A Managed Care Dental Health Plan
Coverage Provided by Flagship Dental Plans

ENROLLEE BENEFIT SUMMARY AND EVIDENCE OF COVERAGE

GROUP PREPAID DENTAL PLAN FOR:
EMPLOYER: **MONMOUTH UNIVERSITY**
GROUP ID NUMBER: **7484-9001 (473)**

FHS-DPO-USA-EOC-7/2002
Plan NJ6 Standard

INTRODUCTION

Flagship Dental Plans welcomes you as an enrollee of the DeltaCare managed care dental benefit program.

This booklet represents a general description of the provisions of your group prepaid dental benefit program provided by Flagship Dental Plans. It is, however, a summary and not a contract. Your rights and benefits under the Plan are subject to the terms, conditions and limitations of the Group Contract between Flagship Dental Plans and your Employer. The complete Group Contract may be obtained from, or examined at, the offices of Flagship Dental Plans or your Employer.

Please read this booklet carefully. It will serve as your reference in learning when your coverage begins and ends, what services are covered, the conditions, limitations and exclusions that apply as well as information on how to contact Flagship Dental Plans (FLAGSHIP) directly to answer any of your questions or provide any other assistance you may need in using your dental benefit program.

FLAGSHIP member services representatives can be reached by calling or writing to:

Flagship Dental Plans
1639 Route 10
P.O. Box 369
Parsippany, New Jersey 07054
In New Jersey 1-800-722-3524
Outside of New Jersey 1-800-848-3524

Once you have read this booklet, FLAGSHIP recommends that you call your selected or assigned Plan Dentist and make an appointment for a routine check-up of your dental health. Your Plan Dentist will assess the condition of your teeth and gums, determine if any dental health problems exist, and establish an appropriate treatment plan.

Dental health plays an important role in your overall health. Be sure to follow your Plan Dentist's recommendations for taking care of your teeth and gums, maintain a schedule of routine check-ups, and keep your appointments.

EVIDENCE OF COVERAGE

Flagship Dental Plans (FLAGSHIP), a dental plan organization duly licensed in the State of New Jersey, agrees to furnish prepaid dental benefits to Employees and their eligible Dependents, if applicable, subject to the terms and conditions of the group contract between FLAGSHIP and the Employer.

I. DEFINITIONS

Throughout this booklet, FLAGSHIP references terms that are important in understanding your coverage. Please review the following definitions carefully before reading the entire booklet.

1. Employee is defined to be any employee of the Employer who is eligible for coverage as provided in section II herein, and who shall have enrolled in the FLAGSHIP dental plan and been designated as an Employee to FLAGSHIP by the Employer.

2. "Dependents" are defined to be an Employee's lawful spouse, domestic partner and unmarried dependent children, including stepchildren, foster children and legally adopted children, from age two (2) until the end of the calendar year in which age nineteen (19) or age twenty-three (23) is attained if attending an accredited school on a full-time basis. Those dependents in military service are not eligible.

An unmarried dependent child over the limiting age is eligible as a Dependent if he is incapable of self-support because of physical or mental incapacity that commenced prior to reaching the limiting age, providing a physician's certificate verifying the incapacity is submitted to FLAGSHIP following attainment of the limiting age.

To become and remain a Dependent Child, each person must: (a) be claimed by the Employee as a dependent for Federal Income Tax purposes, or (b) be declared a dependent of the Employee by legal documents.

The provisions of this section notwithstanding, "Dependent" shall include any person to the extent he is enrolled as a Dependent pursuant to the terms of a duly entered support order entered pursuant to and in accordance with federal or state law.

3. "Covered Person" is defined to be the Employee and each eligible Dependent, only if and while such person is covered by this Contract. A Covered Person shall cease to be eligible at the end of the Contract Month during which such Covered Person ceases to meet the definition of a Dependent and/or Employee.

4. "Contract Term" is defined as the period of twelve months commencing on the Effective Date through June 30, 2014 and each succeeding twelve month period thereafter.

5. "Dentist" is defined as any person fully licensed to practice dentistry at the time and place services eligible under this Contract are rendered.

6. "Plan Dentist" is defined as a Dentist who is licensed to practice dentistry in the state where the dental services are rendered and who has agreed, in writing, with FLAGSHIP to perform services under this Contract and to accept payments from FLAGSHIP on a capitation basis.

