

# 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<sup>1</sup> 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](http://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 ET, if you want to verify that your dentist participates in the Dentegra EPB network.

## VISIT [dentegra.com/ FELRA](http://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.

<sup>1</sup> Exclusive Provider Benefit (EPB) plan.

# Benefit Highlights

**Contact us:** Dentegra Insurance Company:  
560 Mission Street, San Francisco, CA 94105  
**Customer Service:**  
877-280-4204  
**Claims Address:**  
P.O. Box 1850, Alpharetta, GA 30023-1850

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

## Covered Services (only at a Dentegra EPB network dentist)

Diagnostic		In-network Copayment	Out-of-network Copayment
<b>D0120</b>	Periodic oral evaluation — established patient (1 in 6 months)	\$0.00	Not covered
<b>D0140</b>	Limited oral evaluation — problem focused (1 in 6 months)	\$0.00	Not covered
<b>D0150</b>	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
<b>D0170</b>	Re-evaluation — limited, problem focused (established patient; not post-operative visit) (1 in 6 months)	\$0.00	Not covered
<b>D0210</b>	Intraoral — complete series of radiographic images (1 in 60 months)	\$0.00	Not covered
<b>D0220</b>	Intraoral — periapical — first radiographic image	\$0.00	Not covered
<b>D0230</b>	Intraoral — periapical — each additional radiographic image (1 in the same day)	\$0.00	Not covered
<b>D0240</b>	Intraoral — occlusal radiographic image (2 in the same day)	\$0.00	Not covered
<b>D0270</b>	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
<b>D0272</b>	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
<b>D0274</b>	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
<b>D0277</b>	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
<b>D0330</b>	Panoramic diagnostic image (1 in 60 months)	\$0.00	Not covered
<b>D0340</b>	2D cephalometric radiographic image — acquisition, measurement and analysis	\$0.00	Not covered
<b>D0460</b>	Pulp vitality tests (1 in same day)	\$0.00	Not covered
<b>D0470</b>	Diagnostic casts	\$20.00	Not covered
Preventive		In-network Copayment	Out-of-network Copayment
<b>D1110</b>	Prophylaxis — adult (1 in 6 months)	\$0.00	Not covered
<b>D1120</b>	Prophylaxis — child (1 in 6 months)	\$0.00	Not covered
<b>D1206</b>	Topical application of fluoride varnish (to age 19)	\$0.00	Not covered
<b>D1208</b>	Topical application of fluoride — excluding varnish (to age 19)	\$0.00	Not covered
<b>D1510</b>	Space maintainer — fixed, unilateral — per quadrant	\$10.00	Not covered
<b>D1516</b>	Space maintainer — fixed — bilateral, maxillary	\$20.00	Not covered
<b>D1517</b>	Space maintainer — fixed — bilateral, maxillary	\$20.00	Not covered
<b>D1551</b>	Re-cement or re-bond bilateral space maintainer — maxillary	\$0.00	Not covered
<b>D1552</b>	Re-cement or re-bond bilateral space maintainer — mandibular	\$0.00	Not covered
<b>D1553</b>	Re-cement or re-bond unilateral space maintainer — per quadrant	\$0.00	Not covered
Basic Restorative		In-network Copayment	Out-of-network Copayment
<b>D2140</b>	Amalgam — one surface, primary or permanent (1 in 24 months)	\$0.00	Not covered
<b>D2150</b>	Amalgam — two surfaces, primary or permanent (1 in 24 months)	\$0.00	Not covered
<b>D2160</b>	Amalgam — three surfaces, primary or permanent (1 in 24 months)	\$0.00	Not covered
<b>D2161</b>	Amalgam — four or more surfaces, primary or permanent (1 in 24 months)	\$0.00	Not covered
<b>D2330</b>	Resin-based composite — one surface, anterior (1 in 24 months)	\$0.00	Not covered
<b>D2331</b>	Resin-based composite — two surfaces, anterior (1 in 24 months)	\$0.00	Not covered
<b>D2332</b>	Resin-based composite — three surfaces, anterior (1 in 24 months)	\$0.00	Not covered
<b>D2335</b>	Resin-based composite — four or more surfaces or involving incisal angle (anterior) (1 in 24 months)	\$0.00	Not covered
<b>D2390</b>	Resin-based composite crown, anterior	\$0.00	Not covered

