YOU MUST READ AND AGREE TO THE FOLLOWING STATEMENT PRIOR TO GAINING ACCESS TO THIS DOCUMENT

The Self-Insured Dental benefit plan booklet contained in the attached .pdf file is not a contract of coverage. It is provided as a convenience to you and its purpose is to help you understand the coverage available to you under the benefit plan provided by your employer. Remember that the actual benefit plan document(s) held by your employer shall govern the terms and conditions of the coverage. In the event of a conflict or discrepancy between the coverage documents held by your employer and the benefit plan contained in the attached .pdf file, please contact your Plan Sponsor. Since the .pdf file may change at any time, always remember to consult the actual coverage document(s) before making any coverage decisions.

Benefit Booklet

for

Public Risk Management DENTAL PLAN
Plan 2

A Self-Insured Group Dental Benefit Plan

Administered by Florida Combined Life Insurance Company, Inc.
("Claims Administrator")

For Customer Service Assistance: 1-888-223-4892

If you, or someone you're helping, has questions about your dental plan, 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 your dental plan, 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 your dental plan, 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 your dental plan, 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 your dental plan, 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SBM項目的名稱 about your dental plan
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 your dental plan, 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 your dental plan, 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 your dental plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-223-4892.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص your dental plan ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-223-4892.

Se tu o qualcuno che stai aiutando avete domande su your dental plan, 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 your dental plan 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 your dental plan 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 your dental plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-223-4892.

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ ાંથી કોઇને your dental plan વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો િ ત કરિ મ ટે,આ 1-888-223-4892 પર કોલ કરો.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ your dental plan

คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892

1557 Non-Discrimination

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

The Claims Administrator:

- 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 the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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.*

SCHEDULE OF BENEFITS

Public Risk Management

Coverage Effective Date: [Specific to the Group]
Plan Year: January 1 through December 31

Persons covered under the Group Dental Benefit Plan (or “Plan”) have the right to obtain care from any dental provider of their choice. They may, however, be able to lower the amount they pay, as their share of covered dental expenses under this Plan by obtaining services from Participating Dentists.

The sponsor of this Plan has contracted with Florida Combined Life Insurance Company, Inc. (“Claims Administrator”) to provide certain third party administrative services including claims processing and customer services, and access to its provider network. The Claims Administrator and any third party contracted by the Claims Administrator to provide dental benefits through their network, has agreements with certain dental providers called Participating Dentists, to accept the lesser of their actual charge or the allowance of the Claims Administrator or third party, as applicable. The covered person is responsible for any deductible or percentage not payable under this Plan. Benefits for covered dental services provided by Participating and Non-Participating Dentists are shown in this Schedule of Benefits. See the Provider Alternatives provision for further details.

	Participating Dentists	Non-Participating Dentists
DEDUCTIBLE FOR PREVENTIVE SERVICES	$0	$0
INDIVIDUAL DEDUCTIBLE PER PERSON, PER PLAN YEAR FOR BASIC AND MAJOR SERVICES	$50	$50
FAMILY DEDUCTIBLE PER PLAN YEAR FOR BASIC AND MAJOR SERVICES	$100	$100
DENTAL SERVICES WAITING PERIOD:		
BASIC	6 Months	
MAJOR	12 Months	
ORTHODONTIC SERVICES	None	

PREVENTIVE, BASIC AND MAJOR SERVICES

Plan Year Maximum per person $2,000

PLAN PERCENTAGE PAYABLE	Participating Dentists	Non-Participating Dentists
PREVENTIVE	100	90
BASIC	80	60
MAJOR	50	40

ORTHODONTIA SERVICES
(Applicable to Covered Dependent Children to Age 19)

Orthodontia Lifetime Maximum per person....... $1,000

Plan Percentage Payable..................................... 50%

PLAN INFORMATION

Introduction

Public Risk Management, the Plan Sponsor, has created this plan to provide dental benefits to employees of participating employers. This booklet summarizes the provisions of that plan.

Plan Highlights

Claims Administration

Although Public Risk Management pays all claims out of its own assets and retains discretionary authority over any benefit questions that may arise, it has hired a third party administrator to provide routine claims administration services. These services are provided to the plan by:

Florida Combined Life Insurance Company, Inc.
PO Box 1047, Elk Grove Village, Il 60009-1047
(888) 223-4892

The claims administrator is not an insurer of benefits or a fiduciary of the plan; it has no discretionary authority with respect to matters of eligibility of benefits; it is not responsible for plan financing and does not guarantee plan benefits.