7. "Plan Dental Specialist" is defined as a Dentist who is licensed to practice dentistry in the state where the services are rendered and who limits his practice to one or more approved specialties and has been designated by FLAGSHIP to provide certain specialty dental services for Covered Persons under this Contract.

8. Whenever, in describing or referring to any person or party, any word importing the masculine gender is used, the same shall be understood to include and to apply to females as well as to males.

II. TREATMENT PLANNING

The objective of FLAGSHIP's dental benefit program is to assist all Covered Persons in obtaining and maintaining a good level of oral health. To achieve this goal, your Plan Dentist will carefully design a treatment plan and provide instructions regarding home care, specifically for you. While your Plan Dentist can treat dental health problems and help you maintain your oral health, you are responsible for good oral hygiene and for following your Plan Dentist's recommended course of action. Your treatment plan will be prioritized as follows:

1. Procedures that could have an immediate effect on your overall oral health.
2. Active dental decay and periodontal (gum) problems that would not have an immediate effect on your oral health.
3. Replacement of missing teeth that are not causing a gross lack of function

Please note that individual circumstances may cause your Plan Dentist to deviate from this treatment-planning concept. Be sure to ask your dentist any questions you may have about your dental health and your treatment plan.

III. WHO IS ELIGIBLE FOR COVERAGE?

A. Employees who meet the following requirements are eligible for coverage under this dental benefit program:

1. Full-time Employees actively at work as defined in the Group Contract

2. Employees who have completed the required waiting period, if any, and are employed on a full time basis by the Employer.

3. Employees who have enrolled with FLAGSHIP.

B. Dependents, if included in the Group Contract, and who meet the following requirements are eligible for coverage under this dental benefit program:

1. The lawful spouse or domestic partner of an Employee for whom coverage has been elected.

2. Unmarried dependent children, including step children, foster children and legally adopted children, of the Employee from age two (2) until the end of the calendar year in which age nineteen (19) or age twenty-three (23) is attained if attending an accredited school on a full-time basis for whom coverage has been elected.

3. An unmarried dependent child over the limiting age is eligible as a Dependent if he is incapable of self-support because of physical or mental incapacity that commenced prior to reaching the limiting age, providing a physician's certificate verifying the incapacity is submitted to FLAGSHIP following attainment of the limiting age.

4. The provisions of this section notwithstanding, "Dependent" shall include any person to the extent he is enrolled as a Dependent pursuant to the terms of a duly entered support order entered pursuant to and in accordance with federal or state law.

IV. HOW DO I ENROLL IN THE PLAN?

To enroll in the FLAGSHIP plan, Employees must complete and file through the Employer with FLAGSHIP individual applications on behalf of themselves, and their Dependents, if any, as a prerequisite to coverage under this Contract subject to the following:

1. Each Employee becoming eligible subsequent to the Effective Date shall file an application through the Employer with FLAGSHIP on or before the date that he becomes eligible.

2. Any person becoming an Employee subsequent to the Effective Date and eligible for coverage may be added to the eligible group if he files an application through the Employer with FLAGSHIP on the date he becomes eligible.

3. The Employer maintains records from which determines the type of coverage selected, the names, birth dates and addresses of all Employees and Dependents covered by this Contract. Such information shall be furnished to FLAGSHIP by the Employer at such time or times and in such form and detail as may be required by FLAGSHIP to maintain a currently accurate record of all Covered Persons. The Employer shall, as required, make verifications as to Dependents entitled to receive benefits under this Contract.

4. FLAGSHIP relies on the information furnished to it, and the Employer agrees to hold FLAGSHIP harmless for any inaccuracy of such information. Clerical errors or delays in keeping or reporting data relative to coverage shall not invalidate coverage which would otherwise be validly in force. The Employer shall be responsible for subscription charges for all Covered Persons appearing on lists of Covered Persons submitted to FLAGSHIP.

V. WHEN DOES COVERAGE BEGIN?

An Employee's coverage begins on the first day of the month after he becomes eligible, provided that he is actively at work and has signed a FLAGSHIP enrollment form. Otherwise, his coverage begins on the first day of the month after he returns to work and has signed a FLAGSHIP enrollment form.

