

# *First Continental Life & Accident Insurance Company*

First Continental Life & Accident Insurance Company  
101 Parklane Boulevard, Suite 301  
Sugar Land, TX 77478  
(877) 493-6282  
(the "Company")

Policy No.: ODP185MO  
Policy Effective Date: May 1, 2005  
Policyholder: First Continental Life & Accident Insurance Co.  
Policy Issue Date: May 1, 2005  
Participating Employer Center For Life  
Participating Employer Group No.: K106632-D  
Participating Employer Effective Date: May 1, 2005  
Participating Employer Issue Date: May 1, 2005

In consideration of the Application made by the Policyholder, the applications made by each Participating Employer, and receipt of any and all Premiums when due, First Continental Life & Accident Insurance Company agrees to provide the coverage described herein subject to all provisions of the Policy and any amendments added to the Policy.

The first premium with respect to each Participating Employer is due on the Participating Employer Effective Date. Insurance with respect to the Participating Employer shall terminate at the end of the day before the Participating Employer Renewal Date; unless (1) First Continental Life & Accident Insurance Company offers to renew the insurance for another Contract Year at the premium rates in effect at the time of renewal, and (2) such offer is accepted by the Participating Employer. The Policy shall renew each Policy Renewal Date unless Terminated in accordance with the Policy Termination provision. The Entire Contract provision of the Policy determines all rights and Benefits of persons who are insured hereunder.

In witness whereunto, First Continental Life & Accident Insurance Company has caused the Policy to be signed and issued as of the Policy Issue Date specified above, and it shall take effect on the Policy Effective Date specified above.

**The Insurance Policy under which this certificate is issued is not a policy of Worker's Compensation Insurance. You should consult your employer to determine whether your employer is a subscriber to the Worker's Compensation System.**

**"READ YOUR CERTIFICATE CAREFULLY!"**

**James A. Taylor**  
President

**GROUP DENTAL INSURANCE CERTIFICATE  
RENEWAL AT OPTION OF THE COMPANY**

**TOLL FREE INFORMATION AND COMPLAINT NUMBER: 1-877-493-6282**

The Insurance Company certifies that the person named above is insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

The group policy may be amended or canceled without the consent of the Insured Person.

This certificate replaces all certificates previously issued to the Insured Person under said policy.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

ANY DENTAL CARE INSURANCE BENEFITS PAYABLE UNDER THE POLICY DESCRIBED HEREIN MAY BE COMBINED WITH THE BENEFITS PAYABLE UNDER OTHER PLANS OR PROGRAMS SO THAT THE TOTAL REIMBURSEMENT FOR ALLOWABLE EXPENSES DOES NOT EXCEED THE ACTUAL EXPENSES INCURRED.

**James A. Taylor**  
President

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**SCHEDULE OF BENEFITS**

**Group Name:** First Continental Life & Accident  
Insurance Company Specimen  
Policy

**Group Policy Number:** K106632-D

Class of Employees Eligible for Insurance	Active Full-time Employees	
Persons Covered	Employee and Dependent	
Employment Elimination Period	Employees eligible the 1st of the month following the Participating Employer's 0 day Elimination Period	
Takeover Benefits	Not Provided	
Predetermination of Benefits Amount Applicable to All Classes of Service		\$300.00
Maximum Contract Year Payment Applicable to Each Insured Person for Covered Services Other Than Orthodontics		\$1,000
Annual Deductible Amount Applicable to Each Insured Person for Covered Services Other Than Orthodontics		\$50/\$150
Deductible Waived for Class I Services		Yes
Waiting Period for Class II Services Applicable to Each Insured Person Who is a Late Entrant		12 Months
Waiting Period for Class III Services Applicable to Each Insured Person Whether or Not a Late Entrant		N/A
Orthodontic (Class IV) Services (If Provided, Available Only for Dependent Children under Age 19)		No
Lifetime Maximum Payment Applicable to Each Child for Orthodontic Services (If Provided)		NA
Annual Deductible Amount Applicable to Each Child for Orthodontic Services (If Provided)		NA
Waiting Period Applicable to Each Child for Orthodontic Services (If Provided), Whether or Not Child is a Late Entrant for Orthodontic Services		NA

**Percentage of Covered Dental Expenses Payable:** Covered charges in excess of the Lifetime Deductible Amount will be paid by First Continental Life & Accident Insurance Company up to the Maximum Contract Year Payment or Orthodontia Lifetime Maximum (if applicable) at the Coinsurance Rates below:

Class I	Preventive Services	100%
Class II	Basic Services	80%
Class III	Major Services	50%
Class IV	Orthodontic Services (If Provided)	0%

## **SCHEDULE OF BENEFITS**

Waiting Period(s) shown above may be reduced or eliminated if both: (1) Takeover Benefits are provided; and (2) the Insured Person is eligible for Takeover Benefits. A person is not eligible for Takeover Benefits if the person: (1) is a Late Entrant; (2) becomes insured under the Policy after the Participating Employer's Effective Date; or (3) was not insured under the Participating Employer's prior plan that was replaced by coverage under the Policy. See the Takeover Benefits provision in the Dental Expense Benefits section for a complete explanation.

**SCHEDULE OF BENEFITS  
(Continued)**

ELIGIBILITY

Personal Insurance

Each full-time, active employee working at least 30 hours per week for a Participating Employer, including each full-time, active owner or partner, is a Member of the Eligible Class for Personal Insurance.

If a husband and wife are both eligible to become Members, and if either of them insure their dependent children, then either the husband or wife, whomever so elects, will be considered a dependent of the other. As a dependent, the person will not be a Member eligible for insurance as an employee, but will be eligible for insurance as a dependent.

Dependent Insurance

Each full-time active employee working at least 30 hours per week for a Participating Employer, including each full-time, active owner or partner, who has eligible dependents is a Member of the Eligible Class for Dependent Insurance.

Either spouse who elects to be a dependent rather than a Member of the Eligible Class for Personal Insurance, as explained above, is not a Member of the Eligible Class for Dependent Insurance.

EMPLOYMENT ELIMINATION PERIOD

Employees who become employed by a Participating Employer will qualify for Insurance after completing an elimination period of continuous active service as specified on the approved Participating Employer Application. The length of the elimination period is selected by each Participating Employer and must be the same for each of the Participating Employer's employees.

PARTICIPATION

For Insurance on the Members of a Participating Employer to be placed in force and to remain in force, a minimum number of 2 Members must be participating at all times.

Personal Insurance

Under certain conditions, for Insurance on the Members of a Participating Employer to be placed in force and to remain in force, a certain percentage of Members in each Group must be insured at all times.

Percentage of Members Eligible for Personal Insurance:

	<u>Percentage</u>
a. Participating Employers paying the entire employee premium	100%
b. Participating Employers requiring Insureds to contribute towards their premiums	20%

Dependent Insurance

Percentage of Members Eligible for Dependent Insurance:

	<u>Percentage</u>
a. Participating Employers paying the entire dependent premium	100%
b. Participating Employers requiring Insureds to contribute towards the dependent premium	No Minimum %

**SCHEDULE OF BENEFITS  
(Continued)**

CONTRIBUTIONS

Personal Insurance

An Insured may or may not be required to contribute to the payment of his or her Insurance premiums. Each Participating Employer will make this decision. This decision, and the amount of the contribution, is specified in the approved Participating Employer Application and must be applied equally to all of the Participating Employer's Insureds.

Dependent Insurance

An Insured may or may not be required to contribute to the payment of Insurance premiums for his or her dependents. Each Participating Employer will make this decision. This decision, and the amount of the contribution, is specified in the approved Participating Employer Application and must be applied equally to all of the Participating Employer's Insureds.