All claims should be filed with the claims administrator at the address indicated above. See the Claim Processing section of this plan for additional information on how to file claims.

Amendment and Termination

Public Risk Management has the right to amend the plan at any time. The employer will notify covered employees of any changes as required by law. However, this booklet may not contain all amendments and some changes may go into effect before notice is received.

Public Risk Management intends that this plan will continue indefinitely. However, future circumstances cannot be foreseen and therefore Public Risk Management reserves the right to terminate this plan at any time. Expenses incurred after this plan ends will not be covered.

The Enrollment and Effective Date and Date on Which Coverage Terminates sections of the plan contain additional information about amendment and termination.

Appeals

Any covered person who disagrees with a decision made by the plan regarding eligibility or benefits may appeal that decision by following the procedures in the Complaint and Grievance Procedures and Claim Processing sections of this plan. This includes, but is not limited to, decisions regarding:

- Eligibility, enrollment and termination of coverage.
- COBRA eligibility, election and termination.
- The amount of benefits payable under the plan.
- Case management.
- Coordination of benefits.

Appeals that do not follow the procedures described in the Complaint and Grievance Procedures or Claim Processing sections of this plan will not be considered.

OTHER IMPORTANT PROVISIONS

Plan Document

Public Risk Management has established this plan pursuant to certain legal documents maintained by it called the Plan Document. This booklet is intended to summarize the Plan Document and describe the benefits available under the plan. While Public Risk Management believes that the descriptions in this booklet are accurate if there is any discrepancy between this booklet and the Plan Document, the terms of the Plan Document will control.

Public Risk Management, acting as the Plan Administrator has the right to interpret and construe the terms and provisions of this plan and determine eligibility for coverage in the amount and manner and time of payment of benefits under the plan. It has the right to resolve any conflicts for ambiguities in the plan and the right to determine any issues of fact or law which may bear on the plans obligation to pay benefits. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion the claimant is entitled to them.

Amendment and Termination

Public Risk Management has the right, in its sole discretion, from time to time, to amend this plan by written amendments signed by the President or other authorized officer. The effective date of any such amendment shall be the date it is signed or such other date as the amendment may specify. Public Risk Management will notify the participants of amendments.

Public Risk Management has the right to terminate or suspend this plan at any time, in its entirety or in part. The plan will pay no benefits for expenses incurred on or after the effective date of termination.

Except as described in this provision, no act or statement of any person shall have any effect of amending the plan, creating coverage or of waiving any of its provisions or requirements.

Employee Contributions

Public Risk Management may require covered persons to contribute toward the cost of their coverage. Public Risk Management may determine the amount of their required contributions from time to time at its discretion and will advise participants in advance of any changes in such amount.

Plan Funding

From time to time at its discretion, Public Risk Management may determine the funding methods for benefits under this plan which may include, without limitation, policies of insurance, self funding and partial self funding. Currently, Public Risk Management self-funds and pays all benefits due under this plan out of it general assets. Employee contributions are used exclusively for plan benefits and are deemed to be expended before any employer contributions.

Limits of Liability

No person shall have any claim against Public Risk Management, the plan, Plan Administrator or Claim Administrator except for the amount of regular plan benefits due under this plan.

This plan does not create a contract of employment between the employer and any employee nor does it affect the status of any person as an employee-at-will.

Construction

Words used in this plan which take the masculine form shall be construed to include the feminine form. Similarly, words used in a singular or plural shall be construed as including the plural or singular respectively as circumstances and context may require.

Section and paragraph headings are included for ease of reference and do not explain, limit, or expand any provision in this plan.

The plan shall be construed and administered to comply in all respects to applicable federal law.

Effective Date

The Effective Date of the plan is October 1, 2008.

