Dentegra® Dental PPO

Children's Plan 85 + Adult Preferred for Small Businesses

Dentegra is leading the charge to redefine the dental insurance industry…

making quality dental care affordable and accessible to more people, and the quick and easy choice for you.

At Dentegra Insurance Company (Dentegra), we believe your smile is unlike any other (and that's a good thing!). That's why we're focused on providing dental insurance coverage that's affordable and simple to use. It's all the good stuff — plus a first-rate network of dentists. This brochure contains an overview of our PPO plan benefits and information about Dentegra. You can also learn more about our company by visiting us at dentegra.com.

Our plans

With Dentegra® Insurance Company (Dentegra) you get more than just great dental benefits. Dentegra contracts with a top-notch network of dentists that can save your employees money when compared to an out-of-network dentist. Plus, the cost savings provided by a PPO plan can help keep your overall dental program costs stable. And because we know your time is precious, we offer dental benefits that are easy to understand and easy to use, so that you can focus on other areas of your business. Our PPO plans:

- Focus on preventive care at affordable costs
- Provide simple and secure online services for benefits, eligibility, dentist directories and more
- Afford opportunities to save on claims by visiting a Dentegra dentist

How it works

Dentegra PPO plans are simple to use. A PPO plan pays a percentage of enrollees' dental costs for covered services — they are responsible for the remaining percentage, commonly called "coinsurance." Although we encourage enrollees to visit a Dentegra PPO dentist for the savings and quality care our network offers, our plan gives them freedom to visit any licensed dentist, anywhere, anytime. Here are some of the key features:

Plan Features

- Most plans require the patient to first satisfy a plan deductible. After that, Dentegra pays the percentage of charges outlined in the list of benefits.*
- Most preventive and diagnostic services such as checkups and cleanings are covered at 100%. Enrollees don't pay anything, and they don't have to wait until they satisfy any deductible for these services.

* For adult supplemental plans, once the plan maximum is reached, all charges are the responsibility of the patient.

Dentegra Insurance Company
100 First Street
San Francisco CA 94105

Customer Service
Phone: 800-503-4161

Claims
P.O. Box 1850
Alpharetta, GA 30023-1850

dentegra.com

- Enrollees usually pay less when they visit a Dentegra dentist because our contracted dentists agree to accept lower fees for Dentegra patients. (They can, however, see any dentist, although non-network dentist charges may be higher.)
- For pediatric (children's) coverage, our plans pay 100% of covered services after the enrollee out-of-pocket maximum is reached, and there is no cap on the annual amount the plan will pay for covered services.**
- Our plans make it easy to have a healthy smile for both adults and children by covering important preventive and basic care such as checkups, cleanings, X-rays and fillings.

Submitting a claim

- **Claims are no problem with Dentegra.** When services are provided by a Dentegra dentist, enrollees pay only their portion for services. Our network dentists agree to file all claim forms and receive payment directly from us.
- **For enrollees who choose to visit an out-of-network dentist**, the enrollee may need to submit the claim.
- **Dentegra provides a dental benefits statement** after the claim has been processed that lists the services provided, the costs of the dental treatment and the amount of any fees owed to the dentist.

Online Services

Dentegra's online services — simplicity is in the details. Wherever you are — work, home or on the go — you and your employees can manage your account with such time-saving features as viewing eligibility and claims or locating a network dentist. Our online tools are also a snap to use on a smart phone, so we're there for you when you need us.

Our Company

Dentegra was created specifically to meet the needs of a consumer-oriented health insurance marketplace, through technology, innovation and collaboration. We're all about simple, affordable, quality insurance with a variety of plan choices, so that you can choose the option that best fits your needs.

** For adult supplemental plans, once the plan maximum is reached all charges are the responsibility of the patient.

This benefit information is only a summary and not intended or designed to replace or serve as the plan's Group Contract. Please consult the Evidence of Coverage for a complete description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the Evidence of Coverage, the terms of the Evidence of Coverage will prevail.

Smile. Your pearly whites are in good hands.

