Florida
Combined Life

An Independent Licensee of the
Blue Cross and Blue Shield Association

5285369800 RM6600383 003

D. Michelle Urso
2965 Alternate 19 N
Palm Harbor, FL 34683

BlueDental

Florida
Combined Life
An Independent Licensee of the
Blue Cross and Blue Shield Association

Florida Combined Life Insurance Company, Inc.
Post Office Box 45132 Jacksonville, FL 32232-5132
(800) 333-3256

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Florida Combined Life, we know that the privacy of your personal information is important to you. The proper handling of your personal information is one of our highest priorities. We want to be sure that you know why we need to collect personal information from you. We also want you to know how we protect your privacy and the measures we take to safeguard your information.

Customer Information

Florida Combined Life collects and keeps only information that is necessary for us to provide insurance services requested by you and to administer your business with us. We may collect nonpublic personal information:

- From you when you complete an application or other form. This could include information such as name, address, social security number, income and any medical information that you authorized us to collect to underwrite and administer policies and claims.
- From a consumer-reporting agency or Medical Information Bureau as authorized by you.
- As a result of transactions with us, or with our affiliates or others. This could include policy values, policy numbers, payment history, and transactions completed with us.

Sharing Information

We only share your nonpublic personal information with non-affiliated companies or individuals as permitted by law, such as third party administrators and consumer reporting agencies, or to comply with legal or regulatory requirements. In the normal course of our business, we may disclose information we collect about you to companies or individuals that contract with us to perform servicing functions such as record keeping, policy administration, computer processing, joint marketing of products and distribution of statements.

When we provide personal information to a service provider, we require these providers to agree to safeguard your information, to use the information only for the intended purpose, and to abide by applicable law.

How We Protect Information

Only employees with a valid business reason have access to your personal information. These employees are trained and educated on the importance of maintaining the confidentiality and security of this information. They are required to abide by our information handling practices. We maintain security standards to protect confidential information, whether written, spoken, or electronic. We update and test our systems to ensure the protection and integrity of our information.

Maintaining Accurate Information

Our goal is to maintain accurate, up-to-date customer records in accordance with industry standards and state insurance laws. We have procedures in place to keep information current and complete, including timely correction of inaccurate information.

Disclosure of our Privacy Notice

At Florida Combined Life, we recognize and respect the privacy concerns of our potential, current, and former customers. We are committed to safeguarding this information. We are sending you this Notice of Privacy Policy for informational purposes and will update and distribute it as required by law. It is available from our Customer Service Department at 1-800-772-8244. Our Customer Service Department is available between the hours of 8:00 a.m. until 4:00 p.m. Eastern Standard Time, Monday through Friday.

SCHEDULE OF BENEFITS

CONTRACTHOLDER: FREEDOM SENIOR MANAGEMENT LLC

CONTRACT NUMBER: 2K3N44

CERTIFICATE EFFECTIVE DATE: 2021-01-01

PLAN YEAR: January 1st through December 31st

Insureds covered under this contract have the right to obtain care from the dental provider of their choice.

Florida Combined Life Insurance Company., Inc. (FCL) has an agreement with certain dental providers, called Participating Dentists, to accept the lesser of the actual charge or the FCL allowance as payment in full for covered services. Benefits are payable for Participating and Non-Participating Dentists as shown in this Schedule of Benefits. See the Provider Alternatives provision for further details.

Eligibility and Deductibles

Dependent Child(ren) to Age	26/26	
Domestic Partner	Not Eligible	
Dependent Child(ren) of Domestic Partner	Not Eligible	
	Participating Dentists	**Non-Participating Dentists**
Deductible for Preventive Services	None	None
Individual Deductible Per Insured, Per Plan Year for Basic and Major Services	$50	$100
Family Deductible Per Plan Year for Basic and Major Services	$150	$300

Coinsurance payable by FCL for covered services

Preventive	100%	100%
Basic	90%	80%
Major	60%	50%

Maximums and Waiting Periods

Plan Year Maximum***	$1,250	$1,250
Waiting Period for Major Services Initial Enrollment* Subsequent Enrollment**	None None	
Waiting Period for Replacement of Missing Teeth	None	

The following services are covered as follows:

Sealants	Preventive Benefit
Full Mouth/Panoramic X-rays	Preventive Benefit
Space Maintainers	Preventive Benefit
Bitewing X-rays	Preventive Benefit
Non-Surgical Periodontic Services	Major Benefit

* Insureds who enroll on the original effective date

** Insureds who enroll after the original effective date

*** If there is a different Plan Year Maximum for Participating Dentists and Non-Participating Dentists this does not mean there are two independent amounts of benefits for Covered Services, but rather, that once the Plan Year Maximum for Non-Participating Dentists has been paid by FCL no further Non-Participating Dentist benefits will be available, and the only available benefits will be the difference in the Plan Year Maximum for Participating Dentists and Non-Participating Dentists for Covered Services received by a Participating Dentist.

Surgical Periodontic Services	Major Benefit
Endodontic Services	Major Benefit
Prophylaxis (cleaning)	Two times per plan year
Oral Examination	Two times per plan year
Periodontal Maintenance Including Prophylaxis	Two times per plan year

Riders

Orthodontia Services	Child to Age 19	
Waiting Period for Orthodontia Services		
Initial Enrollment*	None	
Subsequent Enrollment*	None	
Orthodontia Lifetime Maximum**** Per Insured	$1,000	$1,000
Orthodontia Coinsurance Payable by FCL	50%	50%

**** If there is a different Orthodontia Lifetime Maximum for Participating Dentists and Non-Participating Dentists this does not mean there are two independent amounts of benefits for Covered Services, but rather, that once the Orthodontia Lifetime Maximum for Non-Participating Dentists has been paid by FCL no further Non-Participating Dentist benefits will be available, and the only available benefits will be the difference in the Orthodontia Lifetime Maximum for Participating Dentists and Non-Participating Dentists for Covered Services received by a Participating Dentist.

* Insureds who enroll on the original effective date
** Insureds who enroll after the original effective date
*** If there is a different Plan Year Maximum for Participating Dentists and Non-Participating Dentists this does not mean there are two independent amounts of benefits for Covered Services, but rather, that once the Plan Year Maximum for Non-Participating Dentists has been paid by FCL no further Non-Participating Dentist benefits will be available, and the only available benefits will be the difference in the Plan Year Maximum for Participating Dentists and Non-Participating Dentists for Covered Services received by a Participating Dentist.

FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203

Florida Combined Life Insurance Company, Inc. (herein referred to as "FCL") agrees to provide the dental benefits described in this contract, subject to its terms. This is a legal contract between the contractholder and FCL. The consideration for this contract is the contractholder's application and the payment of the initial premium.

The provisions on the following pages, including any endorsements, riders, or amendments, are a part of this contract. Also a part of this contract are the provisions of the certificate.

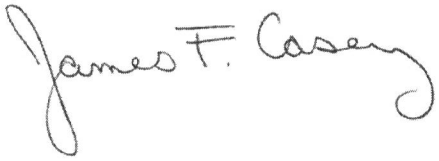
The contract effective date and anniversary are shown on the Schedule of Benefits. All periods of time under this contract will begin and end at 12:01 a.m. at the contractholder's address.

As used in this contract, the words "we," "us," and "our" refer to Florida Combined Life Insurance Company, Inc.

Signed for the Florida Combined Life Insurance Company, Inc. at Jacksonville, Florida, on the contractholder's effective date.



Secretary



President

GROUP DENTAL BENEFITS CONTRACT

This Contract Contains A Deductible Provision

FOR CUSTOMER SERVICE ASSISTANCE: 888-224-4049*

***This telephone number is available to Contractholders to present inquiries or obtain information about coverage and to provide assistance in resolving complaints.**

Florida Combined Life Insurance Company, Inc. and Blue Cross and Blue Shield of Florida, Inc. are Independent Licensees of the Blue Cross and Blue Shield Association.

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SECTION I

GENERAL CONTRACT PROVISIONS

Consideration

The consideration for this contract is the contractholder's application and the payment of the initial premium.

Entire Contract

The entire contract between the contractholder and FCL consists of:

1. this contract, including the Schedule of Benefits and certificate provisions (and any amendment, rider, or endorsement thereto);
2. the group application ; and
3. employees' applications.

Representations on the Group Application

FCL relies on the information the contractholder provides on the group application to determine whether to issue this contract to the contractholder and to determine the appropriate rate and financing method. All statements made on the group application are representations and not warranties, except in the case of fraud.

No statement made by the contractholder shall be used to contest the validity of the contract unless contained in the application or other written statement, signed by the contractholder, and a copy has been given to the contractholder.

Term of this Contract

This contract will take effect as of the proposed effective date set forth on the contractholder's group application, provided that prior to such proposed effective date: (1) FCL approves the group application; (2) FCL receives the applicable premium payment from the contractholder; and (3) FCL receives accurate and complete initial enrollment information from the contractholder. The effective date of this contract is set forth on the Schedule of Benefits. This contract will remain in effect until it is terminated according to the terms of the contract.

Modification of Contract

No provision of this contract may be modified except by written agreement signed by our President, Secretary, or Vice President. The validity of such a change will not be subject to the consent of any certificateholder or any insured. Only these named officers have the authority to modify this contract, waive any of our rights or requirements, or make any promise with respect to benefits under this contract. No agent can change this contract or waive any of its terms.

Any amendment to this contract shall be without prejudice to claims for dental benefits incurred prior to the effective date of the amendment.

Conformity with State Statutes

If, on the effective date, any part of this contract does not conform to minimum state statutory requirements that govern it, the contract is hereby amended to include such minimum requirements.

