[MPI logo[D1]]

Dentegra® Dental PPO

Family Preferred Plan

Combined Policy and Disclosure Form

Provided by:

Dentegra Insurance Company

[dentegra[D2].com]

[MPI website and phone number[D3]]

Notice to Buyer: This Policy provides dental benefits only.

Policy

You must make an election for any eligible person you wish to cover under this Policy. If an election is not made for an individual or dependent, such person will not be eligible under this Policy.

Your dental plan is underwritten by Dentegra® Insurance Company and administered by Delta Dental Insurance Company. Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on your application [through[DS4] the Medical Plan Issuer ("MPI")]. It takes effect on the Effective Date shown in Appendix A attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

READ YOUR POLICY CAREFULLY

Ten (10)-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if you are not satisfied, you may return this Policy within ten (10) days after you received it. Mail or deliver it to Dentegra or to the agent through whom you purchased this Policy. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra as of its Effective Date by:

Anthony S. Barth, Vice Chairman

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INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him or her on a regular basis.

[Eligibility[DS5] under this Policy is determined by the MPI.] This Policy provides dental benefits for adults and children as defined in the following sections:

- ***Eligibility Requirement for Pediatric Benefits*** **(Essential Health Benefits)**
- ***Eligibility Requirement for Adult Benefits***

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

Using This Policy

This Policy discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. An outline of coverage will be provided to you. Keep in mind that "you" and "your" mean the Enrollees who are covered under this Policy. "We," "us" and "our" always refer to Dentegra.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our website at dentegra.com or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim and assist you in filing a claim.

You can access our automated information line at 1-800-471-0284 to obtain information about Enrollee Benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s), please mail your inquiry to the following address:

Dentegra Insurance Company

P.O. Box 1850

Alpharetta, GA 30023-1850

Identification Number

Please provide the Enrollee's identification ("ID") number to your Provider whenever you receive dental services. The Enrollee ID number should be included on all claims submitted for payment. ID cards are not required, but if you wish to have one you may obtain one by visiting our website at dentegra.com.

DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Adult Benefits: dental services under this Policy for people [age 19 years and older[D6]].

Benefits: the amounts that Dentegra will pay for covered dental services under this Policy.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim, request a Pre-Treatment Estimate or request prior authorization.

Deductible: a dollar amount that an Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits. Please note that expenses for non-covered services do not apply to the Deductible.

Dentegra PPO Contracted Fee ("PPO Provider's Contracted Fee"): the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating Enrollees.

Dentegra PPO Provider ("PPO Provider"): a Provider who contracts with Dentegra and agrees to accept the Dentegra PPO Contracted Fee as payment in full for services provided under a PPO plan. A PPO Provider also agrees to comply with Dentegra's administrative guidelines.

Effective Date: the original date the plan starts.

Eligible Dependent: a person who is a dependent of an Eligible Primary as described in this Policy. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Eligible Primary: a person who meets the conditions of eligibility in this Policy. Eligible Primaries are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Eligible Pediatric Individual: a person who is eligible for Pediatric Benefits as described in this Policy.

Enrollee: an Eligible Primary ("Primary Enrollee"), Eligible Dependent ("Dependent Enrollee") or Eligible Pediatric Individual ("Pediatric Enrollee") enrolled under this Policy to receive Benefits;

persons eligible and enrolled under this Policy for Adult Benefits may also be referred to as "Adult Enrollees."

Enrollee Pays: an Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Essential Health Benefits ("Pediatric Benefits"): for the purposes of this Policy, Essential Health Benefits are certain pediatric oral services that are required to be included in this Policy under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal agencies and are available for Eligible Pediatric Individuals.

Maximum: the maximum dollar amount we will pay toward the cost of dental care.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the financial obligation for the Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.

[**Medical**[DS7] **Plan Issuer ("MPI"):** the entity providing the medical plan that is issued and delivered to the Primary Enrollee with this dental plan as a Packaged Offering.]

Non-Dentegra Provider: a Provider who is not a PPO Provider and who is not contractually bound to abide by Dentegra's administrative guidelines.

