax number: 313.972.4662
Email: claims@dencap.com

IX. Specialty Claims Payment

DENCAP will pay claims for specialty care treatment according to the *Schedule of Benefits*.

Provider Payment: If the dentist submits the claim, DENCAP will pay the dentist directly. DENCAP will pay clean claims within 45 days after receipt. If we cannot process a claim, we will reject it within 30 days and tell the provider why. The provider has 45 days after the notice to correct and resubmit the claim.
Member Reimbursement: If you pay the dentist for services and submit a claim with proof of payment, DENCAP will reimburse you.

Member Responsibility: You are responsible for any difference between DENCAP's payment and the maximum approved amount.

As a member, you are responsible for the following:

- Your co-pays and/or co-insurance amounts for covered services
- Payment for all non-covered services

PRE-SERVICE CLAIMS

Some services, especially specialist care, require DENCAP approval before treatment. The treating provider must send the request, and all required clinical records before providing care.

REVIEW PROCESS

DENCAP will review prior authorization requests and provide a determination within 7 calendar days for standard requests and 72 hours for requests certified as urgent by the treating provider. If we need more information, DENCAP will request it from the provider. If we deny a request, we will send written notice of the denial, including the reason for the decision and your rights to appeal.

A request is considered approved if DENCAP does not approve, deny, or ask for more information within the time stated above. If we ask for more information, the same time limit starts when we receive it. The request is considered approved if DENCAP does not approve, deny, or otherwise respond within that time.

MEMBER RESPONSIBILITY

The member must get any required prior authorization before receiving services.

If a required referral or authorization is not obtained:

- The service may not be covered.
- You may have to pay the full cost, subject to the terms of your plan

DENIED CLAIMS

If your claim is denied, you will receive an Adverse Determination Notice by mail.

This notice will:

- Explain the reason for denial
- Name the section of the plan on which the denial is based
- Provide instructions for filing a claim appeal

DENIED CLAIMS ADDITIONAL INFORMATION

Notice of Denial: If your claim is denied, you will receive a **Denial Notice** by mail within 30 **days** of the denial.

Right to Appeal: If you believe your claim should have been paid, you may file an appeal. See the ***Appeals*** section for more details.

Requests for Additional Information

If we need more information to process your claim:

- DENCAP will tell you and/or your provider within 30 days of receiving the claim.
- We may extend the claim review period once, up to 10 additional days.

Member Response Time

You and/or your provider will have 10 days from the date of our request to provide the needed information.

Once DENCAP receives the information:

- If the claim **is for covered services and meets plan criteria**, the claim will be approved and processed within **15 days** of approval.
- If the claim is **denied** OR if the additional information requested is **not received**, the claim will not be paid.

X. Appeals, Complaints, Grievances

DENCAP uses a Quality Assurance (QA) Committee to review member care. The Committee helps make sure members receive quality care and proper dental standards are used. It also reviews all appeals and grievances. If you disagree with the decision that has been made about your pre-or-post service claim, you can appeal the decision by following the appeal process. You have 60 days from the date of the notice of adverse benefit determination to file an appeal with DENCAP. You may request a reasonable extension if required.

APPEALS

DENCAP's Dental Director or another qualified reviewer will review your appeal. The reviewer will not be the person who made the first decision or report to that person. The reviewer will consider all information and decide the claim again. You can ask to present your appeal in person. If you would like to present your appeal in person, you must indicate that in your written request we will contact you to set up a meeting date and time.

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

Filing Time Period

Pre-service appeal determinations are made no later than 30 calendar days from date received. Post-service appeal determinations are made no later than 60 calendar days from date received.

If we need more information from you or your dentist, we may extend our response time. The extension will not exceed 10 business days. If after 10 business days the additional information is not provided, DENCAP will make a final determination to close the appeal.