CONTINUATION OF COVERAGE

An Insured or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections following explain when and how insurance can be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Federally Required Continuation

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the Federal government requires the Participating Employer to provide continuation of coverages to Insureds and/or dependents who would otherwise lose their coverage. There are some groups which are not subject to the law. They are:

1. Groups of less than 20 employees.
2. Certain church plans.

For details, the Insured and/or dependent(s) must contact the person who handles the Participating Employer's insurance matters.

## DEFINITIONS

**COMPANY** is First Continental Life & Accident Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office mailing address is 101 Parklane Boulevard, Suite 301, Sugar Land, TX 77478.

**POLICYHOLDER** means the Policyholder stated on the face page of the Policy.

**INSURED** means a person:

- a. who is a Member of the Eligible Class for Personal Insurance; and
- b. who has qualified for insurance by completing the elimination period, if any; and
- c. for whom the insurance has become effective.

For the purpose of Dental Expense Benefits, Insured also means any eligible dependent whom the Insured has elected to enroll under the Policy.

**DEPENDENT INSURANCE** means insurance which provides benefits payable as a result of the treatment of a dependent of an Insured.

**DEPENDENT** means:

- a. an Insured's spouse.
- b. each unmarried child under 25 years of age for whom the Insured is legally responsible.
- c. each unmarried child, but under age 25, who is:
  - i. a full-time student at an accredited school or college; and
  - ii. primarily dependent on the Insured for support and maintenance.
- d. each unmarried child under age 25 or older who:
  - i. becomes Totally Disabled while insured under b. or c. above;
  - ii. is incapable of self-sustaining employment because of mental or physical handicap; and
  - iii. is primarily dependent on the Insured for support and maintenance.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days after the Company asks for it.

For the purpose of the definition of Dependent, "child" means: (a) the Insured's natural child (from moment of birth); (b) the Insured's adopted child (from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Insured's home pending such an order); (c) any child living with the Insured in a regular parent-child relationship and primarily dependent on the Insured for support and maintenance, or (d) any child for whom we have notice, pursuant to a medical support order, that the Insured must provide support in the form of dental insurance (from the date of such notice). For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Insured to provide a child financial support in the form of dental insurance.

**DEPENDENT UNIT** means all the people who are insured as the dependents of any one Insured.

**FAMILY** means an Insured and his or her dependent unit.



**DEFINITIONS**  
**(Continued)**

**ACTIVE SERVICE** means the performance in the customary manner by a Member of all the regular duties of his or her employment with his or her Participating Employer on a full-time basis at one of the Participating Employer's business establishments or at some location to which the Participating Employer's business requires the employee to travel.

**TOTAL DISABILITY** means the complete inability of:

- a. an Insured to perform the material duties of any job for which he or she is reasonably fitted by education, training or experience. An Insured will not be Totally Disabled if he or she engages in any job for wage or profit.
- b. a dependent to perform the normal activities of a person of like age and sex.

**PERSONAL INSURANCE** means insurance which provides benefits payable as a result of the treatment, disability, or death of an Insured.

**PHYSICIAN** means any person who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for sickness or injury causing the expenses or loss for which claim is made.

**DENTAL HYGIENIST** means a person who is licensed to practice dental hygiene and who is practicing within the scope of his or her license.

**DENTAL PRACTITIONER** means a dentist, dental hygienist or a denturist.

**DENTIST** means a person who is licensed to practice dentistry or oral surgery and who is practicing within the scope of his or her license.

**DENTURIST** means a person who is licensed to make, fit and repair dentures and who is practicing within the scope of his or her license.

**LATE ENTRANT** means any person:

- a. whose most recent Effective Date of insurance is more than 31 days from the date the person qualifies for insurance, or
- b. who has elected to become insured again after the premium contribution is stopped for reasons other than loss of eligibility for insurance.

**CONFINED** in an institution means registered as a bed patient, unless stated otherwise.

**CONTRACT YEAR** means the 12 month period starting on the Participating Employer's Renewal Date of any year and ending at the end of the day before the Participating Employer's Renewal Date of the following year. However, the first Contract Year starts on the Participating Employer's Effective Date, and the last Contract Year ends on the Participating Employer's Termination Date.

**DEFINITIONS**  
**(Continued)**

**EFFECTIVE DATE**, with respect to a Participating Employer, means the first date coverage under the Policy may become effective for the Participating Employer's Employees. It is shown on the approved Participating Employer Application. The Effective Date for the Policyholder is shown on the policy cover. The Effective Date for an Insured is shown on the individual certificate or is in the Participating Employer's records. All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

**RENEWAL DATE** is the anniversary (month and day) of the Effective Date in each calendar year after the Effective Date.

**ELIMINATION PERIOD** is a period of continuous active service with a Participating Employer that a Member must serve in order to qualify for Personal Insurance. The length of any Elimination Period is shown in the Participating Employer's approved Application.

**WAITING PERIOD** is a period of continuous coverage for an Insured under the Policy, starting on the Insured's most recent Effective Date, during which expenses incurred for certain classes of services are not covered. The lengths of all Waiting Periods, and the classes of service to which they apply, are shown in the Schedule of Benefits.

**PARTICIPATING EMPLOYER** means any business organization which participates and makes dental insurance available.

**ALLOWABLE CHARGE** for a service covered under the Policy means the determination of payable benefits as developed from a statistically valid sample which (a) equitably recognizes geographic variations; (b) is updated periodically; and (c) is collected on the basis of the most current codes and descriptions developed and maintained by recognized authorities.

## CONDITIONS FOR PERSONAL INSURANCE

### ELIGIBILITY

#### ELIGIBLE CLASS FOR PERSONAL INSURANCE

The Members of the Eligible Class for Personal Insurance are shown on the Schedule of Benefits.

Each Member of the Eligible Class for Personal Insurance (referred to here as "Member") will qualify for such insurance on the day he or she completes the required elimination period, if any.

#### ELIMINATION PERIOD

The Elimination Period is shown on the Schedule of Benefits.

An Insured whose eligibility terminates and is established again within 12 months will not have to complete a new elimination period before he or she can qualify for Insurance.

#### PARTICIPATION REQUIREMENTS

In order for coverage under the Policy with respect to a Participating Employer to be placed in force, and to remain in force, certain participation requirements must be met. These requirements are shown on the Schedule of Benefits.

#### CONTRIBUTION REQUIREMENTS

The contribution requirements are shown on the Schedule of Benefits.

### EFFECTIVE DATE

Each Member wanting to be insured must sign an enrollment card. We must approve the form to be used for the card. The Effective Date will be:

1. the first or fifteenth day of the calendar month (whichever corresponds numerically with the Participating Employer's Effective Date) that coincides with or next follows the date on which he or she first qualifies for Insurance, if we receive the signed enrollment card before, on, or within 31 days after that date.
2. the Participating Employer's Renewal Date that coincides with or next follows the date we receive the signed enrollment card, if that date is more than 31 days after the date he or she first qualifies for Insurance. If the Insured's Effective Date is more than 31 days after the first date he or she could have had insurance become effective, the Insured is a Late Entrant and subject to the limitations concerning Late Entrants as shown on the Schedule of Benefits.

#### BENEFIT CLASSIFICATION CHANGE

If an Insured's status changes so that he or she becomes a Member of a different Eligible Class, as shown in the Schedule of Benefits, any change in amounts of insurance because of the new class will take effect on the first or fifteenth day of the calendar month (whichever corresponds numerically with the Participating Employer's Effective Date) that coincides with or next follows the date of change in status.

