DENTAL BENEFITS
DN1 PLAN

COVERED DENTAL EXPENSES

Allegiant Care does not have a network of contracted dentists. You may go to a dentist of your choice. A Fee Schedule of Covered Procedures is included at the end of this section. The Fee Schedule is updated each calendar year based on the average costs for claims submitted for care for our members. The amount on the Fee Schedule is the maximum amount that the Plan will pay to a provider for each dental code.

- ***Example 1:*** If the Fee Schedule amount indicates the Plan will pay $100 for a service and your provider bills $95.00, the Plan will pay $95.00 and you will owe nothing.

- ***Example 2:*** If the Fee Schedule amount indicates the Plan will pay $100 for a service and your provider bills $120.00; the plan will pay $100.00 and you will be responsible for the remaining $20.00.

Many dental conditions can be treated in more than one way. The Plan helps pay dental expenses, but not based on treatment that is more expensive than necessary. If a condition is being treated for which two or more services included on the list are suitable under customary dental practices, the benefit will be paid based on the listed service that would produce a professionally satisfactory result at the lowest cost.

If a dental service is performed that is not on the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, the listed service(s) that the Plan determines would produce a professionally satisfactory result will be used to determine the payment made to the provider.

Your Dental Plan covers “preventive and diagnostic services,” “basic services,” “major services” and “orthodontic services.”

Preventive Care Includes:

- Periodic oral exams - twice in any calendar year
- Emergency treatment for pain
- Routine cleaning and scaling - twice in any calendar year
- Topical fluoride application - twice in any calendar year, up to age 19
- X-rays
    - Bitewing series - one set each in any calendar year
    - Full mouth or panoramic series - one set each in any 36-month period
- Space maintainers (non-orthodontic) for Covered Dependents up to age 14
- Sealants - one per unrestored permanent molar and bicuspids per lifetime for Covered Dependents up to age 19
- Consultations
- X-rays of individual teeth - as necessary

Basic Care Includes:

- Fillings
- Routine extraction
- Oral surgery, including general anesthesia when medically necessary
  - surgical removal of erupted teeth or impacted or unerupted teeth
  - incision and drainage of abscess
  - alveolectomy
  - alveoplasty with ridge extension
- Periodontics - subgingival curettage or root planning and scaling; gingivectomy; osseous surgery with flap entry and closure
- Endodontics - pulp capping; root canal treatment; apicoectomy
- Stainless steel crowns for Covered Dependents up to age 12

Major Care Includes:

- Inlays
- Onlays
- Crowns
- Pontics
- Fixed or removable bridgework
- Full and partial dentures
- Denture repairs, adjustments, relines (including the addition of a tooth or teeth to an existing denture)
- Recement bridge
- Implant crowns

Orthodontic Care Includes:

- Comprehensive full-banded treatment
- Appliances for tooth guidance - one appliance per individual
- Retention appliances - one appliance per individual
- Benefits are payable at the time treatment begins. The full orthodontic benefit will be paid at the time of banding

SCHEDULE OF DENTAL BENEFITS

Preventive and Diagnostic Care	
Deductible	$0
Plan Pays	The Fee Schedule amount reflects 100% of average provider charges.
Calendar Year Maximum	Unlimited
ACA Pediatric Oral Care[1]	***Same benefit as adult care***
Basic Dental Care	
Deductible	$25 Individual/$50 family (including Basic and Major care); may be satisfied by any combination of covered family members.
Plan Pays	The Fee Schedule amount reflects 80% of average provider charges.
Calendar Year Maximum	Periodontics: $1,200 per individual
ACA Pediatric Oral Care	***Calendar year maximum for Periodontics does not apply***
Major Dental Care	
Deductible	$25 Individual/$50 family (including Basic and Major care); may be satisfied by any combination of covered family members.
Plan Pays	The Fee Schedule amount reflects 50% of average provider charges.
Calendar Year Maximum	Prosthodontics: $1,200 per individual
ACA Pediatric Oral Care	***Calendar year maximum for Prosthodontics does not apply***
Orthodontic Care	
Deductible	$0
Plan Pays	75% of total charges up to $1,500
Lifetime Maximum	$1,500 per Individual
ACA Medically Necessary Pediatric Orthodontic Care[2]	***If care is deemed medically necessary, the plan pays 50% with no maximum benefit.[3]***

Important note**:** Members must be covered for a minimum of six consecutive months under the DN1 Plan to be eligible for Orthodontic Benefits.