Open Enrollment Period: [the[DS8] period of the year that the MPI has established when the Primary Enrollee may change coverage selections for the next Policy Year.] [the[DS9] period of the year that the Primary Enrollee may change coverage selections for the next Policy Year.]

Out-of-Pocket Maximum: the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the [Calendar Year/Policy[DS10] Year] provided a PPO Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from a Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met.

[**Packaged**[DS11] **Offering:** the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

Policy: this agreement between Dentegra and the Primary Enrollee including any application [supplied[DS12] by the MPI]. This Policy constitutes the entire agreement between the parties.

Policy Benefit Level: the percentage of the Maximum Contract Allowance that Dentegra will pay.

Policyholder: the Primary Enrollee who enrolls for coverage.

Policy Year: [the[DS13] period established by the separate medical plan provided by the MPI as a Packaged Offering.] [the[DS14] 12 months starting on the Effective Date and each subsequent 12

month period thereafter.] [Deductibles[DS15], Maximums and Out-of-Pocket Maximums will be determined using this Policy Year rather than on a Calendar Year basis.]

Premium: the amount payable as provided in Appendix A attached to this Policy.

Pre-Treatment Estimate: an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation, dental clinic, or independent practice of a licensed dental hygienist.

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Spouse: a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

Waiting Period: the amount of time an Enrollee must be enrolled under this Policy for specific services to be covered.

ELIGIBILITY AND ENROLLMENT

[A[D16] person may be covered under only one Dentegra individual policy at a time. If an individual is enrolled to receive Benefits as a Primary Enrollee, Dependent Enrollee, Pediatric Enrollee or another similar defined term under another Dentegra individual policy, said individual is not eligible under this Policy.]

[The[DS17] MPI is responsible for establishing eligibility and reporting enrollment. We process enrollment as reported by the MPI.]

This Policy includes Pediatric Benefits and Adult Benefits. Enrollees are eligible for either Pediatric or Adult Benefits according to the requirements listed below:

Eligibility Requirement for Pediatric Benefits

Pediatric Enrollees eligible for Pediatric Benefits are:

- a Primary Enrollee or an emancipated minor [through the end of the month in which he or she turns 19[D18]]; and/or
- a Primary Enrollee's Spouse through the end of the month in which he or she turns 19 and dependent children from birth through the end of the month in which he or she turns 19. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.

A newborn dependent child is eligible from the moment of birth. Dentegra may require notification of a birth and payment of required premium or fee within 31 days after the birth.

Eligibility Requirement for Adult Benefits

Adult Enrollees eligible for Adult Benefits are:

- a Primary Enrollee 19 years of age or older; and/or
- a Primary Enrollee's Spouse age 19 and older and dependent children from age 19 to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of Spouse.

A dependent [unmarried child 26 years of age or older may continue eligibility for Adult Benefits if:

- he or she is incapable of self-support because of a mental or physical disability;
- he or she is chiefly dependent on the Primary Enrollee or Spouse for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Enrollment Period

[Enrollees[DS19] in the medical plan provided by the MPI who do not have dental coverage under another dental plan are required to enroll under this dental plan. Enrollment under this dental plan for coverage begins on the date enrollment under the medical plan begins and terminates on the date that enrollment under the medical plan terminates.]

[Enrollees[DS20] in this Policy must enroll for a minimum of 12 months. If coverage is voluntarily discontinued, Enrollees may not re-apply during the 12 month period immediately following the voluntary termination.]

Renewal

[You[DS21] will receive renewal information from the MPI provided Dentegra continues to make this Policy available through the MPI at the renewal period. The Primary Enrollee may elect to continue coverage, subject to the applicable Premium available through the MPI for this plan at the time of renewal.]

[Dentegra[DS22] will provide 60 days advance written notice of any change in Premium at renewal.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, Dentegra may refuse renewal due to:

- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits;
- the Primary Enrollee failing to comply with material provisions of this Policy; or
- Dentegra ceasing to renew all Policies issued on this form to residents of the state where you live.

