DENTEGRA®
Insurance Company

Get Happy

You've got Dentegra

The world is yours with Dentegra. We believe your smile is a powerful asset. That's why we've created a dental plan that is easy to understand and use — so you spend less time managing your dental plan and more time enjoying your life.

HOW your EPB[1] plan works

- You must visit a Dentegra EPB network dentist to receive benefits under your plan. If you reside or work in GA, FL, MS, MT, TX or anywhere more than 20 miles from an EPB Network Provider, you may be treated by a Non-Network Provider.
- You can change dentists any time without notifying us.
- You are responsible for any applicable copayments and charges for non-covered services.

FIND a network dentist

- Visit our website at **dentegra.com/FELRA** to find a Dentegra EPB network dentist.
- Call Customer Service at **877-280-4204**, Monday to Friday, 8 am to 8 pm, Eastern time, if you want to verify that your dentist participates in the Dentegra EPB network.

VISIT dentegra.com/FELRA

- View benefits, eligibility and claims status by registering for an online account.
- Go green and go paperless! Update your statement delivery preference to online.
- Find a Dentegra EPB network dentist.
- Call Customer Service at **877-280-4204** Monday to Friday, 8 am to 8 pm, Eastern time, for information on benefits, eligibility and claim.

Sweet SIMPLICITY

- Just show the Dentegra EPB dental office your ID card, or your digital ID card on your smartphone, to receive services. The office will handle the rest!
- If you don't have your ID card with you, simply provide your name, date of birth and enrollee identification number.
- To make an appointment, simply call your Dentegra EPB dentist directly.
- Dentegra EPB providers will complete and submit your claims paperwork for you.

[1] Exclusive Provider Benefit (EPB) plan.

Connect with us:
dentegra.com/FELRA

Benefit Highlights

Group Name: **Food Employers Labor Relations Association & United Food and Commercial Workers VEBA Fund**
Group Number: **21284**
Effective Date: **6/1/2021**
Plan Name: **Plan I**

Contact us:
Dentegra Insurance Company:
560 Mission Street, San Francisco, CA 94105
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Claims Address:
P.O. Box 1850, Alpharetta, GA 30023-1850

Covered Services (only at a Dentegra EPB network dentist)

Diagnostic		In-network Copayment	Out-of-network Copayment
D0120	Periodic oral evaluation — established patient (1 in 6 months)	$0.00	Not covered
D0140	Limited oral evaluation — problem focused (1 in 6 months)	$0.00	Not covered
D0150	Comprehensive oral evaluation — new or established patient (1 in 6 months; also 1 in a lifetime with a match on provider to suspend)	$0.00	Not covered
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit) (1 in 6 months)	$0.00	Not covered
D0180	Comprehensive periodontal evaluation — new or established patient (1 in 6 months; also 1 in a lifetime with a match on provider to suspend)	$30.00	Not covered
D0210	Intraoral — complete series of radiographic images (1 in 60 months)	$0.00	Not covered
D0220	Intraoral — periapical — first radiographic image	$0.00	Not covered
D0230	Intraoral — periapical — each additional radiographic image (1 in the same day)	$0.00	Not covered
D0240	Intraoral — occlusal radiographic image (2 in the same day)	$0.00	Not covered
D0270	Bitewing — single radiographic image (To age 18 — 2 in a calendar year; over the age of 18 — 1 in a calendar year)	$0.00	Not covered
D0272	Bitewings — two diagnostic images (To age 18 — 2 in a calendar year; over the age of 18 — 1 in a calendar year)	$0.00	Not covered
D0273	Bitewings — three diagnostic images (To age 18 — 2 in a calendar year; over the age of 18 — 1 in a calendar year)	$0.00	Not covered
D0274	Bitewings — four diagnostic images (To age 18 — 2 in a calendar year; over the age of 18 — 1 in a calendar year)	$0.00	Not covered
D0277	Vertical bitewings — seven to eight radiographic images (To age 18 — 2 in a calendar year; over the age of 18 — 1 in a calendar year)	$0.00	Not covered
D0330	Panoramic diagnostic image (1 in 60 months)	$0.00	Not covered
D0340	Cephalometric radiographic image (1 in a lifetime)	$0.00	Not covered
D0460	Pulp vitality tests (1 in the same day)	$0.00	Not covered
D0470	Diagnostic casts in-network copayment $20 out-of-network Not covered	$20.00	Not covered
Preventive		**In-network Copayment**	**Out-of-network Copayment**
D1110	Prophylaxis — adult (1 in 6 months)	$0.00	Not covered
D1120	Prophylaxis — child (1 in 6 months)	$0.00	Not covered
D1206	Topical application of fluoride varnish to age 19	$0.00	Not covered
D1208	Topical application of fluoride – excluding varnish to age 19	$0.00	Not covered
D1510	Space maintainer – fixed, unilateral – per quadrant	$10.00	Not covered
D1516	Space maintainer – fixed – bilateral, maxillary	$20.00	Not covered
D1517	Space maintainer – fixed – bilateral, mandibular	$20.00	Not covered
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$0.00	Not covered
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$0.00	Not covered
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$0.00	Not covered
D1556	Removal of fixed unilateral space maintainer – per quadrant	$0.00	Not covered
D1557	Removal of fixed bilateral space maintainer – maxillary	$0.00	Not covered
D1558	Removal of fixed bilateral space maintainer – mandibular	$0.00	Not covered
D1575	Distal shoe space maintainer - fixed, unilateral – per quadrant	$11.00	Not covered

