FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.

P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203

Florida Combined Life Insurance Company, Inc. (herein referred to as "FCL") agrees to provide the dental benefits described in this policy, subject to its terms. This is a legal contract between you and FCL. **READ YOUR POLICY CAREFULLY.**

TEN (10)-DAY RIGHT TO EXAMINE POLICY

We want you to be satisfied with this policy. If you are not satisfied, you may return the policy and identification cards to us within ten (10) days of the delivery date and we will return all premiums paid. The policy will be considered void from its beginning. The provisions on the following pages, including any endorsements, riders, or amendments, are part of this policy. The policy effective date and policy anniversary are shown on the policy schedule. All periods of time under this policy will begin and end at 12:01 a.m. eastern time. As used in this policy, the words “we,” “us,” and “our” refer to Florida Combined Life Insurance Company, Inc.

Signed for the Florida Combined Life Insurance Company, Inc. at Jacksonville, Florida on the policy effective date.

Chief Executive Officer and President

INDIVIDUAL COPAYMENT PPO DENTAL POLICY

This Policy Contains A Deductible Provision And A Waiting Period For Certain Insureds and Certain Services. Other Insurance Reduces Benefits. Premiums Subject To Change.

This Policy is a Minimum One (1) Year contract and all necessary dental services will be provided as described in the Policy.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy’s out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. Y**OU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT**. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer’s website or contacting your insurer or agent directly.

Renewable at Option of Company

For Customer Service Assistance: 1-888-223-4892. Customers may call this number to present inquiries, obtain information about coverage, or receive assistance in resolving complaints.

Florida Combined Life Insurance Company, Inc. and Blue Cross and Blue Shield of Florida, Inc. are Independent Licensees of the Blue Cross and Blue Shield Association

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PEDIATRIC POLICY SCHEDULE

Policy Number:

Policyholder:

Policy Effective Date:

Policy Anniversary:

This Pediatric Policy Schedule applies only to Covered Persons who meet the Pediatric definition. Pediatric Dental Benefits end on the last day of the Calendar Year of the Covered Person's 19th birthday.

Persons covered under this contract have the right to obtain care from the dental provider of their choice.

FCL has an agreement with certain dental providers, called Participating Dentists, to accept the FCL allowance which is a combination of the amount paid by FCL plus the specified copayment paid by the insured, plus any applicable deductible as payment in full for covered services. The copayments You owe for services provided by Participating Dentists are shown in the Participating Dentist Schedule attached to this policy. Benefits are payable for Participating and Non-participating Dentists as shown below. See the Provider Alternatives provision for further details.

	Participating Dentists	Non-Participating Dentists
DEDUCTIBLE PER PERSON FOR ALL SERVICES	$25.00	$25.00
	Deductible payments made to participating providers also apply toward the deductible payable to non-participating providers. Likewise, deductible payments made to non-participating providers will reduce the deductible payable to participating providers.	
COPAYMENTS PER PERSON FOR COVERED SERVICES	**See Section VII Pediatric Benefits**	**None**
COINSURANCE PAYABLE BY FCL FOR COVERED SERVICES:		
Preventive	None	80%
Basic	None	60%
Major	None	40%
Medically Necessary Dental Implants	None	30%
Medically Necessary Orthodontia	None	30%

MAXIMUM OUT-OF-POCKET LIMIT FOR COVERED SERVICES BY PARTICIPATING DENTISTS PER POLICY WITH ONE COVERED CHILD PER CALENDAR YEAR **$450.00**

MAXIMUM OUT-OF-POCKET LIMIT FOR COVERED SERVICES BY PARTICIPATING DENTISTS PER POLICY WITH MORE THAN ONE COVERED CHILD PER CALENDAR YEAR..... $900.00

CALENDAR YEAR MAXIMUM PER COVERED CHILD……Unlimited

ADULT POLICY SCHEDULE

Policy Number:

Insured:

Policy Effective Date:

Policy Anniversary:

This Adult Policy Schedule applies to Covered Persons age 19 and older. There are no Adult benefits available to Covered Persons who have not attained the age of 19.

Persons covered under this contract have the right to obtain care from the dental provider of their choice.

When a Covered Person moves from a Pediatric plan to an Adult plan, benefits paid during the Calendar Year in which the Covered Person turns age 19, will count toward the Adult Annual Maximum.

FCL has an agreement with certain dental providers, called Participating Dentists, to accept the FCL allowance which is a combination of the amount paid by FCL plus the specified copayment paid by the insured, plus any applicable deductible as payment in full for covered services. The copayments You owe for services provided by Participating Dentists are shown in the Participating Dentist Schedule attached to this policy. Benefits are payable for Participating and Non-participating Dentists as shown below. See the Provider Alternatives provision for further details.

	Participating Dentists	Non-Participating Dentists
DEDUCTIBLE FOR PREVENTIVE SERVICES	None	None
DEDUCTIBLE PER COVERED PERSON, PER CALENDAR YEAR FOR BASIC AND MAJOR SERVICES	$ 50	$ 50

Deductible payments made to participating providers also apply toward the deductible payable to non-participating providers. Likewise, deductible payments made to non-participating providers will reduce the deductible payable to participating providers.

WAITING PERIOD PER COVERED PERSON:

Preventive	None
Basic	6 consecutive months
Major	6 consecutive months

COPAYMENTS PER COVERED PERSON FOR COVERED SERVICES See Section VIII

Adult Benefits	**None**

COINSURANCE PAYABLE BY FCL FOR COVERED SERVICES:

Preventive	None	80%
Basic	None	60%
Major	None	40%

CALENDAR YEAR MAXIMUM PER COVERED PERSON……$1,000

(Applies to covered services provided by Participating and Non-Participating Dentists, combined)

ROLLOVER BENEFIT

SECTION I

DEFINITIONS

Accidental injury – means damage to the mouth, teeth, and supporting tissue caused solely by an unexpected and accidental means but it does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

Adult – means a Covered Person who has attained the age of 19.

Adverse Benefit Determination - means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the policy with respect to a claim.

Allowance Or Allowable Expense - means the maximum amount on which FCL will base payment for dental benefits covered under the policy. The allowance is determined and established solely by FCL and is subject to change at any time without notice to or consent of the policyholder.

Authorized Entity – A Health Insurance Marketplace or other entity authorized by law or regulation through which individuals and groups can purchase insurance to meet the requirements of the federal Affordable Care Act.

Calendar Year – means a twelve (12) month period beginning January 1 and ending December 31.

Calendar Year Maximum – means the maximum amount that may be payable by FCL for each Covered Person for covered dental benefits. No further benefits are payable once the Calendar Year Maximum has been met.

Child – means a Covered Person or Dependent age 18 or under on the coverage effective date who is eligible for Pediatric Benefits. Pediatric Benefits end on the last day of the Calendar Year in which the Child turns age 19.

Coinsurance - means the sharing of expenses for covered dental benefits between FCL and the insured. After the Covered Person's deductible is met, FCL will pay a percentage of the allowance, as shown on the policy schedule. The insured is responsible for the remaining percentage of the allowance, if any, for all non-covered services; and charges in excess of any benefit maximum.

For services received from a non-participating dentist, the insured is also responsible for the difference between the FCL allowance and the actual dentist charges, if any.

Copayment – means the amount payable by an insured, in addition to the Deductible if applicable, for a covered service provided by a participating dentist. The copayment amount is expressed as a dollar amount rather than as a percentage.

Cosmetic Dentistry – means services provided by a Dentist primarily for the purpose of improving appearance.

Covered Person – means anyone eligible to receive Dental Benefits under this policy.

Deductible – means the amount of charges the insured must pay each Calendar year before our reimbursement for dental benefits begins. To calculate the amount to be applied towards satisfying the deductible, only allowable expenses are applied. For Example:

if the deductible amount = $50.00
and the charges = $30.00
and the allowable expense = $25.00
then the amount applied towards the deductible = $25.00

Dental Benefits - means those medically necessary covered services and supplies as set forth in this policy and any rider or endorsement attached to it.

Dental Services Waiting Period - if shown in the policy schedule, means the period of time the Covered Person must wait before benefits are payable for specific dental services.

Dentist - means a duly licensed doctor of Dental Surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the service is rendered, and acting within the scope of his or her license.

Dependents- dependents include:

1. Your legal spouse or Domestic Partner (if recognized by state or local requirements);
2. Your or Your spouse or Domestic Parter's natural, adopted, foster, or step-child(ren); or other child(ren) in court ordered custody of the insured until 26 if:
   a. dependent upon You for support; and
   b. living in Your household, or is a full-time or part-time student; or
3. Your or Your spouse or Domestic Partner's natural, adopted, foster, or step-child(ren); or other child(ren) in court ordered custody of the insured until the
   end of the calendar year in which the child turns thirty (30) if the child:
   a. Is unmarried and does not have a dependent of his or her own;
   b. Is a resident of this state or a full-time or part-time student; and
   c. Is not provided coverage under another dental insurance policy or eligible for benefits under Title XVIII of the Social Security Act.
4. Your or Your Spouse or Domestic Partner's Covered Dependent's Newborn Child for 18 months after birth.

Child Only coverage is limited to dependents age 18 or under on the Policy effective date.

A dependent cannot be in full-time military service.

The age limit of twenty-six (26) or thirty (30) (if the child meets the conditions in the above (a)-(c)) that applies to dependent children will not apply to any Covered Person who continues to be both: (1) incapable of self-sustaining employment by reason of intellectual or physical disability; and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

The symptoms or causes of intellectual or physical disability must have existed prior to the limiting age and while the child was covered under this policy.

If a claim is denied because the child has reached the limiting age, it is your responsibility to provide proof that the child meets the policy requirements for extended eligibility. We may, at any time, require proof satisfactory to us that a child continues to meet such requirements.

Domestic Partner – means a person of the same or opposite gender with whom the Covered Person has established a domestic partnership.

Domestic Partnership – means a relationship between a Covered Person and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's' sole Domestic Partner and intend to remain so indefinitely;
2. the individual are not related by blood to a degree of closeness (e.g. siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least eighteen (18) years of age, and are mentally competent to consent to the domestic partnership; and
4. both individuals are financially interdependent.

Emergency – means a sudden, serious dental condition caused by an accident or dental disease that, if not treated immediately, would result in serious harm to the dental health of the Covered Person. Coverage for an Emergency is limited to Palliative care only.

Enhanced Dental Benefits – means enhanced dental benefits for a Covered Person with diabetes, coronary artery disease, stroke, Sjogrens syndrome, oral cancer, head and neck cancers, chronic obstructive pulmonary disease, end-stage renal disease, metabolic syndrome as diagnosed by a Physician, and women that are pregnant.

Experimental or Investigational - means services or supplies that are determined by FCL to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

a. there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
b. approval is required by the FDA and has not been granted for marketing; or
c. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
d. the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Insured - means the policyholder.

Maximum Allowance – means the maximum payment allowed by FCL for the applicable covered service(s) provided by a Dentist.

Medicare - means any coverage under Title XVIII of the Federal Social Security Act. If this Act is amended, this term will mean any coverage provided under the amended Act.

Medically Necessary - means any services, care, or supplies received while covered, which are determined by FCL, to be:

1. consistent with the symptom, diagnosis, and treatment of the Covered Person's condition;
2. in accordance with standards of good dental or medical practice;
3. approved by the appropriate dental or medical body or board for the condition in question;
4. not primarily for the comfort or convenience of the Covered Person, or dentist;
5. the most appropriate, efficient, and economical dental or medical supply, service, or level of care which can be safely provided; and
6. not cosmetic in nature.

FCL will make final determination as to which services are medically necessary based upon review by our consulting dentists.

NOTE: The fact that a dentist may prescribe, order, recommend, furnish or approve a service or supply does not, of itself, make it medically necessary for a covered service; nor does it make the charge an allowable expense under this policy, even though it is not specifically listed as an exclusion.

Medically Necessary Orthodontic Treatment – means treatment as a result of a handicapping malocclusion and congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip.