**CONDITIONS FOR PERSONAL INSURANCE  
(Continued)**

**EFFECTIVE DATE (Continued)**

**EXCEPTIONS**

A Member must be in active service on the date the insurance (or any increase in insurance) is to take effect. If not, the insurance (or increase in insurance) will not take effect until the first or fifteenth day of the calendar month (whichever corresponds numerically with the Participating Employer's Effective Date) that coincides with or next follows the day he or she returns to active service. For this paragraph, a Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

**TERMINATION DATE**

The insurance on any Insured will automatically terminate at the end of the last or fourteenth day of the calendar month (whichever corresponds numerically with the day before the Participating Employer's Effective Date) that coincides with or next follows the earliest of:

1. the date the Insured ceased to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of Insurance premiums;
3. the date all coverage under the Policy is terminated with respect to the Insured's Participating Employer; or
4. the date the Policy is terminated.

**CONTINUATION OF COVERAGE**

If an Insured's coverage ceases according to TERMINATION DATE, the insurance coverage may be continued. See the Schedule of Benefits.

## CONDITIONS FOR DEPENDENT INSURANCE

### ELIGIBILITY

#### ELIGIBLE CLASS FOR DEPENDENT INSURANCE

The Members of the Eligible Class for dependent insurance are shown on the Schedule of Benefits.

Each Member of the Eligible Class for Dependent Insurance (referred to here as "Member") is eligible for the Dependent Insurance (referred to here as "Insurance") under the Policy and will qualify for this insurance on the latest of:

1. the day he or she qualifies for Personal Insurance;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

A Member must be insured for Personal Insurance to insure his or her dependents.

#### PARTICIPATION REQUIREMENTS

In order for the Policy to remain in force for dependents, certain participation requirements must be met. These requirements are shown on the Schedule of Benefits.

#### CONTRIBUTION REQUIREMENTS

The contribution requirements are shown on the Schedule of Benefits.

### EFFECTIVE DATE

Each Insured wishing to insure his or her dependents must sign an enrollment card. We must approve the form to be used for the card. The Insured must insure all of his or her eligible dependents in order to have Dependent Insurance become effective and remain in effect. The Effective Date for each dependent will be:

1. the first or fifteenth day of the calendar month (whichever corresponds numerically with the Participating Employer's Effective Date) that coincides with or next follows the date on which the Insured first qualifies for Dependent Insurance for that dependent, if we receive the signed enrollment card before, on, or within 31 days after that date.
2. the Participating Employer's Renewal Date that coincides with or next follows the date we receive the signed enrollment card, if that date is more than 31 days after the date the Insured first qualifies for Dependent Insurance for that dependent. If we receive the enrollment card more than 31 days after the first date the Insured could have had Dependent Insurance become effective for that dependent, that dependent is a Late Entrant and subject to the limitation concerning Late Entrants as shown on the Schedule of Benefits.

However, if the Insured already has Dependent Insurance in effect when he or she acquires an additional dependent, and if no additional premium is required to provide coverage for that dependent, the Effective Date for that dependent is the first or fifteenth day of the calendar month (whichever corresponds numerically with the Participating Employer's Effective Date) that coincides with or next follows the date the dependent first meets the definition of dependent.

**CONDITIONS FOR DEPENDENT INSURANCE  
(Continued)**

**TERMINATION DATE**

The insurance for all of an Insured's dependents will automatically terminate at the end of the last or fourteenth day of the calendar month (whichever corresponds numerically with the day before the Participating Employer's Effective Date) that coincides with or next follows the earliest of:

1. the date on which the Insured's Personal Insurance terminates.
2. the date on which the Insured ceases to be a Member.
3. the last day of the period for which the Insured has contributed, if required, to the payment of Insurance premiums.
4. the date all Dependent Insurance under the Policy is terminated.
5. the date all Dependent Insurance is terminated with respect to the Insured's Participating Employer.
6. the date all coverage under the Policy is terminated with respect to the Insured's Participating Employer.
7. the date the Policy is terminated.

The insurance for any dependent will automatically terminate at the end of the last or fourteenth day of the calendar month (whichever corresponds numerically with the day before the Participating Employer's Effective Date) that coincides with or next follows the date the dependent ceased to meet the definition of a dependent. See "Definitions."

**CONTINUATION OF COVERAGE**

If a dependent's coverage ceases according to TERMINATION DATE, the insurance coverage may be continued. See the Schedule of Benefits.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**DENTAL EXPENSE BENEFITS**

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The benefits will be determined as follows:

- a. the Covered Expenses reported are separated into the correct Classes of procedure;
- b. then, the Deductible Amount is applied, if any;
- c. the remaining amount for each Class is then multiplied by the Coinsurance Percentage for each Class shown in the Schedule of Benefits.

**DEDUCTIBLE AMOUNT.** The Deductible Amounts shown in the Schedule of Benefits are amounts of Covered Expenses for which no benefits are payable. They apply separately to the Covered Expenses incurred by each Insured.

Any Lifetime Deductible Amount shown in the Schedule must be met from Covered Expenses incurred during a single period of continuous coverage under the Policy. With respect to Covered Expenses subject to this Deductible, benefits will be paid for only those Covered Expenses that exceed the Deductible Amount and are incurred during that period of continuous coverage.

**MAXIMUM AMOUNT.** The Contract Year Maximum Benefit shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses subject to that Maximum and incurred by an Insured during all of periods of continuous coverage under the Policy combined in any one contract year.

**PREDETERMINATION OF BENEFITS.** If the cost of a course of dental treatment for any one Insured is expected to exceed the Predetermination of Benefits Amount shown in the Schedule of Benefits, a treatment plan must be sent to us before treatment begins. We review the plan and determine the expenses that we expect to cover. We then return the plan to the dental practitioner with an estimate of Policy benefits. We suggest that you discuss the cost of the plan and estimated Policy benefits with the dental practitioner before treatment begins. Our predetermination of benefits is valid for a six month period starting on the date of predetermination. If treatment does not begin within that time, a new treatment plan must be sent to us for a new predetermination of benefits.

Predetermination of benefits is not a guarantee of payment for the treatment plan. Even if benefits are predetermined, we pay benefits only for expenses actually incurred while the patient is insured under the Policy. Also, payment of benefits is always subject to all Policy terms and conditions in effect at the time the expense is incurred (including, but not limited to, eligibility and waiting period requirements, deductibles, and maximum benefits).

We do not require predetermination of benefits for emergency care of an accidental injury, or for a course of treatment that isn't expected to exceed the Predetermination of Benefits Amount.

**COVERED EXPENSES.** Covered Expenses means the allowable expenses as determined by us that are incurred by an Insured for the Class I – Preventive, Class II - Basic, Class III - Major and Class IV - Orthodontics (if applicable) Procedures shown on the List of Dental Procedures. But such expenses will be Covered Expenses only to the extent that they are incurred while the patient is insured under the Policy and are for procedures done by a dentist, dental hygienist, or denturist. These expenses are subject to the "Limitations and Exclusions" following.

**ALTERNATIVE PROCEDURES.** If two or more procedures are adequate and appropriate treatment to correct a certain condition, the amount of the Covered Expense will be the charge for the least expensive procedure.

We may ask that pre-operative dental x-rays be given to us to decide if we are liable for the procedures submitted for consideration. If the x-rays are not given to us, we will have to decide the procedures which would provide professionally adequate restoration, replacement or treatment. If we then receive the pre-operative dental x-rays and decide that different procedures are more appropriate we will make adjustments that we deem are proper.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**DENTAL EXPENSE BENEFITS (Continued)**

**START DATE FOR PROCEDURES.** For a denture, partial denture, or other appliance or a change to any appliance (other than a fixed bridge), the procedure starts at the time the impression is made. For a fixed bridge or a crown, inlay, onlay, or other precious or semiprecious metal restoration, the procedure starts at the time the tooth or teeth are prepared. For root canal therapy, the procedure starts at the time the pulp chamber is opened. For any other procedure requiring more than one session to complete, the procedure starts at the time of the first session. For any procedure requiring only one session to complete, the procedure starts at the time the service is rendered or the supply is furnished.

