First Continental Life & Accident Insurance Company

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

Policy No.:	ODP185TX
Policyholder:	First Continental Life & Accident Insurance Company
Participating Employer:	Central Texas Benefits Cooperative
Participating Employer Group No.:	M1033-D,M1034-D,M1035-D,M1115-D,M1116-D,M1127-D,M1128-D,M1129-D, M1130-D.M1150-D,M1213-D, M1221-D,M1264-D,M1339-D, M1368-D, M1371-D, M1383-D, M1384-D, M1429-D, M1521-D, M1522-D, M1523-D, M1524-D, M1623-D, M1624-D, M1767-D
Participating Employer Effective Date:	September 1, 2007
Participating Employer Issue Date:	September 1, 2007

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 whereto, 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

TEXAS TOLL-FREE TELEPHONE NUMBER AND INFORMATION AND COMPLAINT NOTICES

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call First Continental Life & Accident Insurance Company's toll-free telephone number for information or to make a complaint at

1-877-493-6282

You may also write to First Continental Life & Accident Insurance Company:

101 Parklane Boulevard, Suite 301
Sugar Land, TX 77478

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512)475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact First Continental Life & Accident Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis First Continental Life & Accident Insurance Company's para informacion o para someter una queja al

1-877-493-6282

Usted tambien puede escribir a First Continental Life & Accident Insurance Company:

101 Parklane Boulevard, Suite 301
Sugar Land, TX 77478

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512)475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el First Continental Life & Accident Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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SCHEDULE OF BENEFITS

Group Name: Central Texas

Group Policy Number: All group numbers listed on page 1 of Certificate

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	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(Family Ded $150)	$50
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 Waived for all 9-1-09 effective dates and new hires Applicable to Each Insured Person, Who is a Late Entrant	12 Months
Orthodontic (Class IV) Services (If Provided, Available Only for Dependent Children under Age 19)	Yes
Lifetime Maximum Payment Applicable to Each Child for Orthodontic Services (If Provided)	$1,000
Lifetime Deductible Amount Applicable to Each Child for Orthodontic Services (If Provided)	NA
Waiting Period Applicable to Each Child for Orthodontic Waived for all 9-1-09 effectives and new hires Applicable to each insured child Who is a Late Entrant	12 Months

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)	50%

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:

	Percentage
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:

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

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 retardation 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.

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.

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.

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.

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.

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.

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.

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.

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

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.

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 Remnents-fixed deciduous
7140 Extraction-erupted tooth or exposed root

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 Biscuspid (two canals).
3330 Molar (three canals).
3346 Retreatment of previous root canal therapy, anterior.
3347 Retreatment of previous root canal therapy, biscuspid.
3348 Retreatment of previous root canal therapy, molar.

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

CLASS II PROCEDURES – BASIC 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, biscuspid, first root.
3425 Apicoectomy/periadicular surgery, molar, first root.
3426 Apicoectomy/periadicular surgery, biscuspid 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.

****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.
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.

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

CLASS II PROCEDURES – BASIC SERVICES - continued

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 alvelous.
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 fiberotomy, by report.
7960	Frenulectomy (frenectomy or frenotomy) as a separate procedure.
7961	

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.

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.

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

CLASS III PROCEDURES - MAJOR SERVICES - continued

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.

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.

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.

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.

****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.

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.

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

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. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom payments were made.

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 filed by the end of the calendar year after the calendar year in which the loss occurred or the claim will be denied.

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 60 days after receipt of due proof. ("Due proof" means all information necessary for us to adjudicate the claim properly.)

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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Issued by:

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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

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 dentalcare 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

Chief Operations Officer:	Paul Kwauk
Address:	101 Parklane Boulevard, Suite 301 Sugar Land, TX 77478
Telephone:	877-493-6282