dencap
DENTAL PLANS

Dental Health Management Organization (DHMO)

Individual 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.

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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 an enrollee's 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: Co-pays, as outlined in the Schedule of Benefits, apply when you receive care from a network dentist. Network dentists have an agreement to accept DENCAP's fixed fees. This means you pay less and avoid 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

If you see an In-Network general dentist, you only pay the co-pay amount listed in the Schedule of Benefits. The co-pay shown for each covered procedure is considered full payment for that service. If the contracted network fee is lower than the dentist's usual fee, the dentist cannot bill you for the difference. You are responsible for co-pays and any applicable lab or enhancement fees for covered services.

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 by an out-of-network dentist. 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 other materials that include information about your plan, effective date, and how to use your coverage. You may be asked to present your ID card when visiting the dentist and additional ID may be required to verify your identity 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 this ID card is lost or stolen, please notify DENCAP right away, you will be issued a new dental ID 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 emailing info@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

If you or a covered family member began orthodontic treatment under a previous dental insurance plan through an employer or organization, you may be eligible to continue coverage when enrolling in a DENCAP Dental Plan or when transitioning between 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 Customer Service 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 of your dental plan.

MEMBER RIGHTS

Member rights will be honored by all DENCAP staff and its providers.

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:

- Read your Certificate and all other plan materials
- Choose an In-Network Provider and assign them as your "dental home"
- Call Customer Service if you have any questions
- Use your primary care dentist for all non-emergency care
- Keep appointments and cancel in advance if needed
- Follow your dentist's instructions regarding your care
- Pay your 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 DENCAP of address changes, and any changes for your dependent coverage

VII. Coordination of Benefits

Coordination of Benefits (COB) applies when you are covered by more than one dental insurance plan. Coordination of benefits rules is in place to make sure the combined payments of the plans are no more than your actual bills. You are responsible for telling your provider about all applicable insurance(s) before receiving 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 its rules and procedures. If these rules conflict with those of another plan, it may be impossible to receive coverage from both plans, and you will be forced to choose which plan to use.

PLANS THAT DO NOT COORDINATE

The following will not coordinate with DENCAP policies:

- Individual (not group) policies or contracts
- Dental discount plans
- 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 apply:

1. Non-coordinating Plan

If you have another individual 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 Coordination of Benefits Act.

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 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. 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. Clean claims will be paid within 45 days after receipt. Claims unable to be processed will be rejected within 30 days of receipt and the provider will be notified of reasons for the rejection. A provider has 45 days from receiving 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

Certain services, particularly those performed by specialists, require prior authorization from DENCAP before treatment is rendered. The treating provider is responsible for submitting a prior authorization request with all required clinical documentation before services are performed.

REVIEW PROCESS

DENCAP will review the request and provide a determination within 14 calendar days of receiving all necessary information. If additional information is required, the review period may be extended until all documentation is received.

Member Responsibility

It is the member's responsibility to obtain the required prior authorization prior to receiving services. If a required referral or authorization is not obtained:

- The service may be denied for coverage.
- The members may be responsible for the full cost of the service, subject to the terms of their benefit 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 dental service should be covered, or a claim should have been paid, you may file an appeal. See the Appeals section for more details.

Requests for Additional Information

If your claim cannot be processed because additional information is required:

- 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.

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 DIRECT REIMBURSEMENT

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

The form requires you to provide:

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).

Forms can be downloaded from our website at dencap.com/general-policies. 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

X. Appeals, Complaints, Grievances

DENCAP ensures member satisfaction through a Quality Assurance (QA) Committee. QA Committee reviews member care to make sure 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 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 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 person(s) will review your appeal. The person who reviews the appeal will not be the same as, or work for, the person(s) who made the original decision. They will review the information you provided as if they are deciding on the claim for the first time. 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 person(s) will make their decision within the applicable time limit of receiving your request for a review of our original decision.

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 to 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

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 313.972.1400or 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. You have 180 days from the date of discovery of the incident to file a grievance.