**INCURRED DATE FOR EXPENSES.** For a denture, partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration (whether the item is new, replacement, repaired, or modified), the expense is incurred at the time of final placement of the item. For root canal therapy, the expense is incurred at the time the root canal is completed. For any other procedure requiring more than one session to complete, the expense is incurred at the time the last session is completed. For any procedure requiring only one session to complete, the expense is incurred at the time the service is rendered or the supply is furnished.

**LIMITATIONS AND EXCLUSIONS.** Covered Expenses will not include, and no benefits will be payable for, the following:

1. expenses in any Class of services that are incurred during the insured's Waiting Period for services in that Class (as shown in the Schedule of Benefits), except as may be provided under the Takeover Benefits provision following this Limitations and Exclusions provision. (An insured is not eligible for Takeover Benefits if Takeover Benefits are not provided, or if Takeover Benefits are provided but the person: (a) is a Late Entrant; (b) became insured under the Policy after the Participating Employer's Effective Date; or (c) was not insured under the Participating Employer's prior plan that was replaced by coverage under the Policy.)
2. any treatment which is for cosmetic purposes, or to correct congenital malformations, other than medically necessary treatment of congenital cleft in the lip or palate, or both.
3. replacement of any full or partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration within five years of the date of the last placement of the item. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.
4. initial placement of any full or partial denture, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such placement is needed because of the extraction of one or more of the Insured's natural teeth during the same period of continuous coverage. Any portion of the expense that is identifiable as applying specifically to the replacement of a tooth extracted before that period of continuous coverage is not a Covered Expense. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment. Any such appliance must include the replacement of the extracted tooth or teeth.
5. addition of a new tooth or teeth to an existing full or partial denture, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such addition is a replacement of a natural tooth or teeth extracted during the same period of continuous coverage. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment.
6. any expense incurred before the Insured's insurance under the Policy starts; or any expense incurred during any period of continuous coverage for the Insured under this Policy if the procedure starts before the period of continuous coverage starts.



**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**

**DENTAL EXPENSE BENEFITS (Continued)**

**LIMITATIONS AND EXCLUSIONS (Continued).**

7. any procedure that starts, or any expense that is incurred (regardless of when the procedure starts), after the Insured's insurance under this Policy ends. But this exclusion does not apply for any denture, partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration if both: (a) the procedure starts while the Insured's insurance under this Policy is in effect; and (b) the expense is incurred within 90 days after the Insured's insurance under this Policy ends.
8. duplication of appliances, or replacement of lost or stolen appliances.
9. appliances, restorations, or procedures to: (a) alter vertical dimension; (b) restore or maintain occlusion; (c) splint or replace tooth structure lost as a result of abrasion or attrition; or (d) treat jaw fractures or disturbances of the temporomandibular joint.
10. any procedure that is not shown on the List of Dental Procedures.
11. education or training in, or supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
12. charges for broken appointments or the completion of claim forms.
13. sealants that are: (a) not applied to a permanent molar; (b) applied before attaining age 6 or after attaining age 16; or (c) reapplied to a molar within 3 years from the date of a previous sealant application.
14. subgingival curettage or root planing (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
15. charges because of an Insured's injury arising out of, or in the course of, work for wage or profit.
16. charges because of an Insured's sickness, injury or other condition for which he or she is eligible for benefits under any Worker's Compensation act or similar laws.
17. charges for which the Insured is not liable or which would not have been made had no insurance been in force.
18. services that: (a) are not recommended by a dentist; (b) are not required for necessary care and treatment; or (c) do not have a reasonably favorable prognosis.
19. charges because of an Insured's sickness, injury or other condition due to war or any act of war, declared or not, or sustained while on full-time active duty in the armed forces of any country.
20. benefits payable to an Insured if payment is not legal where the Insured is living when expenses are incurred.
21. services related to: equilibration; bite registration or bite analysis.
22. crowns for the purpose of periodontal splinting.
23. charges for: implants; overdentures, precision or semi-precision attachments and associated endodontic treatment, any other customized attachments, or any specialized prosthodontic techniques or characterizations.
24. charges for: myofunctional therapy, orthognathic surgery, or athletic mouthguards.
25. procedures for which benefits are payable under the Participating Employer's medical expense benefit plan for employees and their dependents. See the Coordination of Benefits provision for an explanation.
26. services rendered by the Insured's spouse, parent, parent-in-law, brother or sister, brother-in-law or sister-in-law, child (of the Insured or the Insured's spouse), or any person residing in the Insured's household.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**

**DENTAL EXPENSE BENEFITS (Continued)**

**LIMITATIONS AND EXCLUSIONS (Continued).**

**TAKEOVER BENEFITS.** Takeover Benefits are provided only if so indicated in the Schedule of Benefits. If Takeover Benefits are provided, an insured is eligible for Takeover Benefits only if the person both: (1) was insured under the Participating Employer's prior plan the day before the Participating Employer's Effective Date under the Policy; and (2) has been continuously insured under the Policy since the Participating Employer's Effective Date. If Takeover Benefits are provided and the insured is eligible for Takeover Benefits, then we will reduce the insured's Waiting Period(s) by the length of time, ending on the day before the Participating Employer's Effective Date, that the insured was continuously covered for similar classes of service under the Participating Employer's prior plan.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**

**LIST OF COVERED DENTAL EXPENSES PROCEDURES**

The following is a complete list of the dental procedures for which benefits are payable under this section. No benefits are payable for a procedure that is not listed.

**CLASS I PROCEDURES – PREVENTIVE SERVICES**

**PROC. NO. DESCRIPTION OF SERVICE**

**\*\*ORAL EVALUATION (EXAMINATION) AND PROPHYLAXIS (CLEANING).** Oral evaluation is limited to once in any six-month period. Prophylaxis is limited to once in any six-month period. Fluoride application is limited to once in any 12-month period.

- 0120 Periodic oral evaluation.
- 0140 Limited oral evaluation, problem focused.
- 0150 Comprehensive oral evaluation.
- 0160 Detailed and extensive oral evaluation, problem focused, by report.
- 0170 Re-evaluation-limited problem focused
- 0180 Comprehensive periodontal evaluation
- 1110 Prophylaxis for individuals age 12 and over, treatment to include scaling and polishing.
- 1120 Prophylaxis for children under age 12.
- 1203 Topical application of fluoride without prophylaxis (only for children under 19).

**\*\*X-RAYS**

- 0270 Bitewing, single film (limited to once in any six month period).
- 0272 Bitewing, two films (limited to once in any six month period).
- 0274 Bitewing, four films (limited to once in any six month period).

**\*\*OTHER DIAGNOSTIC PROCEDURES**

- 0460 Pulp vitality tests
- 0470 Diagnostic casts
- 0471 Diagnostic photographs

**TREATMENT OF PAIN**

- 2940 Sedative filling
- 9110 Emergency palliative treatment of dental pain; minor procedure

**CLASS II PROCEDURES - BASIC SERVICES**

**SEALANTS**

- 1351 Sealant, per tooth (once in any 36 month period, only for permanent molars, only for children at least 6, but less than 16 years of age).

**X-RAYS.**

- 0210 \*Intraoral, complete series (including any bitewings).
- 0220 Intraoral, periapical, first film.
- 0230 Intraoral, periapical, each additional film (benefit for a single series of 0220 and 0230 films, including any bitewings, not to exceed benefit for a single 0210 series).
- 0240 Intraoral, occlusal film.
- 0250 Extraoral, first film.
- 0260 Extraoral, each additional film.
- 0290 Posterior/anterior/lateral skull and facial bone survey.
- 0330 \*Panoramic film.