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<b>D2391</b>	Resin-based composite — one surface, posterior	\$10.00	Not covered
<b>D2392</b>	Resin-based composite — two surfaces, posterior	\$18.00	Not covered
<b>D2393</b>	Resin-based composite — three surfaces, posterior	\$21.00	Not covered
<b>D2394</b>	Resin-based composite — four or more surfaces, posterior	\$29.00	Not covered
<b>D2740</b>	Crown — porcelain/ceramic substrate	\$125.00	Not covered
<b>D2750</b>	Crown — porcelain fused to high noble metal	\$125.00	Not covered
<b>D2751</b>	Crown — porcelain fused to predominantly base metal	\$125.00	Not covered
<b>D2752</b>	Crown — porcelain fused to noble metal	\$125.00	Not covered
<b>D2790</b>	Crown — full cast high noble metal	\$125.00	Not covered
<b>D2791</b>	Crown — full cast predominantly base metal	\$125.00	Not covered
<b>D2792</b>	Crown — full cast noble metal	\$125.00	Not covered
<b>D2920</b>	Re-cement or re-bond crown	\$0.00	Not covered
<b>D2930</b>	Prefabricated stainless steel crown — primary tooth	\$30.00	Not covered
<b>D2931</b>	Prefabricated stainless steel crown — permanent tooth	\$30.00	Not covered
<b>D2932</b>	Prefabricated resin crown	\$30.00	Not covered
<b>D2940</b>	Protective restoration	\$0.00	Not covered
<b>D2950</b>	Core buildup, including any pins when required	\$0.00	Not covered
<b>D2951</b>	Pin retention — per tooth, in addition to restoration	\$0.00	Not covered
<b>D2952</b>	Post and core in addition to crown, indirectly fabricated	\$0.00	Not covered
<b>D2954</b>	Prefabricated post and core in addition to crown	\$0.00	Not covered
<b>D2980</b>	Crown repair necessitated by restorative material failure	\$0.00	Not covered
<b>Endodontics</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D3110</b>	Pulp cap — direct (excluding final restoration) (1 in 12 months)	\$0.00	Not covered
<b>D3120</b>	Pulp cap — indirect (excluding final restoration)	\$0.00	Not covered
<b>D3310</b>	Endodontic therapy, anterior tooth (excluding final restoration) (1 in a lifetime)	\$225.00	Not covered
<b>D3320</b>	Endodontic therapy, bicuspid tooth (excluding final restoration) (1 in a lifetime)	\$225.00	Not covered
<b>D3330</b>	Endodontic therapy, molar (excluding final restoration) (1 in a lifetime)	\$350.00	Not covered
<b>D3920</b>	Hemisection (including any root removal), not including root canal therapy (1 in a lifetime)	\$110.00	Not covered
<b>Periodontics, Enrollee Pays</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D4210</b>	Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant	\$200.00	Not covered
<b>D4211</b>	Gingivectomy or gingivoplasty — one or three contiguous teeth or tooth bounded spaces per quadrant	\$55.00	Not covered
<b>D4240</b>	Gingival flap procedure, including root planning — four or more contiguous teeth or tooth bounded spaces per quadrant	\$200.00	Not covered
<b>D4241</b>	Gingival flap procedure, including root planning — one or three contiguous teeth or tooth bounded spaces per quadrant	\$55.00	Not covered
<b>D4260</b>	Osseous surgery (including elevatin of a full thickness flap and closure) — four or more contiguous teeth or tooth bounded spaces per quadrant	\$325.00	Not covered
<b>D4261</b>	Osseous surgery (including elevatin of a full thickness flap and closure) — one or three contiguous teeth or tooth bounded spaces per quadrant	\$100.00	Not covered
<b>D4277</b>	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$200.00	Not covered
<b>D4278</b>	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
<b>D4341</b>	Periodontal scaling and root planning — four or more teeth per quadrant	\$70.00	Not covered
<b>D4342</b>	Periodontal scaling and root planning — one or three teeth per quadrant	\$35.00	Not covered
<b>D4355</b>	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$0.00	Not covered
<b>D4910</b>	Periodontal maintenance (1 in 6 months)	\$35.00	Not covered
<b>Prosthodontics (Removable)</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D5110</b>	Complete denture — maxillary (1 in 60 months)	\$30.00	Not covered
<b>D5120</b>	Complete denture — mandibular (1 in 60 months)	\$30.00	Not covered
<b>D5130</b>	Immediate denture — maxillary (1 in 60 months)	\$30.00	Not covered

