DENTAL BENEFITS

SCHEDULE OF DENTAL BENEFITS

Effective January 1, 2011:

Calendar Year Deductibles:
$150 Individual – In-Network
$250 Individual – Out-of-Network
$300 Family – In-Network
$500 Family – Out-of-Network

Calendar Year Benefit Maximums
$2,000 Individual

Lifetime* Orthodontic Benefit Maximum:
$1,500 Individual

The following schedule summarizes your dental benefits. Please refer to the remainder of the Plan Document for additional Plan provisions, which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
Preventative Services and Diagnostic Services (Type I)	NO		
In-Network		100%	
Out-of-Network		80%	
Basic Services (Type I)	YES		Subject to the annual calendar year maximum.
Fillings In-Network		80%	
Fillings Out-of-Network		60%	
All Other In-Network		60%	
All Other Out-of-Network		40%	
Major Services (Type II)	YES		Subject to the annual calendar maximum.
In-Network		50%	
Out-of-Network		30%	
Orthodontic Services (Type II) In-Network and Out-of Network	NO	50%	Subject to the lifetime orthodontic maximum. Orthodontia expenses do not apply toward the annual calendar year maximum.

***The word "lifetime" refers to the period of time a Covered Person is a participant in this Plan or any other plan sponsored by San Antonio Police Officers and Firefighters Benefit Plan and Trust.**

Type I procedures include covered preventative, diagnostic and basic procedures. Type II procedures include covered major and orthodontic procedures. Both Type I and Type II covered procedures are described in the section entitled "Covered Dental Expenses", below.

General
Dental Benefits provided under this Plan shall be subject to the limitations and exclusions described in this Dental Benefits Section, and to all other terms, provisions, and conditions of this Plan. Except as otherwise stated in this Plan Document, all Dental Benefits shall be paid exclusively for Covered Dental Expenses, subject to the Calendar Year Maximum, the Orthodontic Lifetime Maximum, and any other maximums which may be adopted by the Trustees from time to time.

Free Choice of Dentist
A participant shall have free choice of any legally qualified dentist. If more than one dentist furnishes services or materials for a dental procedure, the Plan shall not be liable for more than its liability had one dentist furnished the services or materials.

About Your Dental Benefits
The Section below, from "Deductibles" to "Benefit Maximums" describes some basic conditions that must be satisfied for this Plan to pay Dental Benefits. These conditions commonly are included in dental benefit plans, but are often overlooked or misunderstood by participants, so it is important that you read them.

Deductibles
A deductible is the amount of Covered Expenses you must pay during a Calendar year before the Plan begins to consider dental care expenses for reimbursement.

Calendar Year Deductible means the deductible to which each Covered Person under this Plan is subject per calendar year for dental Benefits, except that deductibles for Orthodontic Treatment and Preventive and diagnostic procedures, as defined by this Plan, are waived.

Family Deductible means the maximum deductible per calendar year for a Family. After the Family Deductible is met during a calendar year, no further deductible for any Family member shall be required, regardless of the number of persons in the Family. It is calculated as the cumulative sum of all amounts that count toward a Calendar Year Deductible for all Family members; such that the individual Calendar Year Deductible does not have to be met for any Family member as a prerequisite to a Family meeting the Family Deductible, and all amounts that count toward the Calendar year Deductible for any family members are added together to determine if the Family Deductible has been met. The in-network and out-of-network Family Deductibles must be met separately.

The annual individual and family Deductible amounts are shown on the Schedule of Dental Benefits.

Allocation of Deductible
The Plan Administrator reserves the right to allocate the amount of the Deductible to any Covered Dental Expenses, and to apportion the Benefits to the Covered Person and any assignees. Such allocation and apportionment shall be binding upon the Covered Person and all assignees.

Deductible Carry-Over
Covered Expenses incurred in the last three (3) months of a calendar year which were used to meet a participant's Calendar Year Deductible for that year may be used to meet the Calendar Year Deductible for the immediately following calendar year for that participant.

Co-insurance
Co-insurance percentages represent the portions of Covered Expenses paid by you and by the Plan after satisfaction of any applicable Deductible.