Non-Participating Dentist - means a dentist who HAS NOT signed an agreement with FCL to accept the allowance as payment in full for his or her services.

Out-of-Pocket Maximum – The limit on the Deductibles, Copayments and Coinsurance for Covered Services provided by Participating Dentists that the insured is required to pay in a Calendar year, as shown on the Schedule of Benefits. After this limit is reached, Covered Services from Participating Dentists are paid 100% by Us for the remainder of the Calendar year unless subject to the Exclusions and Limitations.

Participating Dentist - means a dentist who HAS signed an agreement with FCL. If a Covered Person receives covered services or supplies from a participating dentist, payment of dental benefits will be made directly to the participating dentist. These dentists will file claims on the insured's behalf.

Palliative – means treatment used in an Emergency situation to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. Palliative treatment usually is performed for, but not limited to, the following acute conditions:

1. Treatment of a tooth needing initial endodontic treatment due to tooth pain;

2. Prescription for a pain medication associated with a dental infection;
3. Sensitivity, irritation, or inflammation of the soft tissue requiring application of topical medication; or
4. Covering exposed dentin due to a tooth fracture.

Pediatric – means a Covered Person who is age 18 or under on the Policy effective date. Pediatric benefits end on the last day of the Calendar Year of the Covered Person's 19th birthday.

Physician - means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Policy - means the document that is issued by FCL to a policyholder. The document outlines the terms and conditions of insurance.

Policy Anniversary - means the same day and month as the policy effective date for each year the policy stays in force.

Policyholder – means the owner of the insurance policy.

Predetermination - means the pretreatment review by FCL of a treatment plan to determine the eligibility of the Covered Person and the amount payable under this policy.

Qualified Health Plan – means a health plan that is certified and meets the standards issued or recognized by each Authorized Entity through which the plan is offered.

Special Enrollment Period – means for purchases made on the Exchange or Marketplace, the period of time outside any applicable open enrollment period during which eligible individuals who experience certain qualifying events may enroll as Dependents in this Policy.

Sound Natural Tooth – means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured, capped, crowned, implanted or treated endodontically);
2. Has been properly restored with small amalgam or composite restorations;
3. Has not become extensively decayed or shows radiographic evidence of periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled with a large restoration, cracked or fractured).

TeleDentistry - is the use of electronic information, imaging and communication technologies, such as interactive audio, and video to provide and support dental care delivery, diagnosis, consultation, treatment, transfer of dental information and education.

Treatment Plan - means the dentist's written report of a series of procedures and estimated charges recommended for the treatment of dental disease, defect or injury, which is prepared for a Covered Person as a result of an examination made by such dentist.

We, Us, And Our - means Florida Combined Life Insurance Company, Inc. (FCL).

You And Your - The owner of this policy.

SECTION II

GENERAL PROVISIONS

Consideration

This policy is issued in consideration of your application for this policy and the payment of the initial premium for this policy.

Entire Policy

The entire contract between you and FCL consists of this policy (and any amendment, rider, or endorsement thereto); policy schedule; and the application attached to this policy.

Representations on the Applications

FCL relies on the information provided on the application to determine eligibility for coverage under this policy. All statements made on the application are representations and not warranties, except in the case of fraud. A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy only if any of the following apply:

a. The misrepresentation, omission, concealment, or statement is fraudulent or is material either to the acceptance of the risk or to the hazard assumed by FCL.
b. If the true facts had been known to FCL pursuant to a policy requirement or other requirement, FCL in good faith would not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

No statement made by you shall be used to deny or reduce benefits unless contained in the application or other written statement signed by you, and a copy has been given to you.

You must notify FCL within 10 days of any incomplete or incorrect information on the application.

If the age of a Covered Person has been misstated on the application, and such misstatement causes FCL to accept a premium different than what would have been required at the correct age, FCL will make the appropriate premium adjustment and notify you in writing.

Time Limit on Certain Defenses

After two (2) years from the date of issue, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred.

Term of the Policy

The policy effective date is set forth on the policy schedule. The policy will take effect as of the policy effective date provided that: (1) FCL approves the application; and (2) FCL receives the first premium. This policy will remain in effect until it is terminated according to the terms of the policy.

Modification of the Policy

No provision of this policy may be modified except by written agreement signed by our President, Secretary, or Vice President. Only these named officers have the authority to modify this policy, waive any of our rights or

requirements, or make any promise with respect to benefits under this policy. No agent can change this policy or waive any of its terms.

Any amendment to this policy shall be without prejudice to claims for dental benefits incurred prior to the effective date of the amendment.

Conformity with State and Federal Regulations and Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, or with Federal Regulations or Statutes is hereby amended to conform to the minimum requirements of such regulations or statutes.

Promissory Estoppel

No oral statements, representations, or understandings by any person can change, alter, delete, add, or otherwise modify the express written terms of this policy to provide for services or supplies that are not covered hereunder.

Non-Waiver of Defaults

Any failure by FCL, at any time, to enforce or to require strict adherence to any of the terms or conditions of this policy, shall in no event constitute a waiver of any such terms or conditions and shall not affect FCL's right to strictly enforce any terms or conditions in the future or to avail itself of any legal remedy it may have.

Notices

Any notice or consent required or permitted under this policy shall be considered given if hand-delivered, or if mailed by United States mail or an overnight delivery service (e.g., Federal Express), postage prepaid, and addressed as set forth below. Such notice shall be considered effective as of the date delivered or deposited in the mail.

If to FCL:

Florida Combined Life Insurance Company, Inc.
4800 Deerwood Campus Bldg. 400
Jacksonville, Florida 32246

If to an insured:

To the Policyholder's address currently on file with FCL.

FCL must be notified immediately of any address changes.

Reservation of Right to Contract

FCL reserves the right to contract with any individuals, corporations, associations, partnerships, or other entities, for assistance with the administration of this policy or any section of this policy.

Service Mark Use

This policy constitutes a contract solely between you and Florida Combined Life Insurance Company, Inc. (FCL). Florida Combined Life is an independent corporation and an affiliate of Blue Cross and Blue Shield of Florida, Inc. (BCBSF). Both BCBSF and FCL operate under a license from the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, permitting them to use the Blue Cross

and Blue Shield Service Marks in the State of Florida. Florida Combined Life is not contracting as the agent of BCBSA. This policy is not based on representations by any person, entity, or organization other than FCL. No person, entity, or organization other than FCL shall be held accountable or liable to you for any of FCL's obligations to you created under this policy. This paragraph shall not create any additional obligations whatsoever on part of FCL, other than those obligations created under other provisions of this agreement.

Identification Card(s)

Any identification card(s) issued in no way creates, or serves to verify, eligibility or coverage under the policy. Identification cards are the property of FCL and must be destroyed or returned to FCL immediately following termination of coverage.

Extension of Benefits Upon Policy Termination

If a Covered Person is receiving covered dental treatment as of the termination date of the policy, FCL will provide a limited extension of the dental care benefits provided by the policy, if:

a. a course of treatment or dental procedures were recommended in writing and commenced while the Covered Person was covered under the policy; and
b. the dental procedures were for other than routine examinations, prophylaxis, x-rays, or sealants; and
c. the dental procedures were performed within ninety (90) days after coverage terminated under the policy.

This extension of benefits is for covered services necessary to complete the dental treatment only. This extension of benefits will automatically terminate on the earlier of:

a. the ninety-first (91st) day after the policy terminates; or
b. the date the Covered Person has reached the Calendar Year Maximum Benefit, if applicable.

Non-Duplication Of Coverage Under Government Programs or Extension of Benefits

The dental benefits under this policy shall not duplicate payment for any dental benefits to which the Covered Person is entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Champus, Veterans Administration) to the extent allowed by law, or under any extension of dental benefits of coverage under a prior plan or program which may be provided or required by law.

Change In Provider Networks

FCL's provider networks are subject to change at any time without the consent of or notice to you. It is the insured's responsibility to determine whether a dentist is participating in FCL's provider network(s) at the time the service or supply is rendered.

SECTION III

POLICY PROVISIONS

Clerical Error

Any clerical error or failure will not alter the status of insurance otherwise validly in force or validly terminated. We will make an equitable adjustment of premiums.

Assignment and Delegation

This policy and the obligations hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that FCL may assign this agreement at any time to its successor in interest or to an affiliated entity without your consent. Any assignment, delegation, or transfer made in violation of this provision shall be void and of no effect.

Payment of Premiums

The first premium must be paid to put the policy in force. It is due on the effective date shown on the policy schedule. Premiums are payable at the address listed on the invoice.

Premiums are payable to the date of termination including any grace period in which insurance is provided. If we receive written notice prior to the premium due date, that the policy will terminate on the due date, no premium will be due.

Premiums are paid monthly and are based on the policyholder's attained age at each following renewal. If you have a birthday that puts you into the next age range, your premiums may change and will be adjusted on your first billing statement in the calendar year following your birthday..

We will notify you in writing at least forty-five (45) days prior to any change in premium rate.

Grace Period

FCL allows a three (3)-month grace period to pay each premium, after the first one. During the grace period, the policy will stay in force. If the premium is not paid before the end of the grace period, this policy will terminate effective as of the last paid through date.

However, some persons are eligible to have some or all of their premium paid through the advance payment of the premium tax credit created by the Affordable Care Act. If you are required to pay a share of this premium, you are entitled to a three (3)-month grace period to pay your share of the premiums. If the premium is not paid before the end of the grace period, this policy will terminate effective as of the last day of the first (1st) month of the grace period. During the grace period, the policy will stay in force.

Reinstatement

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by FCL, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this policy. If FCL or its agent requires an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless FCL has previously written you of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, the rights of you and FCL have will remain the same, subject to any provisions noted on or attached to

the reinstated policy. Any premiums FCL accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

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Cancellation, Non-Renewal, or Change in Rates

FCL may modify the rates at any time. We will provide forty-five (45) days' advance written notice of cancellation, non-renewal or change in rates at the policyholder's last address shown in our records. However, if termination is due to non-payment of premium, the policy may be cancelled following ten (10) days' written notice. In any event, if we fail to provide any such notice, the policy will remain in effect at the existing rates until forty-five (45) days after the notice was mailed.

If your coverage is terminated, we will send a written notice to you informing you of the reason(s) why coverage is terminated and the date that your coverage will end. This notice will be provided to you at least forty-five (45) days prior to the last day of coverage.

Any unearned premium will be promptly refunded if coverage is terminated by either party. Cancellation shall be without prejudice to any prior claims which originated prior to the effective date of termination.

Termination by the Policyholder

The policyholder may terminate this policy by giving us written notice at any time prior to terminating coverage. The termination will take effect on the requested date stated by the policyholder in writing or on the last day of the insurance month for which the policyholder has requested termination. Any unearned premium will be promptly refunded. Cancellation shall be without prejudice to any prior claims which originated prior to the effective date of termination.

In the event that FCL accepts premium for a covered individual after the date requested for termination, the coverage as to such individual will continue for that period for which an identifiable premium was accepted.

Termination by FCL

FCL may terminate the policy:

1. if you fail to pay the premium within the grace period; or
2. if we cancel all contracts with this same form number and provide each covered individual with at least 90 days' notice before the date of nonrenewal; or
3. if you no longer reside, live, or work in the state of Florida;
4. you are no longer eligible for coverage in a Qualified Health Plan through an Exchange;
5. the 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted; or
6. upon the death of the policyholder.

Coverage under the policy will terminate for your dependent(s):

1. if your policy is terminated for any reason; or
2. when they reach the limiting age as specified in this policy; or
3. in the case of your spouse, upon divorce or legal separation.

Any unearned premium will be promptly refunded. Cancellation shall be without prejudice to any prior claims which originated prior to the effective date of termination.

If the policy terminates due to the death of the policyholder, an individual dental policy may be issued, upon written request, to Dependents whose coverage terminates. The written request must be received by FCL within sixty (60) days of the policyholder's death.