\*Only one of the two procedures 0210 and 0330 will be allowed in any 36 month period.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.  
NO.**                    **DESCRIPTION OF SERVICE**

**CLASS II PROCEDURES - BASIC SERVICES - continued**

**BASIC RESTORATIONS (FILLINGS)**, excluding inlays, onlays, crowns and bridges.

**Amalgam Restorations.**

2140	One surface, permanent.
2150	Two surfaces, permanent.
2160	Three surfaces, permanent.
2161	Four or more surfaces, permanent.

**Resin Restorations.** Benefit for resin restoration of a posterior tooth not to exceed benefit for amalgam restoration of the same tooth involving the same number of surfaces.

2330	One surface, anterior.
2331	Two surfaces, anterior.
2332	Three surfaces, anterior.
2335	Four or more surfaces or involving incisal angle, anterior.
2391	One surface, posterior.
2392	Two surfaces, posterior.
2393	Three or more surfaces, posterior.
2394	Four or more surfaces, posterior.

**SIMPLE EXTRACTIONS**, excluding surgical extractions and extractions of impacted teeth. Fee includes any local anesthesia and routine post-operative visits. Not covered if preliminary to, or otherwise associated with, orthodontic therapy.

7111	Coronal Remnants-fixed deciduous
7140	Extraction-erupted tooth or exposed root

**CLASS III PROCEDURES - MAJOR SERVICES**

**SPACE MAINTAINERS.** Fee includes all adjustments within six months after installation. Allowable only for the purpose of maintaining spaces created by extractions of primary teeth or unerupted teeth.

1510	Fixed space maintainer, unilateral.
1515	Fixed space maintainer, bilateral.
1520	Removal space maintainer, unilateral.
1525	Removable space maintainer, bilateral.
1550	Recementation of space maintainer.

**MAJOR RESTORATIONS (FOIL, INLAYS, ONLAYS, CROWNS)**, covered only when needed due to decay or traumatic injury.

**Foil, Inlays and Onlays.**

2410	Gold foil, one surface.
2420	Gold foil, two surfaces.
2430	Gold foil, three or more surfaces.
2510	Inlay, metallic, one surface.
2520	Inlay, metallic, two surfaces.
2530	Inlay, metallic, three or more surfaces.
2543	Onlay, metallic, three surfaces.
2544	Onlay, metallic, four or more surfaces.
2610	Inlay, porcelain/ceramic, one surface.
2620	Inlay, porcelain/ceramic, two surfaces.
2630	Inlay, porcelain/ceramic, three or more surfaces.
2642	Onlay, porcelain/ceramic, two surfaces.
2643	Onlay, porcelain/ceramic, three surfaces.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.  
NO.**                    **DESCRIPTION OF SERVICE**

**CLASS III PROCEDURES - MAJOR SERVICES – continued**

**Foil, Inlays and Onlays - continued**

2644	Onlay, porcelain/ceramic, four or more surfaces.
2650	Inlay, composite/resin, one surface (laboratory processed).
2651	Inlay, composite/resin, two surfaces (laboratory processed).
2652	Inlay, composite/resin, three or more surfaces (laboratory processed).
2662	Onlay, composite/resin, two surfaces (laboratory processed).
2663	Onlay, composite/resin, three surfaces (laboratory processed).
2664	Onlay, composite/resin, four or more surfaces (laboratory processed).

**Crowns and Related Procedures.**

2710	Resin.
2720	Resin with high noble metal.
2721	Resin with predominantly base metal.
2722	Resin with noble metal.
2740	Porcelain/ceramic substrate.
2750	Porcelain fused to high noble metal.
2751	Porcelain fused to predominantly base metal.
2752	Porcelain fused to noble metal.
2790	High noble metal, full cast.
2791	Predominantly base metal, full cast.
2792	Noble metal, full cast.
2810	Metallic, 3/4 cast.
2930	Prefabricated stainless steel, primary tooth.
2931	Prefabricated stainless steel, permanent tooth (available to children under age 19 only).
2932	Prefabricated resin crown (available to children under age 19 only).
2933	Prefabricated stainless steel crown with resin window (available to children under age 19 only).
2950	Core build-up, including any pins.
2951	Pin retention, per tooth, in addition to restoration.
2952	Cast post and core in addition to crown.
2954	Prefabricated post and core in addition to crown.
2955	Post removal, not in conjunction with endodontic therapy.

**ENDODONTICS.** Endodontic surgical procedures include any local anesthesia and routine post-operative visits.

**Endodontic Therapy for Primary Teeth,** including necessary X-rays and cultures but excluding final restoration, limited to use on primary teeth only.

3110	Direct pulp cap.
3120	Indirect pulp cap.
3220	Therapeutic pulpotomy.
3230	Resorbable-filling pulpal therapy, anterior.
3240	Resorbable-filling pulpal therapy, posterior.

**Root Canals,** including necessary X-rays and cultures but excluding final restoration, limited to use on permanent teeth only.

3310	Anterior (one canal).
3320	Bicuspid (two canals).
3330	Molar (three canals).
3346	Retreatment of previous root canal therapy, anterior.
3347	Retreatment of previous root canal therapy, bicuspid.
3348	Retreatment of previous root canal therapy, molar.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.  
NO.                    DESCRIPTION OF SERVICE**

**CLASS III PROCEDURES - MAJOR SERVICES - continued**

**Other Endodontic Procedures.**

3351	Apexification/recalcification, initial visit.
3352	Apexification/recalcification, interim visit.
3353	Apexification/recalcification, final visit.
3410	Apicoectomy/periradicular surgery, anterior (single root).
3421	Apicoectomy/periadicular surgery, bicuspid, first root.
3425	Apicoectomy/periadicular surgery, molar, first root.
3426	Apicoectomy/periadicular surgery, bicuspid or molar, each additional root.
3430	Retrograde filling, per root.
3450	Root amputation, per root.
3460	Endodontic osseous implant.
3470	Intentional replantation, including necessary splinting.
3920	Hemisection, including any root removal but not including root canal therapy.

**PERIODONTICS.** Periodontic surgical procedures include any local anesthesia and routine post-operative visits.

4110	Periodontal examination.
4210	Gingivectomy or gingivoplasty, per quadrant.
4211	Gingivectomy or gingivoplasty, per tooth (fewer than 6 teeth).
4220	**Gingival curettage, surgical, per quadrant, by report.
4240	Gingival flap procedure, including root planing, per quadrant.
4249	Clinical crown lengthening, hard tissue.
4250	Mucogingival surgery, per quadrant.
4260	Osseous surgery, including flap entry and closure, per quadrant.
4263	Bone replacement graft, first site in quadrant.
4264	Bone replacement graft, each additional site in quadrant.
4266	Guided tissue regeneration, resorbable barrier, per site, per tooth.
4267	Guided tissue regeneration, nonresorbable barrier, per site, per tooth (includes membrane removal).
4270	Pedicle soft tissue graft procedure.
4271	Free soft tissue graft procedure, including donor site surgery.
4273	Subepithelial connective tissue graft procedure, including donor site surgery.
4274	Distal or proximal wedge procedure when not performed in conjunction with surgical procedures in the same anatomical area.
4320	Provisional splinting, intracoronal.
4321	Provisional splinting, extracoronal.
4341	**Periodontal scaling and root planing, per quadrant.
4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.
4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.
4910	Periodontal maintenance procedures following active therapy.

\*\*Payment for 4220 and 4341 requires presence of periodontal disease as confirmed by both x-rays and pocket depth summaries of each tooth involved.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.**  
**NO.**                    **DESCRIPTION OF SERVICE**

**CLASS III PROCEDURES - MAJOR SERVICES - continued**

**REMOVABLE PROSTHODONTICS (PARTIAL AND COMPLETE DENTURES).** Fees for both partial and complete dentures and relining include adjustments within 6 months after installation. Relines are not covered until more than 6 months after installation. Adjustments are not covered as separate procedures until more than 6 months after installation. Precision attachments, overdentures, specialized techniques, and characterizations are considered optional and the additional expense for these shall be borne by the patient. All partials include conventional clasps, rests, and teeth.

