Capital Blue Cross Dental
Flagger Force, LLC

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

HIGHLIGHTS	Member Cost-Sharing
NETWORK: BlueCross Dental PPO Preferred	
DEDUCTIBLE	
Per benefit period* Deductible waived for diagnostic and preventive	$50 per member $150 per family
BENEFIT PERIOD PROGRAM MAXIMUM	
When the program maximum is reached, the Member pays 100% until the end of the benefit period	$1,500 per member per benefit period
DIAGNOSTIC AND PREVENTIVE (Deductible Waived)	
Routine Exams (oral exams limited to twice in twelve months)	Covered in full
X-rays • Periapical X-rays as required • Bitewing X-rays twice in twelve months • Full Mouth or Panoramic X-rays once in three years	Covered in full
Fluoride Treatments (twice in twelve months for dependent children to age 19)	Covered in full
Fluoride Treatments (once in twelve months for adults)	20%
Prophylaxis (twice in twelve months)	Covered in full
Sealants (for dependent children to age 15 on permanent first and second molars; one sealant per tooth in any three year period)	Covered in full
Space Maintainers (for dependent children to age 19)	Covered in full
Palliative Emergency Treatment (acute condition requiring immediate care)	Covered in full
Consultations	Covered in full
BASIC SERVICES	
Basic Restorative (amalgam “silver” fillings and composite “white” non-molar fillings)	20%
Endodontics (procedures for pulpal therapy and root canal filling)	20%
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	20%
Oral Surgery (extraction and oral surgery procedures, including pre- and post-operative care; general anesthesia is covered when used in conjunction with covered oral surgical procedures)	20%
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	Not Covered
Prosthodontics • Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; prosthetic replacement limited to once in five years • Implant surgical placement and removal; implant supported prosthetics, including repair and recementation	Not Covered
ORTHODONTICS (Deductible Waived)	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	Not Covered
ORTHODONTICS LIFETIME MAXIMUM	
Lifetime maximum per dependent	Not Covered

In-Network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit an Out-of-Network provider, you are responsible for paying the deductible, coinsurance and the difference between the Out-of-Network provider’s charges and the allowed amount.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company’s other health benefits coverage.

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

Paper claims may be submitted to the following address: BlueCross Dental; PO Box 1126; Elk Grove Village, IL 60009

Electronic claims may be submitted using Payor ID CBC01.

Benefits are issued by Capital Advantage Assurance Company®, a subsidiary company of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.