At least 30 days notice of any non-renewal action permitted by this clause will be mailed to the Primary Enrollee at the last address shown in Dentegra's records. If Dentegra fails to provide 30 days notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which Premium has not been paid.]

Termination of Coverage

You have the right to terminate coverage under this Policy by sending Dentegra [or [D23]the MPI] written notice of intent to terminate this Policy. Termination of this Policy and coverage for you and your Dependent and/or Pediatric Enrollees will be effective on [the last day [D24]of the month that we receive your request][the date [D25]reported by the MPI].

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date. [After[D26] that, all requests for a Premium refund will be prorated based upon the number of months remaining in the Policy Year. However, a refund is not

available if Enrollees have received Benefits under this Policy and if less than one month is remaining in the Policy Year since coverage is based on a full calendar month.]

You may keep this Policy in force by timely payment of the Premiums. However, Dentegra may terminate coverage due to:

- [MPI [D27]terminates Packaged Offering or Enrollee no longer eligible through the MPI;] [Enrollee[DS28] no longer eligible under the terms of this Policy;]
- [non[DS29]-payment of Premiums for the Packaged Offering, subject to the MPI's applicable grace period;] [non[DS30]-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;]
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or Enrollee applying for this coverage or filing a claim for Benefits; or
- [Dentegra[DS31] ceasing to offer all Policies issued on this form in a Packaged Offering with the MPI.] [Dentegra[DS32] ceasing to renew all Policies issued on this form to residents of the state where you live.]
- If we terminate this Policy due to nonpayment of Premium and the nonpayment was due to a cognitive impairment or functional incapacity, then you and the Responsible Party have the right to request reinstatement of the Policy. The reinstatement request must be received by us within 90 days of the termination. Your Policy will be reinstated with no break in coverage, provided the full past due premium is received by us within 15 days of our request. We reserve the right to request proof of the impairment.

[If you are no longer[D33] eligible due to age, termination is effective [the last day of the Calendar Year that you lose eligibility[D34]]. If you lose eligibility under the terms of this Policy for reasons other than age, termination is effective the last day of the month in which you lose eligibility.

If your coverage is terminated, we will send a written notice to you (and any authorized representative that you designate) within 10 days, informing you of the reason(s) why coverage is terminated and the date that your coverage will end.] However, we will pay for the completion of Single Procedures started while an Enrollee was eligible if they are completed within 31 days of the date coverage ended.

[Reinstatement[DS35]

This Policy may be reinstated with no break in coverage provided the full Premium due is received by us within 60 days of the date of the past due Premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to your Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to your Policy.]

Continuation of Coverage

Continuation of coverage for dependent children. Upon entry of a valid decree of dissolution of marriage, coverage for the Responsible Party's dependent children may be continued until the

earlier of the following dates: (a) the date the insured's former spouse becomes covered under any other policy; or (b) the date coverage would otherwise terminate under the Policy. Upon request Dentegra will provide the Responsible Party or Enrollee with written verification of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period.

Continuation of coverage for dependents upon death of the Responsible Party. Upon the death of the Responsible Party, coverage for a survivor or survivors of the Responsible Party who were enrolled under the Policy shall continue until the earlier of the following: (a) the date the surviving spouse becomes covered under another policy; or (b) the date coverage would have terminated under the Policy had the Responsible Party lived. Upon request, Dentegra will provide the Responsible Party or Enrollee with written verification of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how the dental plan works and how to make it work best for you.

Benefits, Limitations and Exclusions

We will pay Benefits for the types of dental services as described in Appendix A and the Services, Limitations and Exclusions section that are a part of this Policy. There are no annual or lifetime maximums for the Essential Health Benefit Plan.

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We 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.

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 Policy. Even 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.

The Provider may charge more than the limits of this Policy and these charges may not be covered by this Policy. The Dentegra Provider's Contracted Fee is 20% less than Dentegra's Program Allowance.