The Dental Director or qualified reviewer will decide your appeal within the time limit stated above.
If the appeal is approved, we will send you a letter indicating that the service is approved, and applicable claim(s) will be paid. If the appeal is denied (in whole or in part) you will be notified in writing. The notice of the adverse determination will:

a. Let you know the specific reason(s) for the denial
b. List the reason(s)
c. Contain a description of any additional information 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
Fax number: 313.972.4662
Email: cga@dencap.com

External Review

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 member 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.

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 call DENCAP customer service by calling 313.972.1400 or writing to cga@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 member has 180 days from the date of discovery of the incident to file a grievance.

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

Member Grievance
DENCAP Dental Plans, Inc.
45 E. Milwaukee Street
Detroit, MI 48202
Email: *cga@dencap.com*

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.

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 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 we need more information from you or your dentist, we may extend our response time. The extension will not exceed 10 business days. If after 10 business days the additional information is not provided, DENCAP will make a final determination to close the grievance.

EXPEDITED REVIEW

If your pre-service appeal or grievance needs a quick decision because of a dental emergency or the quality of the care you received is poor, you should call or email DENCAP immediately. Your case will be expedited, and determination will be made by DENCAP no later than 72 hours of receipt.

If our decision is first made over the phone, we will send a written notice within two business days. After our decision, you have 10 calendar days to ask for an additional review by the Michigan Department of Insurance and Financial Services (DIFS) or an independent review organization under state law.

When You Can Ask for an Expedited Review

You may request expedited handling when:

- A dentist or doctor tells us (verbally or in writing) that the delay of a standard review could seriously affect your dental health or recovery.
- You are in pain, at risk of infection, or have a condition that could worsen if not treated quickly.

How to Request Expedited Review

1. Contact our Member Services department immediately and tell them you want to file an expedited appeal or grievance (this depends on your situation).
2. Ask your dentist or physician to confirm that a delay could harm your health or ability to recover.
3. Provide any documents or records that support your request.
4. We will confirm in writing that your case is being handled on an expedited basis.

If You Disagree with Our Decision

- You have the right to appeal within 10 calendar days after our expedited decision.
- You can request an external review:
    - The Michigan Insurance Commissioner (DIFS)
    - An Independent Review Organization under the Patient's Right to Independent Review Act.

External Review

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

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

RECORDS

DENCAP will keep all information and dental records confidential. Information and records will be maintained to the extent and degree professionally required. We keep electronic grievance and appeal records for at least two years. We provide them to authorized parties upon request.

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 policyholder's or their enrolled dependent's records available for inspection and review by you and those people you authorize. Copies shall be made available for inspection and review to an extent legally and professionally acceptable.

DENCAP protects patient health information according to HIPAA legislation. A copy of the DENCAP Dental Plans Notice of Privacy Practices is available by calling DENCAP: 313.972.1400, or by email at info@dencap.com.

You and the people you authorize may inspect the policyholder's or dependent's records. We will provide copies as allowed by law and professional standards.

XI. Cancelation of Coverage

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

Your plan may be automatically canceled:

- When your employer or organization advises DENCAP to cancel your coverage
- The employer or organization cancels their plan with DENCAP
- Your employer or organization has failed to pay DENCAP
- If DENCAP learns of any fraud or misrepresentation by the policyholder, 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 ends may continue coverage only when required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other applicable state law. See Continuation of Coverage, Section XII.

In the case of cancelation due to fraud or misrepresentation (recission), we will issue a notice of cancellation to the enrolling group 30 days before 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 cancels coverage. All cancelations must be submitted to DENCAP using the approved cancelation form and/or submission method.
Retroactive cancelations are allowed for up to 90 days. The member is responsible for paying for any dental services he/she receives during a period of inactive coverage. If a member's coverage under a group policy is canceled, they must wait 12 months before they can re-enroll. This waiting period does not apply if the member has a qualifying event.

PAYMENT OF GROUP PREMIUMS

The group or agent will make payments on behalf of the subscriber. Premiums are due each month before coverage begins. A 14-day grace period will be allowed and the coverage remains active. If the group or agent does not pay, coverage ends after the grace period. We will notify the group.