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Restorative		In-network Copayment	Out-of-network Copayment
D2140	Amalgam — one surface, primary or permanent (1 in 24 months)	$0.00	Not covered
D2150	Amalgam — two surfaces, primary or permanent (1 in 24 months)	$0.00	Not covered
D2160	Amalgam — three surfaces, primary or permanent (1 in 24 months)	$0.00	Not covered
D2161	Amalgam — four or more surfaces, primary or permanent (1 in 24 months)	$0.00	Not covered
D2330	Resin-based composite — one surface, anterior (1 in 24 months)	$0.00	Not covered
D2331	Resin-based composite — two surfaces, anterior (1 in 24 months)	$0.00	Not covered
D2332	Resin-based composite — three surfaces, anterior (1 in 24 months)	$0.00	Not covered
D2335	Resin-based composite — four or more surfaces or involving incisal angle (anterior) (1 in 24 months)	$0.00	Not covered
D2390	Resin-based composite crown, anterior	$132.00	Not covered
D2391	Resin-based composite – one surface, posterior	$10.00	Not covered
D2392	Resin-based composite – two surfaces, posterior	$18.00	Not covered
D2393	Resin-based composite – three surfaces, posterior	$21.00	Not covered
D2394	Resin-based composite – four or more surfaces, posterior	$29.00	Not covered
D2740	Crown – porcelain/ceramic substrate	$125.00	Not covered
D2750	Crown – porcelain fused to high noble metal	$125.00	Not covered
D2751	Crown – porcelain fused to predominantly base metal	$125.00	Not covered
D2752	Crown – porcelain fused to noble metal	$125.00	Not covered
D2753	Crown – porcelain fused to titanium and titanium alloys	$125.00	Not covered
D2790	Crown – full cast high noble metal	$125.00	Not covered
D2791	Crown – full cast predominantly base metal	$125.00	Not covered
D2792	Crown – full cast noble metal	$125.00	Not covered
D2920	Re-cement or re-bond crown	$0.00	Not covered
D2921	Reattachment of tooth fragment, incisal edge or cusp	$0.00	Not covered
D2930	Prefabricated stainless steel crown – primary tooth	$30.00	Not covered
D2931	Prefabricated stainless steel crown – permanent tooth	$30.00	Not covered
D2932	Prefabricated resin crown	$30.00	Not covered
D2940	Protective restoration	$0.00	Not covered
D2941	Interim therapeutic restoration – primary dentition	$0.00	Not covered
D2950	Core buildup, including any pins when required	$0.00	Not covered
D2951	Pin retention – per tooth, in addition to restoration	$0.00	Not covered
D2952	Post and core in addition to crown, indirectly fabricated	$0.00	Not covered
D2954	Prefabricated post and core in addition to crown	$0.00	Not covered
D2980	Crown repair necessitated by restorative material failure	$0.00	Not covered
Endodontics		**In-network Copayment**	**Out-of-network Copayment**
D3110	Pulp cap — direct (excluding final restoration) (1 in 12 months)	$0.00	Not covered
D3120	Pulp cap — indirect (excluding final restoration)	$0.00	Not covered
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament (1 in a lifetime)	$0.00	Not covered
D3310	Endodontic therapy, anterior tooth (excluding final restoration) (1 in a lifetime)	$0.00	Not covered
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration) (1 in a lifetime)	$0.00	Not covered
D3330	Endodontic therapy, molar (excluding final restoration) (1 in a lifetime)	$0.00	Not covered
D3346	Retreatment of previous root canal therapy — anterior (1 in 24 months)	$76.00	Not covered
D3347	Retreatment of previous root canal therapy — bicuspid (1 in 24 months)	$79.00	Not covered