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<b>D5140</b>	Immediate denture — mandibular (1 in 60 months)	\$30.00	Not covered
<b>D5211</b>	Maxillary partial denture — resin base (including retentive/clasping materials, rests, and teeth) (1 in 60 months)	\$30.00	Not covered
<b>D5213</b>	Maxillary partial denture — cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) (1 in 60 months)	\$30.00	Not covered
<b>D5214</b>	Mandibular partial denture — cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) (1 in 60 months)	\$30.00	Not covered
<b>D5410</b>	Adjust complete denture — maxillary (2 in calendar year)	\$0.00	Not covered
<b>D5411</b>	Adjust complete denture — mandibular (2 in calendar year)	\$0.00	Not covered
<b>D5421</b>	Adjust partial denture — maxillary (2 in calendar year)	\$0.00	Not covered
<b>D5422</b>	Adjust partial denture — mandibular (2 in calendar year)	\$0.00	Not covered
<b>D5511</b>	Repair broken complete denture base, mandibular (1 in 6 months)	\$0.00	Not covered
<b>D5512</b>	Repair broken complete denture base, maxillary (1 in 6 months)	\$0.00	Not covered
<b>D5520</b>	Replace missing or broken teeth — complete denture (each tooth) (1 in 6 months)	\$0.00	Not covered
<b>D5611</b>	Repair resin partial denture base, mandibular (1 in 6 months)	\$0.00	Not covered
<b>D5612</b>	Repair resin partial denture base, maxillary (1 in 6 months)	\$0.00	Not covered
<b>D5621</b>	Repair cast partial framework, mandibular (1 in 6 months)	\$0.00	Not covered
<b>D5622</b>	Repair cast partial framework, maxillary (1 in 6 months)	\$0.00	Not covered
<b>D5630</b>	Repair or replace broken retentive clasping materials — per tooth (1 in 6 months)	\$0.00	Not covered
<b>D5640</b>	Replace broken teeth — per tooth (1 in 6 months)	\$0.00	Not covered
<b>D5650</b>	Add tooth to existing partial denture (1 in 6 months)	\$0.00	Not covered
<b>D5660</b>	Add clasp to existing partial denture — per tooth (1 in 6 months)	\$0.00	Not covered
<b>D5670</b>	Replace teeth and acrylic on cast metal framework (maxillary) (1 in 6 months)	\$0.00	Not covered
<b>D5671</b>	Replace teeth and acrylic on cast metal framework (mandibular) (1 in 6 months)	\$0.00	Not covered
<b>D5730</b>	Reline complete maxillary denture (chairside) (1 in 6 months)	\$0.00	Not covered
<b>D5731</b>	Reline complete mandibular denture (chairside) (1 in 6 months)	\$0.00	Not covered
<b>D5740</b>	Reline maxillary partial denture (chairside) (1 in 6 months)	\$0.00	Not covered
<b>D5741</b>	Reline mandibular partial denture (chairside) (1 in 6 months)	\$0.00	Not covered
<b>D5750</b>	Reline complete maxillary denture (laboratory) (1 in 6 months)	\$0.00	Not covered
<b>D5751</b>	Reline complete mandibular denture (laboratory) (1 in 6 months)	\$0.00	Not covered
<b>D5760</b>	Reline maxillary partial denture (laboratory) (1 in 6 months)	\$0.00	Not covered
<b>D5761</b>	Reline mandibular partial denture (laboratory) (1 in 6 months)	\$0.00	Not covered
<b>Prosthodontics (Fixed)</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D6210</b>	Pontic — cast high noble metal	\$125.00	Not covered
<b>D6211</b>	Pontic — cast predominantly base metal	\$125.00	Not covered
<b>D6212</b>	Pontic — cast noble metal	\$125.00	Not covered
<b>D6240</b>	Pontic — porcelain fused to high noble metal	\$125.00	Not covered
<b>D6241</b>	Pontic — porcelain fused to predominantly noble metal	\$125.00	Not covered
<b>D6242</b>	Pontic — porcelain fused to noble metal	\$125.00	Not covered
<b>D6245</b>	Pontic — porcelain/ceramic	\$125.00	Not covered
<b>D6545</b>	Retainer — cast metal for resin bonded fixed prosthesis	\$50.00	Not covered
<b>D6740</b>	Retainer — porcelain/ceramic	\$125.00	Not covered
<b>D6750</b>	Retainer crown — porcelain fused to high noble metal	\$125.00	Not covered
<b>D6751</b>	Retainer crown — porcelain fused to predominantly base metal	\$125.00	Not covered
<b>D6752</b>	Retainer crown — porcelain fused to noble metal	\$125.00	Not covered
<b>D6783</b>	Retainer crown — $\frac{3}{4}$ porcelain/ceramic	\$125.00	Not covered
<b>D6790</b>	Retainer crown — full cast high noble metal	\$125.00	Not covered
<b>D6791</b>	Retainer crown — full cast predominantly base metal	\$125.00	Not covered
<b>D6792</b>	Retainer crown — full cast noble metal	\$125.00	Not covered
<b>D6930</b>	Re-cement or re-bonded fixed partial denture	\$0.00	Not covered
<b>Oral and Maxillofacial Surgery</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D7111</b>	Extraction, coronal remnants — primary tooth (1 in a lifetime)	\$0.00	Not covered

