CERTIFICATES OF INSURANCE

FCL DENTAL 3000

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CERTIFICATES OF INSURANCE INCLUDED IN THIS PDF

	PAGE #S	GROUP CERTIFICATES OF INSURANCE
	02-39	Group Dental Insurance Certificates of Insurance underwritten by: First Continental Life & Accident Insurance Company

ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.
CALL **866-438-4274** WITH ANY QUESTIONS.

First Continental Life and Accident Insurance Company

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

Policy No.	POL TX IMPL MEM21
Policy Effective Date:	January 1, 2022
Policyholder:	United Business Association
Policy Issue Date:	January 1, 2022
Participating Group:	United Business Association - 3000 MAC
Participating Group No.:	MA2297-D+
Participating Group Effective Date:	January 1, 2022
Participating Group Issue Date:	January 1, 2022

In consideration of the Application made by the Policyholder, the applications made by each Participating Group, and receipt of any and all Premiums when due, First Continental Life and Accident Insurance Company (FCL Dental) 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 Group is due on the Participating Group Effective Date. Insurance with respect to the Participating Group shall terminate at the end of the day before the Participating Group Renewal Date; unless (1) First Continental Life and Accident Insurance Company (FCL Dental) 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 Group. 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 and 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.

"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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

First Continental Life and Accident Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: First Continental Life and Accident Insurance Company at 1-877-493-6282
Toll-free: 1-877-493-6282
Email: compliance@fcldental.com
Mail:101 Parklane Boulevard, Suite 301, Sugar Land, TX 77478

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov Email:
ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

First Continental Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: First Continental Life and Accident Insurance Company at 1-877-493-6282
Teléfono gratuito: 1-877-493-6282
Correo electrónico: compliance@fcldental.com
Dirección postal: 101 Parklane Boulevard, Suite 301, Sugar Land, TX 77478

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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SCHEDULE OF BENEFITS

Group Name United Business Association - 3000 MAC **Group Policy Number** MA2297-D+

Class of Members Eligible for Insurance	Active Members
Persons Covered	Members and Dependent
Member Elimination Period	Members eligible the 1st of the month following the Participating Group's Elimination Period
Takeover Benefits	Provided
Predetermination of Benefits Amount Applicable to All Classes of Service	$300.00
Maximum Contract Per Year Payment Applicable to Each Insured	$3000
Deductible Amount Per Visit Applicable to Each Insured Person for Covered Services Other Than Orthodontics Family Max	$25
Deductible Waived for Class I Services	No
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	12 Months
Orthodontic (Class IV) Services (If Provided, Available Only for Dependent Children under Age 19)	None
Lifetime Maximum Payment Applicable to Each Child for Orthodontic Services (If Provided)	N/A
Lifetime Deductible Amount Applicable to Each Child for Orthodontic Services (If Provided)	N/A
Waiting Period Applicable to Each Child for Orthodontic Services (If Provided), Whether or Not Child is a Late Entrant for Orthodontic Services	N/A

Percentage of Covered Dental Expenses Payable: Covered charges in excess of the 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%

DEFINITIONS

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 Group's Effective Date; or (3) was not insured under the Participating Group'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.

Our website for members and providers to login to view benefits or find providers is: www.fcldental.com.

DEFINITIONS

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.

ANNUAL: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

ANNUAL MAXIMUM: The maximum amount First Continental Life and Accident Insurance Company will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year.

CERTIFICATE EFFECTIVE DATE: The date shown on the Statement of Coverage as the Certificate Effective Date.

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

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

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

COINSURANCE: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

COVERED DEPENDENT means an eligible member who is enrolled in and covered under this Policy of insurance.

COVERED MEMBER means an Eligible Member who is enrolled in and covered under this Policy of Insurance.

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.

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

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

EFFECTIVE DATE, with respect to a Participating Group, means the first date coverage under the Policy may become effective for the Participating Group's Members. It is shown on the approved Participating Group 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 in the Participating Group'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.

DEPENDENT coverage will also apply to domestic partners and their legal children. As such, they will be included in the following definitions:

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 and domestic partner and their legal children.
   i. Domestic Partner means two persons in a committed relationship, who attest by affidavit that they have met the following requirements:
      1. Are either the same or opposite sex;
      2. Have shared a continuous committed relationship with each other for not less than 6 months, intend to do so indefinitely, and have no such relationship with any other person;
      3. Are jointly responsible for each other's welfare and financial obligations;
      4. Reside in the same household;
      5. Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence;
      6. Each is over the age 18, or legal age, and is mentally and legally competent to enter a contract; and
      7. Neither is married to a third party.

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. primarily dependent on the Insured for support and maintenance.

d. each unmarried child 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.

e. a grandchild of a member who is:
   i. unmarried;
   ii. under 26 years of age; and
   iii. a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

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

A person **may not** be an Insured Dependent for more than one Insured Member.

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 is a party to a suit in which the insured seeks to adopt the child; (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 or dental 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.

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 that the Insured has elected to enroll under the Policy.

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.

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

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.

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

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

TELEDENTISTRY, AND TELEHEALTH

(1) "Dentist," "health professional," and "physician" have the meanings assigned by Section 1455.001, Insurance Code.