Policy Renewal

You may elect to renew this policy:

1. by timely payment of premiums; and
2. on each policy anniversary;
3. if you have not received a notice of cancellation or non-renewal from FCL prior to your renewal date.

Premium rates applicable to this policy will be the rates currently in use on each renewal date of the policy. FCL may cancel your policy with forty-five (45) days' advance written notice. However, such action will not be taken solely due to an insured's health status.

Child-Only Coverage

The parent or legal guardian in whose name coverage is issued is considered the policyholder. In the case of Child-Only coverage, as a parent or legal guardian, you have contracted on behalf of your Dependent Child for the benefits described in this policy. It is your responsibility to assure your Dependent Child's compliance with any and all terms and conditions outlined in this policy.

Claims Processing

If dental benefits are obtained from a dentist who does not file the claim on the claimant's behalf, it is the claimant's responsibility to file the claim with FCL.

Notice of Claim

Written notice of claim must be given to us:

1. within 20 days after the date a loss covered by the policy occurs; or
2. as soon thereafter as reasonably possible.

The notice may be given to us at our home office or to one of our authorized representatives. Notice should include your name and policy number.

CLAIM SUBMISSIONS ADDRESS:
FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
P.O. BOX 69436
HARRISBURG, PA 17106-9436

Claim Forms

We will furnish claim forms for filing proof of loss within fifteen (15) days after we receive notice of the claim. If we do not do so, the claimant can meet the proof of loss requirement by giving us this proof:

1. within the time limit for filing "Proof of Loss" stated below; and
2. covering the occurrence, nature, and extent of the loss.

Proof of Loss

Written proof of loss:

1. must be furnished to us at our home office; and
2. should be furnished within ninety (90) days of the date the dental benefit was provided.

If proof of loss is not sent within the time requested, the claim will not be denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any event, the proof required must be sent no later than one (1) year from the ninety (90) day period, unless the insured was legally incapacitated.

To file a claim, the claimant must obtain an itemized statement from their dentist and attach it to a completed ADA claim form. You may obtain an ADA claim form by contacting us at our home office. The itemized statement must contain the following information:

a. the date the dental benefit was provided;
b. a description of the dental benefit;
c. the amount actually charged by the dentist;
d. the dentist's name and address;
e. the patient's name; and
f. the policyholder's name.

Payment, Contest or Denial of Claims

We will pay, contest or deny a claim, or any part of a claim, within the timeframes described below.

Payment of Claims

We will pay a claim or any part of a claim that establishes proof of loss and contains, as determined by us, all the information we need to pay the claim, as follows:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within forty (40) days of our receipt.

To Whom Benefits Are Paid

Payment of Claims: Benefits will be paid to you, unless such payment for services is provided by a Participating Dentist in which case the benefits will be paid to the Participating Dentist. Loss-of-life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the insured's estate. Any other benefits unpaid at death may be paid, at the insurer's option, either to the insured's beneficiary or estate.

Change of Beneficiary: You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Contested Claims

If a claim is contested or additional information is needed, we will provide notice that the claim or any part of the claim is contested, within forty-five (45) days after receipt of the claim.

If we are unable to determine if a claim or any part of a claim is payable because additional information is needed, we may contest the claim as set forth below.

This notice will identify:

1. the contested portion or portions of the claim;
2. the reason(s) for the contest;
3. the date we reasonably expect to notify the claimant of the decision; and
4. the additional information needed.

If we request additional information, we must receive it within forty-five (45) days of the request. Upon receipt of the requested information, we will pay or deny the claim within sixty (60) days of receipt of additional information. If we do not receive the requested information, the claim will be processed based on the information we possess at the time, and it may be denied.

Denied Claims

If a claim is denied, we will provide notice in writing that the claim or any part of the claim is denied, within forty-five (45) days after receipt of the claim.

This notice will identify:

1. the denied portion or portions of the claim; and
2. reason(s) for the denial.

It is the claimant's responsibility to provide all information determined by us as necessary to process a claim. If we do not receive the necessary information, the claim or any part of the claim may be denied.

Any claim denied as not medically necessary will be provided an opportunity for an appeal to FCL's licensed dentist who is responsible for the medical necessity reviews. This appeal may be by telephone, and FCL's licensed dentist will respond within a reasonable time, not to exceed fifteen (15) days.

Any claim that is denied is an adverse benefit determination. A claimant has the right to appeal an adverse benefit determination for a claim as specified in "Appeal of an Adverse Benefit Determination."

FCL will pay or deny all claims within one hundred twenty (120) days after receipt of a completed claim.

Processing of the claim will be considered complete on the date notice of the claim decision is deposited in the mail by FCL or otherwise electronically transmitted.

Any claims payment not made within the applicable timeframe shall bear simple interest at the rate specified by law.

FCL will investigate any allegation of improper billing by a dentist, upon written notice from an insured. If we determine that a claimant was billed for a service that was not actually performed, any payment amount will be adjusted, and if applicable, a refund will be requested. In such a case, if payment to the dentist is reduced solely due to the notice from you, FCL will pay you twenty (20) percent of the amount of the reduction, up to $500.

Appeal of an Adverse Determination

You, or a representative designated by you in writing, have the right to appeal an adverse benefit determination. Your written appeal must be filed with FCL within 180 days of the original adverse benefit determination.

We will review the appeal under the following guidelines:

1. we must receive the appeal orally or in writing;
2. you may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
3. if the adverse benefit determination is based on the lack of medical necessity of a specific service or experimental, investigational or other similar limitations or exclusions, you may request at no charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the policy to the insured's circumstances;
4. during the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;
5. we may consult with appropriate dentists, as necessary; and
6. any independent medical or dental consultant who reviews an insured's adverse benefit determination on FCL's behalf will be identified upon request.

We will review your appeal of an adverse benefit determination and notify you of our review decision within sixty (60) days of our receipt.

You, or a dentist acting on your behalf, who has had a claim denied as not medically necessary, has the right to appeal the claim denial. The appeal may be directed to an independently contracted employee of FCL who

is a licensed dentist responsible for medical necessity reviews. The appeal may be by telephone and the dentist will respond to you within a reasonable time, not to exceed fifteen (15) business days.

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Please call Customer Service at 1-888-223-4892 for the process for appealing the continued denial and for the correct forms to fill out for the appeal. You must appeal within 4 months of the final determination.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims under the contract, we may need information, including medical information, from the dentist who rendered the service or supply. Insureds shall cooperate with FCL in its effort to obtain such information by, among other ways, signing any release of information form as requested by us. An insured's failure to fully cooperate with us will result in a denial of the pending claim and we will not be liable for such claim.

Physical Examination

We, at our expense, have the right to have the Covered Person examined by a dentist of our choice as often as is reasonably necessary while a claim is pending.

Legal Actions

No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Fraud, Misrepresentation or Omission in Applying for Benefits

FCL relies on the information provided on the itemized statement and the claim form when processing a claim. All information must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in denial of the claim if any of the following apply:

1. The misrepresentation, omission, concealment, or statement is fraudulent or is material to the acceptance of the risk or to the hazard assumed by the insurer; or
2. If the true facts had been known to the insurer in good faith would not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

Explanation of Benefits Form

All claims decisions, including denial and claims review decisions, will be given to you in writing in an explanation of benefits form. This form may indicate:

a. the reason(s) the claim was denied;
b. a reference to the policy provision upon which the denial is based;
c. a description of additional material or information necessary to make the claim payable and why such material or information is necessary; and
d. an explanation of the steps to be taken if you want a claim denial decision reviewed.

Alternate Treatment

Frequently, several alternate methods exist to treat a dental condition. We will make payment based upon the Maximum Allowance for the less expensive procedure provided that the less expensive procedure meets accepted standards of dental treatment as determined by Us. Our decision does not commit the

Covered Person to the less expensive procedure. However, if the Covered Person and the dentist choose the more expensive procedure, the insured is responsible for the additional charges beyond those paid or allowed by Us.

Example:

Resin fillings are covered for anterior teeth; however, resin fillings in posterior teeth are paid at the amalgam allowances as determined by FCL. Resin may be used for restoration of the posterior teeth, but only the amount normally paid for an amalgam will be reimbursed. The insured is responsible for the difference (if any) in cost.

- D2391 is paid as D2140
- D2392 is paid as D2150
- D2393 is paid as D2160
- D2394 is paid as D2161

IF YOU HAVE ANY QUESTIONS ON YOUR SUBMISSION OF CLAIMS OR BENEFITS
CALL 1-888-223-4892
OR WRITE TO
FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
DENTAL CUSTOMER SERVICE
ADDRESS: P.O. BOX 69436
HARRISBURG, PA 17106-9436

SECTION IV

ELIGIBILITY AND EFFECTIVE DATE

Eligibility

A Child is eligible for **PEDIATRIC** coverage under this policy if the Child is:

1. a resident of the state of Florida; and
2. a United States citizen or lawfully present at time of application.

The following individuals are eligible for **ADULT** coverage under this policy:

1. You; and
2. Your legal spouse or Domestic Partner (if recognized by state or local requirements); and
3. Your or Your spouse or Domestic Partner's natural, adopted, foster, or step-child(ren); or other child(ren) in court ordered custody between the ages of nineteen (19) and the limiting age as specified in the definition of "Dependent"; and
4. are a United States citizen or lawfully present at the time of application.

Extension of Eligibility For Certain Children

The limiting age for children covered by the Adult plan may be extended for a child with an intellectual or physical disability as specified in the definition of "Dependent."

Changes In Coverage/Effective Date

Adding Existing Dependents

If enrolled through an Authorized Entity, the Policyholder may also add or remove Dependents or change benefit plans during Special Enrollment Periods. Policyholders must notify the Authorized Entity within sixty (60) days of one of the following events:

1. gaining a Dependent through birth, adoption, placement for adoption, or court order of placement or custody of a child;
2. gaining a Dependent through marriage, domestic partnership or other lawful union between two adults;
3. You permanently move to a different state;
4. loss of other coverage under another plan that provided pediatric minimum essential oral health coverage (for example, loss of Medicaid or state CHIP coverage), except when such loss is due to failure to pay premiums;
5. gaining status as a citizen, national or lawfully present individual;
6. You are determined to be newly eligible or ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;
7. Your enrollment or non-enrollment was unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Authorized Entity;
8. You demonstrate to the Authorized Entity that We substantially violated a material provision of this Policy in relation to You;
9. You demonstrate to the Authorized Entity that You meet certain other exceptional circumstances.

If You are an American Indian and enrolled through an Authorized Entity, You may enroll in or change from one plan to another one time per month. American Indian is someone who is a member of an Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation under the federal Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

If not enrolled through an Authorized Entity and you have eligible Dependents that were not named on the original application, you may still apply for coverage for them. Such coverage will take effect on the first day of the month following the date you request such change and pay the additional premium (if any) required to add such Dependent coverage.

Marital Status

If you wish to add Dependents to your coverage, due to a change in marital status, such change will take effect on the first day of the month following the date we receive the additional premium and approve the change request. We must receive requests to add Dependents to your coverage within thirty (30) days after the date of the marriage.

Newborn Children

Coverage for a newborn child will take effect from the moment of birth, provided we receive a change request within thirty (30) days after the date of birth. If we receive a change request within this thirty (30)-day period, premium will not be charged for the first thirty (30) days of coverage. If we do not receive a change request within thirty (30) days after the date of birth, we may charge an additional premium from the date of birth. If advance notice of sixty (60) days is given prior to the birth of a child, we may not deny coverage due to your failure to timely notify us of the birth.

Coverage for a newborn child born to a covered Dependent, other than your Dependent spouse, will automatically terminate eighteen (18) months after the birth of the newborn child.

Newborn coverage also includes coverage for the transportation of a newborn child to and from the nearest available facility appropriately staffed and equipped to treat his or her dental condition. The attending physician must certify that the transportation is necessary to protect the health and safety of the child. Not more than $1,000 will be paid for this transportation.