The Plan's Co-insurance percentages are shown on the Schedule of Dental Benefits. Your co-insurance percentage is the percentage remaining after subtracting the Plan's from 100%.

Alternative Procedures
If two or more procedures are separately adequate and appropriate treatment for the correction of a specific condition, the amount of the Covered Dental Expenses shall be limited to the charge for the least expensive procedure.

When Expenses Are Incurred
Except as provided otherwise in this paragraph, expenses are considered incurred at the time service is rendered or a supply is furnished. For an appliance, or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened.

Benefit Maximums
Total dental payments for each Covered Person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or lifetime. Whenever the word lifetime appears in this Plan in reference to benefit maximums, it refers to the period of time you participate in this Plan or any other plan sponsored by San Antonio Police Officers and Firefighters Benefit Plan and Trust.

The benefit maximums applicable to the Plan's dental benefits are shown on the Schedule of Dental Benefits.

COVERED DENTAL EXPENSES

Covered Dental Expenses (Type I and Type II)
Covered dental expenses means Reasonable and Customary Charges incurred for the Necessary Care and Treatment of a Covered Person for any of the Type I or Type II procedures described in this Plan Document, or their equivalents. The Trustees may require pre-determination for any Type II procedure in advance of any such procedure being performed, including all Orthodontic Expense Benefits.

Covered Preventative and Diagnostic Services (Type I)
The Plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the Plan. Covered Preventative and Diagnostic Services include, and the deductible is waived, for the following:

Visits and Examinations An initial exam; a periodic exam; an emergency exam; prophylaxis for children under age fourteen (limited to two treatments every 365 days); prophylaxis for individuals age fourteen and over, treatment to include scaling and polishing (limited to two treatments every 365 days, or, if more than two are performed in 365 days, payment shall not exceed 80% of the total cost of all treatments in a 365 day period): and topical application of fluoride, including prophylaxis (limited to two treatments every 365 days).

X-rays All film fees for interpretation and diagnosis, except for Injuries, Sickness or Orthodontia; single film; additional films (up to twelve each); entire denture series consisting of at least fourteen films, including bitewings if necessary (limited to once every three years); intra-oral, occlusal view, maxillary and mandibular, each; superior or inferior maxillary, extra-oral, each additional; two bitewing films, including examination (once every six months); four bitewing films, including examination (once every six months); and panoramic survey, maxilla and mandible firm (once every three years).

Other Visits and Consultations Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures); professional visit after hours (payment will be made on the basis of the services rendered or the visit. whichever is greater): special consultation fee by a specialist for case presentation when diagnostic procedures have been performed by a general dentist; and emergency palliative treatment, per visit.

Space Maintainers All adjustments within six months after installation; fixed space maintainer, unilateral; fixed space maintainer, bilateral; removable space maintainer, unilateral; removable space maintainer, bilateral; diagnostic casts; removable appliance to correct thumb sucking; fixed or cemented appliance to correct thumb sucking; and office visit for observation, adjustment, and activation, more than six months after installation.

Covered Basic Services (Type I)
The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered basic services according to all provisions, requirements and limitations of the plan. Covered Basic Services include, and the deductible is NOT waived for, the following:

Pathology Biopsy of hard oral tissue; biopsy of soft oral tissue; and histopathologic examination.

Oral Surgery:

Extractions Local anesthesia and routine post-operative visits; single uncomplicated extraction; extractions of each additional tooth; surgical removal of erupted teeth; and post-operative visit (sutures and complications) after multiple extractions and impaction.

Impacted Teeth Removal of tooth (soft tissue); removal of tooth (partially bony); and removal of tooth (completely bony).

Alveolar and gingival reconstruction Alveolectomy (without extractions), per Quadrant; alveolectomy (with extraction), per Quadrant; stomatoplasty, complicated, with ridge extension, per arch; removal of exostosis, maxilla or mandible; and excision of hyperplastic tissue, per arch.