(2-a) "Teledentistry dental service" means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

(3) "Telehealth service" means a health service, other than a telemedicine medical service or a teledentistry dental service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

INFORMED CONSENT. (a) A treating physician, dentist, or health professional who provides or facilitates the use of telemedicine medical services, teledentistry dental services, or telehealth services shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine medical services, teledentistry dental services, or telehealth services are provided.

(b) A dentist who delegates a teledentistry dental service shall ensure that the informed consent of the patient includes disclosure to the patient that the dentist has delegated the service.

CONFIDENTIALITY. A treating physician, dentist, or health professional who provides or facilitates the use of telemedicine medical services, teledentistry dental services, or telehealth services shall ensure that the confidentiality of the patient's clinical [medical] information is maintained as required by Chapter 159, by Subchapter C, Chapter 258, or by other applicable law.

(a) The Texas Medical Board, in consultation with the commissioner of insurance, as appropriate, may adopt rules necessary to:

(1) ensure that patients using telemedicine medical services receive appropriate, quality care;

(2) prevent abuse and fraud in the use of telemedicine medical services, including rules relating to the filing of claims and records required to be maintained in connection with telemedicine medical services;

(3) ensure adequate supervision of health professionals who are not physicians and who provide telemedicine

medical services; and

(4) establish the maximum number of health professionals who are not physicians that a physician may supervise through a telemedicine medical service.

(b) The State Board of Dental Examiners, in consultation with the commissioner of insurance, as appropriate, may adopt rules necessary to:

(1) ensure that patients using teledentistry dental services receive appropriate, quality care;

(2) prevent abuse and fraud in the use of teledentistry dental services, including rules relating to the filing of claims and records required to be maintained in connection with teledentistry dental services;

(3) ensure adequate supervision of health professionals who are not dentists and who provide teledentistry dental services under the delegation and supervision of a dentist; and

(4) authorize a dentist to simultaneously delegate to and supervise through a teledentistry dental service not more than five health professionals who are not dentists.

PRACTITIONER-PATIENT RELATIONSHIP FOR TELEMEDICINE MEDICAL SERVICES OR TELEDENTISTRY DENTAL SERVICES.

(a) For purposes of Section 562.056, a valid practitioner-patient relationship is present between a practitioner providing a telemedicine medical service or a teledentistry dental service and a patient receiving the service as long as the practitioner complies with the standard of care described in Section 111.007 and the practitioner:

(1) has a preexisting practitioner-patient relationship with the patient established in accordance with rules adopted under Section 111.006;

(2) communicates, regardless of the method of communication, with the patient pursuant to a call coverage agreement established in accordance with:

(A) Texas Medical Board rules with a physician requesting coverage of medical care for the patient; or

(B) State Board of Dental Examiners rules with a dentist requesting coverage of dental care for the patient; or

(3) provides the telemedicine medical services or teledentistry dental services through the use of one of the following methods, as long as the practitioner complies with the follow-up requirements in Subsection (b), and the method allows the practitioner to have access to, and the practitioner uses, the relevant clinical information that would be required in accordance with the standard of care described in Section 111.007:

(A) synchronous audiovisual interaction between the practitioner and the patient in another location;

(B) asynchronous store and forward technology, including asynchronous store and forward technology in conjunction with synchronous audio interaction between the practitioner and the patient in another location, as long as the practitioner uses clinical information from:

(i) clinically relevant photographic or video images, including diagnostic images; or

(ii) the patient's relevant clinical records, such as the relevant medical or dental history,

laboratory and pathology results, and prescriptive histories; or

(C) another form of audiovisual telecommunication technology that allows the practitioner to comply with the standard of care described in Section 111.007.

SECTION 8. Section 111.006, Occupations Code, is amended by adding Subsection (c) to read as follows:

(c) The State Board of Dental Examiners and the Texas State Board of Pharmacy shall jointly adopt rules that establish the determination of a valid prescription in accordance with Section 111.005. Rules adopted under this subsection must allow for the establishment of a practitioner-patient relationship by a teledentistry dental service provided by a dentist to a patient in a manner that complies with Section 111.005(a)(3) and must be substantially similar to the rules adopted under Subsection (a) of this section. The State Board of Dental Examiners and the Texas State Board of Pharmacy shall jointly develop and publish on each respective board's Internet website responses to frequently asked questions relating to the determination of a valid prescription issued in the course of the provision of teledentistry dental services.

STANDARD OF CARE FOR TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES. (a) A health professional providing a health care service or procedure as a telemedicine medical service, a teledentistry dental service, or a telehealth service is subject to the standard of care that would apply to the provision of the same health care service or procedure in an in-person setting.

(b) An agency with regulatory authority over a health professional may not adopt rules pertaining to telemedicine medical services, teledentistry dental services, or telehealth services that would impose a higher standard of care than the standard described in Subsection (a).

SECTION 10. Chapter 111, Occupations Code, is amended by adding Section 111.0075 to read as follows:

LICENSING FOR TELEDENTISTRY DENTAL SERVICES. A health professional providing a health care service or procedure as a teledentistry dental service is subject to the licensing requirements that would apply to the provision of the same health care service or procedure in an in-person setting.