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<b>D7140</b>	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (1 in a lifetime)	\$0.00	Not covered
<b>D7210</b>	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
<b>D7220</b>	Removal of impacted tooth — soft tissue (1 in a lifetime)	\$0.00	Not covered
<b>D7230</b>	Removal of impacted tooth — partially bony (1 in a lifetime) (1 in same day)	\$0.00	Not covered
<b>D7240</b>	Removal of impacted tooth — completely bony (1 in a lifetime)	\$0.00	Not covered
<b>D7241</b>	Removal of impacted tooth — completely bony, with unusual surgical complications (1 in a lifetime)	\$0.00	Not covered
<b>D7250</b>	Removal of residual tooth roots (cutting procedure) (1 in a lifetime)	\$0.00	Not covered
<b>D7310</b>	Alveoplasty in conjunction with extractions — four or more teeth or tooth spaces, per quadrant (1 in a lifetime)	\$0.00	Not covered
<b>D7510</b>	Incision and drainage of abscess — intraoral soft tissue (1 in a lifetime)	\$0.00	Not covered
<b>Orthodontics</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D8070</b>	Comprehensive orthodontic treatment of the transitional dentition	\$425.00	Not covered
<b>D8080</b>	Comprehensive orthodontic treatment of the adolescent dentition	\$425.00	Not covered
<b>D8090</b>	Comprehensive orthodontic treatment of the adult dentition	\$425.00	Not covered
<b>Adjunctive General Services</b>		<b>In-network Copayment</b>	<b>Out-of-network Copayment</b>
<b>D9110</b>	Palliative (emergency) treatment of dental pain — minor procedures (1 in the same day)	\$0.00	Not covered
<b>D9215</b>	Local anesthesia in conjunction with operative or surgical procedures (1 in the same day)	\$0.00	Not covered
<b>D9222</b>	Deep sedation/general anesthesia — first 15 minutes	\$0.00	Not covered
<b>D9223</b>	Deep sedation/general anesthesia — each subsequent 15 minute increment	\$0.00	Not covered
<b>D9230</b>	Inhalation of nitrous oxide/analgesia, anxiolysis	\$0.00	Not covered
<b>D9239</b>	Intravenous moderate (conscious) sedation/analgesia — first 15 minutes	\$0.00	Not covered
<b>D9243</b>	Intravenous moderate (conscious) sedation/analgesia — each subsequent 15 minute increment	\$0.00	Not covered
<b>D9248</b>	Non-intravenous conscious sedation (1 in same day)	\$0.00	Not covered
<b>D9310</b>	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician (2 in a calendar year)	\$0.00	Not covered
<b>D9999</b>	Unspecified adjunctive procedure, by report	\$10.00	Not covered

**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 more than 20 miles from an EPB Network Provider for your Group, 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.**

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