Deleting Dependents From Coverage

If you wish to delete an eligible Dependent from coverage, a change request should be submitted to us. Coverage for such Dependent will terminate on the first day of the month following the date we receive the change request. Cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

SECTION V

YOUR OBLIGATIONS

Deductible Limit

The deductible per person per Calendar year is shown on the policy schedule. This deductible must be met by each Covered Person before benefits for covered services are payable.

Copayment

Copayments are fees payable by the insured directly to the participating dentist for covered services. Copayment fees are shown in Section VII of this policy.

Coinsurance

Allowable expenses for dental benefits will be paid at the percentage shown on the policy schedule for covered services provided by a non-participating dentist.

The insured's choice of dentist will determine the amount he or she is responsible for.

For services received from a non-participating dentist, the insured is also responsible for the difference between the FCL allowance for non-participating dentists and the actual dentist charges, if any.

Predetermination of Benefits

If treatment can reasonably be expected to involve allowable expenses of more than $500, a description of the procedures to be performed and an estimate of the dentist's charges (treatment plan) may be filed with FCL for approval prior to the start of treatment.

The main purpose of a predetermination of benefits is to inform the insured and the dentist of the amount of FCL's financial liability, prior to services being performed.

Requests for a predetermination of benefits should be submitted within thirty (30) days of the date of the initial diagnosis or exam. The insured must submit, for our review, x-rays, a complete treatment plan, and in some cases, more substantiating material such as a study model. All predetermination of benefits will be subject to the Calendar year maximum.

Preauthorization

Medically Necessary services including but not limited to implants and orthodontia services for pediatric Covered Persons are only covered if preauthorized by FCL. Typically the health care or dental care provider will obtain this preauthorization, but it is your responsibility to ensure the preauthorization is obtained before the services are rendered. Services that are not preauthorized when required are not payable by FCL.

SECTION VI

PROVIDER ALTERNATIVES

There is a choice of two provider alternatives which will affect how coverage is provided for dental benefits. The following describes the arrangement used to make payment under the policy.

Participating Dentist

These are dentists who have a signed agreement currently in effect with FCL to participate in our dental plan. Participating dentists have agreed to accept the lesser of the actual charge or the FCL allowance as payment in full for covered services. Insureds are not responsible for charges in excess of the allowance. The insured is responsible for the deductible, coinsurance, and the payment of charges for non-covered services and charges in excess of any maximum benefit limitations. The participating dentist will file the claim on the insured's behalf and payment will be made directly to the participating dentist. A list of participating dentists will be made available. This list is subject to change without prior notice to insureds.

Non-Participating Dentist

These are dentists who do NOT have a signed agreement currently in effect with FCL to participate in our dental plan. Non-participating dentists have not agreed to accept the FCL allowance as payment in full. Insureds are responsible for the difference between the FCL allowance and the non-participating dentist charge, if any; the non-participating deductible and coinsurance shown on the policy schedule; the payment of charges for non-covered services; and charges in excess of any maximum benefit limitations.

Selection of a Dentist

FCL does not have the right to select a dentist for insureds. Insureds must select their own dentist and nothing in this policy will interfere with the relationship between an insured and any such dentist selected. In any event, FCL shall not be liable for any action on the part of any dentist, or an agent or employee of the dentist.

SECTION VII

PEDIATRIC BENEFITS

The following are covered Pediatric Dental Benefits and member Copayments for Covered Persons until the last day of the calendar year of the Covered Person's 19th birthday. Payment for covered Pediatric services provided by non-participating dentists will not exceed FCL's Maximum Allowance for non-participating dentists. See the "Limitations and Exclusions" section for other limits on Pediatric services.

Benefit Level	ADA Code	Description of Service	Member Pays $
Preventive Services			
	0120	Periodic oral evaluation – established patient – Maximum two per calendar year (any combination with 0140, 0150, 0180)	**0**
	0140	Limited oral evaluation – problem focused – Maximum two per calendar year (any combination with 0120, 0150, 0180)	**0**
	0150	Comprehensive oral evaluation – new or established patient – Maximum two per calendar year (any combination with 0120, 0140, 0180)	**0**
	0180	Comprehensive periodontal evaluation – new or established patient – Maximum two per calendar year (any combination with 0120, 0140, 0150)	**0**
	0210	Intraoral – complete series (including bitewings) – one every 60 months	**17**
	0220	Intraoral – periapical first film	**4**
	0230	Intraoral – periapical each additional film	**2**
	0240	Intraoral – occlusal radiographic image	**10**
	0270	Bitewing – single film – 1 set every 6 months	**0**
	0272	Bitewings – two films – 1 set every 6 months	**0**
	0274	Bitewings – four films – 1 set every 6 months	**0**
	0277	Vertical Bitewings - 7-8 films – 1 set every 6 months	**0**
	0330	Panoramic film – one every 60 months	**14**
	0340	Cephalometric radiographic image	**28**
	0350	Oral/facial photographic images	**13**
	0391	Interpretation of Diagnostic Image	**0**

	0396	3D printing of a 3D dental surface scan to obtain a physical model – As Needed combined with D0470	**18**
	0470	Diagnostic casts – As Needed combined with D0396	**18**
	1110	Prophylaxis – adult – Two per calendar year	**0**
	1120	Prophylaxis – child – Two per calendar year	**0**
	1206	Topical fluoride varnish – Two per calendar year	**0**
	1208	Topical application of fluoride – Two per calendar year	**0**
	1301	Immunization Counseling – Integral	**0**
	1330	Oral Hygiene Instruction – Integral to D1110, D1120, D4346, D4910	**0**
	1351	Sealant – per tooth – one per permanent tooth every 36 months	**6**
	1352	Preventive Resin Restoration in a moderate to high risk caries patient – permanent tooth – I per tooth every 36 months	**6**
	1354	Interim caries arresting medicament application per tooth – Two per tooth per calendar year. Excludes 3rd molars.	**0**
	1510	Space maintainer – fixed – unilateral	**47**
	1516	Space maintainer – fixed – bilateral maxillary	**66**
	1517	Space maintainer – fixed – bilateral mandibular	**66**
	1520	Space maintainer – removable – unilateral	**53**
	1526	Space maintainer – removable – bilateral maxillary	**75**
	1527	Space maintainer – removable – bilateral mandibular	**75**
	1551	Re-cement or re-bond bilateral space maintainer – maxillary	**0**
	1552	Re-cement or re-bond bilateral space maintainer – mandibular	**0**
	1553	Re-cement or re-bond unilateral space maintainer – per quadrant	**0**
	4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation – Two per calendar year combined with codes 1110, 1120 and 4910	**0**
Basic Services			

	2140	Amalgam – one surface, primary / permanent	**15**
	2150	Amalgam – two surfaces, primary / permanent	**19**
	2160	Amalgam – three surfaces, primary / permanent	**23**
	2161	Amalgam – four or more surfaces, primary / permanent	**28**
	2330	Resin – based composite one surface, anterior	**20**
	2331	Resin – based composite two surfaces, anterior	**26**
	2332	Resin – based composite three surfaces, anterior	**30**
	2335	Resin – based composite, four or more surfaces or involving incisal angle (anterior)	**32**
	2910	Recement inlay, onlay or partial coverage restoration	**11**
	2920	Recement crown	**11**
	2929	Prefabricated porcelain/ceramic crown – primary tooth – one per tooth every 60 months	**39**
	2930	Prefabricated stainless steel crown – primary tooth – one per tooth in 60 months under age 15	**37**
	2931	Prefabricated stainless steel crown – permanent tooth – one per tooth in 60 months under age 15	**38**
	2940	Sedative filling	**12**
	2951	Pin retention – per tooth, in addition to restoration – one per tooth – no frequency limitation	**6**
	3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament – not payable within 45 days of root canal	**47**
	3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development – not payable within 45 days of root canal	**47**
	3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration – one per tooth, limited to primary incisor teeth to age 6 and primary molars and cuspids to age 11	**47**

	3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration. One per tooth, limited to primary incisor teeth to age 6 and primary molars and cuspids to age 11	**47**
	4341	Periodontal scaling and root planing – four or more teeth per quadrant – one every 24 months	**61**
	4342	Periodontal scaling and root planing – one to three teeth per quadrant – one every 24 months	**46**
	4910	Periodontal maintenance – 4 in 12 months combined with prophylaxis	**34**
	5410	Adjust complete denture – upper – No frequency limitations	**10**
	5411	Adjust complete denture – lower – No frequency limitations	**10**
	5421	Adjust partial denture – maxillary – No frequency limitations	**10**
	5422	Adjust partial denture – mandibular – No frequency limitations	**9**
	5511	Repair broken complete denture base, mandibular	**23**
	5512	Repair broken complete denture base, maxillary	**23**
	5520	Replace missing or broken teeth – complete denture (each tooth)	**20**
	5611	Repair resin broken complete denture base, mandibular	**21**
	5612	Repair resin broken complete denture base maxillary	**21**
	5621	Repair cast partial framework, mandibular	**23**
	5622	Repair cast partial framework, maxillary	**23**
	5630	Repair or replace broken retentive clasping materials – per tooth	**20**
	5640	Replace broken teeth – per tooth	**18**
	5650	Add tooth to existing partial denture	**27**
	5660	Add clasp to existing partial denture – per tooth	**31**
	5710	Rebase complete upper denture – 1 per 36 months, payable 6 months after initial insertion	**73**
	5711	Rebase complete lower denture – 1 per 36 months, payable 6 months after initial insertion	**73**

	5720	Rebase upper partial denture – 1 per 36 months, payable 6 months after initial insertion	**66**
	5721	Rebase lower partial denture – 1 per 36 months, payable 6 months after initial insertion	**66**
	5730	Reline complete upper denture (direct) -1 per 36 months, payable 6 months after initial insertion	**38**
	5731	Reline complete lower denture (direct) - 1 per 36 months, payable 6 months after initial insertion	**38**
	5740	Reline upper partial denture (direct) - 1 per 36 months, payable 6 months after initial insertion	**34**
	5741	Reline lower partial denture (direct) - 1 per 36 months, payable 6 months after initial insertion	**34**
	5750	Reline complete upper denture (indirect) - 1 per 36 months, payable 6 months after initial insertion	**59**
	5751	Reline complete lower denture (indirect) - 1 per 36 months, payable 6 months after initial insertion	**57**
	5760	Reline upper partial denture (indirect) -1 per 36 months, payable 6 months after initial insertion	**53**
	5761	Reline lower partial denture (indirect) -1 per 36 months, payable 6 months after initial insertion	**53**
	5850	Tissue conditioning, maxillary	**18**
	5851	Tissue conditioning, mandibular	**19**
	6930	Recement fixed partial denture	**17**
	6980	Fixed partial denture repair, by report	**30**
	7140	Extraction, (elevation and/or forceps removal) erupted tooth or exposed root – one per tooth	**17**
	7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth – one per tooth	**31**
	7220	Removal of impacted tooth – soft tissue – one per tooth	**39**
	7230	Removal of impacted tooth – partially bony – one per tooth	**53**

	7240	Removal of impacted tooth – completely bony – one per tooth	**64**
	7241	Removal of impacted tooth – completely bony, w/ unusual surgical complications – one per tooth	**72**
	7250	Surgical removal of residual roots (cutting procedure) – one per tooth	**32**
	7251	Coronectomy – intentional tooth removal – one per tooth	**64**
	7259	Nerve Dissection – Limited to 1 per permanent tooth	**72**
	7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	**58**
	7280	Surgical access of an unerupted tooth	**73**
	7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	**31**
	7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	**31**
	7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	**42**
	7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	**42**
	7471	Removal of lateral exostosis (maxilla or mandible)	**243**
	7510	Incision and drainage of abscess - intraoral soft tissue	**21**
	7910	Suture of recent small wounds up to 5 cm	**69**
	7921	Collection and application of autologous blood concentrate product – 1 in 36 months	**40**
	7953	Bone replacement graft for ridge preservation – per site	**46**
	7971	Excision of pericoronal gingiva	**31**
	9110	Palliative (emergency) treatment of dental pain, minor procedures	**12**
	9222	Deep sedation/general anesthesia – first 15 minutes	**25**
	9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	**25**
	9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	**19**