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Endodontics		In-network Copayment	Out-of-network Copayment
D3348	Retreatment of previous root canal therapy v molar (1 in 24 months)	$97.00	Not covered
D3410	Apicoectomy/periradicular surgery — anterior (1 in 24 months)	$0.00	Not covered
D3421	Apicoectomy/periradicular surgery — bicuspid (first root) (1 in 24 months)	$0.00	Not covered
D3425	Apicoectomy/periradicular surgery — molar (first root) (1 in 24 months)	$0.00	Not covered
D3426	Apicoectomy/periradicular surgery (each additional root) (1 in 24 months)	$0.00	Not covered
D3471	Surgical repair of root resorption - anterior	$0.00	Not covered
D3472	Surgical repair of root resorption - premolar	$0.00	Not covered
D3473	Surgical repair of root resorption – molar	$0.00	Not covered
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0.00	Not covered
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0.00	Not covered
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0.00	Not covered
D3430	Retrograde filling — per root (1 in 24 months)	$0.00	Not covered
D3920	Hemisection (including any root removal), not including root canal therapy (1 in a lifetime)	$110.00	Not covered
Periodontics		**In-network Copayment**	**Out-of-network Copayment**
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$200.00	Not covered
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$55.00	Not covered
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$200.00	Not covered
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$55.00	Not covered
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$325.00	Not covered
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$100.00	Not covered
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$200.00	Not covered
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$200.00	Not covered
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$70.00	Not covered
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$35.00	Not covered
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$0.00	Not covered
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$0.00	Not covered
D4910	Periodontal maintenance (1 in 6 months)	$35.00	Not covered
Prosthodontics (Removable)		**In-network Copayment**	**Out-of-network Copayment**
D5110	Complete denture — maxillary (1 in 60 months)	$30.00	Not covered
D5120	Complete denture — mandibular (1 in 60 months)	$30.00	Not covered
D5130	Immediate denture — maxillary (1 in 60 months)	$30.00	Not covered
D5140	Immediate denture — mandibular (1 in 60 months)	$30.00	Not covered