If you are out of the country and an emergency occurs, seek treatment immediately. You can see any licensed dentist anywhere in the world for emergency dental services. When you return home, forward the statement to Dentegra, attached to a claim form.

Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (age 19 and older)

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Appendix A for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Service for payment purposes).
  - (3) Specialist Consultations: opinion or advice requested by a general dentist.
- **Basic Services**
  - (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (2) Periodontal Cleanings: periodontal maintenance.
  - (3) Palliative: emergency treatment to relieve pain.
  - (4) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- **Major Services**
  - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
  - (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
  - (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (5) Periodontics: treatment of gums and bones supporting teeth.
  - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, Dentegra will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations for Adult Benefits (age 19 and older)

(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 after hours exams and exams for observation) no more than twice in a Calendar Year**.**

(3) Dentegra will pay for 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.

(4) 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.

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

(6) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(7) Dentegra will not cover to replace an amalgam, resin-based composite or prefabricated resin and 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.

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

(9) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(10) 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.

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

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

(13) 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.

(14) 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.

(15) 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.

(16) 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.

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

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

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

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

(21) 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.

(22) 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.

(23) 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.

(24) 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.

(25) 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.

(26) 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.

(27) 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.

Exclusions for Adult Benefits (age 19 and older)
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) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

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

(15) 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.

(16) 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.

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

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

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

(20) 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.

(21) 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 Policy or was covered under any dental care plan with Dentegra. 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.

(22) 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.

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

(24) endodontic endosseous implant.

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

Description of Dental Services for Pediatric Benefits (under age 19)

Dentegra will pay or otherwise discharge the Policy Benefit Level shown in Appendix A for Essential Health Benefits when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
(2)	Preventive	cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
(3)	Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
(4)	Specialist Consultations:	opinion or advice requested by a general dentist.

- **Basic Services**

(1)	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
(2)	Periodontal Cleanings:	periodontal maintenance.
(3)	Palliative:	emergency treatment to relieve pain.
(4)	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

(1)	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
(2)	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
(3)	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
(4)	Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	treatment of gums and bones supporting teeth.
(6)	Denture Repairs:	repair to partial or complete dentures, including rebase

		procedures and relining.
(7)	Night Guards/Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits.

Limitations for Pediatric Benefits (under age 19)

(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 Policy. 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) Dentegra will pay for oral examinations (except after hours exams and exams for observation) no more than once every six (6) months.

(5) Dentegra will pay for routine cleanings no more than once every six (6) months. Periodontal maintenance in the presence of inflamed gums are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a 12-month period. 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. Periodontal maintenance is only covered when performed following active periodontal therapy.

(6) 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 once every six (6) months. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(7) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered only when Orthodontic Services are covered. If Orthodontic Services are covered, see Orthodontic Limitations as age limits may apply.

(8) Pulp vitality tests are allowed once per day when definitive treatment is not performed. The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.
(9) Caries risk assessments are limited to no more than once in a 36-month period and are a Benefit for Enrollees ages three (3) to 19.

(10) Topical application of fluoride solutions is limited to twice within a 12-month period.

(11) Space maintainer limitations:
a) Space maintainers are limited to the initial appliance.
b) Recementation of space maintainer is limited to once per lifetime.
c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(12) Sealants are limited as follows:
a) to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(13) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(14) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated stainless steel crowns are limited to once per Enrollee per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.

(15) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

(16) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.

(17) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

(18) 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.

(19) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit.

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

(21) Pin retention is covered once per tooth in any 24-month period. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(22) Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.

(23) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
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 graft procedures 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.

(24) Oral Surgery services are covered once in a lifetime except incision and drainage procedures, which are covered once in the same day.

(25) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and 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. Services will only be allowed on teeth that are developmentally mature.

(26) When an alternate Benefit of an amalgam is allowed for inlays/onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period. Services will only be allowed on teeth that are developmentally mature.

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

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

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

(30) 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.

(31) 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.

(32) Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) 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. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. 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. Services will only be allowed on teeth that are developmentally mature. 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 within a 60-month period whether provided under Dentegra or any other dental care plan.

(33) An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

(34) 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.

