FDP
Flagship Dental Plans

FLAGSHIP COMPLETE
Program Overview
Standard Schedule of Dental Benefits and Enrollee Copayments

This **standard** list of covered services, exclusions and limitations for **Flagship Complete** is provided as a program overview and does not constitute an offer of coverage or proof of eligibility. It is for reference purposes only. Enrollees will be provided with an ID card and a benefit booklet that explains how the program works. Coverage is provided by Flagship Dental Plans, a wholly owned subsidiary of Delta Dental of New Jersey, Inc. Subject to the limitations, exclusions and member co-payments set forth, the following services shall be performed as needed and deemed necessary by the Flagship Complete Plan Dentist:

Procedure Description	Enrollee & Dependent Copayment
D0100-D0999 I. DIAGNOSTIC	
OFFICE VISIT CHARGE	$0.00
PERIODIC ORAL EVALUATION	$0.00
FAILURE TO CANCEL APPOINTMENT (24 HOURS PRIOR NOTIFICATION)	$10.00 per 15 minutes of appointed time
LIMITED ORAL EVALUATION	$0.00
COMPREHENSIVE ORAL EVALUATION	$0.00
EXAMINATION BY SPECIALIST	$0.00
DETAILED AND EXTENSIVE ORAL EVALUATION	$0.00
REEVALUATION-LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	$0.00
COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	$0.00
INTRAORAL-COMPLETE SERIES INCLUDING BITEWINGS	$0.00
INTRAORAL-PERIAPICAL-FIRST FILM	$0.00
INTRAORAL-PERIAPICAL-EACH ADD FILM	$0.00
INTRAORAL-OCCLUSAL FILM	$0.00
EXTRAORAL-EACH ADDITIONAL FILM	$0.00
BITEWING-SINGLE FILM	$0.00
BITEWINGS-TWO FILMS	$0.00
BITEWINGS-FOUR FILMS	$0.00
POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY FILM	$0.00
PANORAMIC FILM	$0.00
PULP VITALITY TESTS	$0.00
DIAGNOSTIC CASTS	$0.00

D1000-D1999 II. PREVENTIVE	
PROPHYLAXIS-ADULT	$0.00
PROPHYLAXIS-CHILD	$0.00
TOP APPL FLUOR INCLUDING PROPHY-CHILD	$0.00
SEALANT-PER TOOTH	$0.00
TOP APPL FLUOR EXCL PROPHY-CHILD	$0.00
ORAL HYGIENE INSTRUCTIONS	$0.00
SPACE MAINTAINER-FIXED UNILATERAL	$0.00
SPACE MAINTAINER-FIXED BILATERAL	$0.00
SPACE MAINTAINER-REMOVABLE-UNILATERAL	$0.00
SPACE MAINTAINER-REMOVABLE-BILATERAL	$0.00
RECEMENTATION OF SPACE MAINTAINER	$0.00
D2000-D2999 III. RESTORATIVE	
AMALGAM-ONE SURFACE PRIMARY OR PERMANENT	$0.00
AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	$0.00
AMALGAM-THREE SURFACES PRIMARY OR PERMANENT	$0.00
AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	$0.00
RESIN-ONE SURFACE ANTERIOR	$0.00
RESIN-TWO SURFACES ANTERIOR	$0.00
RESIN-THREE SURFACES ANTERIOR	$0.00
RES->3 SUR OR INV INCISAL ANGLE ANT	$0.00
RESIN BASED COMPOSITE CROWN, ANTERIOR	$0.00
RESIN BASED COMPOSITE ONE SURFACE, POSTERIOR	Optional
RESIN BASED COMPOSITE TWO SURFACE, POSTERIOR	Optional
RESIN BASED COMPOSITE THREE SURFACE, POSTERIOR	Optional
RESIN BASED COMPOSITE FOUR OR MORE SURFACES, POSTERIOR	Optional
INLAY-METALLIC-ONE SURFACE	Optional
INLAY-METALLIC-TWO SURFACES	Optional
INLAY-METALLIC-3 OR MORE SURFACES	Optional
ONLAY-METALLIC-2 SURFACES	$0.00
ONLAY-METALLIC-3 SURFACES	$0.00
ONLAY-METALIC-4 OR MORE SURFACES	$0.00
INLAY-PORCELAIN/CERAMIC-ONE SURFACE	Optional
INLAY-PORCELAIN/CERAMIC-2 SURFACES	Optional
INLAY-PORCELAIN/CERAMIC-3 OR MORE SURF	Optional
ONLAY-PORCELAIN/CERAMIC-2 SURFACES	Optional
ONLAY-PORCELAIN/CERAMIC-3 SURFACES	Optional
ONLAY-PORCELAIN/CERAMIC-4 OR MORE	Optional
INLAY-COMPOSITE/RESIN-ONE SURFACE (LAB PROCESSED)	Optional
INLAY-COMP/RESIN-2 SURFACE (LAB PROCESSED)	Optional
INLAY-COMP/RESIN-3 OR MORE SURFACES (LAB PROCESSED)	Optional
ONLAY-COMP/RESIN-2 SURF LAB PROCESSED	Optional
ONLAY-COMP/RESIN-3 SURF LAB PROCESS	Optional
ONLAY-COMP/RESIN-4+ SURF LAB PROCESS	Optional
CROWN-RESIN-LABORATORY	$0.00
CROWN-RESIN WITH HIGH NOBLE METAL *	$0.00
CROWN-RESIN WITH PREDOMINANTLY BASE METAL	$0.00
CROWN-RESIN WITH NOBLE METAL*	$0.00
CROWN-PORCELAIN/CERAMIC SUBSTRATE*	$0.00

CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL *	$0.00
CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$0.00
CROWN-PORCELAIN FUSED TO NOBLE METAL*	$0.00
CROWN-3/4 CAST HIGH NOBLE METAL*	$0.00
CROWN-3/4 CAST PREDOMINATELY BASE METAL*	$0.00
CROWN-3/4 CAST NOBLE METAL*	$0.00
CROWN-3/4 PORCELAIN/CERAMIC*	$0.00
CROWN-FULL CAST HIGH NOBLE METAL *	$0.00
CROWN-FULL CAST PREDOMINANTLY BASE METAL	$0.00
CROWN-FULL CAST NOBLE METAL*	$0.00
RECEMENT INLAY	$0.00
RECEMENT CROWN	$0.00
PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	$0.00
PREFAB STAINLESS STEEL CROWN-PERMANENT TOOTH	$0.00
PREFABRICATED RESIN CROWN	$0.00
PREFAB STAIN STEEL CROWN W/RESIN WDW	Optional
SEDATIVE FILLINGS	$0.00
CORE BUILDUP INCLUDING ANY PINS	$0.00
PIN RETENTION PER TOOTH IN ADDITION TO RESTORATION	$0.00
CAST POST & CORE IN ADDITION TO CROWN	$0.00
EACH ADDITIONAL CAST POST - SAME TOOTH	$0.00
PREFABRICATED POST & CORE IN ADDITION TO CROWN	$0.00
EACH ADDITIONAL FABRICATED POST - SAME TOOTH	$0.00
TEMPORARY CROWN (FRACTURED TOOTH)	$0.00
D3000- D3999 IV. ENDODONTICS	
PULP CAP-DIRECT EXCLUDING FINAL RESTORATION	$0.00
PULP CAP-INDIRECT EXCLUDING FINAL RESTORATION	$0.00
THERAPEUTIC PULPOTOMY EXC FIN REST	$0.00
PULPAL DEBRIDEMENT, PRIMARY & PERMANENT TEETH	$0.00
PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH	$0.00
PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR PRIMARY TOOTH	$0.00
ANTERIOR (EXCLUDING FINAL RESTORATION)	$0.00
BICUSPID (EXCLUDING FINAL RESTORATION)	$0.00
MOLAR (EXCLUDING FINAL RESTORATION)	$0.00
RETREAT PREVIOUS ROOT CANAL - ANTERIOR	$0.00
RETREAT PREVIOUS ROOT CANAL - BICUSPID	$0.00
RETREAT PREVIOUS ROOT CANAL - MOLAR	$0.00
APICOECTOMY/PERIRADICULAR SURG-ANT	$0.00
APICO/PERIRAD SURG - BICUSPID FIRST ROOT	$0.00
APICO/PERIRAD SURG - MOLAR FIRST ROOT	$0.00
APICO/PERIRAD SURG - EA ADD ROOT	$0.00
RETROGRADE FILLING - PER ROOT	$0.00
ROOT AMPUTATION PER ROOT	$0.00
HEMISECTION (INCLUDING ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	$0.00
D4000-D4999 V. PERIODONTICS (includes preoperative and postoperative evaluations and treatment under local anesthetic)	
GINGIVECTOMY/GINGIVOPLASTY 4 OR MORE CONTIGUOUS TEETH PER QUAD	$0.00
GINGIVECTOMY/GINGIVOPLASTY ONE TO THREE TEETH PER QUAD	$0.00

GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANING 4 OR MORE PER QUAD	$0.00
GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANING - 1 TO 3 PER QUAD	$0.00
CROWN LENGTHENING - HARD TISSUE	$0.00
OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) 4 OR MORE TEETH PER Q	$0.00
OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) 1 TO 3 TEETH PER QUAD	$0.00
BONE REPLACEMENT GRAFT - 1ST SITE IN QUADRANT	$0.00
BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	$0.00
PEDICLE SOFT TISSUE GRAFT PROCEDURE	$0.00
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE)	$0.00
PERIODONTAL ROOT PLANING,4 OR MORE CONTIGUOUS TEETH PER QUAD	$0.00
PERIODONTAL ROOT PLANING, 1 TO 3 TEETH PER QUAD	$0.00
FULL MOUTH DEBRIDEMENT TO ENABLE COMP. EVALUATION	$0.00
PERIODONTAL MAINT PROCEDURES AFTER ACTIVE THERAPY	$0.00
D5000-D5899 VI. PROSTHODONTICS (removable)	
COMPLETE DENTURE – MAXILLARY	$0.00
COMPLETE DENTURE – MANDIBULAR	$0.00
IMMEDIATE DENTURE – MAXILLARY	Optional
IMMEDIATE DENTURE - MANDIBULAR	Optional
MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONV'L CLASPS, RESTS AND TEETH	$0.00
MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONV'L CLASPS, RESTS AND TEETH)	$0.00
MAX PARTIAL DENTURE-CAST METAL FRMWK W/RESIN DENT BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$0.00
MANDIBULAR PARTIAL DENTURE - CAST METAL FRK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$0.00
REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)	$0.00
ADJUST COMPLETE DENTURE – MAXILLARY (WITHIN 6 MONTHS)	$0.00
ADJUST COMPLETE DENTURE – MANDIBULAR (WITHIN 6 MONTHS)	$0.00
ADJUST PARTIAL DENTURE – MAXILLARY (WITHIN 6 MONTHS)	$0.00
ADJUST PARTIAL DENTURE – MANDIBULAR (WITHIN 6 MONTHS)	$0.00
REPAIR BROKEN COMPLETE DENTURE BASE	$0.00
REPLACE MISSING OR BROKEN TEETH - COMPLETE DENT - EACH TOOTH	$0.00
REPAIR RESIN DENTURE BASE	$0.00
REPAIR CAST FRAMEWORK	$0.00
REPAIR OR REPLACE BROKEN CLASP	$0.00
REPLACE BROKEN TEETH - PER TOOTH	$0.00
ADD TOOTH TO EXISTING PART DENTURE	$0.00
ADD CLASP TO EXISTING PART DENTURE	$0.00
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	$0.00
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	$0.00
RELINE COMPLETE MAXILLARY DENTURE - CHAIRSIDE	$0.00
RELINE COMPLETE MANDIBULAR DENTURE - CHAIRSIDE	$0.00
RELINE MAXILLARY PARTIAL DENTURE - CHAIRSIDE	$0.00
RELINE MANDIBULAR PARTIAL DENTURE - CHAIRSIDE	$0.00
RELINE COMPLETE MAXILLARY DENTURE (LAB)	$0.00
RELINE COMPLETE MANDIBULAR DENTURE (LAB)	$0.00
RELINE MAXILLARY PARTIAL DENTURE (LAB)	$0.00