Cysts and Neoplasms Intra-oral incision and drainage of abscess; extra-oral incision and drainage of abscess; excision of pericoronal gingiva; sialolithotomy (removal of salivary calculus); closure of salivary fistula; dilation of salivary duct; transplantation of tooth or tooth bud; removal of foreign body from bone (independent procedure); radical resection of bone for tumor with bone graft; maxillary sinusotomy for removal of tooth fragment or foreign body; closure of oral fistula of maxillary sinus; sequestrectomy for osteomyelitis; condylectomy; and menisecromy.

Miscellaneous Incision and removal of foreign body from soft tissue; frenectomy; suture of soft tissue wound or injury, up to 5 cm; and crown exposure for orthodontia.

Anesthesia General anesthesia or intravenous sedation related to surgical procedures only; not covered if there are no surgical procedures.

Periodontics Subgingival curettage, root planing, per quadrant; correction of occlusion when performed in conjunction with periodontal procedures, per quadrant; gingivectomy (includes post-surgical visits), per quadrant; gingivectomy, osseous or muco-gingival surgery (includes post-surgical visits), per quadrant; gingivectomy, treatment per tooth (fewer than six teeth); periodontal scaling and root planing; periodontal prophylaxis; bone graft; soft tissue graft; tissue regeneration; and crown lengthening.

Endodontics Direct pulp capping; indirect pulp capping; pulpotomy (in addition to restoration), per treatment; remineralization (Calcium Hydroxide, temporary restoration), as a separate procedure only, per tooth; root canals including necessary S-Rays and cultures but excluding final restoration; anterior tooth; bicuspid; molar; apicoectomy (including filling of root canal): and apicoectomy (separate procedure).

Restoration Dentistry Restoration dentistry Benefits excludes inlays, crowns, and bridges, but includes the following:

Sealants Limited to children under age sixteen and to molars and bicuspids, occlusal surfaces only, and limited to one sealant per tooth every two years.

Amalgam Restorations: Primary Teeth Cavities involving one, two, three, or four tooth surfaces.

Amalgam Restorations: Permanent Teeth Cavities involving one tooth surface; cavities involving two tooth surfaces; cavities involving three tooth surfaces; and cavities involving four or more tooth surfaces.

Synthetic Restorations Silicate cement filling; acrylic or plastic filling; composite resin involving one surface; composite resin involving two surfaces; composite resin involving three surfaces; and sedative filling.

Crowns Stainless steel (primary teeth only).

Covered Major Services (Type II)

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered major services (Type II) according to all provisions, requirements and limitations of the plan.

Full and Partial Denture Repairs Acrylic Broken dentures, no teeth involved; repair denture, replace one missing or broken tooth; replace additional missing or broken tooth, each tooth; replace missing or broken tooth on denture, no other repairs, and partial denture repairs, based on time and laboratory charges.

Restorative Crowns and gold restorations are covered only when necessitated by decay or Injury. Otherwise, the following restorative Benefits are provided:

Inlays One, two, three, or more tooth surfaces; and onlays per tooth, in addition to inlay allowance.

Crowns Plastic (acrylic); plastic with gold; plastic with nonprecious metal; plastic with semiprecious metal; porcelain; porcelain with gold; porcelain with nonprecious metal; semiprecious metal; gold (full); nonprecious metal (full); semiprecious metal (full); 3/4 gold; and gold dowel pin, in addition to crown.

Prosthetics:

Bridge abutments

Pontics Cast gold; cast nonprecious; cast semiprecious; slotted facing; slotted pontic; porcelain fused to gold; porcelain fused to nonprecious metal; porcelain fused to semiprecious metal; plastic processed to gold; plastic processed to nonprecious metal; plastic processed to semiprecious metal; crown retainer-porcelain; and crown retainer fused to non-precious metal.

Implant Services Surgical placement of implant body (endosteal implant) and abutment placement or substitution (endosteal implant). The maximum Benefit available for one or both of these procedures in connection with any tooth or teeth shall not exceed the maximum Benefit otherwise available for the placement of a corresponding fixed bridge, including any necessary attachments.

Removable (Unilateral Bridges) One piece chrome casting, clasp attachments (all types, per unit).

Recementation Inlay; crown; and bridge.