Dentegra® Dental PPO

For Small Businesses
Children's Plan 85 + Adult Preferred

Plan Highlights	Children's Plan 85	Adult Preferred
Eligibility	Children up to age 19	Primary enrollee, spouse and eligible dependents (age 19 to 26)
Annual Deductible & Maximums		
Deductible Per person	$25	$50
Per family	Not Applicable	$150
Deductible waived for Diagnostic & Preventive Services	Yes	Yes
Benefit Maximums *Maximum the plan will pay each year for services per person*	Not Applicable	$1,000
Enrollee Out-of-Pocket Maximum *After this amount is reached, the plan pays 100% of the remaining covered services for that year. Applies only to pediatric services provided by PPO dentists.*	$700 one child /$1,400 two or more children	None
Covered Services (% Dentegra Pays)*		
Diagnostic Services X-Rays, Exams, Specialist Consultation	100%	100%
Preventive Services Cleanings, Sealants (pediatric only)	100%	100%
Basic Services Basic Restorative, Emergency Palliative Treatment; Periodontal Cleaning, General Anesthesia & IV Sedation (adults only)	80%	80%
Major Services Crowns & Casts, Prosthodontics, Endodontics, Periodontics, Implants, Oral Surgery, Denture Repairs (adults only)	50%	50%
Orthodontic Benefits	50% Medically Necessary	Not a Benefit
Dental Accident Benefits	Not a Benefit	100% $1,000 lifetime maximum
Waiting Period(s) Major Benefits	Not Applicable	12 months

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement to dentists is based on Dentegra PPO contracted fees for all dental providers.

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Limitations and Exclusions

A. Limitations – Children's Plan 85

General

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dental services are available from birth with an age one dental visit encouraged.

(5) A second opinion is allowed.

(6) Emergency treatment is available withough prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensice, abnormal bleeding, fractures of facial bones or dislocation of the mandible.

(7) Denials of services to the Provider shall include an explanation and identify the reviewer including their contact information.

(8) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

(9) Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.

(10) Services that are considered experimental in nature will not be considered.

(11) This Contract will not cover any charges for broken appointments.

Diagnostic and Preventive Services

(1) Diagnostic and preventive services are linked to the Provider, thus allowing an Enrollee to transfer to a different Provider/Provider's office and receive these services. The new Provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.

Diagnostic services include:
* Indicates Diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

1. Clinical oral evaluations once every 6 months *
   a) Comprehensive oral evaluation – complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   b) Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   c) Oral evaluation for patient under the age of 3 and counseling with primary caregiver*

   d) Limited oral evaluations that are problem focused
   e) Detailed oral evaluations that are problem focused
2. Diagnostic Imaging with interpretation
   a) A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   b) An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   c) Additional films/views needed for diagnosing can be provided as needed.
   d) Bitewings, periapicals, panoramic and cephlometric radiographic images
   e) Intraoral and extraoral radiographic images
   f) Oral/facial photographic images
   g) Maxillofacial MRI, ultrasound
   h) Cone beam image capture
3. Tests and Examinations
4. Viral culture
5. Collection and preparation of saliva sample for laboratory diagnostic testing
6. Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
7. Oral pathology laboratory
   a) Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   b) Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   c) Other oral pathology procedures, by report
8. Consultation by specialist or non-primary care Provider

Preventive services include:
* Indicates Preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.
1. Dental prophylaxis once every 6 months*
2. Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
   c) Fluoride varnish once every 3 months for children under the age of 6
3. Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
4. Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   a) fixed – unilateral and bilateral
   b) removable – bilateral only
   c) recementation of fixed space maintainer
   d) removal of fixed space maintainer – considered for provider that did not place appliance

Basic Services

(1) There are no frequency limits on replacing restorations (fillings) or crowns.

(2) Request for replacement of a restoration due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.

(3) Reimbursement for any restoration will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.

(4) The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.

(5) Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.

(6) Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.

(7) Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Basic services include:
1. Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
2. Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
3. Protective restoration/sedative filling
4. Full mouth debridement to enable comprehensive evaluation
5. Periodontal maintenance
6. Palliative treatment for emergency treatment – per visit

7. Anesthesia
   a) Local anesthesia NOT in conjunction with operative or surgical procedures.
   b) Regional block
   c) Trigeminal division block.
   d) Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
   e) Intravenous conscious sedation/analgesia – 2 hour maximum time
   f) Nitrous oxide/analgesia
   g) Non-intravenous conscious sedation – to include oral medications
8. Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
   a) One unit equals 15 minutes of additional time
   b) Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
      i. Office or Clinic maximum – 2 units
      ii. Inpatient/Outpatient hospital – 4 units
      iii. Skilled Nursing/Long Term Care – 2 units
9. Professional visits
   a) House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
   b) Hospital or ambulatory surgical center call
      i. For cases that are treated in a facility.
      ii. For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
      iii. General anesthesia and outpatient facility charges for dental services are covered
      iv. Dental services rendered in these settings by a dentist not on staff are considered separately
   c) Office visit for observation – (during regular hours) no other service performed
10. Drugs
   a) Therapeutic parenteral drug
      i. Single administration
      ii. Two or more administrations - not to be combined with single administration
   b) Other drugs and/or medicaments – by report
11. Application of desensitizing medicament – per visit
12. Occlusal adjustment - Limited - (per visit)

Major Services

(1) There are no frequency limits on replacing restorations (fillings) or crowns.

