APEX DENTAL

Association for Better Health

Your access to overall health

Become a member today

Association for Better Health

Welcome to Association for Better Health (ABH)!

Please review this Member Guide which list important phone and I.D. numbers exclusively for you as a member of the ABH.

Through your membership in ABH, you will enjoy numerous health, travel, consumer, and business related discounts and services. All of your discounts are explained in detail in this guide. You can also find information about your ABH discounts and services online at www.associationforbetterhealth.org; Group Code: ABH18

While we believe you will be pleased with your overall membership, we cannot warrant or guarantee the performance of any discount or service.

You can count on the Association for Better Health to continuously and aggressively seek out new discounts to add further value to your membership. As always, we invite and encourage your suggestions on ways ABH can be increasingly beneficial to you.

If you have any questions about your discounts, call 1-800-992-8044.

Again, a most cordial welcome to Association for Better Health.

Sincerely,
Association for Better Health Member Services

Annual Maximum Benefit Options:
$1,500, $3,000, $5,000

OFFICE VISIT COPAY(S)

- Office Visit- $25 Copay per visit

PREVENTIVE CARE (100% Coverage) - No Waiting Period

- Routine Exam (1 in 6 months)
- Bitewing X-rays (1 in 6 months)
- Cleaning (1 in 6 months)
- Fluoride for Children 19 & under (1-12 months)

BASIC CARE (80% Coverage) - No Waiting Period

- Full Mouth/Panoramic X-rays (1 in 3 years)
- Simple restorative services (filings)
- Sealants (age 15 and under)
- Simple Extractions

MAJOR CARE (50% Coverage) - *12 Month Waiting Period

- Periodontics (surgical)
- Major restorative services (crowns and inlays)
- Replacement of prosthodontics, dentures, crowns and inlays Prosthetics (bridges, dentures)
- Denture relines
- Implants
- Space Maintainers
- General anesthesia (for services dentally necessary)
- Endodontics/root canal therapy
- Oral Surgery

Max Care Dental $1500				Max Care Dental $3000				Max Care Dental $5000			
Member Only	Member & Spouse	Member & Child	Member & Family	Member Only	Member & Spouse	Member & Child	Member & Family	Member Only	Member & Spouse	Member & Child	Member & Family
$43.15	$76.73	$85.51	$122.91	$48.58	$86.16	$95.60	$133.33	$55.39	$97.22	$109.80	$157.58

This is a benefit summary and does not list all covered procedures. Please refer to your policy/certificate for all procedures and at what coinsurance they are covered.

MAC PLAN - Services completed by an out of network provider will most likely incur beyond what the contracted provider would charge for the same procedure.

***Waiting period for Major services may be waived with proof of prior coverage provided by the member. Proof of prior
coverage will only be accepted from the prior carrier within 30 days of effective date, and showing 12 months of continuous fully insured coverage with no lapse.***

Dental benefits offered and administered by First Continental Life and Accident Insurance Company 101 Parklane Blvd. Suite 301 | Sugar Land, Texas 77478.

BENEFIT AND SUMMARY COVERAGE

Limitations and Exclusions

Reinstatement: If a member's coverage terminates, they cannot re-enroll for 12 months from the date of termination.

Covered expenses will not include and no benefits will be payable:
1. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.

2. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.

3. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.

4. For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.

5. For any expense incurred or procedure begun before the Insured's current period of continuous coverage.

6. For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance ends.

7. To duplicate appliances or replace lost or stolen appliances.

8. For 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.

LIMITATIONS AND EXCLUSIONS CONTINUED

9. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

10. For broken appointments or the completion of claim forms.

11. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected and the premium is not paid.

12. For sealants which are:
    a. not applied to a permanent molar;
    b. applied before age 6 or after attaining age 16; or
    c. reapplied to a molar within three years from the date of a previous sealant application.

13. For 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.

14. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.

15. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Workers Compensation Act or similar laws.

16. For charges for which the Insured is not liable or which would not have been made had no insurance been in force.

17. For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.

18. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.

19. To an Insured if payment is not legal where the Insured is living when expenses are incurred.

20. For any services related to: equilibration, bite registration or bite analysis.

21. For crowns for the purpose of periodontal splinting.

22. For charges for: any overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.

23. For charges for myofunctional therapy, orthognathic surgery or athletic mouth guards.

24. For procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.

25. Services or supplies provided by a family member or a member of the Insured's household.

Note: This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. See your certificate for details.
Predetermination of Benefits: As a service to protect the Insured, First Continental Life & Accident Insurance Co. will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps Insured's better understand their coverage. The Insured should submit the treatment plan to First Continental Life & Accident Insurance Co. for review and predetermination of benefits before the service begins.

DENTAL FAQ

Does my Dental Plan have a waiting period?

There are NO WAITING PERIODS for preventive and basic dental care! There is a 12-month waiting period for major dental care for those who are enrolled in any of the plans. Waiting period for major services may be waived with proof of prior coverage provided by the member. All benefits begin on your effective date.

Who is eligible to purchase the plan?

Anyone age 18 and older in approved states and a current member of ABH. You can request coverage for your dependents; dependent eligibility varies based on state law.

Are my rates guaranteed?

You'll receive a 30-day notice prior to any rate change (more if required by state law).

When will I receive my insurance id cards?

Member ID cards are generated and sent electronically upon enrollment. If you need a new one or have lost it, you can log onto the portal to obtain a replacement or call 1(346)-460-5451

What is your refund/cancellation policy?