Repairs, crowns, and bridges

Denture and Partials Fees for dentures, partials, and relining include adjustments within six months after installation. No extra benefit is paid for adjustments because the fees for the dentures, partials, and relining include adjustment fees. Cosmetic techniques and characterizations are not Covered Expenses. Covered Expenses shall include expenses for temporary dentures and partials.

Dentures and partials include: Complete upper denture; complete lower denture partial upper with chrome clasps, acrylic base: partial lower with chrome clasps, acrylic base; partial lower, chrome lingual bar and acrylic base; partial upper,

chrome palatal bar and acrylic base; stress breaker; stayplate, upper; stayplate, lower; immediate splint denture, upper; immediate splint denture, lower; adjustment to dentures more than six months after installation; office reline, complete denture; office reline, partial denture; lab reline, complete denture; lab reline, partial denture; special tissue conditioning, per denture; denture duplication (jump case), complete denture; duplicate of denture; partial denture; addition to teeth of partial denture to replace extracted natural teeth; first tooth, without clasp or abutment; first tooth, with clasp or abutment; each additional tooth; and each additional clasp with rest.

Covered Orthodontic Services (Type II)
The Plan will provide benefits, as outlined on the Schedule of Dental Benefits, for expenses related to orthodontic services according to all provisions, requirements and limitations of the Plan.

Orthodontic Benefits A Covered Person must be covered by the Plan for twelve months before becoming eligible for Orthodontic Benefits. If a Covered Person, while covered for Orthodontic Benefits by the Plan, receives Orthodontic Treatment from a licensed doctor of dentistry, the Plan will pay Benefits in accordance with the following:

Orthodontic Treatment "Orthodontic Treatment" means the movement of teeth by means of active appliances to correct a functional malocclusion, i.e. a malocclusion which interferes with chewing, swallowing or speech, including any one of the following: overbite or overjet; maxillary and mandibular arches in either protrusive or retrusive relation; cross bite; overcrowding of teeth; and all related diagnostic procedures and materials, including x-rays for orthodontic purposes.

Treatment Program "Treatment Program" or "Program" means an interdependent series of orthodontic services prescribed by a licensed doctor of dentistry for orthodontic treatment. A Treatment Program shall begin with generally accepted required diagnostic procedures and shall end when the services are done, or after 24 consecutive months starting with the day the appliances were inserted, whichever is earlier.

Amount of Benefits the Orthodontic Lifetime Maximum for anyone Covered Person shall be subject to the following maximum payment limits:

This Plan will pay one half (50 percent) for any Beginning of Treatment Program Charge, up to a maximum of $500. "Beginning of Treatment Program Charge" means a provider's initial charge imposed before a Treatment Program is begun or as it is beginning.

For any Monthly Course of Treatment Payment, this Plan will pay the amount monthly which is equal to the amount obtained by subtracting this Plan's portion of any Beginning of Treatment Charge from the Orthodontic Lifetime Maximum, and dividing the remainder by the number of months scheduled by the provider for the Treatment Program. No Monthly Course of Treatment Payment will be made for any month following the month in which the Orthodontic Lifetime Maximum is met or the Treatment Program ends, whichever occurs first. "Monthly Course of Treatment Payment" means a monthly payment for a provider's services rendered under a Treatment Program.

Expenses Incurred An orthodontic expense shall be considered incurred as follows:

For insertion of active appliances: on the date of insertion.

For a service rendered to a person who does not pursue a Program: on the date the service is rendered.

For a person who pursues a Program: at the end of each calendar month of a Program, but not beyond the date the Program ends.

Program Payments With the exception of fees for the initial insertion of active appliances, Covered Expenses and Benefits for a Program shall be based on the estimated cost of the Covered Person's Program, and shall be prorated monthly over the estimated length of the Program, but not for more than a total of 24 consecutive months. The last monthly payment for a Program may be changed if the estimated and actual costs of the Program differ.

Coverage Termination If an individual's Coverage terminates during the course of the individual's Program, the total Benefit shall be equal to the sum of only those monthly Benefits which came due while the individual was a Covered Person.

DENTAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this "Dental Limitations and Exclusions" section. This list is intended to give you a general description of expenses for services and supplies that are not covered by this Plan. The Plan only covers those expenses specifically described as covered in the preceding "Schedule of Dental Benefits" and "Covered Dental Expenses" Sections. There may be expenses in addition to those listed below which are not covered by the Plan. Plan benefits will not be paid for any expenses incurred, as follows:

For any treatment which is primarily for cosmetic purposes or for the correction of congenital malformations. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic;

For the replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement for any such item, unless replacement is required for a person: (i) as a result of Injury sustained by him or her while a Covered Person; or (ii) for reasons other than a defect of such prosthetic appliance, crown, inlay, onlay, or fixed bridge;

For any procedure begun: (i) before the Covered Person was covered under this Plan; (ii) after such individual's status as a Covered Person terminates; or (iii) for any prosthetic dental appliance finally installed or delivered more than 30 days after termination of the individual's status as a Covered Person;

For the replacement of lost, misplaced, or stolen appliances;

For appliances, restorations, or procedures to alter vertical dimension, restore or maintain occlusion, splint or replace tooth structure lost as a result of abrasion or attrition, or treat disturbances of the temporomandibular joint;

In connection with an Injury arising out of or in the course of any employment for wage or profit;

By an individual in connection with a Sickness for which he or she is entitled to benefits under any Workers' Compensation Act or similar legislation;

For which the individual is not legally required to pay or which would not have been made had no Coverage existed;

For services which do not qualify as Necessary Care and Treatment;

In connection with war or any act of war, whether declared or undeclared;

For any procedure or other item not included in the "Schedule of Dental Benefits" and "Covered Dental Expenses" Sections of this Plan Document. This exclusion shall not apply to any procedure or item which is the equivalent of a procedure or item included in the "Schedule of Dental Benefits" and "Covered Dental Expenses" Sections, as determined by the Trustees;

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

For missed appointments or the completion of claim forms;

Which exceed Reasonable and Customary Charges;

Which are for dental care furnished by or through (i) a Health Maintenance Organization, or similar organization; or (ii) the United States Government or any political subdivision thereof;

Which are for dental care that does not meet the standards established by the American Dental Association;

Expenses related to services or supplies of the type intended for sport or home use;

For over dentures, including root canal therapy and supportive restorations;

In connection with orthodontic treatment of a person before that person is a Covered Person for at least twelve consecutive months;

After the Covered Person's coverage terminates, except as provided in section below;

For which payment under this Plan is prohibited by any law of the jurisdiction in which such person is living at the time the expenses are incurred;

For any services other than services performed by a Physician, or by a dental student or dental hygienist working under the direct supervision of a Physician; and

For services or supplies, including drugs and medicines, furnished by a hospital or other facility, except a dental school.

EXTENSION OF DENTAL BENEFITS

Dental charges incurred by a Covered Person for dental care furnished within 30 days after termination of the individual's status as a Covered Person shall be considered Covered Expenses, according to the terms of the Dental Care Benefits, if such charges would otherwise be payable, and:

the service involves an appliance, or modification of an appliance, for which the impression was taken prior to the termination of the individual's status as a Covered Person;

the service involves a crown, bridge or gold restoration for which the tooth was prepared prior to the termination of the individual's status as a Covered Person; or

the service involves root canal therapy for which the pulp chamber was opened prior to the termination of the individual's status as a Covered Person; and

the procedure is completed within 30 days after termination of the individual's status as a Covered Person.

Payment shall be made under this section only to the extent the Covered Person is not otherwise entitled to payment under any other like dental coverage of any type or source.

VISION BENEFITS

Vision benefits under this Plan shall be provided to Covered Members, Covered Dependents, and Covered Persons through the Ameritas Fully-Insured Focus® VSP. The vision benefits provided are more specifically described in the Ameritas Fully-Insured Focus® VSP Summary Plan Description.

COORDINATION OF BENEFITS

Notwithstanding any other provision of this Plan, all Benefits with respect to a Covered Person, including, but not limited to, lifetime maximum limitations and deductible provisions, shall be coordinated with the benefits received by the Covered Person under any other program of benefits.