ERISA

FCL is not the plan sponsor or administrator as defined by the Employee Retirement Income Security Act ("ERISA"), as amended, and federal regulations. The contractholder, as either plan sponsor or administrator of an employee welfare benefit plan, is responsible for ensuring compliance with ERISA.

Promissory Estoppel

No oral statements, representations, or understandings by any person can change, alter, delete, add, or otherwise modify the express written terms of this contract to provide for services or supplies that are not covered hereunder.

Non-Waiver of Defaults

Any failure by FCL, at any time, to enforce or to require strict adherence to any of the terms or conditions of this contract, shall in no event constitute a waiver of any such terms or conditions and shall not affect FCL's right to strictly enforce any terms or conditions in the future or to avail itself of any legal remedy it may have.

Notices

Any notice or consent required or permitted under this contract shall be considered given if hand-delivered, or if mailed by United States mail or an overnight delivery service (e.g., Federal Express), postage prepaid, and addressed as set forth below. Such notice shall be considered effective as of the date delivered or deposited in the mail.

If to FCL:

Florida Combined Life Insurance Company, Inc.
4800 Deerwood Campus Parkway, Bldg. 200
Jacksonville, Florida 32246

If to Contractholder:

To the address currently on file with FCL

If to an Insured:

To the certificateholder's address currently on file with FCL.

FCL must be notified immediately of any address changes.

Reservation of Right to Contract

FCL reserves the right to contract with any individuals, corporations, associations, partnerships, or other entities, for assistance with the administration of this contract or any section of this contract.

Service Mark Use

This contract constitutes a contract solely between the contractholder and Florida Combined Life Insurance Company, Inc. (FCL). Florida Combined Life is an independent corporation and a subsidiary of Blue Cross and Blue Shield of Florida, Inc. (BCBSF). Both BCBSF and FCL operate under a license from the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, permitting them to use the Blue Cross and Blue Shield Service Marks in the State of Florida. Florida Combined Life is not contracting as the agent of BCBSA. This contract is not based on representations by any person, entity, or organization other than FCL. No person, entity, or organization other than FCL shall be held accountable or liable to the contractholder for any of FCL's obligations to the contractholder created under this contract. This paragraph shall not create any additional obligations whatsoever on the part of FCL, other than those obligations created under other provisions of this agreement.

SECTION II

POLICY PROVISIONS

Furnishing and Verification of Information

The contractholder will furnish us, on a timely basis, all information we need to administer the coverage and to determine premiums under this contract. Such information includes, but is not limited to, data on: 1.) new eligible employees; 2.) the insureds; and 3.) terminations. The contractholder will keep records of the insureds and the specifics of their coverage.

The contractholder must also provide us proofs we may reasonably require regarding this contract or an insured under this contract. We have the right to review the contractholder's records pertaining to the benefits under this contract.

If the coverage is home-office administered, the billing statement we prepare is the contractholder's record of enrollment information received and processed as of the date the statement is prepared. The contractholder must check it to see if it is correct and must let us know if it is not correct.

If the coverage is self-administered with respect to premium records and remittance, the contractholder is responsible for the preparation and accuracy of billing statements and for maintaining accurate enrollment information.

Clerical Error

Any clerical error or failure will not alter the status of insurance otherwise validly in force or validly terminated. We will make an equitable adjustment of premiums.

Individual Certificates

We will provide the contractholder with dental benefit certificates for each insured employee. The contractholder will give the certificates to the insured employees. The certificates will set forth the following:

1. the certificateholder's coverage;
2. the limitations and requirements of this contract; and
3. any dependent's coverage.

Assignment and Delegation

This contract and the obligations hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that FCL may assign this agreement at any time to its successor in interest or to an affiliated entity without the consent of the contractholder. Any assignment, delegation, or transfer made in violation of this provision shall be void and of no effect.

Premiums

The first premium must be paid to put the group contract in force. It is due on the effective date shown on the Schedule of Benefits. Each premium after the first is due on or before the date shown on the contractholder's application for group dental insurance.

Premiums are payable to the date of termination, including any grace period in which insurance is provided. If we receive written notice prior to the premium due date, that the contract will terminate on the due date, no premium will be due. This notice must comply with the requirements of "Termination by the Contractholder."

Payment of Premium

Premiums are payable at the address listed on the invoice. Payment to any person or entity not authorized and approved by us in writing will not be payment to us. A check will not be payment unless honored by the bank.

Grace Period

FCL allows a thirty-one (31)-day grace period to pay each premium, after the first one. The contract will remain in force until the end of the grace period. The contractholder will be charged a premium for the grace period. A grace period will not begin if the contractholder gives us written notice that the contract is to be cancelled. This notice must comply with the requirements of "Termination by the Contractholder."

Premiums for Associated Companies

The contractholder is responsible for the amount and for the timely payment of any premium which applies to any associated companies, whether or not separate premium statements are produced.

Right to Change Premium Rates

FCL may modify the rates at any time, after the contract has been in force for twelve (12) months. However, we may change premium rates at any time if the benefits and provisions of the contract are modified. We will give the contractholder forty-five (45) days' advance written notice any time the rates are changed. The contractholder shall immediately notify each certificateholder whose contribution requirement is changed due to a change in rates.

Contract Termination and Renewal

If the contract terminates for any reason, the contractholder must pay all premiums then due and unpaid. The contractholder's receipt of any premium notice for a month after the termination date will not affect the termination date, unless we notify the contractholder of such in writing. If, prior to the termination date, FCL receives a premium for a month after the termination date, the contract will not continue in force beyond such termination date, unless agreed to in writing by us. If we do not agree to accept such payment, it will be refunded.

We will honor all valid claims that arise prior to the termination date.

Termination by the Contractholder

The contractholder may terminate this contract, at the end of an insurance month, by giving us thirty-one (31) days' advance written notice. The termination will take effect on the last day of the insurance month for which the contractholder has requested termination.

Termination for Nonpayment of Premium

Unless the contractholder gives us written notice of termination before a premium becomes due, the contractholder must pay the premium then due and unpaid. Insurance will remain in force during the grace period. If a premium is not paid before the grace period ends, the contract will terminate at the end of that period.

Termination by the Insurance Company

FCL may terminate this contract at the end of an insurance month, provided we give the contractholder forty-five (45) days' advance written notice. Upon receipt of such notice, the contractholder shall immediately notify each certificateholder of the termination. This advance written notice does not apply for termination due to nonpayment of premium.

Contract Renewal

The contract may be renewed:

1. if FCL and the contractholder agrees;
2. by timely payment of premiums; and
3. on each contract anniversary.

Termination of an Insured's Coverage under this Contract

Notice of Termination by the Contractholder

If an insured fails to continue to meet the eligibility requirements, the contractholder shall, if possible, provide FCL with advance written notice of such ineligibility. In any event, written notice of such ineligibility shall be provided by the contractholder to FCL no later than ten (10) days after such insured is no longer eligible.

Financial Responsibilities of the Contractholder

The contractholder shall support and cooperate with FCL to recover any payments FCL made for or on behalf of any insured whose coverage under this contract terminated or should have been terminated prior to the date the service or supply was provided. In the event the contractholder does not provide FCL with notice that an insured fails to continue to meet the applicable eligibility requirements within the ten (10) day period as required above, the contractholder shall be liable to FCL for any premium due on the insured's behalf or to the extent of any payments made by FCL for services or supplies provided after such ten (10) day period.

FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203

Florida Combined Life Insurance Company, Inc. (herein referred to as "FCL") has issued a group insurance contract to your employer, the contractholder. The contract is between the contractholder and FCL, and through which you are provided dental insurance coverage.

This is your certificate of coverage, as long as you are a certificateholder. While this insurance is in effect, FCL agrees to provide dental benefits as set forth in this certificate, subject to its terms, conditions, limitations, and exclusions.

This certificate is issued in consideration of the employee's application for dental insurance coverage and the payment by the contractholder of the applicable premium rates. All periods of time under this certificate will begin and end at 12:01 a.m. at the contractholder's address.

Any provision of this certificate which, on its effective date or anytime thereafter, is in conflict with the laws of the State of Florida, or Federal law, is hereby amended to conform to the minimum requirements of such laws.

Signed for the Florida Combined Life Insurance Company, Inc. at Jacksonville, Florida, on the certificateholder's effective date.

Secretary **President**

GROUP DENTAL BENEFITS CERTIFICATE

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. Y**OU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT**. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

This Certificate Contains A Deductible Provision

FOR CUSTOMER SERVICE ASSISTANCE: 1-888-223-4892*

***This telephone number is available to Certificateholders to present inquiries or obtain information about coverage and to provide assistance in resolving complaints.**

Florida Combined Life Insurance Company, Inc. and Blue Cross and Blue Shield of Florida, Inc., are Independent Licensees of the Blue Cross and Blue Shield Association.

If you, or someone you're helping, has questions about BlueDental Choice Plus PPO Policy, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-223-4892.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de BlueDental Choice Plus PPO Policy, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-223-4892.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan BlueDental Choice Plus PPO Policy, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-888-223-4892.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về BlueDental Choice Plus PPO Policy, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-223-4892.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o BlueDental Choice Plus PPO Policy, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-888-223-4892.

如果您，或是您正在協助的對象，有關於 插入項目的名稱 BlueDental Choice Plus PPO Policy 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-888-223-4892。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de BlueDental Choice Plus PPO Policy, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-223-4892.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa BlueDental Choice Plus PPO Policy, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-223-4892.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу BlueDental Choice Plus PPO Policy, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-223-4892.