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D5211	Maxillary partial denture — resin base (including any conventional clasps, rests and teeth) (1 in 60 months)	$30.00	Not covered
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests and teeth) (1 in 60 months)	$30.00	Not covered
D5213	Maxillary partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (1 in 60 months)	$30.00	Not covered
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (1 in 60 months)	$30.00	Not covered
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$30.00	Not covered
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	$30.00	Not covered
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$30.00	Not covered
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$30.00	Not covered
D5410	Adjust complete denture — maxillary (2 in calendar year)	$0.00	Not covered
D5411	Adjust complete denture — mandibular (2 in calendar year)	$0.00	Not covered
D5421	Adjust partial denture — maxillary (2 in calendar year)	$0.00	Not covered
D5422	Adjust partial denture — mandibular (2 in calendar year)	$0.00	Not covered
D5511	Repair broken complete denture base — mandibular (1 in 6 months)	$0.00	Not covered
D5512	Repair broken complete denture base — maxillary (1 in 6 months)	$0.00	Not covered
D5520	Replace missing broken tooth — complete denture (each tooth) (1 in 6 months)	$0.00	Not covered
D5611	Repair resin denture base — mandibular (1 in 6 months)	$0.00	Not covered
D5612	Repair resin denture base — maxillary (1 in 6 months)	$0.00	Not covered
D5621	Repair cast framework — mandibular (1 in 6 months)	$0.00	Not covered
D5622	Repair cast framework — maxillary (1 in 6 months)	$0.00	Not covered
D5630	Repair or replace broken clasp (1 in 6 months)	$0.00	Not covered
D5640	Replace broken teeth — per tooth (1 in 6 months)	$0.00	Not covered
D5650	Add tooth to existing partial denture (1 in 6 months)	$0.00	Not covered
D5660	Add clasp to existing partial denture — per tooth (1 in 6 months)	$0.00	Not covered
D5670	Replace all teeth and acrylic on cast metal framework (maxillary) (1 in 6 months)	$0.00	Not covered
D5671	Replace all teeth and acrylic on cast metal framework (mandibular) (1 in 6 months)	$0.00	Not covered
D5730	Reline complete maxillary denture (chairside) (1 in 6 months)	$0.00	Not covered
D5731	Reline complete mandibular denture (chairside) (1 in 6 months)	$0.00	Not covered
D5740	Reline maxillary partial denture (chairside) (1 in 6 months)	$0.00	Not covered
D5741	Reline mandibular partial denture (chairside) (1 in 6 months)	$0.00	Not covered
D5750	Reline complete maxillary denture (laboratory) (1 in 6 months)	$0.00	Not covered
D5751	Reline complete mandibular denture (laboratory) (1 in 6 months)	$0.00	Not covered
D5760	Reline maxillary partial denture (laboratory) (1 in 6 months)	$0.00	Not covered
D5761	Reline mandibular partial denture (laboratory) (1 in 6 months)	$0.00	Not covered
Prosthodontics (Fixed)		**In-network Copayment**	**Out-of-network Copayment**
D6210	Pontic – cast high noble metal	$125.00	Not covered
D6211	Pontic – cast predominantly base metal	$125.00	Not covered
D6212	Pontic – cast noble metal	$125.00	Not covered
D6240	Pontic – porcelain fused to high noble metal	$125.00	Not covered
D6241	Pontic – porcelain fused to predominantly base metal	$125.00	Not covered