	9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increments	**19**
	9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	**0**
	9610	Therapeutic parenteral drug, single administration	**11**
	9930	Treatment of complications (post-surgical) – unusual circumstances, by report	**8**
	9944	Occlusal guard hard appliance – full arch. Removable dental appliance designed to minimize the effect of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances. 1 in 12 months for patients 13 thru 18	**52**
Major Services			
	0160	Detailed and extensive oral evaluation – problem focused	
	2510*	Inlay – metallic – one surface – Alternate Benefit code D2140	
	2520*	Inlay – metallic – two surface – Alternate Benefit code D2150	
	2530*	Inlay – metallic – three or more surfaces – Alternate Benefit code D2160	
	2542*	Onlay – metallic – two surfaces – one per tooth per 60 months	
	2543*	Onlay – metallic – three or more surfaces (not payable in conjunction with D2520, D2530) – one per tooth per 60 months	
	2544*	Onlay – metallic – four or more surfaces (not payable in conjunction with D2520, D2530) – one per tooth per 60 months	
	2740*	Crown – porcelain/ceramic substrate – one per tooth per 60 months	
	2750*	Crown – porcelain fused to high noble metal- one per tooth per 60 months	
	2751*	Crown – porcelain fused to predominantly base metal- one per tooth per 60 months	
	2752*	Crown – porcelain fused to noble metal- one per tooth per 60 months	

	2780*	Crown – ¾ cast high noble metal- one per tooth per 60 months	
	2781*	Crown – ¾ cast predominately base metal- one per tooth per 60 months	
	2783*	Crown – ¾ cast noble metal- one per tooth per 60 months	
	2790*	Crown – full cast high noble metal- one per tooth per 60 months	
	2791*	Crown – full cast predominantly base metal- one per tooth per 60 months	
	2792*	Crown – full cast noble metal- one per tooth per 60 months	
	2794*	Crown – titanium- one per tooth per 60 months	
	2950	Core buildup, including any pins- one per tooth per 60 months	
	2954	Prefabricated post and core in addition to crown- one per tooth per 60 months	
	2980	Crown repair, by report	
	2981	Inlay repair necessitated by restorative material failure	
	2982	Onlay repair necessitated by restorative material failure	
	2983	Veneer repair necessitated by restorative material failure	
	2990	Resin infiltration of incipient smooth surface lesions – 1 in 36 months	
	3110	Pulp cap – direct (excluding final restoration)	
	3310	Root Canal - Anterior (excluding final restoration)	
	3320	Root Canal - Bicuspid (excluding final restoration)	
	3330	Root Canal - Molar (excluding final restoration)	
	3346	Root Canal - Retreatment – anterior	
	3347	Root Canal - Retreatment – bicuspid	
	3348	Root Canal - Retreatment – molar	
	3351	Apexification/recalcification/pulpal regeneration - initial visit (apical closure/ calcific repair of perforations, root resorption, pulp space disinfection, etc.)	
	3352	Apexification/recalcification/pulpal regeneration - interim medication replacement	

	3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
	3355	Pulpal regeneration – initial visit	
	3356	Pulpal regeneration interim medication replacement	
	3357	Pulpal regeneration – Completion of treatment	
	3410	Apicoectomy/periradicular surgery - anterior	
	3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
	3425	Apicoectomy/periradicular surgery - molar (first root)	
	3426	Apicoectomy/periradicular surgery - (each additional root)	
	3450	Root amputation - per root	
	3920	Hemisection (including any root removal), not including root canal therapy	
	4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant - one per 36 months per area of mouth	
	4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant - one per 36 months per area of mouth	
	4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth - one per 36 months per area of mouth	
	4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces - one per 36 months per area of mouth	
	4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant - one per 36 months per area of mouth	
	4249	Clinical crown lengthening – hard tissue - one per tooth by report	
	4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth per quadrant - one per 36 months per area of mouth	

	4261	Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – one per 36 months per area of mouth	
	4263	Bone replacement graft – retained natural tooth - first site in quadrant – one per 36 months per area of mouth	
	4270	Pedicle soft tissue graft procedure – one per 36 months per area of mouth	
	4273	Autogenus connective tissue graft procedures (including donor and recipient surgical sites) – first tooth – one per 36 months per area of mouth	
	4275	Soft tissue allograft – one per 36 months per area of mouth	
	4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft – one per 36 months per area of mouth	
	4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site – one per 36 months per area of mouth	
	4355	Full mouth debridement to enable comprehensive periodontal evaluation & diagnosis - one per 36 months. Not to be completed on the same day as D0150, D0160, or D0180	
	5110	Complete denture – maxillary (upper) – one per 60 months	
	5120	Complete denture – mandibular (lower) – one per 60 months	
	5130	Immediate denture – maxillary (upper) – one per 60 months	
	5140	Immediate denture– mandibular (lower) – one per 60 months	
	5211*	Upper partial – resin base (incl. any conventional clasps, rests, & teeth) – one per 60 months	
	5212*	Lower partial – resin base (incl. any conventional clasps, rests, & teeth) – one per 60 months	
	5213*	Upper partial – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – one per 60 months	

	5214*	Lower partial – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – one per 60 months	
	5282*	Removable unilateral partial denture - one piece cast metal (including any retentive/clasping materials, rests and teeth), maxillary - one per 60 months	
	5283*	Removable unilateral partial denture – one piece cast metal (including any retentive/clasping materials, rests and teeth), mandibular – one per 60 months	

Implant Services are only Covered Benefits when Medically Necessary. Pre-authorization is required. Codes 6010 through 6190

Benefit Level	ADA Code	Description of Service	Member Pays $
	6010	Surgical placement of implant body: endosteal implant – one per tooth every 60 months	450
	6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant – one per tooth every 60 months	**450**
	6040	Surgical placement: eposteal implant – one per tooth every 60 months	**450**
	6050	Surgical placement: transosteal implant – one per tooth every 60 months	**450**
	6055	Connecting bar - implant supported or abutment supported – one per 60 months	**174**
	6056	Prefabricated abutment- includes placement – one per tooth every 60 months	**112**
	6057	Custom abutment – one per tooth every 60 months	**146**
	6058	Abutment supported porcelain/ ceramic crown – one per tooth every 60 months	**294**
	6059	Abutment supported porcelain fused to metal crown (high noble metal) – one per tooth every 60 months	**290**
	6060	Abutment supported porcelain fused to metal crown (predominantly base metal) – one per tooth every 60 months	**274**
	6061	Abutment supported porcelain fused to metal crown (noble metal) – one per tooth every 60 months	**280**

	6062	Abutment supported cast metal crown (high noble metal) – one per tooth every 60 months	**279**
	6063	Abutment supported cast metal crown (predominantly base metal) – one per tooth every 60 months	**240**
	6064	Abutment supported cast metal crown (noble metal) – one per tooth every 60 months	**252**
	6065	Implant supported porcelain/ceramic crown – one per tooth every 60 months.	**289**
	6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) – one per tooth every 60 months.	**282**
	6067	Implant supported metal crown (titanium, titanium alloy, high noble metal) – one per tooth every 60 months.	**274**
	6068	Abutment supported retainer for porcelain/ ceramic FPD – one per tooth every 60 months.	**294**
	6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal) – one per tooth every 60 months.	**290**
	6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly based metal) – one per tooth every 60 months.	**274**
	6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal) – one per tooth every 60 months.	**280**
	6072	Abutment supported retainer for cast metal FPD (high noble metal) – one per tooth every 60 months.	**286**
	6073	Abutment supported retainer for cast metal FPD (predominantly base metal) – one per tooth every 60 months.	**259**
	6074	Abutment supported retainer for cast metal FPD (noble metal) – one per tooth every 60 months.	**279**
	6075	Implant supported retainer for ceramic FPD – one per tooth every 60 months.	**289**
	6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, of high noble metal) – one per tooth every 60 months.	**282**

	6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, of high noble metal) – one per tooth every 60 months.	**271**
	6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis – one per 60 months.	**24**
	6090	Repair implant supported prosthesis, by report – one per tooth every 60 months.	**83**
	6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment – one per tooth every 60 months	**138**
	6100	Surgical removal of Implant body – one per tooth with D6105 every 60 months.	**120**
	6101	Debridement of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces, including flap entry and closure – one per tooth with D6102 every 60 months	**160**
	6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces and including flap entry and closure – one per tooth with D6101 every 60 months	**228**
	6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure - one per tooth every 60 months with D6104. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.	**114**
	6104	Bone graft at time of implant placement – one per tooth with D6103 every 60 months	**114**
	6110	Implant/abutment supported removable denture for edentulous arch – maxillary - one per tooth every 60 months	**378**

	6111	Implant/abutment supported removable denture for edentulous arch – mandibular - one per tooth every 60 months	**378**
	6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary - one per tooth every 60 months	**378**
	6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular - one per tooth every 60 months	**378**
	6114	Implant/abutment supported fixed denture for edentulous arch – maxillary - one per tooth every 60 months	**350**
	6115	Implant/abutment supported fixed denture for edentulous arch – mandibular - one per tooth every 60 months	**350**
	6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary - one per tooth every 60 months	**350**
	6117	Implant/abutment supported fixed denture for partially edentulous arch –mandibular - one per tooth every 60 months	**350**
	6180	Implant maintenance procedures when a full arch fixed hybrid prothesis is not removed including cleansing of prosthesis and abutments – two per year	**10**
	6190	Radiographic/surgical implant index, by report – one per 60 months	**171**
	6193	Replacement of an implant screw – one per tooth per 3 year period	**100**
	6210*	Pontic – cast high noble metal – one per 60 months	**306**
	6211*	Pontic – cast predominantly base metal – one per 60 months	**263**
	6212*	Pontic - cast noble metal – one per 60 months	**274**
	6214*	Pontic – titanium – one per 60 months	**283**
	6240*	Pontic – porcelain fused to high noble metal – one per 60 months	**316**
	6241*	Pontic – porcelain fused to predominantly base metal – one per 60 months	**288**
	6242*	Pontic – porcelain fused to noble metal – one per 60 months	**302**
	6245*	Pontic – porcelain/ceramic – one per 60 months	**299**

	6545	Retainer – cast metal for resin bonded fixed prosthesis – one per 60 months	**123**
	6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis – one per 60 months	**115**
	6549	Resin Retainer – for resin bonded fixed prosthesis – one per 60 months	**123**
	6600	Retainer inlay porcelain/ceramic, two surfaces – one per 60 months	**241**
	6604	Retainer inlay – cast predominately base metal, two surfaces – one per 60 months	**239**
	6605	Retainer inlay – cast predominately base metal, three or more surfaces – one per 60 months	**257**
	6609	Retainer onlay – porcelain/ceramic, three or more surfaces – one per 60 months	**312**
	6613	Retainer onlay – cast predominately base metal, three or more surfaces– one per 60 months	**248**
	6740	Crown – porcelain/ceramic – one per 60 months	**350**
	6750	Crown – porcelain fused to high noble metal – one per 60 months	**315**
	6751	Crown – porcelain fused to predominantly base metal – one per 60 months	**288**
	6752	Crown – porcelain fused to noble metal – one per 60 months	**302**
	6780	Crown - 3/4 cast high noble metal – one per 60 months	**267**
	6781	Crown – 3/4 cast predominantly base metal – one per 60 months	**200**
	6782	Crown – 3/4 cast noble metal – one per 60 months	**225**
	6783	Crown – 3/4 porcelain/ceramic – one per 60 months	**267**
	6790	Crown – full cast high noble metal – one per 60 months	**301**
	6791	Crown – full cast predominantly base metal – one per 60 months	**266**
	6792	Crown – full cast noble metal – one per 60 months	**280**
	7252	Partial extraction for immediate implant placement – 1 per permanent maxillary anterior tooth	**31**

The Following Services are only Covered Benefits when Medically Necessary.