SUMMARY PLAN DESCRIPTION AND STATEMENT OF RIGHTS

PLAN NAME:	Public Risk Management Group Dental Plan
PLAN NUMBER:	xxx
PLAN EFFECTIVE DATE:	October 1, 2008
PLAN YEAR ENDS:	December 31
EMPLOYER::	Public Risk Management and participating employers 3434 Hancock Bridge Parkway, Suite 203 Ft Myers, FL 33903
EMPLOYER IDENTIFICATION NO:	xx-xxxxxx
TYPE OF PLAN:	This plan is a self-funded welfare plan which provides Dental benefits to persons covered herein. No benefits are payable by an insurance company.
TYPE OF ADMINISTRATION:	Contract administration
PLAN ADMINISTRATOR:	Public Risk Management 3434 Hancock Bridge Parkway, Suite 203 Ft Myers, FL 33903
PLAN SPONSOR:	Public Risk Management 3434 Hancock Bridge Parkway, Suite 203 Ft Myers, FL 33903
NAMED FIDUCIARY:	Public Risk Management 3434 Hancock Bridge Parkway, Suite 203 Ft Myers, FL 33903
AGENT FOR SERVICE OF LEGAL PROCESS:	Public Risk Management 3434 Hancock Bridge Parkway, Suite 203 Ft Myers, FL 33903
CLAIMS ADMINISTRATOR:	Florida Combined Life Insurance Company, Inc. PO Box 1047 Elk Grove Village, IL 60009-1047 (888) 223-4892
CONDITIONS OF ELIGIBILITY AND BENEFITS:	See plan booklet
CONTRIBUTIONS AND FUNDING:	Funded from employer's general assets out of the employer and employee contributions.

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SECTION I

DEFINITIONS

Allowance Or Allowable Expense - means the maximum amount upon which the Claims Administrator will base payment for covered dental services under the Plan or the maximum amount established by a third party contracted by the Claims Administrator to provide benefits through their network. The allowance is determined and established solely by the Claims Administrator or such third party and is subject to change at any time without notice to, or consent from, the plan sponsor or any individual covered under the Plan.

Annual Open Enrollment Period - means the period in each plan year so designated by the plan sponsor during which individuals can apply for coverage under the Plan.

Claims Administrator - means the entity contracted by the plan sponsor to carry out certain limited administrative claims processing services. The Claims Administrator does not have any financial responsibility or obligation to fund any claims submitted by or on behalf of the participants of the Plan.

Covered Dental Services - means those medically necessary covered services and supplies as set forth in this benefit booklet and any rider or endorsement attached to it.

Covered Person - means the employee, or other individual, who meets and continues to meet the applicable eligibility requirements for coverage under the Plan and who is actually enrolled under the Plan.

Deductible - means the amount of charges, up to the allowable expenses, a covered person must pay each plan year before payment for covered dental services 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

Any charges credited by FCL towards the Calendar Year Deductible requirements during the last three months of the prior Calendar year will be carried over to reduce the Calendar year Deductible requirement for the next Calendar Year.

Dental Services Waiting Period - means, if shown in the Schedule of Benefits, the period of time a covered person must wait before benefits are payable under the Plan for specific covered 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, at the time and place a service is rendered, is acting within the scope of his or her license and is legally qualified to practice medicine or dentistry and perform surgery.

Dependent - Your spouse, if not legally separated from you. Any child, until the end of the calendar year in which that child reaches age twenty-six (26). The term “child” also includes a legally adopted child or foster child, from the date of placement in the residence; step-child; or any child who lives with you and depends on you for more than 50% of his support.

Any child between the ages of 27 and 30, until the end of the calendar year in which that child reaches age 30, if that child:

a. is unmarried and does not have a dependent of his or her own;
b. is a resident of the state of Florida, or is a full-time or part-time student; and
c. is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other like insurance policy or is not entitled to benefits under Title XVIII of the Social Security Act.

A handicapped child over twenty-six (26) years of age, who was insured under this certificate before reaching age twenty-six (26).

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, the child's insurance will not terminate at age (26) if you give us proof that the child is:

a. incapable of self-sustaining employment; and
b. chiefly dependent on you for support and maintenance.

The insurance will continue as long as the child remains handicapped, unless coverage terminates according to Termination provisions applicable to dependents. To keep this coverage in force, we may require proof at our expense of the child's continued incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 26.

A dependent cannot be:

1. insured as an employee under the certificate;
2. insured under more than one insured employee;
3. in full-time military service; or
4. insured for contributory insurance, unless you have made a written request for dependent insurance.

Employee - means a person who is directly employed by the plan sponsor on a permanent basis and who works the number of hours each week as established by plan sponsor as his or her normal work week.

Experimental or Investigational - means services or supplies that are experimental or investigational. A drug, a device, a procedure or treatment is experimental or investigational, as defined herein, if:

a. there is insufficient data on outcomes available from controlled clinical trials published in the peer reviewed literature to substantiate the safety and effectiveness of the drug, procedure, or treatment for the disease or injury involved; or
b. approval is required by the U.S. Food and Drug Administration and such approval has not been granted for marketing for the use or indication in question; or
c. a recognized national medical or dental society or regulatory agency has determined, in writing, that the drug, device, procedure or treatment 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 indicates that the drug, device, procedure, or treatment is experimental, investigational or for research purposes.