نإ ناك كيدل وأ ىدل صخش مدعاست ةلئسأ صوصخب BlueDental Choice Plus PPO Policy ، كيدلف قحلا يف لوصحلا ىلع مدعاسملا تامولعملاو ةيرورضلا كتغلب نم نود ةنإ ةقلك. ثدحتلل عم مجرتم لصتا ب 1-888-223-4892.

Se tu o qualcuno che stai aiutando avete domande su BlueDental Choice Plus PPO Policy, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-888-223-4892.

Falls Sie oder jemand, dem Sie helfen, Fragen zum BlueDental Choice Plus PPO Policy haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-223-4892 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 BlueDental Choice Plus PPO Policy 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-223-4892 로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie BlueDental Choice Plus PPO Policy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-223-4892.

જો તમે કે તમે મદદ કરી રહ્યા હો તેમને BlueDental Choice Plus PPO Policy વિશે પ્રશ્નો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઇ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-888-223-4892.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ BlueDental Choice Plus PPO Policy คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892

1557 NON-DISCRIMINATION NOTICE

Florida Combined Life Insurance Company, Inc. (FCL) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. FCL does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

FCL:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 1-888-223-4892

If you believe that FCL has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
Email civilrightscoordinator@fclife.com.

You can file a grievance in person or by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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SECTION I

DEFINITIONS

Adverse Benefit Determination - means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the certificate with respect to a claim.

Allowance Or Allowable Expense - means the maximum amount on which FCL will base payment for dental benefits covered under the contract or the maximum amount established by a third party contracted by FCL to provide dental benefits through their network. The allowance for participating dentists is determined and established solely by FCL or the contracted third party and is subject to change at any time without notice to or consent of the contractholder or any insured. The allowance for non-participating dentists is based on usual and customary charges.

Annual Open Enrollment Period - means a specified period of time during which individuals can apply for coverage. This period occurs prior to the effective date of the contract; and thereafter, annually for a specified period of time, established by us, which occurs prior to the contract anniversary date.

The annual open enrollment period is shown on the contractholder's application for insurance.

Certificateholder - means the employee, or other individual, who meets and continues to meet the applicable eligibility requirements and is covered under this certificate, other than as a dependent.

Coinsurance - means the sharing of expenses for covered dental benefits between FCL and the insured. After the insured's deductible is met, FCL will pay a percentage of the allowance, as shown on the Schedule of Benefits. The insured is responsible for the remaining percentage of the allowance, if any, and for all non-covered services.

For services received from a non-participating dentist, the insured is also responsible for the difference between the FCL allowance and the actual dentist charges, if any.

Contract - means this certificate, the contract issued to the contractholder, the application for coverage signed by the contractholder, the applications completed by the contractholder's employees, the identification card issued to the insured and any attached endorsements, amendments or riders.

Contract Anniversary Date - means the same day and month as the contract effective date for each year the contract stays in force.

Contractholder - means your employer who has contracted with FCL to provide dental benefits to its employees. The contractholder will also act on behalf of any subsidiary, division or affiliate specified in the contractholder's application for insurance. Every action taken by the contractholder will be binding on them.

Deductible - means the amount of charges, up to the allowable expenses, an insured must pay each Plan Year before our reimbursement for dental benefits begins. To calculate the amount to be applied towards satisfying the deductible, only allowable expenses are applied. For Example:

if your deductible amount = $50.00
and the charges = $30.00
and the allowable expense = $25.00
then the amount applied towards your deductible = $25.00

Dental Benefits - means those medically necessary covered services and supplies as set forth in this certificate and any rider or endorsement attached to it.

Dental Services Waiting Period - if shown in the Schedule of Benefits, means the period of time an insured must wait before benefits are payable for specific dental services.

Dentist - means a duly licensed doctor of Dental Surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the service is rendered, and acting within the scope of his or her license.

Dependent - means your legal spouse and/or natural, newborn, adopted, foster, or step child(ren), or a child for whom you have been court-appointed as legal guardian or legal custodian. A child may be considered a dependent until the end of the calendar year in which the child reaches the age specified in the Schedule of Benefits. The definition of Dependent and all references to dependent and legal spouse include a domestic partner who has met all the eligibility requirements of a domestic partnership, unless domestic partners are excluded in the Schedule of Benefits. The definition of dependent also includes the dependents of a domestic partner unless excluded in the Schedule of Benefits.

A dependent cannot be: (1) insured as a dependent and an employee; (2) insured under more than one insured employee; or (3) in full-time military service.

The age limit that applies to dependent children will not apply to any insured child who: (1) remains dependent on you for support and maintenance; and (2) is incapable of self-sustaining employment due to physical handicap or mental retardation.

The symptoms or causes of physical handicap or mental retardation must have existed prior to the limiting age and while the child was covered under this contract.

If a claim is denied because the child has reached the limiting age, it is your responsibility to provide proof that the child meets the contract's requirements for extended eligibility. We may, at any time, require proof satisfactory to us that a child continues to meet such requirements. This extended eligibility provision does not modify any eligibility requirement other than the limiting age requirement.

Employee - means a person who is directly employed by the contractholder on a permanent basis and normally works at least the number of hours each week as specified on the contractholder's application.

Experimental or Investigational - means services or supplies that are determined by FCL to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

a. there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

b. approval is required by the FDA and has not been granted for marketing; or

c. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or

d. the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same

drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Insured - means the certificateholder or any eligible dependent covered under this certificate. Eligibility requirements for certificateholders and eligible dependents are specified in the Eligibility For Coverage and Enrollment and Effective Date of Coverage sections of this certificate.

Medicare - means any coverage under Title XVIII of the Federal Social Security Act. If this Act is amended, this term will mean any coverage provided under the amended Act.

Medically Necessary - means any services, care, or supplies received while covered, which are determined by FCL, to be: 1) consistent with the symptom, diagnosis, and treatment of the insured's condition; 2) in accordance with standards of good dental or medical practice; 3) approved by the appropriate dental or medical body or board for the condition in question; 4) not primarily for the comfort or convenience of the insured, or dentist; 5) the most appropriate, efficient, and economical dental or medical supply, service, or level of care which can be safely provided; and 6) not cosmetic in nature. FCL will make final determination as to which services are medically necessary based upon review by our consulting dentists.

NOTE: The fact that a dentist may prescribe, order, recommend, furnish or approve a service or supply does not, of itself, make it medically necessary or a covered service; nor does it make the charge an allowable expense under this certificate, even though it is not specifically listed as an exclusion.

Non-Participating Dentist - means a dentist who HAS NOT signed an agreement with FCL or an agreement with a third party contracted by FCL to provide dental benefits through their network, to accept the allowance as payment in full for his or her services.

Participating Dentist - means a dentist who HAS signed an agreement with FCL or an agreement of a third party contracted by FCL to provide covered dental benefits through their network. If an insured receives covered services or supplies from a participating dentist, payment of dental benefits will be made directly to the participating dentist. These dentists will file claims on the insured's behalf.

Plan Year - with respect to the dental benefits of this contract, means the 12-month period specified on the contractholder's application and on the Schedule of Benefits.

Plan Year Maximum – means the total amount FCL will pay in a Plan Year for Covered Services. This total amount is listed in the Schedule of Benefits. If there is a different Plan Year Maximum for Participating Dentists and Non-Participating Dentists this does not mean there are two independent amounts of benefits for Covered Services, but rather, that once the Plan Year Maximum for Non-Participating Dentists has been paid by FCL no further Non-Participating Dentist benefits will be available, and the only available benefits will be the difference in the Plan Year Maximum for Participating Dentists and Non-Participating Dentists for Covered Services received by a Participating Dentist.

Predetermination - means the pretreatment review by FCL of a treatment plan to determine the eligibility of the insured and the amount payable under the contract.

Treatment Plan - means the dentist's written report of a series of procedures and estimated charges recommended for the treatment of dental disease, defect or injury, which is prepared for an insured as a result of an examination made by such dentist.

Usual and Customary Charges - means an amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar conditions in the locality

where the service is performed. Payment under this contract for covered services provided by a non-participating dentist is based on usual and customary charges.

Waiting Period - means the length of time an individual must be employed by the contractholder before he or she is eligible for coverage under the contract. This period, if any, is specified on the contractholder's application.

We, Us, And Our - means Florida Combined Life Insurance Company, Inc. (FCL).

You And Your - means the certificateholder who is in a class eligible for employee insurance.

SECTION II

GENERAL PROVISIONS

General Contract Provisions

Representations on Group Applications

FCL relies on the information provided by an individual on the application to determine whether he or she is eligible for and entitled to coverage under the contract. All statements made on the application are representations and not warranties, except in the case of fraud.

No statement made by the insured shall be used to deny or reduce benefits unless contained in the application or other written statement signed by the insured, and a copy has been given to the insured.

Identification Cards

The identification card issued to you in no way creates, or serves to verify, eligibility or coverage under the contract. Identification cards are the property of FCL and must be destroyed or returned to FCL immediately following termination of coverage.

Extension of Benefits Upon Contract Termination

If an insured is receiving covered dental treatment as of the termination date of the contract, FCL will provide a limited extension of the dental care benefits provided by the contract, if:

a. a course of treatment or dental procedures were recommended in writing and commenced while the insured was covered under the contract; and
b. the dental procedures were for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and
c. the dental procedures were performed within ninety (90) days after the insured's coverage terminated under the contract, and the termination did not occur as a result of your voluntary termination of coverage.