A Dependent's coverage begins on the same day as the Employee's coverage begins, provided he is an eligible Dependent of the Employee on that date and he has been listed on the FLAGSHIP enrollment form. Otherwise, the Dependents coverage begins on the date he becomes an eligible Dependent and is added to the FLAGSHIP enrollment form.

If the Employee is required to contribute to the plan and he fails to enroll within thirty-one (31) days from his eligibility date, the Employee and his Dependents may not enroll until the earliest of twelve (12) months from the eligibility date or the next Contract Term anniversary date.

VI. WHEN DOES COVERAGE END?

An Employee's coverage terminates on the earliest of the following dates:

1. When the Group Contract between the FLAGSHIP and the Employer terminates.

2. On the last day of the month in which the Employee dies or terminates his employment with the Employer.

3. On the last day of the month in which the Employee fails to pay any required contribution under the FLAGSHIP plan.

A Dependent's coverage terminates on the earliest of the following dates:

1. When the Group Contact between FLAGSHIP and the Employer terminates.

2. On the day the Employee's coverage terminates.

3. On the last day of the month in which the Dependent ceases to be an eligible Dependent of the Employee.

In the event of termination of coverage under the provisions of this section, FLAGSHIP shall not be liable for any benefits for any otherwise eligible services rendered after the last day of the Contract Month in which termination occurs except for completion of covered dental services which were started while this Contract was in effect.

For certain Employer Groups with twenty (20) or more employees, federal law requires the Employer to offer Employees and/or Dependents coverage for a specified period of time after the date when coverage would otherwise terminate due to various qualifying events. The Employer may include as eligible Employees and Dependents any person(s) entitled by law to receive continuation coverage for the period during which each person is entitled to such continuation coverage. The Employee and the Dependent(s) must directly remit the required premium to the Employer. Any such continuation coverage under this contract will terminate upon termination of this contract.

VII. HOW DO I SELECT A PLAN DENTIST?

At the beginning of coverage each Employee must select a Plan Dentist (including a second & third choice) from the list of Plan Dentists provided by FLAGSHIP. Thereafter, the Employee and each of his Dependents must receive all their dental care from the selected Plan Dentist or from a Plan Dentist Specialist to which they are referred by the Plan Dentist with the approval of FLAGSHIP.

The Employee and all covered Dependents of the Employee must select and receive dental services from the same Plan Dentist.

VIII. HOW DO I CHANGE MY PLAN DENTIST?

Employees may change to any other Plan Dentist on the first day of a new "Contract Month," provided that a request for such a change is made prior to the new "Contract Month" in writing or by calling FLAGSHIP. Requests received by the fifteenth of the month will be effective the first of the following month. FLAGSHIP will approve requests for transfer once all outstanding FLAGSHIP copayments are paid to the Plan dentist and the patient has been advised of any treatment in progress. Covered Persons are required to pay any copayments listed in the Schedule of Dental Benefits and Co-Payment directly to the Plan Dentist or Plan Specialist. FLAGSHIP shall have the right to review and possibly deny requests for change of Plan Dentist if the number of requests made by an Employee is deemed excessive.

IX. WHAT HAPPENS IF MY PLAN DENTIST NO LONGER PARTICIPATES?

If a Plan Dentist's participation in the FLAGSHIP Dental Plan is terminated or limited, FLAGSHIP will assign Employees to another dentist within the same geographic region. Each Employee will receive a letter from FLAGSHIP advising him of the assignment and providing him with a complete directory of Plan Dentists. The Employee can contact FLAGSHIP if he wants to select a different Plan Dentist. If a Plan Dentist is to be absent for an extended period of time, Employees assigned to that Plan Dentist shall, if requested by FLAGSHIP, transfer to their second or third choice as selected for the period of the absence.

