FAQ

(Q) **What is a DHMO?**
   (A) A DHMO (Dental Health Maintenance Organization) is a model where the emphasis is on preventive dentistry and containing costs on other necessary dental care. Your DHMO plans has no waiting periods, or deductibles, a $3,300 annual maximum, and reduced costs on dental treatments.

(Q) **Are there any out-of-network benefits?**
   (A) You must seek services within the DENCAP Network in order to use your plans benefits. There are no out-of-network benefits unless it’s an out of town emergency.

(Q) **What if I have a dental emergency?**
   (A) Dental emergencies can be handled by your DENCAP Primary Care Dentist. Often times, there are after hour emergency numbers given on a dentist’s answering service. If you are unable to get a hold of your DENCAP Dentist after hours, please call DENCAP at 888-98-TEETH.

(Q) **What if I have an emergency out of town?**
   (A) If you are out of the DENCAP service area (50 or more miles away from your Primary Care Dentist), DENCAP will reimburse you or your covered dependent for 50% of the amount up to $100.00 for those emergency services which relieve severe pain or discomfort and are covered benefits.

(Q) **How can I pay my premium?**
   (A) Your monthly premium payment can be made by pension deduct, or recurring automatic payments with your debit/credit card, or an ACH bank draft. Annual payments can be made by check, debit/credit card, or an ACH bank draft.

(Q) **How do I assign myself to a dental office location?**
   (A) To assign yourself to an in-network dental office location, you must notify DENCAP over the phone or by email. Our provider directory is your resource for making your selection. You can view it on-line or call us for a paper listing.

(Q) **May I change my Dental Office Location?**
   (A) Yes! Changes are allowed as needed to ensure that you are completely satisfied with your dental experience. Members can change their dental location with a 2 week notice by mail, phone, email or fax.

(Q) **What is the Schedule of Benefits?**
   (A) The Schedule of Benefits is the listing of all covered procedures and the co-payments the patient is responsible for at the Primary Care Dental Office. All in-network Primary Care Offices will follow the Schedule of Benefits for covered procedures. A copy of the Schedule is available to you upon enrollment, and upon request.

(Q) **Can my DENCAP Primary Care Dentist charge me differently than the co-pay listed on the Schedule of Benefits?**
   (A) No. The only time a DENCAP Primary Care Dentist can charge a member anything outside of the agreed co-payments is if the member has reached their annual maximum.

(Q) **What can I do if my dental bill does not match the Schedule of Benefits?**
   (A) First, contact your DENCAP Primary Care Dentist’s billing department to see if there was an error in billing. If you still have concerns, please call DENCAP.

(Q) **When can I use my Specialty Care Coverage?**
   (A) Under the Retiree Advantage Plan, the $800 in specialty care coverage can be used immediately to access specialty care. Each member on the plan receives $800 in specialty care coverage. This renews annually on your effective date. Any procedure done at a specialty care office must have a referral from your assigned primary office.