(35) 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 (6) month period by the same Provider/Provider office.

(36) 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.

(37) 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 36-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 and relining are limited to one (1) per arch in a 36-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.

(38) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. Dentegra will not cover the repair or replacement of any appliances for Night Guard/Occlusal Guard.

(39) Limitations on Orthodontic Services

a) Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
b) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
c) The automatic qualifying conditions are:

i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
ii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
iii. A crossbite of individual anterior teeth causing destruction of soft tissue,
iv. Severe traumatic deviation.

d) The following documentation must be submitted with the request for prior authorization of services by the Provider:
   i. ADA 2006 or newer claim form with service code(s) requested;
   ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
   iii. Cephalometric radiographic image or panoramic radiographic image;
   iv. HLD score sheet completed and signed by the Orthodontist; and
   v. Treatment plan.
e) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
f) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
g) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
i) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
j) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, Dentegra will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
k) Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.

Exclusions for Pediatric Benefits (under age 19)

Dentegra does not pay Benefits for:

(1) services that are not Essential Health Benefits.

(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) maxillofacial prosthetics.

(5) 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).

(6) 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.

(7) 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, or complete occlusal adjustments.

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

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

(10) 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.

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

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

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

(14) interim implants.

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

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

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

(18) 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.

(19) 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.

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

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

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

(23) 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.

(24) 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 Policy or was covered under any dental care plan with Dentegra. 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.

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

(26) endodontic endosseous implant.

(27) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You may have to satisfy a Deductible before we will pay Benefits. You pay the Enrollee Coinsurance even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "*Selecting Your Provider*"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the section titled "*Selecting Your Provider*" for more information.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before the Enrollee receives any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days or until an earlier occurrence of any one of the following events:

- the date this Policy terminates;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under this Policy with your benefits under any other individual or pre-paid plan or insurance plan designed to fully integrate with other plans. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits so that the total benefits paid or provided by all plans do not exceed 100% of total allowable expense.

Coordination with Medicare. Coordination of benefits with Medicare is governed by the following provisions.

A. The policy may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the policy states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage.

B. The policy may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the policy was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the policy will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B.

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B.

When an insured is covered under more than one expense-incurred health plan, payments made the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

You may see any Provider for your covered treatment whether the Provider is a PPO Provider or a Non-Dentegra Provider. **This plan is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider.** To take full advantage of your Benefits, we highly recommend you verify a Provider's participation status within a Dentegra network with your dental office before each appointment. Review this section for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a PPO Provider

You may access information through our website at dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

The PPO plan potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Costs incurred by the Pediatric Enrollee for covered services with a PPO Provider apply towards the Out-of-Pocket Maximum for Pediatric Benefits.

Choosing a Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Dentegra Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.

Costs incurred by the Pediatric Enrollee with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Non-Dentegra Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

Additional Obligations of PPO Providers

- PPO Providers must accept assignment of Benefits, meaning these Providers will be paid directly by Dentegra after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- PPO Providers will complete the dental Claim Form and submit it to Dentegra for reimbursement.
- PPO Providers will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra PPO Contracted Fees.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services

from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "*Claim Form*" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company

P.O. Box 1850

Alpharetta, GA 30023-1850

Payment Guidelines

We do not pay PPO Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your PPO Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

Provider Relationships

The Primary Enrollee and Dentegra agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any PPO or Non-Dentegra Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

GRIEVANCES AND APPEALS

If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also email questions by accessing the "Contact Us" section of our website at dentegra.com.

Grievances or appeals regarding eligibility, the denial of dental services or claims, the policies, procedures, operations of Dentegra or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 1-800-471-0284.

When you write, please include the name of the Enrollee, the ID number and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim

statement or other relevant information. Your claim statement will have an explanation of the claim review and any grievance or appeal process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review in writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask Dentegra to examine any additional information you include that may support your [grievance].