RELINE MANDIBULAR PARTIAL DENTURE (LAB)	$0.00
D6200-D6999 IX. PROSTHODONTICS (fixed)	
PONTIC - CAST HIGH NOBLE METAL *	$0.00
PONTIC - CAST PREDOMINATELY BASE METAL	$0.00
PONTIC - CAST NOBLE METAL*	$0.00
PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL *	$0.00
PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$0.00
PONTIC - PORCELAIN FUSED TO NOBLE METAL*	$0.00
PONTIC-PORCELAIN/CERAMIC	$0.00
PONTIC - RESIN WITH HIGH NOBLE METAL *	$0.00
PONTIC - RESIN WITH PRED BASE METAL	$0.00
PONTIC - RESIN WITH NOBLE METAL*	$0.00
RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	$0.00
RETAINER - PROCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	Optional
INLAY-PORCELAIN / CERAMIC, TWO SURFACES	Optional
INLAY-PORCELAIN / CERAMIC, THREE OR MORE SURFACES	Optional
INLAY-CAST HIGH NOBLE METAL, TWO SURFACES*	Optional
INLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES*	Optional
INLAY-CAST PREDOMINATELY BASE METAL, TWO SURFACES	Optional
INLAY-CAST PREDOMINATELY BASE METAL, THREE OR MORE SURFACES	Optional
INLAY-CAST NOBLE METAL, TWO SURFACES	Optional
INLAY-CAST NOBLE METAL, THREE OR MORE SURFACES	Optional
ONLAY-PORCELAIN / CERAMIC, TWO SURFACES	Optional
ONLAY-PORCELAIN / CERAMIC, THREE OR MORE SURFACES	Optional
ONLAY-CAST HIGH NOBLE METAL, TWO SURFACES *	$0.00
ONLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES *	$0.00
ONLAY-CAST PREDOMINATELY BASE METAL, TWO SURFACES	$0.00
ONLAY-CAST PREDOMINATELY BASE METAL, THREE OR MORE SURFACES	$0.00
ONLAY-CAST NOBLE METAL, TWO SURFACES*	$0.00
ONLAY-CAST NOBLE METAL, THREE OR MORE SURFACES*	$0.00
CROWN - RESIN WITH HIGH NOBLE METAL*	$0.00
CROWN - RESIN WITH PREDOMINATELY BASE METAL	$0.00
CROWN - RESIN WITH NOBLE METAL*	$0.00
CROW-PORCELAIN/CERAMIC	$0.00
CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL *	$0.00
CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$0.00
CROWN-PORCELAIN FUSED TO NOBLE METAL*	$0.00
CROWN-3/4 CAST HIGH NOBLE METAL*	$0.00
CROWN- 3/4 CAST PREDOMINATELY BASE METAL	$0.00
CROWN-3/4 CAST NOBLE METAL*	$0.00
CROWN-FULL CAST HIGH NOBLE METAL *	$0.00
CROWN- FULL CAST PREDOMINATELY BASE METAL	$0.00
CROWN-FULL CAST NOBLE METAL*	$0.00
CAST POST AND CORE IN ADDITION TO RETAINER	$0.00
CAST POST AND CORE AS PART OF RETAINER	$0.00
PREFABRICATED POST AND CORE	$0.00
CORE BUILD UP FOR RETAINER	$0.00
EAST ADDITION CAST POST-SAME TOOTH	$0.00

EAST ADDITION PREFABRICATED POST-SAME TOOTH	$0.00
RECEMENT BRIDGE (FIXED PARTIAL DENTURE)	$0.00
D7000 - D 7999 XI. ORAL SURGERY (includes preoperative and postoperative evaluations and treatment under local anesthetic)	
CORONAL REMNANTS - DECIDUOUS TEETH	$0.00
EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEP REMOVAL)	$0.00
SURGICAL REMOVAL OF ERUPTED TOOTH	$0.00
REMOVAL OF IMPACTED TOOTH -SOFT TISSUE	$0.00
REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$0.00
REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$0.00
REMOVAL OF IMP'D TOOTH - COMPLETELY BONY WITH COMPLICATIONS	$0.00
SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS - CUTTING PROCEDURE	$0.00
OROANTRAL FISTULA CLOSURE	$0.00
SURG EXPOSURE OF IMP'D/UNERUPTED TOOTH - FOR ORTHO REASONS	$0.00
SURGICAL EXPOSURE OF IMPACTED/UNERUPTED TOOTH - TO AID ERUPTION	$0.00
BIOPSY OF ORAL TISSUE - HARD	$0.00
BIOPSY OF ORAL TISSUE - SOFT	$0.00
ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	$0.00
ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	$0.00
VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$0.00
VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)	$0.00
EXCISION OF BENIGN LESION UP TO 1.25CM	$0.00
EXCISION OF BENIGN LESION GREATER THAN 1.25CM	$0.00
EXCISION OF MALIGNANT TUMOR-LESION DIAMETER UP TO 1.25 CM	$0.00
EXCISION OF MALIGNANT TUMOR-LESION DIAMETER GREATER THAT 1.25 CM	$0.00
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25CM	$0.00
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25CM	$0.00
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25CM	$0.00
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25CM	$0.00
DESTRUCTION OF LESIONS BY PHYSICAL METHODS: ELECTROSURGERY, CHEMOTHERAPY, CRYOTHERAPY	$0.00
REMOVAL OF EXOSTOSIS-MAXILLA OR MANDIBLE	$0.00
REMOVAL OF TORUS PALATINUS	$0.00
REMOVAL OF TORUS MANDIBULARIS	$0.00
SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	$0.00
INCISION & DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	$0.00
INCISION & DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	$0.00
REMOVAL OF FOREIGN BODY, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE	$0.00
REMOVAL OF REACTION-PRODUCING FOREIGN BODIES-MUSCULOSKELETAL SYSTEM	$0.00
REMOVAL OF DEAD BONE	$0.00
FRENULECTOMY-SEPARATE PROCEDURE	$0.00
EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	$0.00