[1] Pediatric Oral Care benefits are limited to dependents that are under the age of 18.
[2] Eligibility for Medically Necessary Orthodontia will be determined using the Handicapping Labio-Lingual Deviation Form.
[3] A dependent who is eligible for Medically Necessary Orthodontia alternatively can choose to use the non-pediatric Orthodontia benefit under which the Plan pays 75% up to a $1,500 lifetime maximum.

DN1 Benefit Restrictions	
Pre-Determination of Benefits	• Any non-emergency prosthodontic or periodontic treatment more than $250 should be submitted to Allegiant Care for pre-determination of benefits prior to services being rendered. • Submission of a pre-determination does not guarantee approval and is subject to eligibility status on the date of service.
Gold Restorations	• Gold restorations (fillings, inlays, onlays and crowns) are covered only if teeth cannot be restored with a less expensive filling material or of the tooth is an abutment to a covered partial denture or fixed bridge.
Missing Teeth	• Benefits will be provided for the replacement of teeth missing prior to the effective date of coverage.
Orthodontic Care	• Members must be covered for at least six consecutive months under the DN1 Plan to be eligible for Orthodontic Benefits.

PRE-TREATMENT ESTIMATE OF BENEFITS

Getting an estimate of benefits before getting treatment helps to avoid any misunderstanding between the patient, the dentist and the Plan. A pre-treatment estimate of benefits is not required but recommended for services costing more than $250. Here is how it works:

- Have your dentist complete a dental claim and describe what work needs to be done — the "treatment plan;"
- Include any other supporting x-rays or charts;
- Send the pretreatment estimate to Allegiant Care; and
- Allegiant Care tells you and your dentist the estimated amount the Plan will pay.

You should discuss the treatment plan with your dentist before work is started. If the dentist changes the treatment plan, a new estimate of benefits should be submitted as the amount of payment may change.

FILING CLAIMS

WHEN TO FILE A CLAIM

A dental charge is incurred for purposes of filing a claim:

- For an appliance or modification of an appliance — on the date the impression is taken
- For a crown, bridge or gold restoration — on the date the tooth is prepared
- For root canal therapy — on the date the pulp chamber is opened
- For orthodontic services — (initial) on the date teeth are banded or the device is placed in the oral cavity
- For implants — on the date of insertion
- For all other services — on the date the service is rendered

Note: Claims must be filed within one year of the date of service. After one year no benefits will be paid.

HOW TO FILE A CLAIM

- The dentist must submit x-rays for all major and adult orthodontic expenses.
- The dentist must mail the completed claim form to the Plan.

Note: Payment will be based upon the Dental Fee Schedule and Plan Limitations and Exclusions. You and your dentist will receive notification of payment amount or denial.

WHERE TO FILE A CLAIM

- Claims can be mailed to: Allegiant Care, PO Box 4604, Manchester, NH 03108-4604; or, for electronic submission, the dentist can use Payor ID # 38238 and Group # R40.

PRE-EXISTING DENTAL CONDITION LIMITATION

No benefits will be paid for any pre-existing dental condition except for replacement of missing teeth. A pre-existing dental condition is a treatment or service that was started prior to the effective date of coverage under the Plan. Pre-existing conditions also include:

- an appliance or an appliance modification if the impression was made before the patient was covered;
- a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; and
- root canal therapy if the pulp chamber was opened before the patient was covered under this Plan.

COORDINATION OF BENEFITS

All members must submit a Coordination of Benefits (COB) Form showing all covered dependents and all other insurance coverage. Failure to submit the COB Form may result in delay of claim payment. If additional insurance information is not disclosed and claims are paid incorrectly, the member will be responsible for reimbursing the Plan for those claims.

DENTAL BENEFITS AFTER COVERAGE ENDS

Coverage does not include services or supplies furnished after dental coverage ends even if an estimate of benefits has already been made; provided however, that benefits will be paid for the following procedures, but only if work is already in process when coverage ends and your dentist completes the service within 90 days of the end of coverage:

- an appliance or modification of an appliance
- a crown, bridge or gold restoration
- root canal therapy

DENTAL BENEFIT LIMITATIONS

Limitations to the Dental Plan include the following:

1. Periodic oral exams are covered twice in any calendar year.
2. Prophylaxis, routine or periodontal, is covered twice in any calendar year.
3. Topical application of fluoride is covered twice in any calendar year for Covered Dependents up to age 19.
4. Bitewing x-rays are covered once in any calendar year.
5. Full mouth x-rays and panoramic x-rays are each covered once in any 36-month period.
6. Space maintainers are covered for Covered Dependents up to age 14.
7. One sealant treatment per unrestored permanent molars and bicuspids are covered per lifetime for Covered Dependents up to age 19.
8. Replacement of an existing partial by a new partial or replacement of an existing full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth are covered only if the existing denture or bridgework was installed at least five years before its replacement and cannot be made serviceable.
9. Periodontic services are limited to $1,000 per calendar year, prosthetic services are limited to another separate $1,000 per calendar year.
10. Multiple restorations (fillings) on one surface shall be considered a single procedure.
11. Crowns are covered once every five years and only if the tooth cannot be adequately restored with a filling material such as amalgam.
12. A full denture is covered in the same arch once every five years.
13. Denture relinings are covered once every three years; denture rebasings are covered once every five years.
14. Orthodontic appliances are covered to the lifetime maximum shown on your Schedule of Benefits.
15. Stainless steel crowns are covered for Covered Dependents up to age 12.
16. When scaling and root planing is done on a "per quadrant basis," each quadrant will be covered once in any 12 -month period.
17. Root canal therapy is limited to once per lifetime per tooth.
18. Mouth guards, night guards, occlusal guards, and athletic guards are covered once in a five-year period.
19. Implants are not a covered benefit of the plan.
20. Implant abutments are not a covered benefit of the plan.

Note: If an expense is covered under the Dental Plan **and** under another part of the Plan, the benefit paid under the dental portion of the Plan will be equal to the excess benefit not paid by any other of our Plans.

DENTAL BENEFIT EXCLUSIONS

In addition to the General Plan Exclusions, the Dental Plan does not cover expenses for the following:

1. Services or supplies not described as covered expenses in the Schedule of Dental Benefits.
2. Any charge incurred prior to the Plan member or dependent's effective date of coverage under this Plan.
3. Pre-existing dental conditions as defined herein.
4. Dental services for a child who is not a dependent as defined under this Plan.
5. Covered Dental Expenses after the Annual Maximum Benefit/Lifetime Maximum Benefit has been exhausted.
6. Any charge incurred after termination of coverage under this Plan (except as specifically provided herein).
7. Any charge for failure to keep a scheduled dentist appointment.
8. Any charge for completing claim forms.
9. Instruction supplies for dietary or nutritional counseling, oral hygiene or dental plaque control.
10. Services or supplies which are not necessary or do not meet accepted standards of dental practice (including experimental procedures).
11. Any duplicate dental service or appliance, including the replacement of lost, missing or stolen devices or appliances.
12. Orthodontic treatment while the person is not covered under this dental plan; orthodontic services incurred prior to being covered under the Dental Plan for at least six months.
13. Appliances or restoration, other than full dentures, used mainly to alter vertical dimension, stabilize periodontally involved teeth or restore occlusion.
14. Diagnosis or treatment of temporomandibular joint (TMJ) dysfunction.
15. Care, services, supplies or treatment not prescribed or provided by a dentist (as defined herein) or dental hygienist under the supervision of a dentist (exception: in the State of Maine, a cleaning by a licensed hygienist will be covered).
16. Fluoride rinses or any "over-the-counter" drug which can be purchased without a prescription.
17. Emergency exam charges when done in conjunction with a procedure (except x-rays) on the same visit.
18. Personalization or characterization of teeth or dentures.
19. Prescription drugs, premedications and/or related analgesia.
20. Denture relining within three months of initial placement.
21. A crown not required for the restoration of a tooth.
22. Periodontal splinting.
23. Gold restorations when a less expensive restorative material can be used satisfactorily.
24. Services or supplies received from a hospital are considered medical rather than dental.
25. Periodontal scaling and root planing, when provided on the same day of treatment as a prophylaxis, will have benefit payment appropriately adjusted.
26. The same surface of a tooth restored during any 12-month period is not covered unless there are extenuating circumstances.

27. Periodontal postoperative consultations and evaluation.
28. Pulp vitality tests.
29. Temporary full or partial dentures, bridges and crowns.
30. Fixed bridges or removable cast partials for Covered Persons up to age 16.
31. Specialized techniques, including precision attachments, or overdentures.
32. Only the number of pontics needed to fill an area where abutment teeth have moved to partially close an endentulous area.
33. Additional abutments needed due to abnormal conditions.
34. Diagnostic models/photographs, except for orthodontic treatment.
35. Appliances, procedures or restoration to correct congenital or developmental malformations or dentistry for cosmetic purposes.
36. Replacement or repairs of space maintainers and orthodontic appliances.
37. Altering or restoring vertical dimension.
38. Equalibration/occlusal adjustments.
39. Indirect pulp caps.