X. SCHEDULE OF DENTAL BENEFITS AND CO-PAYMENTS

Subject to the limitations, exclusions and member co-payments set forth herein, the following services shall be performed as needed and deemed necessary by the Plan Dentist:

Procedure Description	Patient Copayment NJ-6
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 min
LIMITED ORAL EVALUATION	$0.00
COMPREHENSIVE ORAL EVALUATION	$0.00
EXAMINATION BY SPECIALIST	$25.00
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
BACTERIOLOGIC STUDIES FOR DETERMINATION OF PATHOLOGIC AGENTS	$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	$20.00
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	$75.00
RESIN BASED COMPOSITE ONE SURFACE, POSTERIOR	$20.00
RESIN BASED COMPOSITE TWO SURFACE, POSTERIOR	$25.00
RESIN BASED COMPOSITE THREE SURFACE, POSTERIOR	$35.00
RESIN BASED COMPOSITE FOUR OR MORE SURFACES, POSTERIOR	$50.00
INLAY-METALLIC-ONE SURFACE	Optional
INLAY-METALLIC-TWO SURFACES	Optional
INLAY-METALLIC-3 OR MORE SURFACES	Optional
ONLAY-METALLIC-2 SURFACES	$270.00
ONLAY-METALLIC-3 SURFACES	$270.00
ONLAY-METALIC-4 OR MORE SURFACES	$270.00
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	$100.00
CROWN-RESIN WITH HIGH NOBLE METAL *	$290.00
CROWN-RESIN WITH PREDOMINANTLY BASE METAL	$290.00
CROWN-RESIN WITH NOBLE METAL*	$290.00
CROWN-PORCELAIN/CERAMIC SUBSTRATE*	$290.00
CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL *	$290.00
CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$290.00
CROWN-PORCELAIN FUSED TO NOBLE METAL*	$290.00
CROWN-3/4 CAST HIGH NOBLE METAL*	$270.00
CROWN-3/4 CAST PREDOMINATELY BASE METAL*	$270.00
CROWN-3/4 CAST NOBLE METAL*	$270.00
CROWN-3/4 PORCELAIN/CERAMIC*	$270.00
CROWN-FULL CAST HIGH NOBLE METAL *	$290.00
CROWN-FULL CAST PREDOMINANTLY BASE METAL	$290.00
CROWN-FULL CAST NOBLE METAL*	$290.00
RECEMENT INLAY	$0.00
RECEMENT CROWN	$0.00
PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	$75.00
PREFAB STAINLESS STEEL CROWN-PERMANENT TOOTH	$75.00
PREFABRICATED RESIN CROWN	$100.00
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	$225.00
CAST POST & CORE IN ADDITION TO CROWN	$175.00
EACH ADDITIONAL CAST POST - SAME TOOTH	$175.00
PREFABRICATED POST & CORE IN ADDITION TO CROWN	$225.00
EACH ADDITIONAL FABRICATED POST - SAME TOOTH	$175.00
TEMPORARY CROWN (FRACTURED TOOTH)	$100.00
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 ANY 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 QUAD	$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	$300.00
COMPLETE DENTURE - MANDIBULAR	$300.00
IMMEDIATE DENTURE - MAXILLARY	Optional
IMMEDIATE DENTURE - MANDIBULAR	Optional
MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONV'L CLASPS, RESTS AND TEETH	$320.00
MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONV'L CLASPS, RESTS AND TEETH)	$320.00
MAX PARTIAL DENTURE-CAST METAL FRMWK W/RESIN DENT BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$340.00
MANDIBULAR PARTIAL DENTURE - CAST METAL FRK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$340.00
REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)	$300.00
ADJUST COMPLETE DENTURE - MAXILLARY	$0.00
ADJUST COMPLETE DENTURE - MANDIBULAR	$0.00
ADJUST PARTIAL DENTURE - MAXILLARY	$0.00
ADJUST PARTIAL DENTURE - MANDIBULAR	$0.00
REPAIR BROKEN COMPLETE DENTURE BASE	$50.00
REPLACE MISSING OR BROKEN TEETH - COMPLETE DENT - EACH TOOTH	$60.00
REPAIR RESIN DENTURE BASE	$60.00
REPAIR CAST FRAMEWORK	$60.00
REPAIR OR REPLACE BROKEN CLASP	$60.00
REPLACE BROKEN TEETH - PER TOOTH	$60.00
ADD TOOTH TO EXISTING PART DENTURE	$70.00
ADD CLASP TO EXISTING PART DENTURE	$70.00
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	$225.00

REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	$225.00
RELINE COMPLETE MAXILLARY DENTURE - CHAIRSIDE	$75.00
RELINE COMPLETE MANDIBULAR DENTURE - CHAIRSIDE	$75.00
RELINE MAXILLARY PARTIAL DENTURE - CHAIRSIDE	$75.00
RELINE MANDIBULAR PARTIAL DENTURE - CHAIRSIDE	$75.00
RELINE COMPLETE MAXILLARY DENTURE (LAB)	$110.00
RELINE COMPLETE MANDIBULAR DENTURE (LAB)	$110.00
RELINE MAXILLARY PARTIAL DENTURE (LAB)	$110.00
RELINE MANDIBULAR PARTIAL DENTURE (LAB)	$110.00
D6200-D6999 IX. PROSTHODONTICS (fixed)	
PONTIC - CAST HIGH NOBLE METAL *	$290.00
PONTIC - CAST PREDOMINATELY BASE METAL	$290.00
PONTIC - CAST NOBLE METAL*	$290.00
PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL *	$290.00
PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$290.00
PONTIC - PORCELAIN FUSED TO NOBLE METAL*	$290.00
PONTIC-PORCELAIN/CERAMIC	$290.00
PONTIC - RESIN WITH HIGH NOBLE METAL *	$290.00
PONTIC - RESIN WITH PRED BASE METAL	$290.00
PONTIC - RESIN WITH NOBLE METAL*	$290.00
RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	$290.00
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 *	$270.00
ONLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES *	$270.00
ONLAY-CAST PREDOMINATELY BASE METAL, TWO SURFACES	$270.00
ONLAY-CAST PREDOMINATELY BASE METAL, THREE OR MORE SURFACES	$270.00
ONLAY-CAST NOBLE METAL, TWO SURFACES*	$270.00
ONLAY-CAST NOBLE METAL, THREE OR MORE SURFACES*	$270.00
CROWN - RESIN WITH HIGH NOBLE METAL*	$290.00
CROWN - RESIN WITH PREDOMINATELY BASE METAL	$290.00
CROWN - RESIN WITH NOBLE METAL*	$290.00
CROW-PORCELAIN/CERAMIC	$290.00
CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL *	$290.00
CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$290.00
CROWN-PORCELAIN FUSED TO NOBLE METAL*	$290.00
CROWN-3/4 CAST HIGH NOBLE METAL*	$270.00
CROWN- 3/4 CAST PREDOMINATELY BASE METAL	$270.00
CROWN-3/4 CAST NOBLE METAL*	$270.00
CROWN-FULL CAST HIGH NOBLE METAL *	$290.00

CROWN- FULL CAST PREDOMINATELY BASE METAL	$290.00
CROWN-FULL CAST NOBLE METAL*	$290.00
CAST POST AND CORE IN ADDITION TO RETAINER	$225.00
CAST POST AND CORE AS PART OF RETAINER	$225.00
PREFABRICATED POST AND CORE	$225.00
CORE BUILD UP FOR RETAINER	$0.00
EAST ADDITION CAST POST-SAME TOOTH	$175.00
EAST ADDITION PREFABRICATED POST-SAME TOOTH	$175.00
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 HYPERPLASIC 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 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	
ORTHODONTIC TREATMENT (24 MONTHS ACTIVE) – AGE 19 AND OVER	$1,500.00
ORTHODONTIC TREATMENT (24 MONTHS ACTIVE) - UNDER AGE 19	$1,500.00

Noble Metal and High Noble Metal: If used, the patient is responsible for the copayment (if any) plus the additional cost of the metal.

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.

XI. EXCLUSION OF BENEFITS

A. The benefits, as previously outlined, are specifically excluded as services or benefits to be provided under the Group 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;

17. Restorative work caused by orthodontic treatment;

Oral Surgery Treatment Exclusions

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

19. Cysts and malignancies;

20. Prophylactic removal of impactions (asymptomatic, nonpathological);

21. Extractions for the purpose of orthodontics;

Crowns, Fixed and Removable Prosthetic Treatment Exclusions

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

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

24. Extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework (major mouth reconstruction);

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

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

27. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;

XII. LIMITATION OF BENEFITS

B. The benefits, as previously outlined, are subject to the following limitations (all time limitations apply without regard to whether the earlier service(s) was covered under this or any other coverage contract):