DENCAP will accept premium payment from the group after the expiration of the grace period, up to 60 days after cancellation 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.

Some services that began before eligibility ended may be covered if completed within 60 days after the termination date. DENCAP will review the care in progress and decide what amount, if any, it will pay. DENCAP reserves the right to reclaim and/or recover any overpaid amounts from the provider or policyholder in the form of direct requests for repayment or deductions from future claims if a service is paid during a period of ineligibility.

XII. Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may let you and your eligible dependents continue dental coverage after benefits normally end. You must pay the cost. 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 pursue a third party to recover a claim paid to the policyholder.

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 entire policy includes this Certificate of Coverage, the enrollment application, amendments, and riders issued to the enrolling group. We consider statements from the group or subscriber to be true when submitted. **Limitation of Action**

You must complete the process in "Appeals, Complaints, Grievances" before taking legal action against DENCAP. You must take legal action within three years after we notify you of our final decision. If you do not, you give up that right.

Term of Agreement and Renewal
The terms of the agreement are 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 the authority to change the policy or to waive any of its parts.

Relationship Between Parties
DENCAP, its providers, and enrolling groups, are independent contractors. Providers and enrolling groups are not DENCAP agents or employees. DENCAP and its employees are not agents or employees of the providers or groups.
The relationship between a provider and any member is that of dentist and patient. The provider is solely responsible for the services rendered to any member.

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 coverage
- Timely payment for the Policy
- Notifying Subscribers of the cancelation of the Policy

Records

Member Responsibility: You must provide DENCAP with all reasonable information and proof necessary to administer your policy.

Authorization to Access Records: By accepting this policy, you allow any provider, facility, or institution that treated you or your dependents to give DENCAP records about that dental care.

- This authorization applies to all members on the policy.
- DENCAP may request this information at any reasonable time.

Confidentiality: DENCAP agrees that all records and information received are considered confidential. However, DENCAP may release records as necessary to administer plan benefits, conduct appropriate reviews, or carry out quality assessment.

Fees for Records: DENCAP may charge a reasonable fee to cover costs associated with providing copies of records or forms requested by the members.

Authorized Designees: In some cases, DENCAP may designate other people or entities to request and/or release records on its behalf. Such designees have the same rights as DENCAP with respect to these records.

Use of Information: During and after this policy, DENCAP and related entities may use or transfer policy information for research and analysis. We will follow privacy and confidentiality standards.

ERISA

When the policy is purchased by the enrolling group to provide coverage 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

If a question or dispute concerning coverage for dental services arises, 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. Clerical errors do not create a right to coverage.

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

If any part of this policy conflicts with state or federal law on its effective date, that part will follow the minimum legal requirement.

Non-Liability

A member 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 member will be advised if the dentist believes that no acceptable alternative treatment exists. If the member 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 amount DENCAP will pay for care in a 12-month period.

APPEAL
A member'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 OF COVERAGE
This document. DENCAP will provide dental benefits as described in this certificate.

CLEAN CLAIM
A claim that is submitted correctly the first time and has no errors, missing information, or issues that would delay payment.

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 network.
- Out-of-Network Dentist
  A dentist who has not agreed to participate in DENCAP DHMO.
- 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 network with dentists that are contracted to participate and agrees to the plan rules and fees.

ELIGIBLE DEPENDENT
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 be covered 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 formal 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 accepted practice standards. This excludes cosmetic procedures.

OVERPAYMENT
Payments made in error, duplicate payments, or payments for services not covered by this policy due to ineligibility or other related criteria.

POLICY
The benefit that DENCAP provides. 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 policyholder shall be assumed to be true at the time of their submission.

POLICYHOLDER
The person or entity who owns an insurance policy.

POST-SERVICE CLAIM
A request for payment after a member receives dental treatment.

PREMIUM
The monthly amount due to DENCAP to maintain coverage.

PRE-SERVICE CLAIM
A request for approval before you receive dental treatment.

PRIOR AUTHORIZATION
A process that requires your dental provider to get approval from your insurance company before completing certain treatments.

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.