This extension of benefits is for covered services necessary to complete the dental treatment only. This extension of benefits will automatically terminate on the earlier of: (a) the date, ninety (90) days after the contract terminates; or (b) the date the insured becomes covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or services for similar dental procedures.

Non-Duplication Of Coverage Under Government Programs or Extension of Benefits

The dental benefits under this certificate shall not duplicate any dental benefits to which the insured is entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Champus, Veterans Administration) to the extent allowed by law, or under any extension of dental benefits of coverage under a prior plan or program which may be provided or required by law.

Change In Provider Networks

FCL's provider networks included the provider network of a third party contracted by FCL to provide dental benefits through their network are subject to change at any time without the consent of or notice to the contractholder or any insured. It is the insured's responsibility to determine whether a dental care provider is participating in FCL's provider network(s) at the time the service or supply is rendered.

Claims Processing

Participating dentists have agreed to file claims for services and supplies with FCL on the insured's behalf.

If the insured obtains dental benefits from a dental care provider who does not file the claim on the insured's behalf, it is the insured's responsibility to file the claim with FCL.

Notice of Claim

Written notice of claim must be given to us:

1. within twenty (20) days after the date a loss covered by the group contract occurs; or
2. as soon thereafter as reasonably possible.

The notice may be given to us at our home office or to one of our authorized representatives. Notice should include the insured's name and group contract number.

Claim Forms

We will furnish claim forms for filing proof of loss within fifteen (15) days after we receive notice of the claim. If we do not do so, the insured can meet the proof of loss requirement by giving us this proof:

1. within the time limit for filing "Proof of Loss" stated below; and
2. covering the occurrence, nature, and extent of the loss.

Proof of Loss

Proof of loss: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to the insurer within ninety (90) days after the end of each period for which the insurer is liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, the insurer shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

To file a claim, the insured must obtain an itemized statement from the dental care provider and attach it to a completed ADA claim form. The insured may obtain an ADA claim form by contacting us at our home office. The itemized statement must contain the following information: (a) the date the dental benefit was provided; (b) a description of the dental benefit; (c) the amount actually charged by the provider; (d) the provider's name and address; (e) the patient's name; and (f) the certificateholder's name.

Payment, Contest or Denial of Claims

We will pay, contest or deny a claim, or any part of a claim, within the timeframes described below.

Payment of Claims

Benefits not assigned will be paid to the insured. Loss-of-life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the insured's estate. Any other benefits unpaid at death may be paid, at the insurer's option, either to the insured's beneficiary or estate.

We will use our best efforts to pay a claim or any part of a claim that establishes proof of loss and contains, as determined by us, all the information we need to pay the claim, as follows:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within forty (40) days of our receipt.

We may provide the claimant notice of payment within thirty (30) days of receipt.

If we are unable to determine if a claim or any part of a claim is payable because additional information is needed, we may contest the claim as set forth below.

Contested Claims

If a claim is contested or additional information is needed, we will use our best efforts to provide notice that the claim or any part of the claim is contested, within the following timeframes:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within thirty (30) days of our receipt.

This notice will identify:

1. the contested portion or portions of the claim;
2. the reason(s) for the contest;
3. the date we reasonably expect to notify the claimant of the decision; and
4. the additional information needed.

If we request additional information, we must receive it within forty-five (45) days of the request. Upon receipt of the requested information, we will use our best efforts to complete the processing of the claim within fifteen (15) days of receipt. If we do not receive the requested information, the claim will be processed based on the information we possess at the time, and it may be denied.

Denied Claims

If a claim is denied, we will use our best efforts to provide notice that the claim or any part of the claim is denied, within the following timeframes:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within thirty (30) days of our receipt.

This notice will identify:

1. the denied portion or portions of the claim; and
2. reason(s) for the denial.

It is the claimant's responsibility to provide all information determined by us as necessary to process a claim. If we do not receive the necessary information, the claim or any part of the claim may be denied.

Any claim that is denied is an adverse benefit determination. A claimant has the right to appeal an adverse benefit determination for a claim as specified in "Appeal of an Adverse Benefit Determination."

Time of Payment of Claims: After receiving written proof of loss, FCL will pay monthly all benefits then due for covered dental benefits. Benefits for any other loss covered by this policy will be paid as soon as the insurer received proper written proof.

FCL will use its best efforts to pay or deny all claims within the following timeframes:

1. for an electronically filed claim, within ninety (90) days of our receipt;
2. for a claim filed on a paper claim form, within one hundred twenty (120) days after our receipt.

Processing of the claim will be considered complete on the date notice of the claim decision is deposited in the mail by FCL or otherwise electronically transmitted.

Any claims payment not made within the applicable timeframe shall bear simple interest at the rate specified by law.

FCL will investigate any allegation of improper billing by a provider, upon written notice from an insured. If we determine that the insured was billed for a service that was not actually performed, any payment amount will be adjusted, and if applicable, a refund will be requested. In such a case, if payment to the provider is reduced due solely to the notice from the insured, FCL will pay the insured twenty (20) percent of the amount of the reduction, up to $500.

Appeal of an Adverse Determination

The insured, or a representative designated by the insured in writing, has the right to appeal an adverse benefit determination. The insured's written appeal must be filed with FCL within 180 days of the original adverse benefit determination.

We will review the insured's appeal under the following guidelines:

1. we must receive the appeal orally or in writing;
2. the insured may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
3. if the adverse benefit determination is based on the lack of medical necessity of a specific service or experimental, investigational or other similar limitations or exclusions, the insured may request at no charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the certificate to the insured's circumstances;
4. during the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;
5. we may consult with appropriate dentists, as necessary; and
6. any independent medical or dental consultant who reviews an insured's adverse benefit determination on FCL's behalf will be identified upon request.

We will use our best efforts to review an insured's appeal of an adverse benefit determination and notify the insured of our review decision within sixty (60) days of our receipt.

An insured, or a provider acting on behalf of the insured, who has had a claim denied as not medically necessary, has the right to appeal the claim denial. The appeal may be directed to an independently contracted licensed dentist by FCL who is responsible for medical necessity reviews. The appeal may be by telephone and the dentist will respond to the insured within a reasonable time, not to exceed fifteen (15) business days.

A federal law, known as the Employee Retirement Income Security Act of 1974 (ERISA), as amended, may apply to a certificateholder's group plan. If ERISA applies to the certificateholder's plan, the certificateholder or his or her covered dependents are entitled, after exhaustion of the appeal procedures provided for under the plan, to pursue civil action under Section 502(a) of ERISA in connection with an adverse benefit determination or any other legal or equitable remedy otherwise available.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims under the contract, we may need information, including medical information, from the dental care provider who rendered the service or supply. Insureds shall cooperate with FCL in its effort to obtain such information by, among other ways, signing any release of information form as requested by us. An insured's failure to fully cooperate with us will result in a denial of the pending claim and we will not be liable for such claim.

Physical Examination

We, at our expense, have the right to have the insured examined by a dental care provider of our choice as often as is reasonably necessary while a claim is pending. Failure by an insured to fully cooperate with such examination shall result in a denial of the pending claim and we will not be liable for such claim.

Legal Actions

No claimant may sue for payment of a claim:

1. within sixty (60) days after the date proof of loss is sent as required; or
2. if, from the time proof of loss is required to be given, the applicable statute of limitations has expired.

Fraud, Misrepresentation or Omission in Applying for Benefits

FCL relies on the information provided on the itemized statement and the claim form when processing a claim. All information must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in denial of the claim.

Explanation of Benefits Form

All claims decisions, including denial and claims review decisions, will be given to the insured in writing in an explanation of benefits form. This form may indicate:

a. the reason(s) the claim was denied;
b. a reference to the certificate provision upon which the denial is based;
c. a description of additional material or information necessary to make the claim payable and why such material or information is necessary; and
d. an explanation of the steps to be taken if an insured wants a claim denial decision reviewed.

IF YOU HAVE ANY QUESTIONS ON YOUR SUBMISSION OF CLAIMS OR BENEFITS
CALL 1-888-223-4892

OR
WRITE TO

FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
DENTAL ADMINISTRATOR
P.O. BOX 1047, ELK GROVE VILLAGE, IL 60009-1047

SECTION III

ELIGIBILITY

Only the following individuals are eligible to apply for coverage under the contract. FCL may require acceptable proof that an individual meets and continues to meet the eligibility requirements.

Certificateholder Eligibility Class

If you are an employee of the contractholder and you meet each of the following requirements, you are eligible to apply for coverage under the contract:

1. you must be in an eligible class as shown on the contractholder's application;
2. you must work at least the number of hours each week which is specified on the contractholder's application; and
3. you must have completed any applicable waiting period set forth on the contractholder's application.

Dependent Eligibility Class

The following individuals are eligible to apply for dependent coverage under this certificate:

1. your legal spouse; and
2. a child under the limiting age who is your natural, newborn, adopted, foster, or step child(ren), or a child for whom you have been court appointed as legal guardian or legal custodian.

Extension of Eligibility For Certain Dependent Children

The limiting age for dependent children may be extended for a handicapped child as specified in the definition of "Dependent."

SECTION IV

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Initial Enrollment/Electing Coverage

Employees who are eligible to apply for coverage under the contract may do so by completing an application and forwarding it to the contractholder.

Effective Date Of An Individual's Coverage Following Enrollment

Coverage for an individual who meets the eligibility requirements prior to the effective date of the contract will begin on such effective date provided we receive the application during the first annual open enrollment period. The first annual open enrollment period must occur prior to the contract effective date.