LIMITATION ON CERTAIN PRESCRIPTIONS. (a) In this section:

(1) "Controlled substance," "opiate," and "prescribe" have the meanings assigned by Section 481.002, Health and Safety Code.

(2) "National holiday" means a day described by Section 662.003(a), Government Code.

(b) The State Board of Dental Examiners by rule shall establish limits on the quantity of a controlled substance, including an opiate, that a dentist may prescribe to a patient as a teledentistry dental service. Except as provided by Subsection (c), the rules may not authorize a dentist to prescribe more than is necessary to supply a patient for:

(1) if the prescription is for an opiate, a two-day period; or

(2) if the prescription is for a controlled substance

other than an opiate, a five-day period.

(c) For each day in a period described by Subsection (b)(1) or (2) that is a Saturday, Sunday, or national holiday, the period is extended to include the next day that is not a Saturday, Sunday, or national holiday.

(d) Rules adopted under this section must comply with applicable federal laws and rules.

(d) For purposes of this subtitle, a person located in another state practices dentistry in this state and is required to hold a license to practice dentistry in this state if the person through the use of any medium, including an electronic medium, performs an act that constitutes the practice of dentistry on a patient in this state.

RULES REGARDING CALL COVERAGE AGREEMENTS. The board shall adopt rules governing a call coverage agreement between dentists.

IMPERMISSIBLE DELEGATIONS. A dentist may not delegate:

(1) an act to an individual who, by board order, is prohibited from performing the act;

(2) any of the following acts to a person not licensed as a dentist or dental hygienist:

(A) the removal of calculus, deposits, or accretions from the natural and restored surfaces of exposed human teeth and restorations in the human mouth;

(B) root planing or the smoothing and polishing of roughened root surfaces or exposed human teeth; or

(C) any other act the delegation of which is prohibited by board rule;

(3) any of the following acts to a person not licensed as a dentist:

(A) comprehensive examination or diagnosis and treatment planning;

(B) a surgical or cutting procedure on hard or soft tissue;

(C) the prescription of a drug, medication, or work authorization;

(D) the taking of an impression for a final restoration, appliance, or prosthesis;

(E) the making of an intraoral occlusal adjustment;

(F) direct pulp capping, pulpotomy, or any other endodontic procedure;

(G) the final placement and intraoral adjustment of a fixed or removable appliance; or

(H) the placement of any final restoration; or

(4) the authority to an individual to administer a local anesthetic agent, inhalation sedative agent, parenteral sedative agent, or general anesthetic agent, including as a teledentistry dental service as that term is defined by Section 111.001, if the individual is not licensed as:

(A) a dentist with a permit issued by the board for the procedure being performed, if a permit is required;

(B) a certified registered nurse anesthetist licensed by the Texas Board of Nursing, only if the delegating dentist holds a permit issued by the board for the procedure being performed, if a permit is required; or

(C) a physician anesthesiologist licensed by the Texas Medical Board.

PERFORMANCE OF DELEGATED DUTIES. (a) Except as provided by Section 262.1515, a dental hygienist shall practice dental hygiene:

(1) in the dental office of a supervising dentist licensed by the board; or

(2) in an alternate setting, including a nursing home, the patient's home, a school, a hospital, a state institution, a public health clinic, or another institution, under the supervision of a supervising dentist.

(b) For purposes of this section, a dental hygienist who practices dental hygiene as a teledentistry dental service, as defined by Section 111.001, is practicing in an alternate setting in compliance with Subsection (a)(2).

(c) For purposes of this section and Section 562.112, a valid practitioner-patient relationship is present between a practitioner providing telemedicine medical services or teledentistry dental services and the patient receiving the services if the practitioner has complied with the requirements for establishing such a relationship in accordance with Section 111.005.

(4-d) "Platform" means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service, teledentistry dental service, or telehealth service.

TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

SECTION 23. Sections 62.157(a) and (b), Health and Safety Code, are amended to read as follows:

(a) In providing covered benefits to a child with special health care needs, a health plan provider must permit benefits to be provided through telemedicine medical services, teledentistry dental services, and telehealth services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services, teledentistry dental services, and telehealth services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services, teledentistry dental services, and telehealth services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services, teledentistry dental services, telehealth services, or any combination of those services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services, teledentistry dental services, and telehealth services, including the costs of transportation and lodging and other direct costs.

TELEMEDICINE MEDICAL SERVICES AND TELEDENTISTRY DENTAL SERVICES. (a) In providing covered benefits to a child, a health plan provider must permit benefits to be provided through telemedicine medical services and teledentistry dental services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services and teledentistry dental services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services and teledentistry dental services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services, teledentistry dental services, or both services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services or teledentistry dental services, including the costs of transportation and lodging and other direct costs.

(c) [(d)] In this section, "teledentistry dental service" and "telemedicine medical service" have the meanings assigned by Section 531.001, Government Code.

(1) "Dentist" means a person licensed to practice dentistry in this state under Subtitle D, Title 3, Occupations Code.