General Limitations

1. Coverage is limited to the benefit customarily provided. In all cases in which the Covered Person must 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 plus any applicable copayment;

2. If a Covered Person is more than 35 miles from the office of the assigned 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 Persons health in serious jeopardy. The Covered Person must visit his 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-Plan Dentist or non-Plan Specialist;

3. 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

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

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

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

7. Prophylaxis is limited to two treatment(s) each twelve month period (includes periodontal maintenance following active therapy);

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

9. 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 Panel Dentist who placed the sealant;

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

Restorative Treatment Limitations

11. Amalgam and resin restorations are limited to one treatment per tooth surface with ninety consecutive days;

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

Endodontic Treatment Limitations

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

Periodontal Treatment Limitations

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

15. Gingivectomy or gingivoplasty, periodontal scaling and root planing are limited to one treatment per quadrant during any twenty-four consecutive months and osseous surgery is limited to one treatment per quadrant during any thirty-six consecutive months.

16. Full mouth debridement (gross scale) is limited to one treatment in any twelve consecutive month period;

17. 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

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

19. 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;

20. 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;

21. 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;

22. 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;

23. 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;

24. 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;

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

26. 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;

27. 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;

28. 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 is financially responsible for the difference between the dentist's actual fee for the fixed bridge and the dentist's actual fee for the space maintainer plus the scheduled plan copayment for the space maintainer;

29. 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 is responsible for the difference between the dentist's actual fee for the fixed bridge and the dentist's actual fee for a partial denture plus the scheduled plan copayment for a partial denture;

30. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;

31. If implants are utilized and appliances constructed, FLAGSHIP will make payment 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.

XIII. ORTHODONTIC EXCLUSIONS

C. Orthodontic benefits (if included in the previously outlined benefit schedule) 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;

7. Treatment related to temporomandibular joint disturbances;

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

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

10. Restorative work caused by orthodontic treatment;

11. Extractions for the purpose of orthodontics;

12. Treatment in progress at inception of eligibility;

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

14. Composite and ceramic bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

XIV. ORTHODONTIC LIMITATIONS

D. Orthodontic benefits (if included in the previously outlined schedule of benefits) are only provided through FLAGSHIP Plan Orthodontists and are subject to the following limitations:

1. Orthodontic treatment must be provided by a FLAGSHIP Plan 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 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 $25-$75 in addition to diagnostic record fees, not to exceed $350.00;

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 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 Plan 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-Plan 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-Plan 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.

XV. PROVISION OF DENTAL SERVICES

All dental services specified in the Group Contract must be provided a Plan Dentist. Specialty and orthodontic services shall only be covered if approved in advance in writing by FLAGSHIP after a referral by a Plan Dentist. A Plan Dentist shall have the right to refuse treatment to a Covered Person who repeatedly fails to follow a prescribed course of treatment, who uses the relationship for illegal purposes, or who otherwise makes the professional relationship onerous, provided that the Plan Dentist first submits to FLAGSHIP a complete written statement explaining the basis for the treatment refusal. FLAGSHIP reserves the right to deny coverage to a Covered Person where that individual repeatedly fails to follow a prescribed course of treatment, who uses the relationship for illegal purposes, or who otherwise makes the professional relationship onerous.

FLAGSHIP will actively seek the maintenance of the most modern facilities available through its Plan Dentists. However, the operation and the maintenance of the Plan Dentists' facilities, equipment and the rendition of all professional services are solely and exclusively under the control and supervision of the Plan Dentists.

Plan Dentists are currently compensated by FLAGSHIP through monthly capitation (an amount based on the number of Covered Persons assigned to the Plan Dentist), and by Covered Persons through required copayments where applicable. Plan Specialists are currently compensated through an insurance arrangement based on a schedule of maximum allowable charges for each covered procedure, and by Covered Persons through applicable copayments. FLAGSHIP shall have sole discretion to make changes with respect to its financial arrangements with Plan Dentists and Plan Dental Specialists so long as such changes do not increase the Covered Person's financial obligations. FLAGSHIP shall provide notice to Employers of any material changes in the dentist compensation structure.