Coverage for an individual who first meets the eligibility requirements after the effective date of the contract (e.g., newly hired employees and their dependents), will begin on the date specified on the application, provided we receive the application within the thirty-one (31)-day period after the individual first meets the eligibility requirements.

Any individual who does not apply within the thirty-one (31)-day period after he or she first meets the eligibility requirements, must wait until the next annual open enrollment period to apply. We must receive the application during the annual open enrollment period. Insurance will take effect on the next contract anniversary date.

Changes In Coverage/Effective Date

Marital Status

If you wish to add dependents to your coverage, due to a change in marital status, such change will take effect on the first billing date after we approve the change request. We must receive requests to add dependents to your coverage within thirty (30) days after the date of the marriage.

Newborn Children

Coverage for a newborn child will take effect from the moment of birth. If we receive a change request within sixty (60) days after the date of birth, premium will not be charged for the first thirty (30) days of coverage. If we do not receive a change request within sixty (60) days after the date of birth, we may charge an additional premium from the date of birth.

Coverage for a newborn child born to a covered dependent, other than your dependent spouse, will automatically terminate eighteen (18) months after the birth of the newborn child.

Newborn coverage also includes coverage for the transportation of a newborn child to and from the nearest available facility appropriately staffed and equipped to treat his or her condition. The attending physician must certify that the transportation is necessary to protect the health and safety of the child. Not more than $1,000 will be paid for this transportation.

Adopted/Foster Children

Coverage for an adopted or foster child, other than an adopted newborn child, who has been placed in accordance with Florida law, will begin on the date the child is placed in your home, provided we receive a change request within sixty (60) days after the date the child was placed. FCL will require proof of adoption or foster care. If a change request is received by FCL within this sixty (60)-day period, premium will not be charged for the first thirty (30) days of coverage.

Coverage for an adopted newborn child will begin the earlier of:

a. the moment of birth, provided that you have entered into a written agreement to adopt such child prior to the birth of the child; or
b. the date the adopted newborn child is placed in your home in accordance with Florida law,

with no premium charged for the first thirty (30) days of coverage, if we receive a change request within sixty (60) days of the date of birth or placement of the adopted newborn child.

If we do not receive a change request within sixty (60) days of the date of placement of an adopted or foster child or birth of a newborn, we may charge an additional premium from the date of placement or birth.

If the adopted newborn child is not ultimately placed in your home, there will be no coverage for such newborn child under this certificate. It is your responsibility to notify FCL within ten (10) calendar days if the adopted newborn child is not placed in your home.

If a final decree of adoption is not issued, coverage will not be continued for the proposed adopted child under this certificate. Proof of final adoption must be submitted to FCL. It is your responsibility to notify FCL if the adoption does not take place. We will terminate the coverage of the child on the first billing date following our receipt of your written notice.

If your status as a foster parent of a covered child is terminated, coverage will not be continued for that foster child under this certificate. It is your responsibility to notify FCL that the foster child is no longer in your care. We will terminate the coverage of the child on the first billing date following our receipt of your written notice.

Deleting Dependents From Coverage

If you wish to delete an eligible dependent from coverage, a change request should be submitted to us. Coverage for such dependent will terminate on the first billing date following our receipt of the change request.

Other Provisions Regarding Enrollment and Effective Date of Coverage

Rehired Employees

If you are rehired as an employee of the contractholder, you are considered a newly hired employee under this contract. The provisions of this certificate which apply to newly hired employees and their eligible dependents apply to you and your eligible dependents.

Premium Payments

When a new employee or dependent is added to coverage under this certificate, the coverage will take effect, as set forth in this section, provided we receive the required additional premium payment within thirty (30) days of the date we notify the contractholder of such amount. In no event will an individual be covered under this certificate if FCL does not receive the required premium payment within this time period.

Prior Coverage under an Extension of Benefits

The contractholder's prior carrier may be required to provide certain benefits to the insured under an extension of benefits provision. In no event will FCL pay any claims for dental benefits which are paid under any provision in the prior carrier's plan for extension of benefits after plan termination.

Replacement Provision

The following applies to any person who: (a) was covered under the contractholder's prior dental plan on the date it terminated; and (b) is in a class eligible for coverage under this contract on its effective date. However, this contract must take effect immediately following termination of the prior plan.

Prior Coverage Waiting Period Credit

If an insured covered by this provision must satisfy any waiting period under this contract, he or she will be given credit for any part of the waiting period that was satisfied under the contractholder's prior dental plan.

Prior Coverage Deductible Credit

A deductible credit will be given to all insureds covered by this contract for expenses that were applied toward the deductible of the contractholder's prior dental plan during the ninety (90) days prior to the effective date of this contract, but only to the extent those charges are allowable expenses under this contract and are subject to a similar deductible. Prior coverage credit only applies at the initial enrollment of the group. You and/or the contractholder are responsible for providing FCL with the information necessary to apply this prior coverage credit.

SECTION V

THE DATE ON WHICH INSURANCE TERMINATES

Termination of Certificateholder Coverage

Your coverage under this certificate will automatically terminate on the earliest of:

1. the date the contract terminates;
2. the date you fail to meet any eligibility requirement;
3. the date specified by the contractholder that your coverage terminates;
4. the date the first premium is not paid after the Contractholders thirty-one (31) day grace period ends.
5.

Termination of Dependent Coverage

Your covered dependent's coverage under this certificate will automatically terminate on the earliest of:

1. the date the contract terminates;
2. the date your coverage terminates;
3. the date the dependent fails to meet any eligibility requirement;
4. the date specified by the contractholder that dependent coverage terminates;
5. the date the first premium is not paid after the Contractholders thirty-one (31) day grace period ends.

SECTION VI

YOUR OBLIGATIONS

Individual Deductible Limit

The individual deductible per person, per plan year, which is shown on the Schedule of Benefits, must be met by an insured before covered benefits are payable.

Family Deductible Limit

The family deductible per plan year, if applicable, is shown on the Schedule of Benefits. Once your family has met the family deductible per plan year, no further deductibles must be met during the rest of that plan year. The maximum amount that any one insured can contribute toward satisfaction of the family deductible per plan year is the individual deductible amount.

Coinsurance

After the insured satisfies the deductible, allowable expenses for dental benefits will be paid at the percentage shown on the Schedule of Benefits. The insured's choice of dentist will determine the amount he or she is responsible for.

For services received from a non-participating dentist, the insured is also responsible for the difference between the FCL allowance for non-participating dentists and the actual dentist charges, if any.

Predetermination of Benefits

If treatment can reasonably be expected to involve allowable expenses of more than $500, a description of the procedures to be performed and an estimate of the dentist's charges (treatment plan) may be filed with FCL for approval prior to the start of treatment.

The main purpose of a predetermination of benefits is to inform the insured and the dentist of the amount of FCL's financial liability, prior to services being performed.

Requests for a predetermination of benefits should be submitted within thirty (30) days of the date of the initial diagnosis or exam. The insured must submit, for our review, x-rays, a complete treatment plan, and in some cases, more substantiating material such as a study model. All predetermination of benefits will be subject to the plan year maximum.

SECTION VII

PROVIDER ALTERNATIVES

The insured has the choice of two provider alternatives which will affect how coverage is provided for dental benefits. The following describes the arrangement used to make payment under the contract.

Participating Dentist

These are dentists who have a signed agreement currently in effect with FCL or a third party contracted by FCL to provide benefits through their network, to participate in our dental plan. Participating dentists have agreed to accept the lesser of the actual charge or the FCL allowance of the allowance established by a third party contracted by FCL to provide dental benefits through their network as payment in full for covered services. The insured is not responsible for charges in excess of the allowance. The insured is responsible for the deductible, coinsurance, and the payment of charges for non-covered services and charges in excess of any maximum benefit limitations. The participating dentist will file the claim on the insured's behalf and payment will be made directly to the participating dentist. A list of participating dentists will be made available to you. This list is subject to change without prior notice to, or approval of, the contractholder or certificateholder.

Non-Participating Dentist

These are dentists who do NOT have a signed agreement currently in effect with FCL to participate in our dental plan or with a third party contracted by FCL to provide dental benefits through their network. Non-participating dentists have not agreed to accept the FCL allowance or the allowance established by a third party contracted by FCL to provide dental benefits through their network, as payment in full. The insured is responsible for the difference between the FCL allowance or the allowance established by a third party contracted by FCL to provide dental benefits through their network, and the non-participating dentist charge, if any, the non-participating deductible and coinsurance shown on the Schedule of Benefits, and the payment of charges for non-covered services and charges in excess of any maximum benefit limitations.

Selection of a Dentist

FCL does not have the right to select a dentist for the insured. The insured must select his or her own dentist and nothing in this contract will interfere with the relationship between the insured and any such dentist selected. In any event, FCL shall not be liable for any action on the part of any dentist, or an agent or employee of the dentist.

SECTION VIII

BENEFITS

The maximum benefit payable per plan year, per person is shown on the Schedule of Benefits. The following describes covered dental benefits. Note: Benefits with an asterisk (*) may be covered under a different Service Category or at a different frequency than listed below. Refer to the Schedule of Benefits for information on how these benefits are covered under this Certificate. Payment for covered services provided by non-participating dentists will not exceed, usual and customary charges. See the "Limitations and Exclusions" section for other limits on services.

Preventive

1. *Two (2) routine oral examinations per plan year;
2. *Prophylaxis (cleaning, scaling and polishing of teeth), two (2) times per plan year;
3. Topical application of fluoride in conjunction with prophylaxis for dependent children under fourteen (14) years of age, two (2) times per plan year;
4. *Bitewing x-rays, once per plan year; and
5. *Periodontal maintenance procedures (following active therapy). Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered as the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.