EXCISION OF PERICORONAL GINGIVA	$0.00
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES	
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURE	$0.00
LOCAL ANESTHESIA-NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0.00
REGIONAL BLOCK ANESTHESIA	$0.00
TRIGEMINAL DIV BLOCK ANESTHESIA	$0.00
LOCAL ANESTHESIA	$0.00
GENERAL ANESTHESIA - FIRST 30 MINUTES	$0.00
GENERAL ANESTHESIA - EACH ADDITIONAL 15 MINUTES	$0.00
INTRAVENOUS CONSCIOUS SEDATION / ANALGESIA - FIRST 30 MINUTES	$0.00
INTRAVENOUS CONSCIOUS SEDATION / ANALGESIA - EACH ADD'L 15 MINUTES	$0.00
CONSULTATION	$0.00
OFFICE VISIT OBSERVATION	$0.00
OFFICE VISIT AFTER HOURS	$0.00
CASE PRESENTATION, DETAILED AND EXTENSIVE TREATMENT PLANNING	$0.00
D8000-D8999 XIII. ORTHODONTICS (If included in plan)	
ORTHODONTIC TREATMENT (24 MONTHS ACTIVE) – AGE 19 AND OVER	$0.00
ORTHODONTIC TREATMENT (24 MONTHS ACTIVE) - UNDER AGE 19	$0.00

Noble Metal and High Noble Metal: If used, the patient is only responsible for the difference between the cost which the Flagship Complete Plan Dentist would have incurred for base metal and the actual cost of the noble or high noble metal incurred by the Flagship Complete Plan Dentist.

Optional Services: Coverage is provided for the most cost-effective professionally acceptable treatment. If the patient elects a more expensive treatment, he or she is responsible for the difference in cost between the dentist' s usual fee for the two procedures plus the scheduled plan copayment. This does not apply where the only optional service is a difference in the type of metal used; differences in metal content are governed only by the preceding section relating to Noble Metal and High Noble Metal.

EXCLUSIONS AND LIMITATIONS

A. The following are specifically excluded as services or benefits to be provided or covered by this Contract:

General Exclusions

1. Dental procedures performed for cosmetic purposes;

2. Dental conditions arising out of and due to Covered Person's employment for which Worker's Compensation is payable. Services which are provided to the Covered Person by state government or agency thereof, or are provided without cost to the Covered Person by any municipality, county or other subdivision;

3. Treatment required by reason of war, declared or undeclared;

4. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility;

5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities;

6. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to Covered Person's eligibility with the FLAGSHIP program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;

7. Any service that is not specifically listed as a covered expense;

8. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function;

9. Prescription drugs;

10. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;

11. Cases in which, in the professional judgment of the attending Plan Dentist or Plan Dental Specialist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded;

12. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by FLAGSHIP or needed emergency treatment, defined as the immediate relief of pain, swelling, or infection;

13. "Consultations" for noncovered benefits;

14. Soft tissue management (irrigation, infusion, special toothbrush);

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ);

Restorative Treatment Exclusions

16. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;

Oral Surgery Treatment Exclusions

17. Nitrous oxide and the services of a special anesthesiologist;

Crowns, Fixed and Removable Prosthetic Treatment Exclusions

18. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);

19. Placement of a crown where there is sufficient tooth structure to retain a standard filling;

20. Extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework (major mouth reconstruction) and all treatment associated with the reconstruction;

21. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;

22. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;

23. Implant placement, or implant removal associated with other procedures, including but not limited to prophylaxis and periodontal treatment;

General Limitations

1. Coverage is provided for the least expensive professionally acceptable level of care as determined by Flagship. In all cases in which the Covered Person selects a more expensive course of treatment or the selected treatment includes the use of specialized techniques instead of standard procedures, the Covered Person must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional or more expensive treatment.