When making an appointment with a FLAGSHIP Plan Dentist, remember:

1. Advance appointments are required. Call the dental office first to schedule an appointment.

2. Identify yourself as a Covered Person through the FLAGSHIP DeltaCare program. Your name and the names of your eligible dependents should appear on the monthly list of assigned members that FLAGSHIP provides to the Plan Dentist. If you recently enrolled and do not yet appear on the list, your Plan Dentist may contact FLAGSHIP to verify your eligibility.

3. Your Plan Dentist will provide an appointment. If you request or require specific, limited appointment times, it may take longer to get the appointment.

4. If you cannot keep your appointment, notify the Plan Dentist at least twenty-four (24) hours in advance, or you may be charged a broken appointment fee.

XVI. HOW DO I FILE A COMPLAINT OR GRIEVANCE?

FLAGSHIP will respond in writing to all Covered Persons within 15 working days after receipt of a written complaint or grievance. FLAGSHIP will advise members of their rights under the complaint-grievance system on all claims and other correspondence, which refer to benefits, which have been denied.

For purposes of the Group Contract, a complaint is an issue or claim presented to FLAGSHIP by a Covered Person, either in written or oral form, and is subject to informal resolution by FLAGSHIP within a thirty-day period. A grievance is a complaint that is not resolved to the member's satisfaction or for which the member requests formal grievance consideration during the thirty-day period. The Covered Person or FLAGSHIP shall commit all grievances to written form prior to processing.

If a Covered Person has a grievance regarding eligibility, the denial of dental services or claims, or the policies and procedures of FLAGSHIP, or the dental care rendered by a Plan Dentist or Plan Specialist, the grievance should be addressed in writing to:

FLAGSHIP DENTAL PLANS
P.O. Box 369
Parsippany, New Jersey 07054
Attn: Grievance Review

The correspondence must include 1) the name of the patient, 2) the name, address, telephone number and social security number of the Employee, 3) the name of the Employer and 4) the treating dentist's name and address.

Within 10 working days of the receipt of a written grievance and the above information, FLAGSHIP will forward the complainant and acknowledgement of receipt of the grievance. Certain grievances may also require that the complainant be referred to a dentist for a clinical evaluation of the dental services provided.

Within 15 days of the receipt of the written grievance and the above information, FLAGSHIP shall send to the complainant a written response, which describes the grievance and the resolution of the grievance, or explains why additional time is required to resolve the grievance. The correspondence shall advise that a review of FLAGSHIP's decision shall be taken if a written request, stating the reasons why the grievance should be reviewed, is made within 30 days of the date of FLAGSHIP's response. FLAGSHIP shall undertake a full and fair review upon any request for review. FLAGSHIP may require additional documents as it deems necessary or desirable in making such a review. Within 15 days of the request for review, FLAGSHIP shall notify the complainant in writing of the results of the review, or explain why additional time is required to issue the results of the review.

If the initial decision is appealed, it will be addressed by the 1st Level Grievance Committee. If the 1st Level Grievance Committee's decision is appealed, that appeal will be addressed by the 2nd Level Grievance Committee. At each step, if the decision is not in favor of the Covered Person, the Covered Person will be advised (1) of their right to appeal the decision and (2) of how to use the appeal process.

1st Level Grievance Review Committee
Appeals will first be addressed by the 1st Level Grievance Review Committee. The committee is comprised of one or more FLAGSHIP employees. The Committee will not include any person whose decision is being appealed or who made the initial determination denying a claim or handling a complaint. This first level review may be in the form of a telephone conference, staff meeting or polling of experts by telephone. The Covered Person has the right to submit written material and to have an uninvolved staff person assist, but the member does not have the right to attend or to have representation in attendance at this stage.

The review will be conducted within 30 working days of receipt of the appeal. The decision of the 1st Level Grievance Review Committee will be made known to the member in writing at the earliest possible time following the review but not more than 10 working days after the date of the review.

The written decision will contain a description of the Committee's understanding of the Covered Person's grievance as presented, the Committee's decision in clear terms and the contractual basis or dental rationale in sufficient detail for member to respond further to FLAGSHIP's position, the evidence or documentation used as the basis for the decision, a statement indicating the decision is binding unless the Covered Person appeals, and a description of the process on how to appeal.