FILING 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. 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 ten (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 the nature of your pre-service claim appeal or grievance requires prompt resolution or related to a dental emergency, 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 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

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.

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 (QAGC) minutes. 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 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 you advise DENCAP to cancel your coverage
- You have failed to pay DENCAP
- When you are no longer eligible, or choose another Marketplace Plan
- DENCAP exits the marketplace (for exchange-based plans)
- If DENCAP learns of any fraud or misrepresentation by you or your agent

DENCAP will not continue eligibility for any person covered under this plan beyond the eligibility cancelation date requested by the subscriber. A person whose eligibility is canceled may not continue coverage under this contract, except when reinstating without a gap in coverage, with a qualifying event, or after an 18-month waiting period. In some cases, a reinstatement fee may apply.
In the case of cancelation due to fraud or misrepresentation (recission), DENCAP will issue a notice of cancellation to the subscriber 30 days prior to ending coverage.

SUBSCRIBER CANCELATION

The subscriber or agent must inform DENCAP if a member of the plan wishes to cancel coverage. If the member or agent cancels coverage, then the end date of coverage will be based on the paid-through date. Pre-paid premiums are not refunded except when paid more than 30 days in advance. The members will not be held responsible for future monthly premiums after the date of cancelation.

All cancelations must be submitted to DENCAP via e-mail, fax, or mail.

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

PAYMENT OF PREMIUMS

Premiums are payable monthly in advance of coverage. A 10-day grace period (or 90-day grace period for subscribers who receive Advance Premium Tax Credits (APTC)) will be allowed during which the coverage will remain in place. If a subscriber fails to make payment, the insurance will terminate at the end of the grace period. DENCAP will accept premium payment after the expiration of the grace period, up to 60 days post cancellation date with no lapse in coverage. In some cases, a reinstatement fee may apply.

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.

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. General Policies

Change of Status
You must notify DENCAP 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 from that recovery to the extent of payments made under the plan.

Entire Policy
The policy issued to the subscriber, including the Certificate of Coverage, the enrollment application, amendments, and riders, constitutes the entire policy. All statements made by the subscriber will 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 the agreement is 12 months from the effective date unless otherwise specified. The agreement will automatically be renewed month to month. 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 subscriber. 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 subscribers are solely contractual relationships between independent contractors. Providers and subscribers are not agents or employees of DENCAP. DENCAP or any employee of DENCAP are not agents or employees of providers or subscribers.

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 subscriber is solely responsible for:

- Enrollment
- Coverage classification changes
- Cancelation of coverage
- Timely payment for the Policy
- Notifying dependents 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 authorize any provider, facility, or institution that has delivered services to you (or your enrolled dependents) to release to DENCAP all records or copies of records related to your 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 the term of this policy, DENCAP and its related entities may use and transfer information gathered under the policy for research and analytic purposes, in compliance with privacy and confidentiality standards.

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, subscriber, or authorized representative of the subscriber, it is deemed notice to all affected subscribers and their enrolled dependents. The subscriber is responsible for giving notice to dependents.

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 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.

XIII. 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.

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 network.

- 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 defined by DENCAP and the State of Michigan. A legal dependent includes, but is not limited to a spouse, partner, child up to age 26, or adult disabled dependent.

(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 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.

POLICY
The benefit that DENCAP provides. The Certificate of Coverage, your application, amendments, and riders constitute the entire policy. All statements made by the policyholder shall be assumed true at the time of their submission.

PREMIUM
Monthly amount due to DENCAP to maintain coverage.

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

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

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

PROVIDER
A licensed dentist who gives dental care and treatment. This may include general dentists, specialists, or dental offices.

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

QUALIFYING EVENT
A change in status for you or your legal dependent that allows you or the dependent to be added or removed from your plan.

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 OR POLICYHOLDER
The person who owns the insurance policy, or you, when DENCAP notifies you that you are eligible to receive dental benefits under the plan you applied for.