2. Notwithstanding the preceding limitation, the benefit provided for crowns, bridges, cast post and cores, inlays and onlays is base metal. If noble and high noble metal (precious) is used, the patient is only responsible for the additional cost of the metal.

3. Pediatric dental benefits are limited to Dependent children under age seven (7) upon prior authorization by FLAGSHIP at 100 percent of the fee less applicable copayments, if any;

4. If a Covered Person is more than 35 miles from the office of the assigned Flagship Complete Plan Dentist, and requires services for a "dental emergency", FLAGSHIP shall reimburse the Covered Person for the cost of such treatment, less any applicable copayments, up to a maximum of $100.00 during any 12-month period upon submission to FLAGSHIP of a verifiable claim within 90 days after such treatment is received. A "dental emergency" is immediate treatment necessary to alleviate severe pain, swelling, bleeding or infection, or immediately necessary to avoid placing the Covered Person's health in serious jeopardy. The Covered Person must visit his Flagship Complete Plan Dentist for further treatment. FLAGSHIP is not liable for actions resulting from the negligence, malpractice or other tortious or wrongful acts arising out of treatment provided by a non- Flagship Complete Plan Dentist or non- Flagship Complete Plan Specialist.

5. FLAGSHIP is not liable for specialty dental service claims submitted more than twelve months after the date of completion of the dental service.

Preventive and Diagnostic Limitations

6. Bitewing x-rays are limited to not more than one series of four films in any six-month period;

7. Full mouth x-rays and panoramic x-rays are limited to one set every thirty-six consecutive months;

8. Oral examinations are limited to two each twelve month period;

9. Prophylaxis is limited to two treatment(s) each twelve month period (includes periodontal maintenance following active therapy) when performed by the Covered Person's selected Flagship Complete Plan Dentist;

10. Topical application of fluoride is limited to one application each twelve month period for Dependent children up to age nineteen (19).

11. Sealant benefits include the application of sealants only to the occlusal surface of permanent molars for Covered Persons through age 15. The teeth must be free from caries or restorations on the occlusal surface. Sealant benefits include the repair or replacement of a sealant on any tooth within three years of its application by the same Flagship Complete Plan Dentist who placed the sealant;

12. Fixed and removable space maintainers are limited to one placement per tooth;

Restorative Treatment Limitations

13. Amalgam and resin restorations are limited to one treatment per tooth surface within ninety (90) consecutive days;

14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary first bicuspids; Composite resin or acrylic restorations in posterior teeth are optional. An allowance will be made for amalgam restorations and if performed, the Covered Person is responsible for the additional fee.

15. Inlays and onlays are limited to one per tooth during any 5 consecutive years;

Endodontic Treatment Limitations

16. Root canal therapy, including all necessary post-operative care, is limited to one treatment per tooth.

Periodontal Treatment Limitations

17. Periodontal treatments are limited to four quadrants during any twenty-four consecutive months;

18. Subgingival curettage, gingivectomy or gingivoplasty, periodontal scaling and root planing and osseous surgery are limited to one treatment per quadrant during any twenty-four consecutive months;

19. Full mouth debridement (gross scale) is limited to one treatment in any twenty-four consecutive month period;

20. Bone replacement grafts, pedicle soft tissue grafts and free soft tissue grafts are limited to one treatment per tooth in five consecutive years;

Crown, Fixed and Removable Prosthetic Limitations

21. Crown(s) and bridges are not to be replaced within any five-year period from initial placement;

22. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling (for example; the buccal or lingual walls are fractured to the extent that they do not hold a filling). If the tooth can be restored with a filling, any other restoration (crown or jacket) is considered optional and if performed, the Covered Person is responsible for the additional cost.

23. Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under twelve (12) years of age. An allowance will be made for an acrylic crown. If performed, the Covered Person must pay the additional fee.

24. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one per arch each in any five year period from initial placement;

25. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where repair, or the addition or replacement of teeth to the existing partial is not feasible;

26. If the Covered Person is missing teeth on opposite sides of the same arch, a removable partial denture is considered an adequate replacement. If the Covered Person elects another course of treatment, he/she must pay the additional cost.

27. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants and appliances associated therewith), personalization and characterization, are all considered optional treatment. The Covered Person is responsible for the additional fee.

28. Denture relines and repairs are limited to one per denture during any twelve consecutive months;

29. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

30. A fixed bridge is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement;

31. Fixed bridges are not a benefit for Covered Persons under the age of sixteen (16). If fixed bridges are used under these circumstances, it is considered optional and an allowance will be made for a space maintainer. The Covered Person would be responsible for the additional fee.

32. Fixed bridges used to replace missing teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Covered Person must pay the difference in cost between the Dentist's usual fees for the covered benefit and optional treatment, plus any coinsurance for the covered benefit;

33. If implants are utilized and appliances constructed, FLAGSHIP will allow an alternate benefit based on the cost of a standard full or partial denture. FLAGSHIP will not provide payment for the surgical removal of implants or the prosthetic crown on the implant.

C. Orthodontic benefits (if included) are only provided through FLAGSHIP Plan Orthodontists and are subject to the following exclusions:

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;

2. Retreatment of orthodontic cases;

3. Changes in treatment necessitated by accident of any kind, and/or lack of Covered Person cooperation;

4. Surgical procedures incidental to orthodontic treatment;

5. Myofunctional therapy;

6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;

6. Treatment related to temporomandibular joint disturbances;

7. Supplemental appliances not routinely utilized in typical Phase II orthodontics;

8. Active treatment that extends more than 24 months from the point of banding;

9. Treatment in progress at inception of eligibility;

10. Transfer to another orthodontist after banding has been initiated;

11. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be responsible for the additional charges.

D. Orthodontic benefits (if included) are only provided through Flagship Plan Orthodontists and are subject to the following limitations:

1. Orthodontic treatment must be provided by a Flagship Complete Plan Specialist orthodontist;

2. Lifetime Plan benefits cover 24 months of active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment.

3. For treatment plans extending beyond 24 months of active treatment, the Covered Person will be subject to a monthly office visit fee.

4**.** Should an Covered Person's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Covered Person and not FLAGSHIP will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Covered Person's payment shall be based on the provider’s usual and customary fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Covered Person on such terms and conditions as are arranged between the Covered Person and the orthodontist.

5. If treatment is not required or the Covered Person chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the Covered Person will be charged a consultation fee of $350.00 in addition to diagnostic record fees.

6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the Covered Person is responsible for the cost at the dentist's usual and customary fee.

7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Covered Person's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Flagship Complete Plan Specialist- orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances.

8. FLAGSHIP shall provide benefits for Covered Persons who have commenced orthodontic treatment, defined as the application of orthodontic appliances, prior to coverage under FLAGSHIP provided that orthodontic bands were placed while the Covered Person was covered by the dental coverage contract of the same Employer replaced by FLAGSHIP conditioned upon the following:

    a) Orthodontic treatment in progress applies to Covered Persons with orthodontic bands only. If only records or study models have been taken, FLAGSHIP shall not be liable for benefits if orthodontic banding is performed by a non- Flagship Complete Plan Specialist-Orthodontist;

    b) Benefits for orthodontic treatment in progress shall apply only to a 24 -month treatment plan;

    c) Covered Persons with orthodontic treatment in progress must continue treatment with the orthodontist who placed the orthodontic bands.

    d) Covered Persons requesting benefits for orthodontic treatment in progress shall be subject to the copayments and orthodontic contract limitations of the dental coverage contract that was replaced by FLAGSHIP. Benefits for orthodontic treatment commencing after the effective date of this Group Contract shall be subject to the copayments, limitations, exclusions and administrative policies under this Group Contract.

    e) The Covered Person and the treating dentist shall cooperate with FLAGSHIP with respect to the submission of treatment plans, treatment records, payment schedules, and any other information necessary for benefit determination.

    f) FLAGSHIP shall not be liable for the quality of care rendered by a non- Flagship Complete Plan Specialist-Orthodontist.

    g) All orthodontic benefits under this provision shall be payable directly to the Employee, unless the Employee notifies FLAGSHIP in writing to assign benefits directly to the treating dentist.