To receive a refund, submit a written or verbal notice of cancellation to our office within 30 days of the effective date. No refunds are offered after the 30 days. To cancel please submit written or verbal notice to our office. All cancellation requests will be effective on the next billing period.

What if I have more questions?

For Claims call FCL at: 1(877) 493-6282. Other questions contact Care Customer Service at: 1(346)-460-5451

If I already have a dental plan, may I purchase a FCL dental plan as an additional dental plan?

If you are a member of ABH then the answer is yes. The dental plan you currently have in force will be the primary dental plan and the FCL dental plan will be the secondary dental plan. The insurance carriers will coordinate the payments of dental claims.

May I purchase the FCL dental plan for just my spouse or children?

Yes, however the primary policy holder will also be required to join ABH..

How do major services work on the FCL dental plan such as crowns, inlays, implants, dentures, bridges...?

Those benefits are covered under major services at 50%. There is a 12 month waiting period unless you have had a qualifying dental plan the previous 12 months. FCL will ask for a Certificate of Credible Coverage.

Example: If you were on a prior dental plan for only 6 months then you would have a 6 month waiting period on major services.

DENTAL FAQ CONTINUED

What is the benefit period?
All benefits reset after the first of the year. This is what they call a Calendar year dental plan. Plan benefits run January 1st to December 31st.

Example: The new dental plan starts September 1st. This means if an individual has chosen the $5,000 benefit it will run until the end of the year and then the benefits starts over January 1st through December 31st with another $5,000 benefit for the plan year.

What if I have the $1,500 dental plan and want to change to the dental $5,000 benefit plan?
This plan election can only take place on the anniversary of your enrollment (your effective date).

Do I have to file a claim or submit dental reimbursement paperwork after I see a dentist?
If you use an in-network dentist, the dental office files all the paperwork for you. All dental plans have a $25 office co-pay and benefits are paid according to the description of benefits. There is no filing for claims reimbursement.

Is this a Maximum Allowable Charge Plan (MAC) and what is a MAC plan?
Yes, this is a MAC plan. A MAC plan is a type of PPO plan where you receive greater benefits and less out of pocket expense by going to an in network provider. Services completed by an out of network provider will most likely incur beyond what the contracted provider would charge for the same procedure.

When can I re-enroll after I term my plan?
12 months after the date of termination of your plan.

What if I have more questions or want to know all procedures covered in my policy?
You can call for assistance at: 1(346)-460-5451

APEX DENTAL plusnetwork

FREQUENTLY ASKED NETWORK QUESTIONS

What is the relationship between Happy Smiles and DenteMax?

Happy Smiles dental utilizes Dentemax Plus, one of the largest leasable PPO networks in the United States. DenteMax is one of the largest leasable dental PPO networks in the United States. Happy Smiles Dental PPO proposals are "stacked" and include both the FCL and DenteMax networks to provide maximum provider accessibility for members.

What is DenteMax?

DenteMax is a national, dental Preferred Provider Organization network. DenteMax's group of quality dentists have agreed to accept a set, discounted fee schedule when they see DenteMax patients. This means that you can visit any of our PPO dentists and save on your dental costs.

Why should I go to a DenteMax Dentist?

When you choose a DenteMax dentist, you can save on out-of-pocket expenses. DenteMax fees are generally less than a dentist's usual office fees. In addition, all dentists are credentialed before joining the network. DenteMax checks into a dentist's current practice information and history to make sure that they meet our high-quality standards. This gives you peace of mind knowing that you are being treated by one of the best.

How do I find a DenteMax or other network dentist?

For PPO Dental providers, you can visit the dental Web site at http://plusnetwork.fcldental.com. then in the drop down menu select Dentemax Plus network to find the most up-to-date list of DM dentists. You can also call toll-free at 800-752-1547 and a representative can help you locate a network provider in your area. Directories are available as well and are current as of the printed date.

How do I find out what dental procedures are covered?

A copy of your policy was emailed to you on the day you enrolled or you can go to your portal to access your policy. There is a list of all covered procedures on the policy. Also, you can request a predetermination of benefits from your dental provider. FCL Dental will adjudicate your claim prior to the work being done so you can see what your out of pocket costs will be.

If my dentist does not participate with DenteMax, how can he/she join?

Contact your dentist and advise him/her that you now have dental coverage that uses the DenteMax network. Ask if he/she would be willing to join. If your dentist would like to review our information, he/she can contact us at 800-752-1547. Or you can refer your dentist by phone or via our Web site at www.dentemax.com. We will contact the dental office directly with information on joining our program.

APEX DENTAL plusnetwork

DENTAL NETWORK

In Network

To minimize your out-of-pocket and receive the highest value for your policy maximum, always present your ID card at the time of service to receive the contracted discounts from DentaMax Plus Network.

To locate a participating provider visit: http://plusnetwork.fcldental.com.

Out of Network

Option 1: Member may assign the dental provider the benefits. The dental provider would submit the claim to FCL Dental, receive the compensation and then bill the member the balance owed.

Option 2: Member may pay for the services out of pocket then submit the receipt and Explanation of Benefits (EOB) directly to FCL Dental.

FCL Dental
Attn: Claims
101 Parklane Blvd., Suite 301
Sugar Land, TX 77478
1-877-493-6282
Claims Payor Number: CX090
For Questions and Enrollment Information:
DENTAL NETWORK
1(346)-460-5451