2nd Level Grievance Review Committee
FLAGSHIP's 2nd Level Grievance Committee consists of three persons not previously involved in the grievance. The Committee shall carefully consider and make particular findings of fact on all key factual disputes. The review will be conducted within 30 working days of receipt of the appeal. The decision of the 2nd Level Grievance Review Committee will be made known to the member in writing at the earliest possible time following the review but not more than 10 working days after the date of the review.

Provisions Regarding Covered Person's Rights

(1) The Covered Person has a right to attend the 2nd level hearing and to present his case and has the right to be assisted/represented by a person of his choice.

(2) The Covered Person may again submit written material in support of his claim. Formal rules of evidence are not appropriate, and the Covered Person may arrange for a dentist or other expert to testify on his behalf.

(3) The Covered Person has the right to question Flagship staff concerning the dispute.

(4) The Covered Person's right to a fair and equitable hearing is not made conditional on his appearance at the hearing. Whether or not the Covered Person is present, the hearing will be conducted in the same manner.

(5) FLAGSHIP is responsible for insuring that hearings are held at mutually convenient times. The Covered Person shall be notified in writing, at least fifteen (15) days in advance, of the date and time of the hearing, which will be held within thirty (30) days of receipt of the appeal. Requests for hearing postponement by a Covered Person will be considered.

As a condition for obtaining benefits under this Contract and/or pursuing any claim, complaint or grievance, all Covered Persons are obligated to appear for a clinical review if requested by FLAGSHIP and to provide information and/or documentation which is requested by FLAGSHIP and which is related to any complaint or grievance or to any claims for benefits for requests for authorization for benefits under this contract shall authorize release to FLAGSHIP or its agent any information and/or documentation relating to treatment rendered or charges or payments provided pursuant to the Contract.

XVII. RENEWAL, AMENDMENT OR TERMINATION OF THE CONTRACT

1. The Group Contract shall be automatically renewed from Contract Term to Contract Term unless terminated pursuant to the Group Contract

2. The Group Contract may be amended at any time by mutual agreement of the parties provided that such amendment is reduced to writing, executed by a duly authorized officer of FLAGSHIP, and specifies the date the provisions of such amendment shall be effective.

3. In the event of termination of the Group Contract, all benefits under this contract shall cease and no Covered Person shall, on or after the last day of the Contract Month in which the termination occurs, be entitled to any further benefits.

4. In the event of discontinuation of coverage, the Employer is required to promptly notify all Covered Persons of the discontinuation of coverage and the effective date.

XVIII. EXAMINATION, INFORMATION AND RECORDS

1. As part of its review process, FLAGSHIP may arrange scheduling of Covered Persons for purposes of performing a clinical review of the services provided or recommended by a Plan Dentist, Plan Specialist, or Plan Orthodontist, and may also periodically survey a representative sample of Covered Persons about their perceptions of dental services performed under this Contract.

2. FLAGSHIP may require, as part of the individual application of each Covered Person and/or at any time while this contract is in effect, that the Covered Person and/or his Dependents, sign a release entitling FLAGSHIP to receive from dentists, physicians, hospitals or other sources information and records relating to the examination of, or treatment rendered to, the Covered Person under this Contract.

XIX. GENERAL PROVISIONS

1. The Employer and FLAGSHIP will consult to a reasonable and practical degree concerning all material published or distributed relating to the Group Contract so as to prevent any material from being published or distributed which is contrary to the terms of the Group Contract.

2. No change in the Group Contract or waiver of any of its provisions shall be valid unless approved by a duly authorized officer of FLAGSHIP and evidenced in writing by amendment to the Group Contract.

3. No legal action shall be maintainable against FLAGSHIP for any claim unless the FLAGSHIP Complaint Procedure is first utilized by or on behalf of the affected Covered Person.

4. The benefits and payments under this Contract may not be assigned by the Employer or any Covered Person.

XX. EXCULPATION

All dental services provided by FLAGSHIP shall be in accordance with the accepted dental practices in the community at the time, but FLAGSHIP shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or employee or on the part of any Dentist or others engaged by him in the course of rendering dental services to any Covered Person. In no instance shall any Dentist rendering services be deemed an agent or employee of FLAGSHIP.