5110	Complete upper denture.
5120	Complete lower denture.
5130	Immediate upper denture.
5140	Immediate lower denture.
5211	Upper partial, resin base.
5212	Lower partial, resin base.
5213	Upper partial, cast metal frame with resin base.
5214	Lower partial, cast metal frame with resin base.
5281	Removable unilateral partial, one piece cast metal.
5410	Adjust complete upper denture.
5411	Adjust complete lower denture.
5421	Adjust upper partial.
5422	Adjust lower partial.
5710	Rebase complete upper denture.
5711	Rebase complete lower denture.
5720	Rebase upper partial.
5721	Rebase lower partial.
5730	Office reline, complete upper denture.
5731	Office reline, complete lower denture.
5740	Office reline, upper partial.
5741	Office reline, lower partial.
5750	Lab reline, complete upper denture.
5751	Lab reline, complete lower denture.
5760	Lab reline, upper partial.
5761	Lab reline, lower partial.
5860	**Complete overdenture, by report.
5861	**Partial overdenture, by report.

\*\*Benefit for overdenture not to exceed benefit for corresponding denture (complete or partial, upper or lower).

**FIXED PROSTHODONTICS (BRIDGES).**

**Pontics.**

6210	Cast high noble metal.
6211	Cast predominantly base metal.
6212	Cast noble metal.
6240	Porcelain fused to high noble metal.
6241	Porcelain fused to predominantly base metal.
6242	Porcelain fused to noble metal.
6250	Resin with high noble metal.
6251	Resin with predominantly base metal.
6252	Resin with noble metal.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.  
NO.                    DESCRIPTION OF SERVICE**

**CLASS III PROCEDURES - MAJOR SERVICES - continued**

**Retainers.**

6520	Inlay, metallic, two surfaces.
6530	Inlay, metallic, three or more surfaces.
6543	Onlay, metallic, three surfaces.
6544	Onlay, metallic, four or more surfaces.
6545	Cast metal, for resin bonded fixed prosthesis (bridge to include maximum of one pontic and two metal retainers).
6720	Crown, resin with high noble metal.
6721	Crown, resin with predominantly base metal.
6722	Crown, resin with noble metal.
6750	Crown, porcelain fused to high noble metal.
6751	Crown, porcelain fused to predominantly base metal.
6752	Crown, porcelain fused to noble metal.
6780	Crown, 3/4 cast high noble metal.
6790	Crown, full cast high noble metal.
6791	Crown, full cast predominantly base metal.
6792	Crown, full cast noble metal.
6940	Stress breaker.
6970	Cast post and core in addition to bridge retainer.
6971	Cast post as part of bridge retainer.
6972	Prefabricated post and core in addition to bridge retainer.
6973	Core build-up for retainer, including any pins.
6975	Metal coping.

**RECEMENTATION AND REPAIR.**

2910	Inlay.
2920	Crown.
2980	Crown repair, by report.
5510	Repair broken base.
5520	Replace missing or broken teeth, each tooth.
5610	Repair resin base.
5620	Repair cast framework.
5630	Repair or replace broken clasp.
5640	Replace broken teeth, per tooth.
5650	Add tooth to existing partial.
5660	Add clasp to existing partial.
6930	Recementation of bridge.
6980	Bridge repair, by report.

**\*\*ORAL SURGERY**, including any local anesthesia and routine post-operative visits.

**Surgical Extractions.**

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
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**Impacted Teeth.**

7220	Removal of impacted tooth, soft tissue.
7230	Removal of impacted tooth, partially bony.
7240	Removal of impacted tooth, completely bony.
7241	Removal of impacted tooth, completely bony, with unusual surgical complications.



**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.  
NO.**                    **DESCRIPTION OF SERVICE**

**CLASS III PROCEDURES - MAJOR SERVICES - continued**

**Alveolar or Gingival Reconstruction.**

7310            Alveoplasty in conjunction with extractions, per quadrant.  
7320            Alveoplasty not in conjunction with extractions, per quadrant.  
7340            Vestibuloplasty, ridge extension (secondary epithelialization).  
7350            Vestibuloplasty, ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hyperplastic tissue).  
7970            Excision of hyperplastic tissue, per arch.  
7971            Excision of pericoronal gingiva.  
7970            Excision of hyperplastic tissue, per arch.  
7971            Excision of pericoronal gingiva.

**Removal of Cysts and Neoplasms.**

7285            Biopsy of oral tissue, hard.  
7286            Biopsy of oral tissue, soft.  
7410            Radical excision of lesion, up to 1.25 cm.  
7420            Radical excision of lesion, over 1.25 cm.  
7430            Excision of benign tumor, up to 1.25 cm.  
7431            Excision of benign tumor, over 1.25 cm.  
7440            Excision of malignant tumor, up to 1.25 cm.  
7441            Excision of malignant tumor, over 1.25 cm.  
7450            Removal of odontogenic cyst or tumor, up to 1.25 cm.  
7451            Removal of odontogenic cyst or tumor, over 1.25 cm.  
7460            Removal of nonodontogenic cyst or tumor, up to 1.25 cm.  
7461            Removal of nonodontogenic cyst or tumor, over 1.25 cm.  
7465            Destruction of lesion(s) by physical or chemical method, by report.  
7510            Incision and drainage of abscess, intraoral soft tissue.  
7520            Incision and drainage of abscess, extraoral soft tissue.

**Other Oral Surgical Procedures.**

7250            Surgical removal of residual tooth roots (cutting procedure).  
7270            Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus.  
7272            Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization).  
7281            Surgical exposure of impacted or unerupted tooth to aid eruption.  
7290            Surgical repositioning of teeth.  
7291            Transseptal fibrotomy, by report.  
7960            Frenulectomy (frenectomy or frenotomy) as a separate procedure.

**\*\*ANESTHESIA**, when administered by the dentist in the dentist's office (not covered unless a cutting procedure is being performed at that time).

9220            General anesthesia.  
9240            Intravenous sedation.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**LIST OF COVERED DENTAL EXPENSES PROCEDURES (Continued)**

**PROC.  
NO.                    DESCRIPTION OF SERVICE**

**CLASS IV PROCEDURES – ORTHODONTICS SERVICES**

Class IV procedures are not covered unless the Participating Employer elects the optional orthodontic coverage (as shown in the Schedule of Benefits) and pays the required premium. In any event, orthodontic coverage is not available for employees or spouses, or for dependent children age 19 or older.

- |              |   |
|--------------|---|
| 8030 or 8040 | Limited orthodontic treatment of the permanent dentition.       |
| 8080 or 8090 | Comprehensive orthodontic treatment of the permanent dentition. |
| 8420         | Orthodontic monthly adjustment.                                 |
| 8660         | Pre-orthodontic treatment visit.                                |
| 8670         | Periodic orthodontic treatment (as part of contract).           |
| 8690         | Orthodontic treatment (alternative billing to a contract fee).  |

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**NON-COVERED DENTAL PROCEDURES**

No benefits are payable for procedures that are not listed in one of the above classes of procedures. Following are examples of some of the procedures not listed in one of the above classes, and for which no benefits are payable:

**PROC.  
NO.**

***DESCRIPTION OF SERVICE***

0310	Saliography.
0320	Temporomandibular joint (TMJ) arthrogram, including injection.
0321	X-rays, other temporomandibular joint (TMJ) films, by report.
0322	X-rays, tomographic survey.
0340	X-rays, cephalometric film.
0415	Sterilization or infection control, or bacteriologic studies for determination of pathologic agents.
0425	Caries susceptibility test.
0501	Histopathologic examination.
0502	Other oral pathology procedures, by report.
1204 --- 1205	Topical application of fluoride for individuals age 19 and over
1310	Nutritional counseling for the control or prevention of dental disease.
1320	Tobacco counseling for the control or prevention of oral disease.
1330	Oral hygiene instruction.
2960 --- 2962	Labial veneers.
2970	Temporary crown (for fractured tooth).
3910	Surgical procedure for isolation of tooth with rubber dam.
3950	Canal preparation and fitting of preformed dowel or post.
3960	Bleaching of discolored tooth.
4920	Unscheduled dressing change by someone other than treating dentist.
5810 --- 5821	Interim dentures.
5850 --- 5851	Tissue conditioning.
5862	Precision attachment, by report.
5911 --- 5999	Various prostheses and related procedures.
6010 --- 6199	Various implants and related procedures.
6920	Connector bar.
6950	Precision attachment.
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
7470	Removal of exostosis, maxilla or mandible.
7480	Partial ostectomy (guttering or saucerization).
7490	Radical resection of mandible with bone graft.
7530	Removal of foreign body, skin, or subcutaneous tissue.
7540	Removal of reaction-producing foreign bodies from musculoskeletal system.
7550	Sequestrectomy for osteomyelitis.
7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.
7610 --- 7780	Various procedures for reduction of fractures.
7810 --- 7899	Various procedures related to the temporomandibular joint.
7910 --- 7912	Suture of wounds.
7920	Skin grafts.
7940 --- 7950	Various osteoplastic, osteotomic, and grafting procedures for repair of defects.
7955	Repair of maxillofacial soft and hard tissue defect.
7980 --- 7983	Various procedures related to the salivary gland.
7990	Emergency tracheotomy.
7991	Coronoidectomy.
7995	Synthetic graft, mandible or facial bones, by report.
7996	Mandible implant for augmentation purposes (excluding alveolar ridge), by report.
8210 --- 8220	Appliance therapy to control harmful habits.
9210	Local anesthesia not in conjunction with operative or surgical procedures.
9211	Regional block anesthesia.
9212	Trigeminal block anesthesia.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**NON-COVERED DENTAL PROCEDURES (Continued)**

<b>PROC. NO.</b>	<b><i>DESCRIPTION OF SERVICE</i></b>
9215	Local anesthesia.
9221	General anesthesia, each additional 15 minutes.
9230	Analgesia.
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).
9410	House call.
9420	Hospital call.
9430	Office visit for observation during regularly scheduled office hours with no other services performed.
9440	Office visit after regularly scheduled office hours.
9610	Therapeutic drug injection, by report.
9630	Other drugs and/or medicaments, by report.
9910	Application of desensitizing medicament.
9920	Behavior management, by report.
9930	Treatment of postsurgical complications, unusual circumstances, by report.
9940	Occlusal guard, by report.
9941	Fabrication of athletic mouthguard.
9950	Occlusion analysis, mounted case.
9951 --- 9952	Occlusal adjustment.
9970	Enamel microabrasion.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**COORDINATION OF BENEFITS**

If an Insured is also covered under one or more other Plans, the benefits payable under this Plan will be coordinated with the benefits payable under those other Plans. But there is one exception: If the Participating Employer has a medical expense benefit plan (insured or uninsured) for employees and their dependents, coverage under the Policy is intended to supplement (and not coordinate with) coverage under that plan. Therefore, if a dental procedure is covered in whole or in part under that plan, the charge for that procedure is excluded from being a Covered Expense under the Policy.

**EFFECT ON BENEFITS.** When coordination applies, we adjust the benefits payable for any Claim Determination Period (period) as follows. The benefits that would be payable for Allowable Expenses incurred in that period under this Plan without coordination are reduced so that the sum of those reduced benefits and the benefits payable for those Allowable Expenses under all other Plans, whether or not claim is made, will not exceed the Allowable Expenses.

If, when we coordinate the benefits of this Plan with those of another Plan, (1) the rules set forth below would require this Plan to set its benefits before the other Plan; and (2) the other Plan coordinates benefits and would set its benefits after the benefits of this Plan have been set; then the benefits of that other Plan will be ignored when setting the benefits of this Plan.

**ORDER OF BENEFIT DETERMINATION.** The rules used to determine which of the Plans will pay benefits first are:

1. The benefits of a Plan with no coordination will set its benefits before a Plan with coordination.
2. The benefits of a Plan which covers the person other than as a dependent will be set before the benefits of a Plan which covers that person as a dependent.
3. If the claim is made for a dependent child whose parents are not separated or divorced, the benefits of a Plan that covers a child as a dependent of a person whose month and day of birth occurs earlier in a calendar year will be set before the benefits of a Plan that covers that child as a dependent of a person whose month and day of birth occurs later in a calendar year.

If the month and day of birth of both parents is the same, then the Plan which has covered the parent for the longer period of time will pay its benefits first.

If the other plan has a rule based on gender of the parent and, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. If the claim is made for a dependent child whose parents are separated or divorced, benefits for the child are determined in this order.
  - a. first, the Plan of the parent with custody of the child;
  - b. then, the Plan of the spouse of the parent with custody of the child; and
  - c. finally, the Plan of the parent not having custody of the child.

But, if there is a court decree which sets financial responsibility for the medical, dental or other health care expenses for the child, the benefits of a Plan which covers the child as a dependent of the parent who is responsible shall be set before the benefits of any other Plan which covers the child as a dependent child.

5. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) will be set before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of the benefits, then this rule is ignored.

**PERSONAL AND DEPENDENT DENTAL CARE INSURANCE**  
**COORDINATION OF BENEFITS (Continued)**

**ORDER OF BENEFIT DETERMINATION (Continued).**

6. When the rules above do not apply, the benefits of a Plan which has covered the person for the longer period of time will set before the benefits of a Plan which has covered the person the shorter period of time.

When the benefits of this Plan are reduced, each benefit is reduced, in proportion. It is then charged against any applicable benefit limit of this Plan.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.** We may give or get from any other organization or person any information necessary to decide whether coordination applies. This may be done without the consent of the Insured. Any person claiming benefits under this Plan will be required to give us any information necessary to coordinate benefits.

**FACILITY OF PAYMENT.** When other Plans make payments which should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

**RIGHT OF RECOVERY.** We shall not request a refund or offset against a claim more than twelve months after the claim has been paid, except in cases of fraud or misrepresentation.

**DEFINITIONS.** The following apply only to this provision of the Policy:

1. "Plan" means any of these types of coverage providing medical or dental benefits or services:
  - a. group insurance or group type coverage; whether insured or uninsured, except the Participating Employer's medical expense benefit plan for employees and dependents. "Group type" coverage includes:
    - i. Blue Cross and Blue Shield
    - ii. blanket (other than school accident-type coverage).
    - iii. Health Maintenance Organizations (HMO's).
    - iv. other prepayment, group practice and individual practice plans.
  - b. any coverage under a governmental plan or required or provided by law, except Medicaid.

Each type of coverage in (a) or (b) above is a separate Plan. If an arrangement has two or more parts and this coordination applies to only one part, each of the parts is a separate plan.

2. "Allowable Expense" means any necessary, reasonable and customary expense at least a part of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an Allowable Expense and a benefit paid.

3. "Claim Determination Period" means a contract year or that part of a contract year during which the person for whom claim is made has been covered under this Plan.

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of claim must be given to us within 20 days after the accident causing the injury or, in the case of sickness, within 20 days after the event on which claim is based.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Participating Employer's name, Insured's name, and Participating Employer's Group Number. If it will not be reasonably possible to give written notice within the 20 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

**CLAIM FORMS.** When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

**PROOF OF LOSS.** Written proof of loss must be given to us within 90 days after the date of the loss for which claim is made. If it was not reasonably possible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. In any event, except in the case of legal incapacity, proof must be provided no later than one (1) year from the time proof is otherwise required.