Pre-authorization is required.

Benefit Level	ADA Code	Description of Service	Member Pays $
	8010	Limited orthodontic treatment of the primary dentition	**450**
	8020	Limited orthodontic treatment of the transitional dentition	450
	8030	Limited orthodontic treatment of the adolescent dentition	450
	8070	Comprehensive orthodontic treatment of the transitional dentition	405
	8080	Comprehensive orthodontic treatment of the adolescent dentition	450
	8090	Comprehensive orthodontic treatment of the adult dentition	450
	8091	Comprehensive orthodontic treatment associated with orthognathic surgery when additional surgical intervention is planned	450
	8210	Removable appliance therapy	0
	8220	Fixed appliance therapy	450
	8660	Pre-orthodontic treatment visit	0
	8670	Periodic orthodontic treatment visit (as part of contract)	0
	8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)	0

including routine post-delivery care

Oral Health for Overall Health Enhanced Dental Benefits

Coverage for the following services are provided for each Covered Person who is eligible to receive Enhanced Dental Benefits and has been diagnosed with diabetes, coronary artery disease, stroke, chronic obstructive pulmonary disease, end-stage renal disease, metabolic syndrome, or women that are pregnant:

- Dental Cleanings (oral prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance cleanings) once every three months.
- Periodontal scaling is covered at 100% with no out-of-pocket expense when provided by a participating provider, once for each quadrant every three months when this service is necessary and appropriate.
- Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Covered at 100% with no out-of-pocket expense when provided by a participating provider. Covered once every twenty-four months.

Coverage for the following services is provided for each Covered Person who is eligible to receive Enhanced Dental Benefits and has been diagnosed with Sjögren's syndrome, oral cancer or head and neck cancers:

- Dental Cleanings (oral prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance cleanings) once every three months.
- Fluoride treatment, once every three months.
- Periodic oral evaluation, four every twelve months.
- Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Covered at 100% with no out-of-pocket expense when provided by a participating provider. Covered once every twenty-four months.

Enhanced Dental Benefits are paid at 100% and enrolled members will not be subject to deductibles or copayment provisions that would otherwise apply, do not apply when these benefits are provided by a Participating Dentist. Enhanced Dental Benefits provided by Non-Participating dentists will be subject to any coinsurance due, however the deductible will not apply.

Covered Medical Conditions and Enhanced Dental Benefits	**Automatic Program Enrollment**	**Prophylaxis (Cleanings) (D1110 and D1120), Scaling in the presence of gingival inflammation (D4346) or Periodontal Maintenance (D4910) Visit Every 3 Months** **Full Mouth Debridement (D4355) 1 Every 24 Months**	**Periodic Oral Evaluation (D0120) 4 Every 12 Months** **Fluoride Treatment (D1206 or D1208) Every 3 Months**	**Periodontal Scaling (D4341, D4342), Once per quadrant Every 24 Months**
Diabetes	✓	✓		✓
Coronary Artery Disease	✓	✓		✓
Stroke	✓	✓		✓
Chronic Obstructive Pulmonary Disease	✓	✓		✓
End-Stage Renal Disease	✓	✓		✓
Metabolic Syndrome	✓	✓		✓
Pregnancy	✓	✓		✓
Oral Cancer	✓	✓	✓	
Head & Neck Cancers	✓	✓	✓	
Sjögren's Syndrome	✓	✓	✓	

SECTION VIII

ADULT BENEFITS

The following are covered Adult dental benefits and member copayments for Covered Persons age 19 and older. Payment for covered Adult services provided by non-participating dentists will not exceed FCL's Maximum Allowance for non-participating dentists. See the "Limitations and Exclusions" section for other limits on Adult services.

Benefit Level	ADA Code	Description of Service	Member Pays $
Preventive Services			
	120	Periodic oral evaluation – established patient – Maximum two per calendar year (any combination with 140, 150, 180)	**0**
	140	Limited oral evaluation – problem focused – Maximum two per calendar year (any combination with 120, 150, 180)	**0**
	150	Comprehensive oral evaluation – new or established patient- once per lifetime per provider (any combination with 120, 140, 180)	**0**
	180	Comp periodontal eval – new or established patient – Maximum two per calendar year (any combination with 120, 140, 150, 180)	**0**
	270	Bitewing – single film – once per calendar year	**0**
	272	Bitewings – two films – once per calendar year	**0**
	273	Bitewings – three films – once per calendar year	**0**
	274	Bitewings – four films –once per calendar year	**0**
	277	Vertical Bitewings - 7-8 films – once per calendar year	**0**
	1110	Prophylaxis – adult – Two per calendar year. Includes periodontal maintenance.	**10**
	1301	Immunization Counseling - Integral	**0**
	1330	Oral Hygiene Instruction – Integral to D1110, D1120, D4346, D4910	**0**
	1354	Interim caries arresting medicament application per tooth – Two per tooth per calendar year. Excludes 3rd molars.	**0**

	4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation – Two per calendar year combined with codes 1110, and 4910	**0**
	9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician – once every 6 months	**0**
	9430	Office visit for observation (during regular scheduled hrs) no other services performed- once every 6 months	**0**
Basic Services			
	210	Intraoral – complete series (including bitewings) – once every 36 months	**17**
	220	Intraoral – periapical first film	**4**
	230	Intraoral – periapical each additional film	**2**
	330	Panoramic film – once every 60 months	**14**
	2140	Amalgam – one surface, primary / permanent - once per tooth surface per tooth per 12 months	**15**
	2150	Amalgam – two surfaces, primary / permanent- once per tooth surface per tooth per 12 months	**19**
	2160	Amalgam – three surfaces, primary / permanent- once per tooth surface per tooth per 12 months	**23**
	2161	Amalgam – four or more surfaces, primary / permanent- once per tooth surface per tooth per 12 months	**28**
	2330	Resin – based composite one surface, anterior- once per tooth surface per tooth per 12 months	**20**
	2331	Resin – based composite two surfaces, anterior- once per tooth surface per tooth per 12 months	**26**
	2332	Resin – based composite three surfaces, anterior- once per tooth surface per tooth per 12 months	**30**
	2335	Resin – based composite, four or more surfaces or involving incisal angle (anterior) – once per tooth surface per tooth per 12 months.	**32**
	2391	Resin – based composite one surface, posterior- once per tooth surface per tooth per 12 months	**22**

	2392	Resin – based composite two surfaces, posterior- once per tooth surface per tooth per 12 months	**29**
	2393	Resin – based composite three surfaces, posterior- once per tooth surface per tooth per 12 months	**37**
	2394	Resin – based composite four or more surfaces, posterior - once per tooth surface per tooth per 12 months	**38**
	2910	Recement or re-bond inlay, onlay or partial coverage restoration	**11**
	2920	Recement or re-bond crown – payable 6 months post insertion. 12 month wait between service and maximum 2 per restoration per 60 months	**11**
	2940	Sedative filling	**12**
	2950	Core buildup, including any pins – one per tooth per 60 months	**28**
	2951	Pin retention – per tooth, in addition to restoration – once per 12 consecutive months	**6**
	5410	Adjust complete denture – upper - Two per calendar year – allowed six months after placement	**10**
	5411	Adjust complete denture –lower - Two per calendar year – allowed six months after placement	**10**
	5421	Adjust partial denture – upper - Two per calendar year – allowed six months after placement	**10**
	5422	Adjust partial denture – lower – Two per calendar year – allowed six months after placement	**9**
	5511	Repair broken complete denture base, mandibular	**23**
	5512	Repair broken complete denture base, maxillary	**23**
	5520	Replace missing or broken teeth – complete denture (each tooth)	**20**
	5611	Repair resin broken complete denture base, mandibular	**21**
	5612	Repair resin broken complete denture base maxillary	**21**
	5621	Repair cast partial framework, mandibular	**23**
	5622	Repair cast partial framework, maxillary	**23**
	5630	Repair or replace broken clasp – per tooth	**20**

	5640	Replace broken teeth – per tooth	**18**
	5650	Add tooth to existing partial denture	**27**
	5660	Add clasp to existing partial denture – per tooth	**31**
	5670	Replace all teeth & acrylic on cast metal framework (upper)- Once per 36 months – 60 month replacement rule (denture must be 60 months old for service to be covered)	**75**
	5671	Replace all teeth & acrylic on cast metal framework (lower) Once per 36 months – 60 month replacement rule (denture must be 60 months old for service to be covered)	**75**
	5710	Rebase complete maxillary denture Once per 36 months – allowed six months after initial placement	**73**
	5711	Rebase complete mandibular denture Once per 36 months – allowed six months after initial placement	**73**
	5720	Rebase maxillary partial denture Once per 36 months – allowed six months after initial placement	**66**
	5721	Rebase mandibular partial denture Once per 36 months – allowed six months after initial placement	**66**
	5730	Reline complete maxillary denture (direct) Once per 36 months – allowed six months after initial placement	**38**
	5731	Reline complete mandibular denture (direct) Once per 36 months – allowed six months after initial placement	**38**
	5740	Reline maxillary partial denture (direct) Once per 36 months – allowed six months after initial placement	**34**
	5741	Reline mandibular partial denture (direct) Once per 36 months – allowed six months after initial placement	**34**
	5750	Reline complete maxillary denture (indirect) Once per 36 months – allowed six months after initial placement	**59**

	5751	Reline complete mandibular denture (indirect) Once per 36 months – allowed six months after initial placement	**57**
	5760	Reline maxillary partial denture (indirect) Once per 36 months – allowed six months after initial placement	**53**
	5761	Reline mandibular partial denture (indirect) Once per 36 months – allowed six months after initial placement	**53**
	5850	Tissue conditioning, upper - 2 times per calendar year	**18**
	5851	Tissue conditioning, lower - 2 times per calendar year	**19**
	6930	Recement or re-bond fixed partial denture - payable six month post insertion. 12 month wait between service and maximum two per restoration per 60 months	**17**
	6980	Fixed partial denture repair, by report	**30**
	7111	Extraction, coronal remnants – deciduous tooth – one per lifetime	**11**
	7140	Extraction,(elevation and/or forceps removal)erupted tooth or exposed root – one per tooth per lifetime	**17**
	7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth – one per tooth per lifetime	**31**
	7220	Removal of impacted tooth – soft tissue – one per tooth per lifetime	**39**
	7230	Removal of impacted tooth – partially bony- one per tooth per lifetime	**53**
	7240	Removal of impacted tooth – completely bony –one per tooth per lifetime	**64**
	7241	Removal of impacted tooth – completely bony, w/ unusual surgical complications – one per tooth per lifetime	**72**
	7250	Surgical removal of residual roots (cutting procedure) – one per tooth per lifetime	**32**
	7251	Coronectomy – intentional tooth removal – one per tooth per lifetime	**64**

	7259	Nerve Dissection – Limit one per permanent tooth per lifetime	**72**
	7280	Surgical access of an unerupted tooth – one per tooth per lifetime	**73**
	7282	Mobilization of erupted or malpositioned tooth to aid eruption – one per tooth per lifetime	**45**
	7283	Placement of device to facilitate eruption of impacted tooth – one per tooth per lifetime	**27**
	7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	**31**
	7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	**31**
	7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	**42**
	7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	**42**
	7510	Incision and drainage of abscess - intraoral soft tissue	**21**
	9110	Palliative (emergency) treatment of dental pain, minor procedures	**12**
	9222	Deep sedation/general anesthesia – first 15 minutes	**25**
	9223	Deep sedation/general anesthesia – each subsequent 15 minute increment. Payable with covered surgical procedures only	**25**
	9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	**19**
	9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment. Payable with covered surgical procedures only	**19**
Major Services			
	2510*	Inlay – metallic – one surface – one per tooth per 60 months	**221**
	2542*	Onlay – metallic – two surfaces– one per tooth per 60 months	**239**
	2543*	Onlay – metallic – three or more surfaces (not payable in conj w/2520, 2530)– one per tooth per 60 months	**297**