(1-a) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist:

(a) a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(b) a dentist in providing teledentistry dental services that are delegated and supervised by the dentist;

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service or a teledentistry dental service; or

(D) a dentist.

(3) "Teledentistry dental service," "telehealth service," and "telemedicine medical service" have the meanings assigned by Section 111.001, Occupations Code.

COVERAGE FOR TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES. (a) A health benefit plan:

(1) must provide coverage for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, teledentistry dental service, or telehealth service on the same basis and to the same extent that the plan provides coverage

for the service or procedure in an in-person setting; and

(2) may not:

(A) exclude from coverage a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, a teledentistry dental service, or a telehealth service solely because the covered health care service or procedure is not provided through an in-person consultation; and

(B) subject to Subsection (c), limit, deny, or reduce coverage for a covered health care service or procedure delivered as a telemedicine medical service, teledentistry dental service, or telehealth service based on the health professional's choice of platform for delivering the service or procedure.

(b) A health benefit plan may require a deductible, a copayment, or coinsurance for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, a teledentistry dental service, or a telehealth service. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for the covered health care service or procedure provided through an in-person consultation.

(b-1) Subsection (b) does not authorize a health benefit plan to charge a separate deductible that applies only to a covered health care service or procedure delivered as a telemedicine medical service, teledentistry dental service, or telehealth service.

(c) Notwithstanding Subsection (a), a health benefit plan is not required to provide coverage for a telemedicine medical service, a teledentistry dental service, or a telehealth service provided by only synchronous or asynchronous audio interaction, including:

(1) an audio-only telephone consultation;

(2) a text-only e-mail message; or

(3) a facsimile transmission.

(d) A health benefit plan may not impose an annual or lifetime maximum on coverage for covered health care services or procedures delivered as telemedicine medical services, teledentistry dental services, or telehealth services other than the annual or lifetime maximum, if any, that applies in the aggregate to all items and services and procedures covered under the plan.

TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES STATEMENT. (a) Each issuer of a health benefit plan shall adopt and display in a conspicuous manner on the health benefit plan issuer's Internet website the issuer's policies and payment practices for telemedicine medical services, teledentistry dental services, and telehealth services.

(b) This section does not require an issuer of a health benefit plan to display negotiated contract payment rates for health professionals who contract with the issuer to provide telemedicine medical services, teledentistry dental services, or telehealth services.

SECTION 29. Not later than March 1, 2022:

(1) the State Board of Dental Examiners and the Texas State Board of Pharmacy shall jointly adopt rules as required by

Section 111.006(c), Occupations Code, as added by this Act;

(2) the State Board of Dental Examiners shall adopt:

(A) rules necessary to implement Chapter 111, Occupations Code, as amended by this Act; and

(B) rules as required by Section 254.0035, Occupations Code, as added by this Act; and

(3) the Health and Human Services Commission shall adopt rules as required by Section 531.02172, Government Code, as added by this Act.

SECTION 30. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 31. (a) Except as provided by Subsection (b) of this section, this Act takes effect September 1, 2021.

(b) Sections 1455.004 and 1455.006, Insurance Code, as amended by this Act, take effect January 1, 2022.

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.

ELIGIBILTY

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 Group 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 day of the calendar month 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 Group'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 day of the calendar month 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 day of the calendar month 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 day of the calendar month 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 Group; 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 day of the calendar month (whichever corresponds numerically with the Participating Group'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 Group'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 day of the calendar month (whichever corresponds numerically with the Participating Group'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 day of the calendar month (whichever corresponds numerically with the day before the Participating Group'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 Group.
6. the date all coverage under the Policy is terminated with respect to the Insured's Participating Group.
7. the date the Policy is terminated.

The insurance for any dependent will automatically terminate at the end of the last day of the calendar month (whichever corresponds numerically with the day before the Participating Group'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, 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

LIST OF COVERED DENTAL EXPENSES PROCEDURES

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 Group's Effective Date; or (c) was not insured under the Participating Group'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.

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 - 4342) 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.
of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.

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: 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 and orthognathic surgery

25. procedures for which benefits are payable under the Participating Group’s medical expense benefit plan for employees and their dependents. See the Coordination of Benefits provision for an explanation.

The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors, and nomenclature may be used to describe these covered procedures in compliance with federal legislation. The following represents codes and nomenclature excerpted from the version of the Current Dental Terminology (CDT) in effect on the date that this Contract or amendment was issued. CDT coding and nomenclature are the copyright of the American Dental Association, and have been accepted as the standard for data transmission purposes under federal Administrative Simplification regulations. For the purposes of the following, First Continental Life and Accident Insurance Company's administration of Benefits, Limitations, and Exclusions under this Contract will at all times be based on the current version of CDT whether or not revised. 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. Text that appears in italics below is specifically intended to clarify the delivery of benefits under the First Continental Life and Accident Insurance Company's policy and is not to be interpreted as Current Dental Terminology (CDT) procedure codes, descriptors, or nomenclature.