**PHYSICAL EXAMINATION.** We can examine any pre-operative dental x-rays while a dental claim is pending to determine the proper procedures to be considered.

**TIME OF PAYMENT.** We will pay all benefits within 30 days after receiving the proof of loss unless further investigation is needed, or pay the claimant one percent interest per month.

**PAYMENT OF BENEFITS.** All benefits will be paid to the Insured or the Insured's Designee.

**PAYMENT OF CLAIMS.** If an Insured dies while dental insurance benefits, if any, are unpaid, we may, at our option, pay the person or institution on whose charges claim is based, the person or entity incurring the expenses for such charges, any member of the Insured's immediate family or the Insured's estate.

Any equitable payment made in good faith will release us from liability to the extent of payment.

**LEGAL PROCEEDINGS.** No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than three years after proof of loss is required.

**INCONTESTABILITY.** We cannot contest the validity of the Policy after two years from the date of issue except for non-payment of premiums. We cannot contest the validity of coverage with respect to a Participating Employer under the Policy after two years from the Participating Employer's Effective Date except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for two years while the Insured is alive. Any of the Insured's statements that we contest must be in written application signed by the Insured.

**WORKER'S COMPENSATION.** The Policy does not satisfy any requirements for coverage of worker's compensation insurance.





**NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE MISSOURI LIFE AND  
HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

**Issued by:**

**First Continental Life & Accident Insurance Company  
101 Parklane Boulevard, Suite 301  
Sugar Land, TX 77478  
877-493-6282**

**Marketed by:**

**Dental Source of Missouri and Kansas  
9091 State Line, Suite 101  
Kansas City, MO 64114  
800-369-3485**

## LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Missouri who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy-holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.

The Missouri Life and Health Insurance Guaranty Association  
520 Dix Road, Suite D  
Jefferson City, MO 65109

Missouri Department of Insurance  
P.O. Box 690  
Jefferson City, MO 65102-0690

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. Included is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Generally, persons will be protected by the Life and Health Insurance Guaranty Association if they live in this state, and hold a life or health insurance contract or an annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when:

1. The person is eligible for protection under the laws of another state;
2. The person purchased the insurance from a company that was not authorized to do business in this state;
3. The policy is issued by an organization which is not a member insurer of the Association; or
4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees).

The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars (\$300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars (100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars (\$100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars (\$100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars (\$300,000) for any one insured for any combination of insurance benefits.

**NOTICE OF PRIVACY PRACTICES**  
**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED**  
**AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**  
**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO**  
**US.**

**Our Privacy Promise**

We will keep your medical information private. We will also give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We will follow the privacy practices that we describe in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows it. We reserve the right to make these changes effective for all medical information that we keep, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you at the time of the change. You may request a copy of our notice at any time.

**Uses and Disclosures of Medical Information**

We may use and disclose medical information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may use and disclose your medical information to a physician or other healthcare professional so they can treat you.

**Payment:** We may use and disclose your medical information for these and other related activities:  
to pay claims from physicians, hospitals and other healthcare professionals for services you received that your dental plan covers  
to determine your eligibility for benefits  
to coordinate those benefits  
to determine medical necessity  
to obtain premiums  
to issue explanations of benefits to the subscriber

We may disclose your medical information to a healthcare professional or entity also bound by the federal Privacy Rules so they can obtain payment or engage in payment activities.

**Health Care Operations:** We may use and disclose your medical information in the normal course of our health care operations. This includes:  
determining our risk and premiums for your dental plan  
quality assessment and improvement activities  
reviewing the qualifications of dental care professionals; evaluating practitioner and provider performance;  
conducting training programs, accreditation, certification, licensing or credentialing activities  
medical review, legal services and auditing, including fraud and abuse detection and compliance  
business planning and development  
business management and general administrative activities, including management activities relating to privacy, customer service, resolving internal grievances, and creating de-identified information or a limited data set.

We may disclose your medical information to another entity that has a relationship with you and is also bound by the federal Privacy Rules, for their healthcare operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.

**Your Authorization:** You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. This will not affect any uses and disclosures that your authorization allowed while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any reason except those described in this notice.

**Your Family and Friends:** We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose your name, location, and general condition or death to notify, or help notify (including identifying or locating) a person involved in your care.

Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we will disclose your medical information based on our professional judgment of what we think would be in your best interest.

**Your Employer or Organization Sponsoring Your Group Dental Plan:** We may disclose your medical information and that of others in your group dental plan to the employer or other organization that sponsors it so they can administer the plan. Please see your group dental plan document for a full explanation of the uses and disclosures that the plan sponsor may make of your medical information in providing plan administration. We may disclose summary information about those in your group dental plan to the plan sponsor for two reasons. One is to get premium bids for the dental insurance coverage offered through your group dental plan. The second is to decide whether to modify, amend or terminate your group dental plan. The summary information we may disclose summarizes claims history, claims expenses or types of claims those in your group dental plan have filed. The summary information will not include demographic information about the people in the group dental plan, but the plan sponsor may be able to identify you or others from the summary information.

**Underwriting:** We may receive your medical information for underwriting, premium rating or other activities we do to create, renew or replace a contract of dental insurance or dental benefits. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of dental insurance or dental benefits is placed with us. In that case, our use and disclosure of your medical information will be as described in this notice.

**Disaster Relief:** We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes that are in the public interest or benefit:

- as required by law
- for public health activities. These include disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- to report adult abuse, neglect or domestic violence
- to health oversight agencies
- in response to court and administrative orders and other lawful processes
- to law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and to identify or locate a suspect or other person
- to coroners, medical examiners and funeral directors
- to organ procurement organizations
- to avert a serious threat to health or safety
- in connection with certain research activities
- to the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- to correction institutions regarding inmates
- as authorized by state workers' compensation laws.

**Health-Related Services.** We may use your medical information to contact you about health-related benefits and services or about treatment alternatives. We may disclose your medical information to a business associate to assist us in these activities.

**Marketing.** We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.  
Individual Rights

**Access:** You have the right to look at or get copies of your medical information, with some exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical to do so. To get your medical information, you must make a request in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you \$0.50 for each page and for staff time to copy your medical information. We also will charge for postage if you want us to mail the copies to you. If you request another format, we will charge a cost-based fee for providing your medical information in that format. Contact us using the information listed at the end of this notice for a full explanation of our fees.

**Disclosure Accounting:** You have the right to request in writing to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, healthcare operations, as authorized by you, and for certain other activities, on or after April 14, 2003. We will give you the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fees.

**Restriction:** You have the right to request in writing that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement for us. We will not be bound unless our agreement is in writing.

**Confidential Communications:** You have the right to request that we communicate with you about your medical information by other means or to other locations. You must make your request in writing. You must state that the information could endanger you if we do not communicate to you in confidence as you request. We must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your dental plan. This includes sending explanations of benefits to the subscriber of your dental plan.

Even though you requested that we communicate with you about that dental care in confidence, an explanation of benefits issued to the named insured for dental care that you received (for which you did not request confidential communications), or about the named insured or others covered by the dental plan in which you participate, may contain sufficient information, such as deductible and out-of-pocket amounts, to reveal that you obtained dental care for which we paid.

We will not be bound to your confidential communications request unless our agreement is in writing.

**Amendment:** You have the right to request that we amend your medical information. Your request must be in writing. It must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation. You may respond with a statement of disagreement that we will add to the information you wanted to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

**Electronic Notice:** If you receive this notice on our Web site or by electronic mail (e-mail), you may request this notice in written form. Please contact us using the information listed at the end of this notice to request this notice in written form.

**Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We can give you that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Information**

Privacy Officer: Paul Kwauk

Address: 101 Parklane Boulevard, Suite 301  
Sugar Land, TX 77478

Telephone: (877) 493-6282