Notwithstanding any other provision of this Plan, if the other plan contains no provision for coordination of benefits, that plan shall be primary and this Plan shall be secondary.

This Plan's maximum expenditure amount under this "Coordination of Benefits" Section shall be the amount the Plan would have paid as a secondary Plan if the other plan has a limitation of coverage that shifts primary payment responsibility to this Plan for benefits that, without such limitation, would have been covered under the other plan.

For Covered Expenses incurred by a Covered Member who is covered under another plan as a dependent, this Plan shall be primary and the other plan secondary; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (i) secondary to the plan covering the person as a dependent and (ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the plan covering the person as a dependent shall be primary and the plan covering that person as other than a dependent shall be secondary. When Medicare is to be the primary payer, this Plan shall base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of those parts.

For Covered Expenses incurred by a Covered Person when covered by another plan as a laid off or retired employee, or as the dependent of such employee, this Plan shall be primary and the other plan shall be secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Covered Expenses under this "Coordination of Benefits" Section include only those expenses for which the Covered Person has completed all necessary steps for payment by the other plan. This Plan will not consider expenses Covered Expenses if the other plan does not pay for the expenses because the Covered Person did not complete such steps. In such a case, this Plan will consider expenses as Covered Expenses only to the extent that such expenses would have been billed and payable under the provisions of this Plan had the Covered Person completed all such steps with the other plan.

When this Plan provides COBRA continuation coverage for a Qualified Beneficiary who is covered under another plan, this Plan shall be secondary and the other plan, if it covers that same person as an active employee or the dependent of an active employee, shall be primary. In such a case, however, this Plan shall be primary for a preexisting condition to the extent such condition is excluded under the other plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

For Covered Expenses incurred by a Dependent who is covered under another plan as an employee or member, the other plan shall be primary and this Plan shall be secondary.

If a Child is covered under plans of both parents, of which this Plan is one, then the plan covering the parent whose birthday, excluding year of birth, falls earlier in the calendar year shall be primary and the plan of the other parent secondary. If the other plan has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefit, the rule based on the gender of the parent shall determine the order of benefits. However, when parents are separated or divorced, the primary plan for the Dependent Child shall be the plan of the parent who has custody of the Child. Secondary liability for the Dependent Child rests with the plan of the stepparent who has custody of the Dependent Child, and will be determined before the plan of

the parent who does not have custody of the Child.

If the specific terms of a divorce decree state which parent has responsibility for the medical expenses of a Dependent Child, then the plan of that parent shall be primary and the plan of the other parent shall be secondary.

If the specific terms of a divorce decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the rule outlined in Section above.

When none of the rules stated above are determinative for a person, the plan which has covered that person continuously for the longer period of time shall be primary.

Definitions

Allowable Expenses means the Reasonable and Customary Charges incurred by a Covered Person, all or a portion of which is covered under at least one of the plans covering that Covered Person. When a plan provides benefits in the form of services rather than cash payments, the Reasonable and Customary cash value of each service rendered shall be considered both Allowable Expenses and a Benefit Charge.

Claim Determination Period means a calendar year or that portion of a calendar year during which a person was covered under a plan.

Plan when not capitalized in this Section, means any of the following which provide benefits for, or services in the form of, medical, vision, or dental care or treatment:

group insurance or any other arrangement of coverage persons in a group, including health maintenance organizations ("HMOs"), whether on an insured or uninsured basis;

coverage on a group basis through Blue Cross, Blue Shield or any other prepayment plan;

any coverage for students which is sponsored by, or provided through, a school or other educational institution;

any coverage under government programs, and any other coverage required or provided by any statute; or

any coverage under "No-Fault" Auto Insurance, by whatever names it is called.

Primary means that this Plan provides Benefits without regard to payment by any other plan.

Secondary means that this Plan pays Benefits and adjusts payment so that the total of benefits available from this Plan and any other plan will not exceed 100% of Allowable Expenses.

Amount of Benefits

The total amount of Benefits payable under this Plan for expenses incurred or services provided for a Covered