CLASS I PROCEDURES – PREVENTIVE SERVICES

Clinical Oral Evaluations

****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.

Procedure Code	Procedure Description
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation, problem focused.
D0145	Oral evaluation (patient under 3 years of age)
D0150	Comprehensive oral evaluation.
D0160	Detailed and extensive oral evaluation, problem focused, by report.
D0170	Re-evaluation-limited problem focused
D0180	Comprehensive periodontal evaluation
D0460	Pulp vitality tests
D0470	Diagnostic casts

Diagnostic Imaging

D0270	Bitewing, single film (limited to once in any six month period).
D0272	Bitewing, two films (limited to once in any six month period).
D0274	Bitewing, four films (limited to once in any six month period).
D1110	Prophylaxis-adult (age 12 and older)
D1120	Prophylaxis (age 11 and order)
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride – excluding varnish

CLASS II PROCEDURES - BASIC SERVICES

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

D0210	Intraoral - complete series of radiographic images
D0220	Intraoral – periapical first radiographic images
D0230	Intraoral, periapical, each additional radiographic image
D0240	Intraoral - occlusal
D0250	Extraoral- first radiographic image
D0260	Extraoral - each additional radiographic image
D0290	Posterior- anterior or lateral skull and facial bone survey radiographic image
D0330	Panoramic radiographic image
D1351	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).

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

CLASS II PROCEDURES - BASIC SERVICES – continued

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

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam - three surfaces or permanent
D2161 Amalgam - four or more surfaces, primary or 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.

D2330 Resin-based composite – one surface - anterior
D2331 Resin-based composite, - two surfaces - anterior
D2332 Resin-based composite - three surfaces - anterior
D2335 Resin-based composite - four or more surfaces - anterior
D2391 Resin-based composite - one surface - posterior
D2392 Resin-based composite - two surfaces - posterior
D2393 Resin-based composite - three or more surfaces - posterior
D2394 Resin-based composite - four or more surfaces - posterior
D2940 Protective restoration

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.

D7111 Extraction-coronal remnants - deciduous tooth
D7140 Extraction-erupted tooth or exposed root
D9110 Palliative (Emergency) treatment – Minor procedure

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.

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D1510 Space maintainer-fixed-unilateral
D1515 Space maintainer-fixed-bilateral
D1520 Space maintainer-removable-unilateral
D1525 Space maintainer-removable-bilateral
D1555 Removal of fixed space maintainer
D1550 Recement or re-bond space maintainer

Gold Foil Restoration – Covered only when needed due to decay

D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil – three surfaces

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

CLASS III PROCEDURES - MAJOR SERVICES (Continued)

Inlay/Onlay Restorations - Covered only when needed due to decay

D2510	Inlay-metallic - one surface
D2520	Inlay-metallic - two surfaces
D2530	Inlay-metallic - three or more surfaces
D2543	Onlay-metallic - three surfaces
D2544	Onlay-metallic - four or more surfaces
D2610	Inlay-porcelain/ceramic - one surface
D2620	Inlay-porcelain/ceramic - two surfaces
D2630	Inlay-porcelain/ceramic - three or more surfaces
D2642	Onlay - porcelain/ceramic - two surfaces
D2643	Onlay - porcelain/ceramic - three surfaces
D2644	Onlay - porcelain/ceramic - four or more surfaces
D2650	Inlay Inlay - resin based composite - one surface
D2651	Inlay - resin based composite - two surfaces
D2652	Inlay - resin based composite - three or more surfaces
D2662	Onlay Onlay - resin based composite - two surfaces
D2663	Onlay - resin based composite - three surfaces
D2664	Onlay - resin based composite - four or more surfaces

Crowns-Single Restorations Only - Covered only when needed due to decay

D2710	Crown - resin based composite (indirect)
D2720	Crown - resin with high noble metal
D2721	Crown - resin with predominantly base metal
D2722	Crown - resin with noble metal
D2740	Crown - porcelain/ceramic substrate
D2750	Crown - porcelain fused to high noble metal
D2751	Crown - porcelain fused to predominantly base metal
D2752	Crown - porcelain fused to noble metal
D2790	Crown - full cast high noble metal
D2791	Crown - full cast predominantly base metal
D2792	Crown - full cast noble metal
D2910	Recement crown
D2920	Recement crown
D2930	Prefabricated stainless steel crown- primary tooth
D2931	Prefabricated stainless steel crown- permanent tooth (available to children under age 19 only).
D2932	Prefabricated resin crown (available to children under age 19 only).
D2933	Prefabricated stainless steel crown with resin window (available to children under age 19 only).
D2950	Core build-up, including any pins when required
D2951	Pin retention-per tooth, in addition to restoration
D2952	Post and core in addition to crown, indirectly fabricated
D2954	Prefabricated post and core in addition to crown
D2955	Post removal
D2980	Crown repair necessitated by restorative material failure

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

CLASS III PROCEDURES - MAJOR SERVICES - continued

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.