	2544*	Onlay – metallic – four or more surfaces (not payable in conj w/2520, 2530) – one per tooth per 60 months	**306**
	2610*	Inlay – porcelain/ceramic – one surface – one per tooth per 60 months	**222**
	2620*	Inlay – porcelain/ceramic – two surfaces – one per tooth per 60 months	**241**
	2630*	Inlay – porcelain/ceramic – three or more surfaces – one per tooth per 60 months	**261**
	2642*	Onlay – porcelain/ceramic – two surfaces – one per tooth per 60 months	**273**
	2643*	Onlay – porcelain/ceramic – three surfaces – one per tooth per 60 months	**312**
	2644*	Onlay – porcelain/ceramic – four or more surfaces– one per tooth per 60 months	**325**
	2710*	Crown – resin-based composite (indirect) – one per tooth per 60 months	**148**
	2740*	Crown – porcelain/ceramic substrate – one per tooth per 60 months	**324**
	2750*	Crown – porcelain fused to high noble metal – one per tooth per 60 months	**315**
	2751*	Crown – porcelain fused to predominantly base metal – one per tooth per 60 months	**289**
	2752*	Crown – porcelain fused to noble metal – one per tooth per 60 months	**302**
	2790*	Crown – full cast high noble metal – one per tooth per 60 months	**301**
	2791*	Crown – full cast predominantly base metal – one per tooth per 60 months	**268**
	2792*	Crown – full cast noble metal – one per tooth per 60 months	**285**
	2952	Post and core in addition to crown, indirectly fabricated – one per tooth per 60 months	**113**
	2954	Prefabricated post and core in addition to crown – one per tooth per 60 months	**74**
	2980	Crown repair, by report	**53**

	3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament – one per tooth per lifetime	**47**
	3310	Root Canal - Anterior (excluding final restoration) – one per tooth per lifetime	**196**
	3320	Root Canal - Bicuspid (excluding final restoration) – one per tooth per lifetime	**231**
	3330	Root Canal - Molar (excluding final restoration) – one per tooth per lifetime	**305**
	3346	Root Canal - Retreatment – anterior -once per tooth per lifetime / 12 months post root canal therapy	**256**
	3347	Root Canal - Retreatment – bicuspid - once per tooth per lifetime / 12 months post root canal therapy	**296**
	3348	Root Canal - Retreatment – molar - once per tooth per lifetime / 12 months post root canal therapy	**358**
	3410	Apicoectomy surgery - anterior	**188**
	3421	Apicoectomy surgery - bicuspid (first root)	**227**
	3425	Apicoectomy surgery - molar (first root)	**235**
	3426	Apicoectomy surgery - (each additional root)	**84**
	3430	Retrograde filling - per root	**46**
	3450	Root amputation - per root	**120**
	3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior – Once per tooth per lifetime. If performed on the same date of service as the apicoectomy the periradicular surgery is considered integral to the apicoectomy.	**231**
	3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar – Once per tooth per lifetime. If performed on the same date of service as the apicoectomy the periradicular surgery is considered integral to the apicoectomy.	**231**

	3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar – Once per tooth per lifetime. If performed on the same date of service as the apicoectomy the periradicular surgery is considered integral to the apicoectomy.	**231**
	3920	Hemisection (including any root removal), not including root canal therapy	**105**
	4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant - one per 36 months per area of mouth, age 18 and older	**142**
	4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant – one per 36 months per area of mouth, age 18 and older	**47**
	4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces – one per 36 months per area of mouth, age 18 and older	**158**
	4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant – one per 36 months per area of mouth, age 18 and older	**150**
	4249	Clinical crown lengthening – hard tissue (one per tooth per lifetime, by report), age 18 and older	**212**
	4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth per quadrant – one per 36 months per area of mouth, age 18 and older	**322**
	4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth per quadrant – one per 36 months per area of mouth, age 18 and older	**277**
	4263	Bone replacement graft – retained natural tooth - first site in quadrant – one per 36 months per area of mouth, age 18 and older	**120**

	4264	Bone replacement graft – retained natural tooth - each additional site in quadrant – one per 36 months per area of mouth, age 18 and older	**77**
	4273	Autogenous connective tissue graft procedures – per first tooth (inc. donor and recipient surgical sites) one per 36 months per area of mouth, age 18 and older	**280**
	4275	Non-autogenous connective tissue allograph (including recipient site and donor material), first tooth in graft, one per 36 months, per area of mouth, age 18 and older	**221**
	4276	Combined connective tissue and pedicle graft per tooth, one per 36 months per area of mouth, age 18 and older	**265**
	4277	Free soft tissue graft procedure – 1st tooth, implant, or edentulous tooth position in graft – one per 36 months per area of mouth, age 18 and older	**236**
	4278	Free soft tissue graft procedure – each additional contiguous tooth, implant, or edentulous tooth position in same graft site – one per 36 months per rea of mouth, age 18 and older	**45**
	4341	Periodontal scaling and root planing – four or more teeth per quadrant payable once every 24 months	**61**
	4342	Periodontal scaling and root planing – one to three per quadrant once every 24 months	**46**
	4355	Full mouth debridement to enable comprehensive periodontal evaluation & diagnosis – one per 36 months, age 18 and older. Not to be completed on the same day as D0150, D0160, or D0180.	**34**
	4910	Periodontal maintenance – Two per calendar year - includes prophylaxis	**34**
	5110	Complete denture – maxillary (upper) – once every 60 months	**382**
	5120	Complete denture – mandibular (lower) – once every 60 months	**382**
	5130	Immediate denture – maxillary (upper) – once every 60 months	**418**
	5140	Immediate denture – mandibular (lower) – once every 60 months	**418**

	5211*	Upper partial – resin base (incl. any conventional clasps, rests, & teeth) – once every 60 months	**296**
	5212*	Lower partial – resin base (incl. any conventional clasps, rests, & teeth) – once every 60 months	**303**
	5213*	Upper partial – cast metal framework w/ resin dent bases (incl. clasps, rests) – once every 60 months	**420**
	5214*	Lower partial – cast metal framework w/ resin dent bases (incl. clasps, rests) – once every 60 months	**420**
	5225	Maxillary partial denture – flex base (including any retentive/clasping materials, rests and teeth) – once every 60 months	**420**
	5226	Mandibular partial dental – flex base (including any retentive clasping materials, rests and teeth) – once every 60 months	**420**
	6210*	Pontic – cast high noble metal – once every 60 months	**306**
	6211*	Pontic – cast predominantly base metal – once every 60 months	**263**
	6240*	Pontic – porcelain fused to high noble metal – once every 60 months	**316**
	6241*	Pontic – porcelain fused to predominantly base metal – once every 60 months	**288**
	6242*	Pontic – porcelain fused to noble metal – once every 60 months	**302**
	6245*	Pontic – porcelain/ceramic – once every 60 months	**299**
	6545	Retainer – cast metal for resin bonded fixed prosthesis – once every 60 months	**123**
	6600	Retainer inlay porcelain / ceramic – two surfaces – once every 60 months	**241**
	6601	Retainer inlay porcelain / ceramic – three or more surfaces – once every 60 months	**261**
	6606	Retainer inlay – cast noble metal – two surfaces – once every 60 months	**239**
	6607	Retainer inlay – cast noble metal – three or more surfaces – once every 60 months	**257**
	6608	Retainer onlay – porcelain / ceramic – two surfaces – once every 60 months	**273**

	6609	Retainer onlay – porcelain / ceramic – three or more surfaces– once every 60 months	**312**
	6615	Retainer onlay – cast noble metal - three or more surfaces– once every 60 months	**297**
	6720	Retainer crown – resin with high noble metal – once every 60 months	**299**
	6721	Retainer crown – resin with predominantly base metal – once every 60 months	**250**
	6722	Retainer crown – resin with noble metal – once every 60 months	**277**
	6740	Retainer crown – porcelain/ceramic – once every 60 months	**350**
	6750	Retainer crown – porcelain fused to high noble metal – once every 60 months	**315**
	6751	Retainer crown – porcelain fused to predominantly base metal – once every 60 months	**288**
	6752	Retainer crown – porcelain fused to noble metal – once every 60 months	**302**
	6790	Retainer crown – full cast high noble metal – once every 60 months	**301**
	6791	Retainer crown – full cast predominantly base metal – once every 60 months	**266**
	6792	Retainer crown – full cast noble metal – once every 60 months	**280**
	7961	Buccal / labial frenectomy (frenulectomy)	**98**
	7962	Lingual frenectomy (frenulectomy)	**98**
	7963	Frenuloplasty	**112**

including routine post-delivery care

Oral Health for Overall Health Enhanced Dental Benefits

Coverage for the following services are provided for each Covered Person who is eligible to receive Enhanced Dental Benefits and has been diagnosed with diabetes, coronary artery disease, stroke, chronic obstructive pulmonary disease, end-stage renal disease, metabolic syndrome, or women that are pregnant:

- Dental Cleanings (oral prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance cleanings) once every three months.
- Periodontal scaling is covered at 100% with no out-of-pocket expense when provided by a participating provider, once per quadrant every three months when this service is necessary and appropriate.
- Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Covered at 100% with no out-of-pocket expense when provided by a participating provider. Covered once every twenty-four months.

Coverage for the following services is provided for each Covered Person who is eligible to receive Enhanced Dental Benefits and has been diagnosed with Sjögren's syndrome, oral cancer or head and neck cancers:

- Dental Cleanings (oral prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance cleanings) once every three months.
- Fluoride treatment, once every three months.
- Periodic oral evaluation, four every twelve months.
- Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Covered at 100% with no out-of-pocket expense when provided by a participating provider. Covered once every twenty-four months,

Enhanced Dental Benefits are paid at 100% and enrolled members will not be subject to benefit waiting periods, calendar year maximums, deductibles or copayment provisions that would otherwise apply, do not apply when these benefits are provided by a Participating Dentist. Enhanced Dental Benefits provided by Non-Participating dentists will be subject to any coinsurance due, however the calendar year maximum and deductible will not apply.

Covered Medical Conditions and Enhanced Dental Benefits	**Automatic Program Enrollment**	**Prophylaxis (Cleanings) (D1110 and D1120), Scaling in the presence of gingival inflammation (D4346) or Periodontal Maintenance (D4910) Visit Every 3 Months** **Full Mouth Debridement (D4355) 1 Every 24 Months**	**Periodic Oral Evaluation (D0120) 4 Every 12 Months** **Fluoride Treatment (D1206 or D1208) Every 3 Months**	**Periodontal Scaling (D4341, D4342), Once per quadrant Every 24 Months**
Diabetes	✓	✓		✓
Coronary Artery Disease	✓	✓		✓
Stroke	✓	✓		✓
Chronic Obstructive Pulmonary Disease	✓	✓		✓
End-Stage Renal Disease	✓	✓		✓
Metabolic Syndrome	✓	✓		✓
Pregnancy	✓	✓		✓
Oral Cancer	✓	✓	✓	
Head & Neck Cancers	✓	✓	✓	
Sjögren's Syndrome	✓	✓	✓	

Rollover Benefit

1. A Rollover Benefit is a portion of a Covered Person's un-used Calendar Year Maximum benefit amount that may be carrier over to the next Calendar year, thereby increasing the next Calendar Year Maximum benefit amount, provided each of the following conditions are met:

    a. The Covered Person is an active member of the plan on the last day of the Calendar year; and
    b. The Covered Person submits at least one (1) claim for a Covered Service during a Calendar year; and
    c. The Covered Person's total claims paid during a Calendar year do not exceed $500; and
    d. The Covered Person's accumulated Rollover balance has not exceeded $1,000.

2. Beginning with the second (2nd) Calendar Year of coverage under this Policy, a Covered Person's Calendar Year Maximum of $1,000 may be increased by $350 if all the above listed conditions are met. If coverage under this benefit is first provided during a partial Calendar Year, the Rollover Benefit will be calculated as if coverage was provided for a full Calendar Year.