Send your grievance or appeal to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1850

Alpharetta, GA 30023-1850

We will send you a written acknowledgment within three (3) days upon receipt of your grievance or appeal which will include pertinent information regarding your case and the contact information of the coordinator assigned to your case. We will make a full and fair review within 20 days after we receive the grievance or appeal. We may ask for more documents if needed. We will send you a decision within 20 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

If you believe you need further review of your grievance or appeal, you may contact Maine's Superintendent at the Bureau of Insurance at 1-800-300-5000, if applicable. You have a right to an independent external review, which can be requested to the Maine Bureau of Insurance. You cannot make a request for external review until you have exhausted Dentegra's first level grievance and appeals procedures. A request for external review must be made within 12 months of Dentegra's final decision. A request for an expedited external review can be made if: 1) Dentegra failed to make a decision within the time period required; 2) Dentegra and the Enrollee mutually agree to bypass the internal grievance procedure; 3) the life or health of the Enrollee is in serious jeopardy; or 4) the Enrollee has died.

Included at the end of this Policy is a detailed description of the grievance and appeal process.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment. Premiums are listed in Appendix A attached to this Policy. The Primary Enrollee is responsible for making Premium payments. [Each[D36] Premium is to be paid to the MPI.]

Each[D37] Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay your Premium by visiting our website at dentegra.com or by mailing payment to the address below:

Dentegra Insurance Company

P.O. Box 660138

Dallas, TX 75266-0138

Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of your enrollment. The rate guarantee can be less than a Policy Year if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

No change in Premiums shall become effective within a Policy Year unless Dentegra's liability is changed by law or regulation. Such a change may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Dentegra under this Policy or any immediately preceding Policy between Dentegra and you. Dentegra would provide 60 days written notice of a rate increase to you, and this Policy shall thereby be modified on the date set forth in the notice.

Changing Payment Options

[Please[D38] contact the MPI for information to see if you may change payment options.]

[Payment[D39] options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on your new billing period. You can change your payment option by visiting our website at dentegra.com or by contacting our Customer Service Center toll-free at 1-800-471-0284.]

Grace Period on Late Payments

- [A[DS40] grace period will be granted for the payment of Premium in compliance with the grace period allowed by the MPI.]
- [A[D41] grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. During this time this Policy shall continue in force. If your coverage terminates for non-payment, you will be responsible for the cost of services rendered during the grace period. Coverage will terminate at the end of the grace period unless we receive your Premium before the end of this 31 days.]

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including any application [supplied by the MPI[D42]], constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and

unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Severability

If any part of this Policy or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Policy will remain in full force and effect.

Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Policy.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, information and records relating to the treatment provided to you as may be required to administer the claim. Examination may be required by a dental consultant retained by us in or near your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1850

Alpharetta, GA 30023-1850

Claim Form

We will within 15 days after receiving a notice of a claim provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your Provider a Claim Form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "*Written Notice of Claim/Proof of Loss*" above will be deemed to have been complied with as long as you give us written proof that explains the type and the extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may also download a Claim Form from our website at dentegra.com.

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be processed within 30 days after written proof of loss is received in the form required by the terms of this Policy. We will notify you and your Provider immediately after receipt of written proof of loss of any additional information needed to process the claim.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a PPO Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to you unless you request in writing when filing a proof of claim that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to you or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy unless it is contained in a written application. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at time of application or to terminate your Policy.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action

can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

Conformity with Prevailing Laws

All legal questions about this Policy will be governed by the state of Maine where this Policy was entered into and is to be performed. Any part of this Policy that conflicts with the laws of Maine or federal law is hereby amended to conform to the minimum requirements of such laws.

Third Party Administrator (“TPA”)

Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Appendix A
Benefit Summary

Policyholder: [Insert Name]

Effective Date: [Insert Effective Date]

Policy Year: [Insert Policy Year]

Policy ID Number: [Insert Policy Number]

Premium Remittance:

[Each[D43] Premium is to be paid to the MPI. Please contact the MPI for the appropriate remittance address.]