Basic

1. Palliative (emergency) treatment of an acute condition requiring immediate care;
2. Application of desensitizing medicaments;
3. *Sealants for dependent children through age sixteen (16);
4. *Periapical (root area) x-rays as required;
5. *Complete mouth x-rays or panoramic x-rays (once in any thirty-six [36] consecutive month period.) Panoramic x-ray will be considered a complete mouth x-ray and subject to the same limit;
6. *Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;
7. Repair of broken partial or complete dentures;
8. Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under fourteen (14) years of age. No payment will be made for duplicate space maintainers;
9. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
10. Routine extractions;
11. *Endodontics, including pulpotomy (removal of the soft tissue in a decayed tooth), and root canal treatment. No payment will be made for root canal therapy until treatment is completed. Treatment is considered to be completed on the date the canals are sealed;
12. General anesthesia given in a dentist's office, for services that are: (a) performed by a person qualified to administer general anesthesia; (b) billed by such dentist; and (c) in connection with covered dental services. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation. The allowance for the administration of a local infiltration or block anesthetic in connection with other covered dental services is included in the allowance for those covered dental services;
13. Tissue conditioning treatments for the upper and lower dentures, two (2) times per plan year;
14. Adjustments to the maxillary and mandibular dentures, two (2) times per plan year (six [6] months after the initial insertion of the denture);

15. Recementation of space maintainers once per plan year (must be six [6] months after the initial placement date);
16. Replacement of core build up, if satisfactory proof is provided that at least five (5) years have passed since the date of service when the procedure was performed;
17. Relining and rebasing of immediate dentures if more than six (6) months after the insertion of an initial or replacement denture (not more than one relining or rebasing in any thirty-six [36] consecutive month period);
18. Repair of broken crowns, inlays, onlays or bridges;
19. Surgical removal of teeth;
20. Surgical removal of maxillary or mandibular intrabony cysts;
21. *Apicoectomy (dental root surgery);
22. *Gingivectomy and gingivoplasty;
23. *Periodontal scaling, payable once per quadrant every twenty-four (24) months;
24. *Root amputation - per root;
25. *Hemisection - (including any root removal), not including root canal therapy;
26. Alveoloplasty - per quadrant;
27. *Gingival flap procedure - once per quadrant every thirty-six (36) months; and
28. *Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis - payable once every thirty-six (36) months.

Major

1. Clinical crown lengthening-hard tissue only, subject to dental consultant review for approval and pricing; office notes are required for review;
2. Replacement of cast post and core along with prefabricated post and core procedures, if satisfactory proof is given that at least five (5) years has passed since the date of service when the procedure was performed;
3. Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays);
4. Initial insertion of partial or complete dentures (including any adjustments during the six [6] month period following insertion);
5. Replacement of an existing crown, partial or complete denture or bridge by a new crown, denture or by a new bridge, if satisfactory proof is given that:
   (a) the existing crown, denture or bridge was inserted at least five (5) years before it is replaced; and
   (b) the existing crown, denture or bridge is not serviceable and cannot be made serviceable. If the existing crown, denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable;
6. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every thirty-six (36) months;
7. Free soft tissue graft procedure, including donor site;
8. Frenulectomy;
9. Bone replacement graft - once per site every thirty-six (36) months;
10. Pedicle soft tissue graft - once per site every thirty-six (36) months;
11. Guided tissue regeneration - once per site every thirty-six (36) months;
12. Subepithelial connective tissue graft - once per site every thirty-six (36) months;
13. Surgical placement of permanent endosteal implant once per lifetime for members age sixteen (16) and over;
14. Initial insertion of prefabricated or custom abutment per implant;
15. Replacement of a prefabricated or custom abutment per implant once every five (5) years;

16. Initial insertion of abutment supported or implant supported implant crowns and bridges;
17. Replacement of an existing implant crown or implant bridge by a new implant crown or implant bridge, if satisfactory proof is given that: a) the existing implant crown or implant bridge was inserted at least five (5) years before it is replaced; and b) the existing implant crown or implant bridge is not serviceable and cannot be made serviceable. If the existing implant crown or implant bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable;
18. Implant maintenance twice per year; and
19. Implant repair procedures once per arch every six (6) months.

Enhanced Dental Benefits

Coverage for the following services are provided for each Covered Person who is eligible to receive Enhanced Dental Benefits and has been diagnosed with diabetes, coronary artery disease or who is pregnant:

- Dental Cleanings (oral prophylaxis or periodontal maintenance cleanings) once every three months.
- Periodontal scaling once for each quadrant every 24 months when this service is necessary and appropriate.

Coverage for the following services is provided for each Covered Person who is eligible to receive Enhanced Dental Benefits and has been diagnosed with oral cancer.

- Dental Cleanings (oral prophylaxis or periodontal maintenance cleanings) once every three months.
- Fluoride treatment, once every three months
- Pre-diagnostic cancer screening, once every six months

For these benefits, any calendar year deductible, coinsurance or copayment provisions that would otherwise apply do not apply when these benefits are provided by a Participating Dentist. Enhanced Benefits provided by non-participating dentists will be subject to any coinsurance or copayment due however the calendar year deductible will not apply.

SECTION IX

LIMITATIONS AND EXCLUSIONS

Limitations

1. Any retreatment of root canals is payable one (1) year after completion date of root canal therapy.
2. Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
3. The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
4. Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of dependent children.
5. General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
6. Periodontal services are limited to insureds age eighteen (18) and older.
7. Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
8. Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.
9. All fixed prosthetics are billable upon the seat/insertion date.
10. All removable prosthetics are billable upon final delivery.

Exclusions

The following are excluded under this certificate:

1. Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to an insured's effective date of coverage, (until the insured has been covered under the contract for twelve [12] consecutive months), unless otherwise specified in this certificate.
2. Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
3. Charges for services or supplies when billed by other than a dentist.
4. Benefits for services rendered by a member of your family, (your spouse and the child[ren], brothers, sisters and parents of either you or your spouse).
5. Services rendered primarily for cosmetic purposes.
6. Charges incurred for failure to keep a dental appointment.
7. Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
8. Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone - lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
9. Experimental or investigational treatment.
10. Dental services received or rendered:
    (a) through or in a veteran's hospital or government facility due to a service connected disability;
    (b) which are covered and paid under Worker's Compensation or similar law; or

(c) which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the FCL allowance for expenses actually incurred.

11. Services for which the insured incurs no charge.
12. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
13. Local anesthesia when billed separately by a dentist.
14. Any services paid or payable under the insured's health insurance contract.
15. Services not listed in the Benefits section of this certificate.
16. Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this certificate will be based on the allowance for the least costly service, procedure, or course of treatment.
17. Any additional treatment required due to the insured's failure to follow instructions, or lack of cooperation with the dentist.
18. Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
19. Services rendered before the effective date of coverage.
20. Services rendered after termination of coverage, except as provided under "Extension of Benefits upon Contract Termination."
21. Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
22. Any denture or bridge replacement made necessary by reason of loss, theft, or alteration by an insured.
23. Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the insured's coverage under this certificate.
24. Duplicate or temporary denture, crown, or bridge.
25. Labial Veneer restorations.
26. General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
27. Charges for nitrous oxide.
28. Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or lower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
29. Prescribed drugs, premedication or analgesia.
30. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
31. Charges for oral hygiene, plaque control, or diet instruction.
32. Charges for orthodontia services.
33. Charges for sterilization are included in the allowance for other covered dental procedures.
34. Charges for biohazardous waste disposal are included in the allowance for other covered dental procedures.
35. Charges associated with accidental injuries to sound, natural teeth.

SECTION X

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") is a limitation of benefits for dental benefits under the contract and is designed to avoid the duplication of payment for dental benefits. Coordination of Benefits applies when an insured is covered under other dental plans, programs, or policies providing dental benefits which contain a COB provision or are required by law to contain a COB provision. Such other dental plans, programs, or policies may include, but are not limited to:

1. any group or individual dental insurance, group type self-insurance dental, health maintenance organization dental plan, or other dental plan, program, or policy; or
2. any group or individual dental plan, program, or policy underwritten or administered by FCL.

FCL's payment for covered dental benefits depends on whether FCL is the primary payer, as determined in accordance with the provisions set forth below. If FCL is the primary payer, FCL's payment for dental benefits, if any, will not be reduced due to the existence of other coverage and will be made without regard to the insured's other dental plans, programs, or policies.

In those cases where COB applies and FCL is not the primary payer, FCL's payment for dental benefits, if any, will be reduced so that the combined benefits of both plans will not be more than 100% of the FCL allowance for expenses actually incurred for covered services.

The following rules shall be used by FCL to determine if FCL is the primary payer:

1. The dental benefits of a dental policy, plan, or program that covers the person as an employee, member, or insured, other than as a dependent, are determined before those of the dental policy, plan, or program that covers the person as a dependent.

   However, if the person is also a Medicare beneficiary, and as a result of the rule established under the Social Security Act of 1965, as amended, Medicare is secondary to the dental plan covering the person as a dependent of an active employee, the order in which dental benefits are payable will be determined as follows:

   a. first, dental benefits of a plan that covers a person as an employee, member, or subscriber;
   b. second, dental benefits of a plan of an active employee that covers a person as a dependent;
   c. third, Medicare Benefits.

2. Except as stated in paragraph 3, when two or more dental policies, plans, or programs cover the same child as a dependent of different parents:

   a. the dental benefits of the dental policy, plan, or program of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the dental policy, plan, or program of the parent whose birthday, excluding year of birth, falls later in the year; but
   b. if both parents have the same birthday, the dental benefits of the dental policy, plan, or program which has covered the parent for the longest are determined before those of the dental policy, plan, or program which has covered the parent for the shorter period of time.