3. The Rollover Amount can be accumulated from one Calendar Year to the next up the Accumulated Rollover Maximum amount of $1,000, unless:

    a. The Covered Person's total claims paid during a Calendar Year exceed $500. In this instance, there will be no additional Rollover amount for that Calendar Year; or
    b. No claims for Covered Services are incurred and paid during a Calendar Year. In this instance, there will be no additional Rollover amount for that Calendar Year.

4. If total claims paid during any one Calendar Year exceed the Calendar Year Maximum of $1,000, the excess amount will be deducted from the Accumulated Rollover amount available for that Calendar Year. No additional Rollover Amount will be earned for that Calendar Year and the Accumulated Rollover Amount available for the next Calendar Year will be reduced by the amount deducted for the excess claim amount.

5. To properly calculate the Rollover Amount, claims should be submitted in a timely manner, as described in this Policy.

6. Rollover Amounts are not available for the following expenses related to a Covered Person's dental services:

    a. Deductibles;
    b. Coinsurance;
    c. Copayments;
    d. Balance billed amounts;
    e. Non-covered amounts;
    f. Charges billed by Non-Participating Providers which exceed the allowed amount for the services rendered; or
    g. Orthodontic benefits.

7. When Your Calendar Year Maximum Rollover Benefit Ends

    You will lose your right to any annual rollover benefit or accumulated rollover maximum benefit when you cancel your Policy. The accumulated rollover benefit can be used only while you are covered under this Policy. This means if you cancel your Policy, you lose your right to any rollover benefit that has not been used.

BlueDental Loyalty Program

Our Loyalty Program is designed to reward policyholders and their adult Dependents who are age 19 and older. Members will be assigned a color status depending on how long they have been a BlueDental Copayment QF policyholder.

Period of Time Enrolled	Status	Reward
After 6 Months	Blue	Waiting Periods end
After 12 Months	Silver	Concierge Customer Service that includes a dedicated Loyalty member phone number
After 24 Months	Gold*	One (1) additional cleaning Gold status policyholders and their adult Dependents who are age 19 or older, will qualify for up to three (3) cleanings maximum per calendar year, (any combination of D1110, D4346, D4910). The additional cleaning will not count against the calendar year deductible, or annual maximum and coinsurance will not apply when using an in-network provider. Additional cleanings performed by a non-participating dentist will be subject to any coinsurance due, however the calendar year deductible will not apply. Adult Dependents of a policyholder who are age 19 or older, will receive the same color status benefits as the policyholder.
After 36 Months	Platinum*	Two (2) additional cleanings Platinum status policyholders and their adult Dependents who are age 19 or older, will qualify for up to four (4) cleanings maximum per calendar year, (any combination of D1110, D4346, D4910). The additional cleanings will not count against the calendar year deductible, or annual maximum and coinsurance will not apply when using an in-network provider. Additional cleanings performed by a non-participating dentist will be subject to any coinsurance due, however the calendar year deductible will not apply. Adult Dependents of a policyholder who are age 19 or older, will receive the same color status benefits as the policyholder.

*If a Gold or Platinum policyholder or their adult Dependent age 19 or over, is enrolled in the Oral Health for Overall Health Program, the rules for that program will prevail.

If the policyholder is enrolled in our Oral Health for Overall Health program, their adult Dependents will continue with the color status that the policyholder would have otherwise been eligible.

SECTION IX

LIMITATIONS AND EXCLUSIONS

Limitations

1. Any retreatment of root canals is payable 12 months after completion date of root canal therapy.
2. Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
3. The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
4. Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of children.
5. General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
6. Periodontal maintenance procedures following active therapy is limited to two (2) times per Calendar year. Periodontal prophylaxis will be subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per Calendar year.
7. Periodontal services are limited to Covered Persons age eighteen (18) and older.
8. Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
9. Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.
10. All removable prosthetics are billable upon final delivery.
11. All fixed prosthetics are billable on the seat/insertion date.
12. Intraoral x-rays, complete series including bitewings not covered if performed same day as Panoramic x-ray image.

Exclusions

The following are excluded under this policy:

1.Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.

1. Any services paid or payable under the Covered Person’s health insurance policy.
2. Charges for services or supplies when billed by other than a dentist.
3. Benefits for services rendered by a member of your family, (your spouse and the child[ren], brothers, sisters and parents of either you or your spouse).
4. Services rendered primarily for cosmetic purposes.
5. Charges incurred for failure to keep a dental appointment.
6. Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
7. Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone - lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
8. Experimental or investigational treatment.
9. Dental services received or rendered:
   a. through or in a veteran's hospital or government facility due to a service connected disability;

b. which are covered and paid under Worker's Compensation or similar law; or
c. which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the FCL allowance for expenses actually incurred.

10. Services for which the insured incurs no charge.
11. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
12. Local anesthesia when billed separately by a dentist.
13. Services not listed in this policy or any schedules attached to this policy.
14. Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this policy will be based on the allowance for the least costly service, procedure, or course of treatment.
15. Any additional treatment required due to the Covered Person's failure to follow instructions, or lack of cooperation with the dentist.
16. Treatment for any illness, injury, or medical conditions arising out of: war or act of war whether declared or undeclared (war does not include acts of terrorism), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
17. Services rendered before the effective date of coverage.
18. Services rendered after termination of coverage, except as provided under "Extension of Benefits upon Contract Termination.
19. Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
20. Any denture or bridge replacement made necessary by reason of loss, theft, or alteration by a Covered Person.
21. Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the insured's coverage under this policy.
22. Duplicate or temporary denture, crown, or bridge.
23. Labial Veneer restorations.
24. General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
25. Charges for nitrous oxide.
26. Services, other than those provided to a newborn child, with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or lower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
27. Prescribed drugs, premedication or analgesia.
28. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
29. Charges for, plaque control, or diet instruction.
30. Charges for orthodontia service unless indicated on the Schedule of Benefits.
31. Charges for implants unless indicated on the Schedule of Benefits.
32. Charges for sterilization are included in the allowance for other covered dental procedures.
33. Charges for biohazardous waste disposal are included in the allowance for other covered dental procedures.
34. Charges associated with accidental injuries to a Sound Natural Tooth.
36. Cone Beam Imaging and Cone Beam MRI procedures.
37. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
38. Fabrication of athletic mouthguard.
39. Internal and external bleaching.

SECTION X

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") is a limitation of benefits for dental benefits under the policy and is designed to avoid the duplication of payment for dental benefits. Coordination of Benefits applies when an insured is covered under other dental plans, programs, or policies providing dental benefits which contain a COB provision or are required by law to contain a COB provision. Such other dental plans, programs, or policies may include, but are not limited to:

1. any group or individual dental insurance, group type self-insurance dental, health maintenance organization dental plan, or other dental plan, program, or policy; or
2. any group or individual dental plan, program, or policy underwritten or administered by FCL.

FCL's payment for covered dental benefits depends on whether FCL is the primary payer, as determined in accordance with the provisions set forth below. If FCL is the primary payer, FCL's payment for dental benefits, if any, will not be reduced due to the existence of other coverage and will be made without regard to the insured's other dental plans, programs, or policies.

In those cases where COB applies and FCL is not the primary payer, FCL's payment for dental benefits, if any, will be reduced so that the combined benefits of both plans will not be more than 100% of the FCL allowance for expenses actually incurred for covered services.

The following rules shall be used by FCL to determine if FCL is the primary payer:

1. The dental benefits of a dental policy, plan, or program that covers the person as an employee, member, or insured, other than as a Dependent, are determined before those of the dental policy, plan, or program that covers the person as a Dependent.

   However, if the person is also a Medicare beneficiary, and as a result of the rule established under the Social Security Act of 1965, as amended, Medicare is secondary to the dental plan covering the person as a dependent of an active employee, the order in which dental benefits are payable will be determined as follows:

   a. first, dental benefits of a plan that covers a person as an employee, member, or subscriber;
   b. second, dental benefits of a plan of an active employee that covers a person as a Dependent;
   c. third, Medicare Benefits.

2. Except as stated in paragraph 3, when two or more dental policies, plans, or programs cover the same child as a Dependent of different parents:

   a. the dental benefits of the dental policy, plan, or program of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the dental policy, plan, or program of the parent whose birthday, excluding year of birth, falls later in the year; but
   b. if both parents have the same birthday, the dental benefits of the dental policy, plan, or program which has covered the parent for the longest are determined before those of the dental policy, plan, or program which has covered the parent for the shorter period of time.

   However, if one of the plans does not have a provision which is based on the birthday of the parent, but instead on the gender, and this results in each dental policy, plan, or program determining its benefits before the other, the dental policy, plan, or program which does not have a provision which is based on a birthday will determine the order of dental benefits.

3. If two or more dental policies, plans, or programs cover a Dependent child of divorced or separated parents, dental benefits for the child are determined in this order:

    a. first, the dental policy, plan, or program of the parent with custody of the child;
    b. second, the dental policy, plan, or program of the spouse of the parent with custody of the child; and
    c. third, the dental policy, plan, or program of the parent not having custody of the child.

However, if the specific terms of a court decree makes one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the dental benefits of the dental policy, plan, or program of that parent has actual knowledge of those terms, the dental benefits of that dental policy, plan, or program are determined first. This does not apply with respect to any claim determination period or dental plan, policy, or program year during which any dental benefits are actually paid or provided before that entity has the actual knowledge.

4. The dental benefits of a dental policy, plan, or program which covers a person as an employee other than as a laid-off or retired employee, or as a Dependent of such a person, are determined before those of a dental policy, plan, or program which covers that person as a laid off or retired employee or as a Dependent of such a person. If the other dental policy, plan, or program is not subject to this rule, and if, as a result, the dental policies, plans, or programs do not agree on the order of dental benefits, this paragraph shall not apply.

5. If none of the above rules determine the order of dental benefits, the dental benefits of the policy, plan, or program which has covered the employee, member, or insured the longest period of time are determined before those of the other dental policy, plan, or program.

    If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under a group dental plan, the following order of benefits applies:

    a. first, the dental plan which covers the person as an employee, or as the employee's dependent;
    b. second, the coverage purchased under the dental plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

Coordination of Benefits shall not be permitted against the following types of policies:

1. indemnity;
2. excess insurance;
3. specified illness or accident; or
4. Medicare supplement.

SECTION XI

SUBROGATION AND RIGHT OF REIMBURSEMENT

Subrogation

In the event FCL makes any payment under the policy to or on behalf of an insured for any claim in connection with or arising from a condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, FCL, to the extent of any such payment, shall be subrogated to all causes of action and all rights of recovery such insured has against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated.

The insured shall promptly execute and deliver to FCL such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigation as may be requested by FCL, and shall do whatever is necessary to enable FCL to exercise FCL's subrogation rights and shall do nothing to prejudice such rights. Additionally, the insured or the insured's legal representative shall promptly notify FCL in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to FCL any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgment proceeds without FCL's prior written consent. No waiver, release of liability, or other documents executed by an insured without such notice to FCL shall be binding upon FCL.

Any such right of subrogation or reimbursement provided to FCL under the policy shall not apply or shall be limited to the extent that applicable law eliminates or restricts such rights.

Right of Reimbursement

If any payment, under this policy, is made to an insured for any sickness or injury resulting from the intentional act, negligence, or fault of a third person or entity, FCL shall have a first right to be reimbursed by the insured (out of any claim payments, funds, settlement proceeds, or judgments recovered) one dollar ($1.00) for each dollar paid under this policy, minus its pro rata share for any costs and attorney fees incurred by the insured in pursuing and recovering such proceeds. We shall have the first right of reimbursement, even if the insured has not been made whole for their losses or damages by the amount of the recovery, settlement, or judgment.

FCL’s right of reimbursement shall be in addition to any subrogation right or claim available to us, and the insured shall execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement. An insured shall do nothing to prejudice our right of reimbursement under this policy and no waiver, release of liability, or other documents executed by the insured, without notice to and written consent of FCL, shall be binding upon us.