[Each [D44]Premium is to be paid to:

Dentegra Insurance Company

P.O. Box 660138

Dallas, TX 75266-0138]

Monthly Premium:

[XXXX]

Deductibles & Maximums		
	Adult Benefits **(age 19 and older)**	**Pediatric Benefits** **(under age 19)**
Annual Deductible	The annual Deductible is waived for Diagnostic and Preventive Services.	
Enrollee	$50 each [Calendar Year/Policy Year[MK45]]	$85 each [Calendar Year/Policy Year[MK46]]
Family (three or more	$150 each [Calendar	No family Deductible

Enrollees)	Year/Policy Year[MK47]]	
Annual Maximum Enrollee	$1,000 each [Calendar Year/Policy Year[MK48]]	No annual Maximum
Out-of-Pocket Maximum*		
Pediatric Enrollee	$350 each [Calendar Year/Policy Year[MK49]] for only one covered Pediatric Enrollee	
Multiple Pediatric Enrollees	$700 each [Calendar Year/Policy Year[MK50]] for two or more covered Pediatric Enrollees	

* Out-of-Pocket Maximum applies only to Essential Health Benefits for Pediatric Enrollees. Out-of-Pocket Maximum means the maximum amount of money that a Pediatric Enrollee must pay for covered dental services under this Policy during a [Calendar Year/Policy Year[MK51]] provided Dentegra PPO Providers are used. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

If only one Pediatric Enrollee is covered under this Policy, the financial obligation for covered services received from Dentegra PPO Providers is not more than the Pediatric Enrollee Out-of-Pocket Maximum. If two or more Pediatric Enrollees are covered under this Policy, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple Pediatric Enrollees Out-of-Pocket Maximum. Once the amount paid by the Pediatric Enrollee(s) equals the Out-of-Pocket Maximum shown above, no further payment will be required by the Pediatric Enrollee(s) for the remainder of the [Calendar Year/Policy Year[MK52]] for covered services received from Dentegra PPO Providers.

Policy Benefit Levels & Enrollee Coinsurances				
	Adult Benefits (age 19 and older)		**Pediatric Benefits (under age 19)**	
Dental Service Category	**Dentegra PPO[1]**		**Dentegra PPO[1]**	
	Dentegra[2]	Enrollee[2]	Dentegra[2]	Enrollee[2]
Diagnostic and Preventive Services	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%
Major Services	50%	50%	50%	50%
Medically Necessary Orthodontic Services (requires prior authorization)	Not a covered benefit	Not a covered benefit	50%	50%
Waiting Periods	Major Services are limited to Adult Enrollees who have been enrolled under this Policy for 12 consecutive months.[3]		Medically necessary Orthodontic Services are limited to Pediatric Enrollees who have been enrolled under this Policy for 12 consecutive months.[4]	

[1]Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

[2]Dentegra will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: Dentegra will pay the same Policy Benefit Level for covered services performed by a PPO Provider and a Non-Dentegra Provider. However, the amount charged to Enrollees for covered services performed by a Non-Dentegra Provider may

be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

[3]Waiting Periods are calculated for each Adult Enrollee from the effective date of coverage reported by the [Policyholder][CR53][MPI[CR54]] for said Adult Enrollee. Prior coverage for Adult Enrollees under any Dentegra Exchange plan that included an adult Waiting Period will be credited towards the adult Waiting Period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.

[4]Benefits are not provided for orthodontic treatment including all services related to orthodontic treatment (such as diagnostic and pre-treatment records) until the 12 month Waiting Period is satisfied. Waiting Periods are calculated for each Pediatric Enrollee from the effective date of coverage reported by the [Policyholder][CR55][MPI[CR56]] for said Pediatric Enrollee. Prior coverage for Pediatric Enrollees under a Dentegra exchange certified pediatric essential dental plan will be credited towards the pediatric Waiting Period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.

Dentegra Insurance Company
Maine Grievance and Appeal Process

This document describes Dentegra Insurance Company's Grievance and Appeal process and covers your right to appeal a denial of a claim and to request an independent external review or grievance. Please read this document carefully. It will provide you with information regarding your rights and how you may exercise those rights. If you have any questions regarding this process or need assistance in completing forms, please contact our Grievance and Appeal department toll-free at 1-877-280-4204.