   However, if one of the plans does not have a provision which is based on the birthday of the parent, but instead on the gender, and this results in each dental policy, plan, or program determining its benefits before the other, the dental policy, plan, or program which does not have a provision which is based on a birthday will determine the order of dental benefits.

3. If two or more dental policies, plans, or programs cover a dependent child of divorced or separated parents, dental benefits for the child are determined in this order:

a. first, the dental policy, plan, or program of the parent with custody of the child;
b. second, the dental policy, plan, or program of the spouse of the parent with custody of the child; and
c. third, the dental policy, plan, or program of the parent not having custody of the child.

However, if the specific terms of a court decree makes one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the dental benefits of the dental policy, plan, or program of that parent has actual knowledge of those terms, the dental benefits of that dental policy, plan, or program are determined first. This does not apply with respect to any claim determination period or dental plan, policy, or program year during which any dental benefits are actually paid or provided before that entity has the actual knowledge.

4. The dental benefits of a dental policy, plan, or program which covers a person as an employee other than as a laid-off or retired employee, or as a dependent of such a person, are determined before those of a dental policy, plan, or program which covers that person as a laid off or retired employee or as a dependent of such a person. If the other dental policy, plan, or program is not subject to this rule, and if, as a result, the dental policies, plans, or programs do not agree on the order of dental benefits, this paragraph shall not apply.

5. If none of the above rules determine the order of dental benefits, the dental benefits of the policy, plan, or program which has covered the employee, member, or insured the longest period of time are determined before those of the other dental policy, plan, or program.

   If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group dental plan, the following order of benefits applies:

   a. first, the dental plan which covers the person as an employee, or as the employee's dependent;
   b. second, the coverage purchased under the dental plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

The reference to an individual who is covered under a COBRA continuation plan does not apply to a covered domestic partner or their dependent children if eligible for coverage. Domestic partners and their children are not entitled to continue their coverage under COBRA.

Coordination of Benefits shall not be permitted against the following types of policies:

(1) indemnity;
(2) excess insurance;
(3) specified illness or accident; or
(4) Medicare supplement.

SECTION XI
SUBROGATION

In the event FCL makes any payment under the contract to or on behalf of an insured for any claim in connection with or arising from a condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, FCL, to the extent of any such payment, shall be subrogated to all causes of action and all rights of recovery such insured has against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated.

The insured shall promptly execute and deliver to FCL such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigation as may be requested by FCL, and shall do whatever is necessary to enable FCL to exercise FCL's subrogation rights and shall do nothing to prejudice such rights. Additionally, the insured or the insured's legal representative shall promptly notify FCL in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to FCL any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgment proceeds without FCL's prior written consent. No waiver, release of liability, or other documents executed by an insured without such notice to FCL shall be binding upon FCL.

Any such right of subrogation or reimbursement provided to FCL under the contract shall not apply or shall be limited to the extent that applicable law eliminates or restricts such rights.

SECTION XII

COBRA CONTINUATION OF COVERAGE

Federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, also known as Section 4980B of the Internal Revenue Code of 1986, may apply to the contractholder. If COBRA applies to the contractholder, a qualified beneficiary may be entitled to elect continuation of group dental coverage if such insurance **would otherwise terminate** by reason of a qualifying event.

An insured must contact the contractholder to determine if he or she is entitled to COBRA continuation of coverage. The contractholder is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all covered employees and dependents of their rights under COBRA. If the contractholder or the insured fails to meet its obligations under COBRA and the contract, FCL shall not be liable for any claims incurred by the insured after his or her termination of coverage.

A summary of the COBRA rights of an insured and the general conditions for an insured's qualification for COBRA continuation of coverage is provided below. This summary is not meant to represent that any of the COBRA obligations of the contractholder are met by the purchase of the FCL contract; the duty to meet such obligations remains with the contractholder.

If a contractholder is subject to COBRA, a qualified beneficiary may elect continuation of group dental coverage if such coverage is lost due to one of the following qualifying events:

1. death of a covered active or retired employee. Qualified beneficiaries may elect to continue their group dental coverage for a period of time not to exceed thirty-six (36) months from the date of death.

2. divorce or legal separation from a covered active or retired employee. Qualified beneficiaries may elect to continue their group dental coverage for a period of time not to exceed thirty-six (36) months from the date of divorce or legal separation.

3. the covered employee's entitlement to Medicare. Qualified beneficiaries may elect to continue their group dental coverage for a period not to exceed thirty-six (36) months from the date the employee first becomes entitled to Medicare.

4. a dependent child ceasing to meet the definition of "Dependent" under this contract. The dependent child may qualify to elect to continue group dental coverage for a period not to exceed thirty-six (36) months from the date the child ceased to meet the definition.

5. the covered employee's termination of employment (except for gross misconduct), or reduction in hours of employment. Qualified beneficiaries may elect to continue their group dental coverage for a period not to exceed eighteen (18) months from the date of termination or reduction in hours.

   If, at the time of the employee's termination or reduction in hours, a qualified beneficiary is totally disabled (as defined by the Social Security Administration) and all notification and eligibility requirements are met, that qualified beneficiary may elect an additional eleven (11) months of coverage, for a total of twenty-nine (29) months. Extension of coverage will not be provided if the qualified beneficiary fails to furnish written notice to the contractholder of the disability before the continuation of coverage expires and within the time periods required by COBRA.

6. If a qualified beneficiary is receiving continuation of coverage under paragraph 5, such coverage may continue beyond the stated time if an additional qualifying event (e.g., divorce, legal

separation, or death) later occurs. In no case will the qualified beneficiary receive coverage beyond thirty-six (36) months from the date of the first qualifying event.

7. If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to the contractholder, continuation rights shall be provided to the qualified beneficiaries to the extent required under COBRA.

In order for the group dental coverage to continue pursuant to COBRA, under the FCL contract, the following conditions must be met:

1. a. If coverage would be lost due to a reduction in hours or termination of employment (for reasons other than gross misconduct), the contractholder must notify the qualified beneficiaries of their continuation of coverage rights under COBRA within fourteen (14) days of the event.

   b. If coverage would be lost due to Medicare entitlement, divorce, legal separation, or a dependent child ceasing to be a "Dependent" as defined in this contract, the qualified beneficiary must notify the contractholder, in writing, within sixty (60) days of any of these events. The contractholder must notify the qualified beneficiaries of their continuation of coverage rights within fourteen (14) days of receipt of such notice.

2. The qualified beneficiary must elect to continue the group dental insurance within sixty (60) days of the later of the date that the coverage terminates or the date the notification of continuation of coverage rights is sent by the contractholder.

3. The qualified beneficiary who elects continuation of coverage must not become covered under any other group dental insurance plan. However, COBRA coverage may continue if the new group dental insurance plan contains exclusions or limitations due to a pre-existing condition that would affect the continued coverage.

4. The qualified beneficiary who elects continuation of coverage, must not become entitled to Medicare after such election.

5. A totally disabled qualified beneficiary who elects to extend the continued coverage after eighteen (18) months may not continue such coverage more than thirty (30) days after a determination by the Social Security Administration that such person is no longer disabled. Such person must notify the contractholder of the Social Security determination within thirty (30) days of such determination.

   For purposes of this section, a totally disabled qualified beneficiary is an insured who is determined to be disabled under the Social Security Acts (Title II, OASDI or Title XVII, SSI).

6. The qualified beneficiary who elects continuation of coverage, must meet all premium payment requirements, and all other eligibility requirements set forth in COBRA, and, to the extent not inconsistent with COBRA, in the contract.

7. The contractholder must continue to provide group dental coverage to its employees through FCL.

An election of continuation by any qualified beneficiary shall be deemed to be an election of continuation on behalf of any other qualified beneficiary whose coverage would otherwise terminate by reason of the same qualifying event, unless otherwise specified in the election form.

The qualified beneficiary does not need to show insurability to receive COBRA continuation of coverage. However, the qualified beneficiary must pay the applicable premiums for the coverage being continued.

NOTE: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the contract shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the contractholder.

FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203

GROUP DENTAL BENEFITS
ORTHODONTIA RIDER

This rider is a part of the certificate to which it is attached. The effective date of this rider is the later of the certificate's effective date or the date of the amendment adding this rider to the certificate. Unless amended by this rider, certificate definitions, terms and provisions will apply to this rider.

1. For purposes of this rider, the following definition is added to the certificate:

   Orthodontia - means the branch of dentistry concerned with the interception and treatment of improper alignment of biting or chewing surfaces (malocclusion) of the teeth and their surrounding structures.

2. For purposes of this rider, the following certificate provisions are amended:

   A. "**Benefits**" is amended as follows:

      (i) The following is added to the first paragraph:

      The Orthodontia Lifetime Maximum benefit payable per person is shown on the Schedule of Benefits. If your employer offers more than one FCL dental plan and you change from one FCL dental plan to another FCL dental plan, the Lifetime Maximum benefit does not start over. This applies regardless of the number of times you change FCL dental plans offered by your employer. The Orthodontia Lifetime Maximum benefit is based on the higher benefit of any FCL dental plan offered by your employer, under which you have been enrolled.

      (ii) The following is added under "Basic" benefits:

      Cephalometric x-rays, but only in connection with orthodontic diagnosis, and only once in any thirty-six (36) consecutive month period.

      (iii) The following provision is added:

      <u>Orthodontic Services</u>

      The following is a list of covered services for orthodontic services for the correction of an existing malocclusion and its attendant sequelae through the correction of malposed teeth.