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

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Prosthodontics (Fixed)		In-network Copayment	Out-of-network Copayment
D6242	Pontic – porcelain fused to noble metal	$125.00	Not covered
D6243	Pontic – porcelain fused to titanium and titanium alloys	$125.00	Not covered
D6245	Pontic – porcelain/ceramic	$125.00	Not covered
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$50.00	Not covered
D6740	Retainer crown – porcelain/ceramic	$125.00	Not covered
D6750	Retainer crown – porcelain fused to high noble metal	$125.00	Not covered
D6751	Retainer crown – porcelain fused to predominantly base metal	$125.00	Not covered
D6752	Retainer crown – porcelain fused to noble metal	$125.00	Not covered
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$125.00	Not covered
D6783	Retainer crown – ¾ porcelain/ceramic	$125.00	Not covered
D6784	Retainer crown ¾ – titanium and titanium alloys	$125.00	Not covered
D6790	Retainer crown – full cast high noble metal	$125.00	Not covered
D6791	Retainer crown – full cast predominantly base metal	$125.00	Not covered
D6792	Retainer crown – full cast noble metal	$125.00	Not covered
D6930	Re-cement or re-bond fixed partial denture	$0.00	Not covered
Oral and Maxillofacial Surgery		**In-network Copayment**	**Out-of-network Copayment**
D7111	Extraction, coronal remnants — primary tooth (1 in a lifetime)	$0.00	Not covered
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (1 in a lifetime)	$0.00	Not covered
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated (1 in a lifetime)	$0.00	Not covered
D7220	Removal of impacted tooth — soft tissue (1 in a lifetime)	$0.00	Not covered
D7230	Removal of impacted tooth — partially bony (1 in a lifetime)	$0.00	Not covered
D7240	Removal of impacted tooth — completely bony (1 in a lifetime)	$0.00	Not covered
D7241	Removal of impacted tooth — completely bony, with unusual surgical complications (1 in a lifetime)	$0.00	Not covered
D7250	Surgical removal of residual tooth roots (cutting procedure) (1 in a lifetime)	$0.00	Not covered
D7251	Coronectomy – intentional partial tooth removal	$0.00	Not covered
D7310	Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces, per quadrant (1 in a lifetime)	$0.00	Not covered
D7510	Incision and drainage of abscess — intraoral soft tissue (1 in a lifetime)	$0.00	Not covered
Orthodontics		**In-network Copayment**	**Out-of-network Copayment**
D8070	Comprehensive orthodontic treatment of the transitional dentition	$425.00	Not covered
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$425.00	Not covered
D8090	Comprehensive orthodontic treatment of the adult dentition	$425.00	Not covered
Adjunctive General Services		**In-network Copayment**	**Out-of-network Copayment**
D9110	Palliative (emergency) treatment of dental pain — minor procedures (1 in the same day)	$0.00	Not covered
D9215	Local anesthesia in conjunction with operative or surgical procedures (1 in the same day)	$0.00	Not covered
D9230	Inhalation of nitrous oxide / analgesia, anxiolysis (1 in the same day)	$0.00	Not covered
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$0.00	Not covered

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Adjunctive General Services		In-network Copayment	Out-of-network Copayment
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$0.00	Not covered
D9248	Non-intravenous conscious sedation (1 in the same day)	$0.00	Not covered
D9310	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician (2 in a calendar; also 1 in a Lifetime with a match on provider to suspend)	$0.00	Not covered
D9932	Cleaning and inspection of removable complete denture, maxillary	$0.00	Not covered
D9933	Cleaning and inspection of removable complete denture, mandibular	$0.00	Not covered
D9934	Cleaning and inspection of removable partial denture, maxillary	$0.00	Not covered
D9935	Cleaning and inspection of removable partial denture, mandibular	$0.00	Not covered
D9999	Unspecified adjunctive procedure, by report	$10.00	Not covered

NOTE: The procedures described and maximum allowances indicated on this table are subject to the terms of the contract and Dentegra processing policies. Any procedure not listed on this schedule is not covered. This plan may be updated to be CDT compliant.

Note on additional benefits during pregnancy — When an Enrollee is pregnant, we will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each 12 month period while the Enrollee is covered under the Contract include: one additional oral evaluation and either one additional prophylaxis or one periodontal scaling/root planing procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Dentegra EPB network — Exclusive Provider Network in which dental benefits must be obtained from an EPB Network Provider for your group.

Out-of-network exemption — If an Enrollee resides or works in GA, FL, MS, MT, TX or anywhere more than 20 miles from an EPB Network Provider, the Enrollee may be treated by a Non-Network Provider. In such cases, Benefits will be provided for dental services performed by a Non-Network Provider if such services are listed as covered in the Benefit Highlights. Covered services will be processed in accordance with the terms of this Contract including Limitations and Exclusions (see Evidence of Coverage). Enrollees are responsible for the applicable Enrollee Copayments and balance billing for any amounts over the EPB Network Contracted Fees for the services provided. Dentegra will reimburse the Non-Network Provider the EPB Network Contracted Fee minus the Enrollee Copayment for covered services.

Procedures not shown are not covered. If a condition can be treated by more than one procedure only the least costly professionally adequate service will be covered.

HL_FELRA_Plan 1 #134324A (rev. 3/22)