D3110 Pulp cap - direct (excluding final restoration)
D3120 Pulp cap - indirect (excluding final restoration)
D3220 Therapeutic pulpotomy (excluding final restoration)
D3230 Pulpal therapy (resorbable filling) - anterior primary
D3240 Pulpal therapy (resorbable filling) - posterior primary

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

D3310 Endodontic therapy, anterior (excluding final restoration)
D3320 Endodontic therapy, bicuspid (excluding final restoration)
D3330 Endodontic therapy, molar (excluding final restoration)
D3346 Retreatment of previous root canal-anterior
D3347 Retreatment of previous root canal-bicuspid
D3348 Retreatment of previous root canal-molar

Apexification/Recalcification

D3351 Apexification/recalcification - initial visit
D3352 Apexification/recalcification - interim medication replacement
D3353 Apexification/recalcification - final visit

Apicoectomy/Periradicular Services

D3410 Apicoectomy - anterior
D3421 Apicoectomy - bicuspid (first root)
D3425 Apicoectomy - molar (first root)
D3426 Apicoectomy (each additional root)
D3430 Retrograde filling- per root
D3450 Root amputation- per root
D3460 Endodontic endosseous implant
D3470 Intentional re-implantation (including necessary splinting)

Other Endodontic Procedures

D3920 Hemisection, including any root removal but not including root canal therapy.

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

CLASS III PROCEDURES - MAJOR SERVICES – continued

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

Surgical Periodontal Services

D4210	Gingivectomy or gingivoplasty-four or more teeth/quadrant
D4211	Gingivectomy or gingivoplasty-one to three teeth/quadrant
D4240	Gingival flap incl. root planning-four or more teeth/quadrant
D4249	Clinical crown lengthening-hard tissue
D4260	Osseous surgery - four or more teeth/quadrant
D4263	Bone replacement graft - first site in quadrant
D4264	Bone replacement graft - each additional site in quadrant
D4266	Guided tissue regeneration - resorbable barrier
D4267	Guided tissue regeneration - not resorbable barrier
D4270	Pedicle soft tissue graft procedure
D4273	Subepithelial connective tissue graft, per tooth
D4274	Distal or proximal wedge procedure
D4277	Free soft tissue graft procedure, including donor site surgery, first tooth or edentulous tooth position in graft

Non-Surgical Periodontal Services Service

D4320	Provisional splinting - intracoronal
D4321	Provisional splinting - extracoronal
D4341	**Periodontal scaling & root planing four or more teeth per/quad
D4342	**Periodontal scaling & root planing one to three teeth per/quad
D4355	Full mouth debridement. (limited to once in any twelve month period).
D4381	Localized delivery of antimicrobial agents, per tooth
D4910	Periodontal maintenance (limited to once in any six month period).

****Payment for D4341 and D4342 requires presence of periodontal disease as confirmed by both x-rays and pocket depth summaries of each tooth involved. Limited to one per quad per 24 months.**

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

CLASS III PROCEDURES - MAJOR SERVICES – continued

Prosthodontics, (Removable)

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.

Complete Dentures
D5110 Complete dentures-maxillary
D5120 Complete dentures-mandibular
D5130 Immediate denture- maxillary
D5140 Immediate denture- mandibular
Partial Dentures
D5211 Maxillary partial denture- resin base
D5212 Mandibular partial denture- resin base
D5213 Maxillary partial denture- metal framework/resin base
D5214 Mandibular partial denture- metal framework/resin base
D5281 Removable unilateral partial denture - one piece cast metal
Adjustments to Dentures
D5410 Adjust complete denture- maxillary
D5411 Adjust complete denture- mandibular
D5421 Adjust partial denture- maxillary
D5422 Adjust partial denture- mandibular
Repairs to Complete Dentures
D5511 Repair broken complete denture base, mandibular
D5512 Repair broken complete denture base, maxillary
D5520 Replace missing or broken tooth on denture
Repairs to Partial Dentures
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
D5621 Repair cast partial framework, mandibular
D5622 Repair cast partial framework, maxillary
D5630 Repair or replace broke clasp
D5640 Replace broken tooth-per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
Denture Rebase Procedures
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebas maxillary partial denture
D5721 Rebase mandibular partial denture
Denture Reline Procedures
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (lab)
D5751 Reline complete mandibular denture (lab)
D5760 Reline maxillary partial denture (lab)
D5761 Reline mandibular partial denture (lab)

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

CLASS III PROCEDURES - MAJOR SERVICES – continued

Other Removable Prosthetic Services

D5863 ** Overdenture-complete maxillary
D5864 **Overdenture- partial maxillary
D5865 **Overdenture-complete mandibular
D5866 **Overdenture- partial mandibular

Fixed Partial Denture Pontics

D6210 Pontic - cast high noble metal
D6211 Pontic - cast predominantly base metal
D6212 Pontic - cast noble metal
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic - porcelain fused to predominantly base metal
D6242 Pontic - porcelain fused to noble metal
D6245 Pontic – porcelain / ceramic
D6250 Pontic - resin with high noble metal
D6251 Pontic - resin with predominantly base metal
D6252 Pontic - resin with noble metal

Fixed Partial Denture Retainers - Inlays/Onlays

D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6720 Crown - resin with high noble metal
D6721 Crown - resin with predominantly base metal
D6722 Crown - resin with noble metal
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominantly base metal

Fixed Partial Denture Retainers - Crowns

D6752 Crown - porcelain fused to noble metal
D6780 Crown - 3/4 cast high noble metal
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominantly base metal
D6792 Crown - full cast noble metal

Other Fixed Partial Denture Retainers Services

D6930 Re-cement or re-bond fixed partial denture
D6940 Stress breaker.
D6980 Fixed partial denture repair

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

CLASS III PROCEDURES - MAJOR SERVICES – continued

Implant Services

Implant Services are not covered unless the Participating Association elects the optional implant coverage (as shown in the Schedule of Benefits) and pays the required premium. Services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years. Prosthesis over implant replacement is limited to every 5 years if unserviceable and cannot be repaired.