      1. diagnosis, including radiographs and study models;
      2. active treatment, including necessary appliances; and
      3. retention treatment following active treatment.

   B. "**Limitations and Exclusions**" is amended as follows:

      (i) The following is added under "Limitations":

      Orthodontia services will be limited to the Lifetime Orthodontia Maximum shown on the Schedule of Benefits.

Benefits for covered orthodontia services will be payable in equal monthly amounts during the period covered by the approved treatment plan and while coverage is in effect, not to exceed thirty-six (36) months.

If the treatment plan for covered orthodontia services is completed in less time than specified in the approved treatment plan, we will make payment in the amount of the remainder of the FCL liability, after we receive notice from the dentist.

Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with orthodontic appliance therapy.

Benefit payment for orthodontic services will be limited to thirty-six (36) consecutive months' active treatment or eighteen (18) consecutive months' retention treatment. These limits will include the number of months of such treatment received prior to commencement of this coverage.

(ii) "Exclusions" is amended as follows:

(a) Item 5. is deleted and replaced with the following:

5. Services rendered primarily for cosmetic purposes, except for orthodontic services rendered for correction of defects incurred through traumatic injuries which occurred while this rider is in force.

(b) Item 32. is deleted and replaced with the following:

32. Charges for the replacement and/or repair of any orthodontic appliance furnished under the treatment plan or for any duplicate orthodontic device or appliance.

This rider terminates on the earliest of:

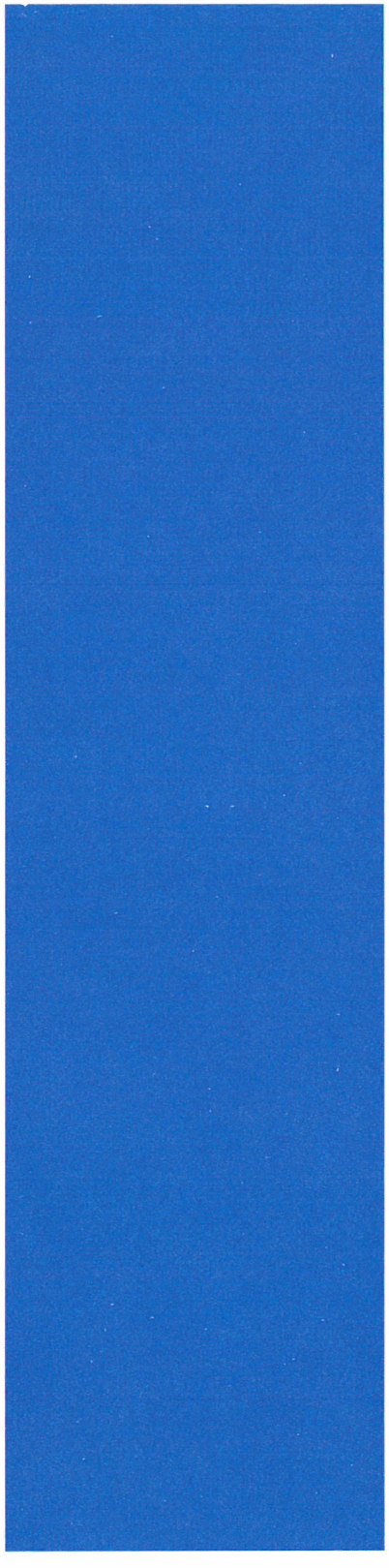
1. the date on which any event specified in section V, "The Date on Which Insurance Terminates," occurs;
2. the date the contractholder notifies us to terminate this rider; or
3. the date you elect to terminate the coverage provided by this rider.

The certificate to which this rider is attached is not changed, other than as herein stated.

Signed for the Florida Combined Life Insurance Company, Inc., at Jacksonville, Florida, on the effective date of this rider.

James F. Casey

President



Florida Blue
In the pursuit of health®

Dental Administration Guide

For BlueDental Choice℠ plans

Thank you for selecting a BlueDental Choice product for your employees' dental care coverage needs. This guide contains information to help you administer your group dental plan.

This guide will explain eligibility, employee and dependent changes and more. Your agent or Florida Blue/FCL representative can review any part of this guide with you and answer questions. If you have employees enrolled in a BlueDental Care℠ product, you will receive a separate Group Administration Guide. We're proud to provide you and your employees with the highest level of personal, professional service.

Service Contacts

Membership Information:

Applications (new hire) and Change Forms (additions, terminations, etc.) may be sent to:
Florida Combined Life
Attn: Membership Services
P.O. Box 44144
Jacksonville, FL 32231
Phone: 866-946-2583
Fax: 904-997-5471
Monday - Tuesday, Thursday: 8:00 a.m. - 5:00 p.m. EST
Wednesday: 1:00 p.m. - 5:00 p.m. EST
Friday: 9:00 a.m. - 5:00 p.m. EST

Billing Inquiries:

Send your payment to:
Florida Combined Life
Dept. 1158
P.O. Box 121158
Dallas, TX 75312-1158
Phone: 866-946-2583
Monday - Thursday: 8:00 a.m. - 5:30 p.m. EST
Friday: 9:00 a.m. - 5:30 p.m. EST

Claims:

Most dentists will file claims on behalf of the patient. If not, employees may send all claims to:
Florida Combined Life
Dental Claims Dept.
P.O. Box 1047
Elk Grove Village, IL 60009-1047

Customer Service Representatives:

Agent and employer support: 888-224-4049
Member and employee support: 888: 223-4892
Monday - Friday: 8:00 a.m. - 8:00 p.m. EST

For Supply Requests:

Please contact the representative who services your account.
Note: This guide does not replace or override the information contained within the Group Policy. This guide does not cover information about health insurance coverage.

EnrollPoint – We know that finding ways to be more efficient is always a priority. That's why we offer EnrollPoint, an online Florida Blue tool that allows you to quickly and efficiently manage your group's benefits. With EnrollPoint, you can make changes anywhere, anytime; you don't have to mail paper forms. The site is designed to include your plan's rules and provisions so you can make year-around changes to:

- New-hire benefit elections and declinations
- Terminations
- Life-event changes
- Address changes
- Rehires

EnrollPoint advantages include:

- Access to benefit information 24 hours a day
- A user-friendly system that simplifies the benefit administration process and saves time
- Access via a secure site – no need to download software
- Automation that removes the guesswork from employee eligibility dates and plan eligibility
- Improved data accuracy that replaces error-prone paper applications
- Benefit changes that can be seen in real-time
- Detailed reports that can be generated on-demand or on a schedule

Eligibility – (adding employees) An employee who is hired after the initial enrollment period and who meets eligibility requirements can enroll in the plan within 30 days of becoming eligible. Employers can make the change using EnrollPoint or by submitting a completed and signed Group Member Life & Dental Enrollment Application (Form 50625) to Florida Combine Life. All information on the application must be complete and legible, including the group name, group number and the effective date of coverage for the employee. Provide the employee with a copy of the form, and retain a copy for your records.

Making Changes – Changes can be made in EnrollPoint or an employee can complete and sign a Change Notice (Form 50415-1012). Please be sure all information on the form is complete and legible, and retain a copy for your records.

Refusing Coverage – If an employee refuses dental coverage, employers can make the change using EnrollPoint or by submitting a completed and signed Group Member Life & Dental Enrollment Application (Form 50625) to Florida Combine Life. The appropriate boxes must be checked and the Coverage Refusal section must be signed. If voluntary dental coverage is offered, this action is not required.

Terminations – When an employee who has dental coverage terminates his or her employment, Florida Combines Life must be notified within 30 days of the date of termination to prevent employers from being liable for any premiums due after the date of termination. The employer can make the change using EnrollPoint or by submitting a completed and signed Change Form (50415-1012) to Florida Combine Life.

Provider Directory – To help your employees find the dentist that best meets their needs, go to floridabluedental.com/find-a-dentist.

COBRA – FCL will comply with COBRA as administered by your organization. Employees and/or their dependents that would otherwise lose coverage may choose to keep group coverage for up to 18, 29 or 36 additional months, depending on the circumstances.

When an employee chooses to continue individual and/or dependent coverage under COBRA, you must notify Florida Combined Life no later than 60 days following the event that has made the employee and/or dependents eligible for this coverage.

The employee has 60 days to make this decision. If the employee accepts the COBRA extension, coverage will be restored as of the termination date with no lapse in coverage, and your organization will be billed retroactively to the termination date.

If your group has only dental coverage (no active health plans with Florida Blue), Florida Blue will not administer continuation of coverage. If your group utilizes a third party administrator, Florida Blue will not administer continuation of coverage. Your COBRA employee/dependents will remain on your invoice, and it will be the responsibility of the group to pay for their premiums. If your group utilizes Florida Blue to administer continuation of coverage, your COBRA employee/dependents will no longer appear on your invoices. Florida Blue will directly bill and collect premiums for your COBRA members. If your group is classified as a State Continuation of coverage, as outlined in the Florida Health Insurance Coverage Continuation Act (FHICCA), ancillary coverages are not an option to continue under that classification.

ID Cards – Employees may replace lost ID cards by calling Florida Combined Life Customer Service at 888-223-4892. Representatives are available from Monday - Friday, 8:00 a.m. - 8:00 p.m. EST.



To access applications and change forms, visit floridabluedental.com/employers/forms.

Dental plans are offered by Florida Combined Life Insurance Company, Inc. (FCL), an affiliate of Florida Blue and an Independent Licensee of the Blue Cross and Blue Shield Association.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227.

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227.