Claims Appeal Process

If your claim is denied in whole or in part there is an appeal process available to you. The claim statement that you received which contains information regarding the payment or non-payment of your claim outlines the specific reason(s) and plan provision(s) upon which the determination of payment or non-payment was made. The complaint/grievance/appeal process outlined on the reverse side of the claim statement is superseded by this document. Please follow the procedures outlined to appeal a claim denial. You may request, free of charge, copies of any internal rule(s), guideline(s), protocol(s) and or an explanation of the scientific or clinical judgment that was relied upon to deny your claim.

Reconsideration of your claim may occur when your dentist re-submits the original claim and provides additional information which allows processing of the claim to be completed.

First Level Appeal

If a claim continues to be denied after reconsideration, and you or your attending dentist would like to appeal the denial of benefits, you may file an appeal by writing to Dentegra within one hundred eighty (180) days of the date you received the claim statement that contained the denied services.

Your letter should state why the claim(s) should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim(s) including the denial notice, should accompany your letter to Dentegra requesting an appeal review. Please send your appeal letter and related documentation to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Once Dentegra has received your appeal, we will send you a letter of acknowledgement within three (3) days upon receipt of your [complaint, grievance or appeal]. The appellate review will be performed within twenty (20) days of receipt of your letter, so long as all information necessary to perform the review has been submitted. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. If after review, Dentegra continues to deny the claim, we will notify you and your attending dentist in writing of the decision.

The appeal will be conducted by a dentist who is neither the person who originally made the claim denial that is subject of the appeal nor a subordinate of such individual. If the appeal is based in whole or in part on the lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the plan offering, the appellate review will be performed by a dentist who has appropriate training and experience in the pertinent field of dentistry. The identity of the dentist will be provided in any decision letter and is also available to you or your dentist by contacting our Grievance and Appeal department.

Second Level Appeal

If you or your attending dentist determines that your first level appeal warrants further consideration, you should advise Dentegra in writing as soon as possible. This is considered a second level or final appeal. The second level appeal will be immediately referred to our Dental Affairs Committee. This final appeal may include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested by you or your attending dentist. The Dental Affairs Committee will conduct a review meeting forty-five (45) business days of receipt of your appeal of the claim denial. You have the right to appear in person before the Dental Affairs Committee at the review meeting. You will be notified at least fifteen (15) business days in advance of the review meeting date. The Dental Affairs Committee will render a final decision within five (5) business days of completing the review meeting of the appeal of the claim denial. The decision of the Dental Affairs Committee shall be final insofar as Dentegra is concerned. If your second level appeal is denied, you will receive a final adverse decision letter.

Please send your appeal letter and related documentation to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Independent External Review by the Maine Bureau of Insurance

You or your authorized representative has the right to an independent external review of an adverse health care treatment decision by the Maine Bureau of Insurance. You are required to exhaust Dentegra's grievance and appeal procedures prior to making a request for independent external review unless you are requesting an expedited external review. A request for external review must be made within twelve (12) months of the date you have received a final adverse health care treatment decisions from Dentegra.

A request for an expedited external review may be submitted to the Maine Bureau of Insurance if 1) Dentegra failed to make a decision on a grievance within the time period required; 2) Dentegra and you mutually agree to bypass the Dentegra grievance and appeal procedures; 3) your life is in serious jeopardy; or 4) the Enrollee has died.

You have the right to attend the external review, submit and obtain supporting material to the adverse health care treatment decision under review, ask questions of any representative of Dentegra and have outside assistance.

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by us, you have the right seek assistance or file a complaint with the Maine Bureau of Insurance at:

Consumer Health Care Division
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333
Tel. 1-800-300-5000 (in Maine) or 1-207-624-8475
TTY 1- 888-577-6690
Website: www.maine.gov

If you have any questions regarding the grievance and appeal process or information outlined in this notice, please contact our Customer Service Center, toll-free at 1-877-280-4204.