Surgical Services

D6010 Surgical placement of implant body: endosteal implant
D6040 Surgical placement: eposteal implant
D6050 Surgical placement: transosteal implant

Single Crowns, Abutment Supported

D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)

Fixed Partial Denture Retainer, Abutment Supported

D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal fad (high noble metal)
D6073 Abutment supported retainer for cast metal fad (predominantly base metal)
D6074 Abutment supported retainer for cast metal fad (noble metal)

Fixed Partial Denture Retainer, Implant Supported

D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for porcelain fused to metal fad (titanium, titanium alloy, or high noble metal)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)

Other Implant Services

D6094 Abutment supported crown – (titanium)
D6100 Implant removal, by report
D6194 Abutment supported retainer crown for fad (titanium)

Fixed Partial Denture Pontics

D6205 Indirect resin based composite
D6210 Cast high noble
D6211 Cast predominately base metal
D6212 Cast noble metal
D6214 Titanium
D6240 Porcelain fused to high noble metal
D6241 Porcelain fused to predominately base metal
D6242 Porcelain fused to noble metal
D6245 Porcelain/ceramic

Inlays / Onlays

D6608 Porcelain/ceramic, two surfaces
D6609 Porcelain/ceramic, three or four surfaces
D6610 Cast high noble metal, two surfaces
D6611 Cast high noble metal, three or four surfaces
D6612 Cast predominately base metal. two surfaces
D6613 Cast predominately base metal, three or more surfaces
D6614 Cast noble metal, two surfaces
D6615 Cast noble metal, three or more surfaces
D6634 Titanium

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

CLASS III PROCEDURES - MAJOR SERVICES – continued

Oral and Maxillofacial Surgery including any local anesthesia and routine post-operative visits.

Surgical Extractions

D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth-soft tissue
D7230	Removal of impacted tooth-partial bony
D7240	Removal of impacted tooth-completely bony
D7241	Removal of impacted tooth-completely bony-complications
D7250	Surgical removal of residual roots

Other Surgical Procedures

D7270	Tooth re-implantation and/or stabilization
D7272	Tooth transplantation
D7280	Surgical access of an unerupted tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
D7285	Incisional biopsy of oral tissue – hard
D7286	Incisional biopsy of oral tissue- soft
D7290	Surgical repositioning of teeth
D7291	Transseptal fiberotomy

Alveoloplasty - Surgical Preparation of Ridge

D7310	Alveoloplasty in conjunction with extractions/four + per quad
D7320	Alveoloplasty not in conjunction with extractions/four + per quad

Vestibuloplasty

D7340	Vestibuloplasty - ridge extension (secondary epithelialization)
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts

Surgical Excision of Soft Tissue Lesions

D7410	Radical excision of lesion up to 1.25 cm
D7440	Excision of malignant tumor up to 1.25 cm
D7441	Excision of malignant tumor greater than 1.25 cm

Surgical Excision of Intra-Osseous Lesions

D7450	Removal of odontogenic cyst/tumor up to 1.25 cm
D7451	Removal of odontogenic cyst/tumor greater than 1.25 cm
D7460	Removal of nonodontogenic cyst/tumor up to 1.25 cm
D7461	Removal of nonodontogenic cyst/tumor greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method

Surgical Incision

D7510	Incision and drainage of abscess, intraoral soft tissue
D7520	Incision and drainage of abscess, extraoral soft tissue

Other Repair Procedures

D7960	Frenulectomy
D7970	Excision of hyperplastic tissue- per arch
D7971	Excision of percoronal gingiva

Anesthesia – When administered by the dentist in the dentist's office (not covered unless a cutting procedure is being performed at that time.

D9222	Deep dedation/general anesthesia-first 15 minutes
D9223	Deep sedation/general anesthesia - each 15 minute increment
D9239	Intravenous conscious sedation – first 15 minutes
D9243	Intravenous conscious sedation – each 15 minutes increment
D9995	Teledentistry – Synchronous
D9996	Teledentistry - Asynchronous

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

CLASS III PROCEDURES - MAJOR SERVICES – continued

Teledentistry

D9995	Teledentistry – Synchronous
D9996	Teledentistry - Asynchronous

CLASS IV PROCEDURES – ORTHODONTICS SERVICES

Class IV procedures are not covered unless the Participating Group 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 members or spouses, or for dependent children age 19 or older, unless Adult Orthodontic benefits are elected. Orthodontic takeover benefits will reduce the insured's Lifetime Maximum allowed.