(2) Request for replacement of a resoration due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.

(3) Reimbursement for any restoration will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.

(4) The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.

(5) Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.

(6) Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.

(7) Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

(8) Endodontic service includes all necessary radiographs or views needed for endodontic treatment.

(9) Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.

(10) Emergency services for pain do not require prior authorization.

(11) Endodontic service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

(12) All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.

(13)New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.

(14)All needed dental treatment must be completed prior to denture fabrication.

(15)Enrollee identification must be placed in dentures in accordance with State Board regulation.

(16)Insertion of dentures includes adjustments for 6 months post insertion.

(17)Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

(18)Local anesthesia, suturing and routine post op visit for suture removal are included with service.

Major services include:

1. Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
2. Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
   a) Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
   b) Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
   c) Provisional crowns are not covered.
3. Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
4. Core buildup including pins
5. Pin retention
6. Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
7. Additional fabricated (custom fabricated/cast) and prefabricated post
8. Post removal
9. Temporary crown (fractured tooth)
10. Additional procedures to construct new crown under existing partial denture
11. Coping
12. Crown repair
13. Therapeutic pulpotomy for primary and permanent teeth
14. Pulpal debridement for primary and permanent teeth
15. Partial pulpotomy for apexogensis
16. Pulpal therapy for anterior and posterior primary teeth
17. Endodontic therapy and retreatment
18. Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
19. Apexification: initial, interim and final visits
20. Pulpal regeneration
21. Apicoectomy/Periradicular Surgery
22. Retrograde filling
23. Root amputation
24. Surgical procedure for isolation of tooth with rubber dam
25. Hemisection
26. Canal preparation and fitting of preformed dowel or post
27. Post removal
28. Periodontal Surgical services
   a) Gingivectomy and gingivoplasty
   b) Gingival flap including root planning
   c) Apically positioned flap
   d) Clinical crown lengthening
   e) Osseous surgery
   f) Bone replacement graft – first site and additional sites
   g) Biologic materials to aid soft and osseous tissue regeneration
   h) Guided tissue regeneration
   i) Surgical revision
   j) Pedicle and free soft tissue graft
   k) Subepithelial connective tissue graft
   l) Distal or proximal wedge
   m) Soft tissue allograft
   n) Combined connective tissue and double pedicle graft
29. Periodontal Non-Surgical Periodontal Service
   a) Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
   b) Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
   c) Localized delivery of antimicrobial agents
30. Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

31. Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
    a) Resin base and cast frame dentures including any conventional clasps, rests and teeth
    b) Flexible base denture including any clasps, rests and teeth
    c) Removable unilateral partial dentures or dentures without clasps are not considered
32. Overdenture – complete and partial
33. Denture adjustments –6 months after insertion or repair
34. Denture repairs – includes adjustments for first 6 months following service
35. Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
36. Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
37. Precision attachment, by report
38. Maxillofacial prosthetics - includes adjustments for first 6 months following service
    a) Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
    b) Obturator prosthesis: surgical, definitive and modifications
    c) Mandibular resection prosthesis with and without guide flange
    d) Feeding aid
    e) Surgical stents
    f) Radiation carrier
    g) Fluoride gel carrier
    h) Commissure splint
    i) Surgical splint
    j) Topical medicament carrier
    k) Adjustments, modification and repair to a maxillofacial prosthesis
    l) Maintenance and cleaning of maxillofacial prosthesis
39. Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years. Covered services include: implant body, abutment and crown.
40. Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
    a) The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
    b) A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
    c) Considerations and requirements noted for single crowns apply.
    d) Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
    e) Abutment teeth must be periodontally sound and have a good long term prognosis
    f) Repair and recementation
41. Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.
42. Extraction of teeth:
    a) Extraction of coronal remnants – deciduous tooth,
    b) Extraction, erupted tooth or exposed root
    c) Surgical removal of erupted tooth or residual root
    d) Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
43. Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
44. Other surgical Procedures
    a) Oroantral fistula
    b) Primary closure of sinus perforation and sinus repairs
    c) Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
    d) Surgical access of an unerupted tooth
    e) Mobilization of erupted or malpositioned tooth to aid eruption
    f) Placement of device to aid eruption
    g) Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
    h) Surgical repositioning of tooth/teeth
    i) Transseptal fiberotomy/supra crestal fiberotomy
    j) Surgical placement of anchorage device with or without flap
    k) Harvesting bone for use in graft(s)
45. Alveoloplasty in conjunction or not in conjunction with extractions
46. Vestibuloplasty
47. Excision of benign and malignant tumors/lesions
48. Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
49. Destruction of lesions by electrosurgery
50. Removal of lateral exostosis, torus palatinus or torus madibularis
51. Surgical reduction of osseous tuberosity

52. Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
53. Surgical Incision
    a) Incision and drainage of abcess - intraoral and extraoral
    b) Removal of foreign body
    c) Partial ostectomy/sequestrectomy
    d) Maxillary sinusotomy
54. Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
55. Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same Provider.
    a) Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
    b) Manipulation under anesthesia
    c) Condylectomy, discectomy, synovectomy
    d) Joint reconstruction
    e) Services associated with TMJD treatment require prior authorization
56. Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
57. Arthroscopy
58. Occlusal orthotic device – includes placement and removal to same provider
59. Surgical and other repairs
    a) Repair of traumatic wounds – small and complicated
    b) Skin and bone graft and synthetic graft
    c) Collection and application of autologous blood concentrate
    d) Osteoplasty and osteotomy
    e) LeFort I, II, III with or without bone graft
    f) Graft of the mandible or maxilla – autogenous or nonautogenous
    g) Sinus augmentations
    h) Repair of maxillofacial soft and hard tissue defects
60. Frenectomy and frenoplasty
61. Excision of hyperplastic tissue and pericoronal gingiva
62. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
63. Emergency tracheotomy
64. Coronoidectomy
65. Implant – mandibular augmentation purposes
66. Appliance removal – “by report” for provider that did not place appliance, splint or hardware
67. Occlusal guard – for treatment of bruxism, clenching or grinding
68. Athletic mouthguard covered once per year
69. Occlusal adjustment - Complete (regardless of the number of visits), once in a lifetime
70. Odontoplasty
71. Internal bleaching

Orthodontic Services – Medically Necessary

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

(1) Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.

(2) Orthodontic consultation can be provided once annually as needed by the same Provider.

(3) Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.

(4) Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or Provider providing the extractions and extractions should not be provided without proof of approval for orthodontic service.

(5) Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.

(6) Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.

(7) The placement of the appliance represents the treatment start date.

(8) Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.

(9) Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

(10) Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

(11) Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

B. Exclusions – Children's Plan 85

Dentegra does not pay Benefits for:

(1) services not included on Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, complete occlusal adjustments or and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than general anesthesia, nitrous oxide, and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures procedures if such procedures included.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) laboratory processed crowns for Enrollees under age 12.

(12) fixed bridges and removable partials for Enrollees under age 16.

(13) interim implants.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(21) Deductibles and/or any service not covered under the dental plan.

(22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(23) the initial placement of any prosthodontic appliance , unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under [any dental care plan with Dentegra or the Contractholder's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(24) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a Prior Authorization is obtained.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.

(26) endodontic endosseous implant.

(27) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.

C. Limitations – Adult Preferred

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:
a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration; or
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Dentegra will pay for oral examinations (except afterhours exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year**.** A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

(3) X-ray limitations:
a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(5) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(6) Dentegra will not cover to replace an amalgam, resin-based composite or prefabricated stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(7) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(8) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(9) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(10) Pin retention is covered not more than once in any 24-month period.

(11) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(12) Periodontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

(13) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(14) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(15) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are covered not more than once in any 60 month period.

(16) Core buildup, including any pins, are covered not more than once in any 60 month period.

(17) Post and core services are covered not more than once in any 60 month year period.

(18) Crown repairs are covered not more than once in any 60 month period.

(19) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(20) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(21) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra’s payment for implant removal is limited to one (1) for each implant during the Enrollee’s lifetime whether provided under Dentegra or any other dental care plan.

(22) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(23) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(24) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder’s prior plan, if applicable.

(25) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(26) Limitations on Dental Accident Services:
a) The dental accident must occur while the Enrollee is covered under the Contract.
b) Services and procedures must be provided within 180 days following the dental accident and while the Enrollee is covered under the Contract.

D. Exclusions – Adult Preferred

Dentegra does not pay Benefits for:

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected endodontic and periodontal surgical procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) interim implants.

(12) indirectly fabricated resin-based Inlays/Onlays.

(13) overdentures.

(14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(20) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(22) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Dentegra or the Contractholder's prior dental plan, if

applicable. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues).

(25) endodontic endosseous implant.

(26) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.