Limited Orthodontic Treatment

D8030	Limited orthodontic of the adolescent dentition
D8040	Limited orthodontic treatment of the transitional definition

Interceptive Orthodontic Treatment

D8060	Interceptive orthodontic treatment of the transitional definition

Comprehensive Orthodontic Treatment

D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition

Other Orthodontic Services

D8660	Pre-orthodontic treatment
D8690	Orthodontic treatment (alternative billing to a contract fee)

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE
LIST OF NON-COVERED DENTAL EXPENSES 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***
D0190	Screening of patient.
D0191	Assessment of patient.
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw.
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch, mandible
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch, maxilla, with/out cranium.
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures
D0369	Maxillofacial MRI capture and interpretation.
D0370	Maxillofacial ultrasound capture and interpretation
D0371	Sialoendoscopy capture and interpretation.
D0380-D0386	Image Capture Only
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.
D0393--D0395	Post processing of image or image sets.
D0416	Viral culture, diagnostic test to identify viral organisms, most often herpes virus.
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing.
D0418	Analysis of saliva sample, chemical or biological analysis of saliva sample for diagnostic purposes.
D0421	Genetic test for susceptibility of oral diseases
D0601--D0603	Caries risk assessment and documentation.
D1310	Nutritional counseling for the control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease.
D1330	Oral hygiene instructions
D2929	Prefabricated porcelain/ceramic crown, primary tooth
D2941	Interim therapeutic restoration – primary dentition
D2949	Restorative foundation for an indirect restoration.
D2983	Veneer repair necessitated by restorative material failure.
D2990	Resin infiltration of incipient smooth surface lesions
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery.
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D4921	Gingival irrigation – per quadrant
D5899	Unspecified removal prosthodontic procedure, by report
D6190	Radiographic/surgical implant index, by report.
D7490	Radical resection of mandible with bone graft.
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540	Removal of reaction producing foreign bodies musculoskeletal system.
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7920-D7921	Skin grafts
D7951-D7952	Sinus augmentation
D7990	Emergency tracheotomy
D7991	Coronoidectomy.
D7996	Mandible implant for augmentation purposes (excluding alveolar ridge), by report
D7998	Intraoral placement of a fixation device not in conjunction with a fracture
D8694	Repair of fixed retainers, includes reattachment.
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays.

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 Group has a medical expense benefit plan (insured or uninsured) for member 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. A provision establishing an order in which contracts pay their claims and permitting secondary contracts to reduce their benefits so that the combined benefits of all contracts do not exceed total allowable expenses.

If, when we coordinate the benefits of this Contract with those of another Contract, (1) separate parts of a contract for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one contract, and there is no COB among the separate parts of the contract; (2) its contract must state the types of coverage that will be considered in applying the COB provision of that contract; (3) A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

In determining the amount to be paid by the secondary contract on a claim, should the contract wish to coordinate benefits, the secondary contract must calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its contract that is unpaid by the primary contract. The secondary contract may reduce its payment by the amount that, when combined with the amount by the primary contract, results in the total benefits paid or provided by all contracts for the claim equaling 100 percent of the total allowable expense for that claim. In addition, the secondary contract must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

1. The benefits of a Contract with no coordination will set its benefits before a Contract with coordination.
2. The benefits of a Contract which covers the person other than as a dependent will be set before the benefits of a Contract 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 Contract 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 Contract 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 Contract which has covered the parent for the longer period of time will pay its benefits first.

   If the Contracts do not agree on the order of benefits, the rule in the other Contract will dertermine 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 contract covering the custodial parent;
   b. then, the contract covering the custodial parent's spouse;
   c. then, the contract covering the noncustodial parent; and
   d. finally, the contract covering the noncustodial parent's spouse.

   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 Contract which covers the child as a dependent of the parent who is responsible shall be set before the benefits of any other Contract which covers the child as a dependent child.
5. When the rules above do not apply, the benefits of a Contract which has covered the person for the longer period of time will set before the benefits of a Contract which has covered the person the shorter period of time.

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

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 pay to any organizations making these payments any amounts that will satisfy the intent of the above terms. Amounts paid 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 a form of coverage with which coordination is allowed:
   a. group insurance or group type coverage; whether insured or uninsured, except the Participating Group's medical expense benefit plan for employees and dependents. "Group type" coverage includes:
      i. limited benefit policies, excluding Disability Income Protection Coverage;
      ii. uninsured arrangements of group or group-type contracts:
      iii. H the medical benefits coverage in automobile insurance contracts;
      iv. Medicare or other governmental benefits; as permitted by law; and
      v. Group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care.
   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. "Secondary Plan" means a plan that is not a primary plan.

3. "Allowable Expense" means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.
   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.
4. "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.
5. If you are covered by more than one health benefit plan, you should file all your claims with each 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 Group's name, Insured's name, and Participating 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 91 days after the date of the loss for which claim is made. If it was not reasonably possible to give written proof within the 91day 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 30 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 61 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 Group under the Policy after two years from the Participating Group'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.