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, for coverage and payment purposes only, any services, care, or supplies received by a covered person were: 1) consistent with the symptom, diagnosis, and treatment of the covered person'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 covered person, or dentist; 5) the

most appropriate, efficient, and economical dental or medical supply, service, or level of care which could have safely been provided; and 6) not cosmetic in nature.

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

Non-Participating Dentist - means a dentist who HAS NOT signed an agreement with the Claims Administrator, or with a third party contracted by the Claims Administrator, to accept the allowance for his or her covered services.

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.

Participating Dentist - means a dentist who HAS signed an agreement with the Claims Administrator and/or with a third party contracted by the Claims Administrator to provide dental benefits through their network. If a covered person receives covered dental 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 covered person's behalf.

Plan Percentage Payable - means the percentage of the allowance that will be paid by the Plan for expenses incurred for covered dental services, after a covered person's deductible is met. This percentage is shown on the Schedule of Benefits. The covered person is responsible for paying the remaining percentage of the allowance, if any, and for all non-covered services.

Plan Sponsor - means the employer that established the Group Dental Benefit Plan.

Plan Year - with respect to the dental benefits of this Plan, means the 12-month period determined by the plan sponsor and shown on the Schedule of Benefits.

Predetermination - means the pretreatment review of a treatment plan to determine the eligibility of the covered person and the amount payable, if any, under this Plan.

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 a covered person as a result of an examination made by such dentist.

Waiting Period - means the length of time an individual must be employed by the plan sponsor before he or she is eligible for coverage under the Plan. This period, if any, is established by the plan sponsor.

We, Us, And Our - means the Claims Administrator.

You And Your - means the employee who is in a class eligible for employee dental coverage.

SECTION II

GENERAL PLAN PROVISIONS

Representations Made During Enrollment

The plan sponsor relies on the information you provide during the enrollment process to determine eligibility for coverage under the Plan. All statements made during the enrollment process are representations and not warranties, except in the case of fraud.

Identification Cards

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

Extension of Benefits Upon Plan Termination

If a covered person is receiving covered dental treatment as of the termination date of the Plan, a limited extension of the dental care benefits provided under the Plan, if:

a. a course of treatment or dental procedures were recommended in writing and commenced while the covered person was covered under the Plan; 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 covered person's coverage terminated under the Plan, and the termination did not occur as a result of your voluntary termination of coverage.

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

The dental benefits available under this Group Dental Benefit Plan shall not duplicate any dental benefits to which the covered person is entitled, or eligible for, under state or federal government programs (e.g., Medicare, Medicaid, Champus, Veterans Administration) or Workers' Compensation 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

The Claims Administrator's provider networks and the provider networks of any third party contracted by the Claims Administrator are subject to change at any time without the consent of, or notice to, the plan sponsor or any covered person. It is the covered person's sole responsibility to determine whether a dental care provider is a participating dentist at the time the service or supply is rendered.

Complaint and Grievance Procedure

If a covered person is dissatisfied with a decision made, or an action taken, by us, or has a complaint about a participating dentist, the covered person has the right to complain to us either by phone or in person. If an acceptable resolution of the complaint cannot be reached, the covered person must file a written grievance with us not later than 60 (sixty) days after we provide a suggested resolution. We will review the grievance and respond in writing within thirty (30) days of receipt. If a covered person wishes to appeal our decision on their grievance, we must receive a written appeal within sixty (60) days of the date of the original grievance decision. Appeals will be reviewed and a final determination made within thirty (30) days after we receive the written appeal. The final determination of the appeal will be binding on the covered person.

Claims Processing

Participating dentists have agreed to file claims a covered person has for dental benefits under the Plan for services and supplies they provide. The covered person may be required to assign their claim for benefits to the participating dentist.

If the covered person obtains services or supplies from a dental care provider who does not file a claim for services and supplies rendered, it is the covered person's responsibility to file the claim with us.

Notice of Claim

In the event a covered person wishes to file a claim for dental benefits, written notice of claim must be given to us:

1. within 20 days after the date a loss covered by the Plan occurs; or
2. as soon thereafter as reasonably possible.

The notice may be given to us at the address shown on the ID card or to one of our authorized representatives. Notice should include the covered person's name and group number.

Claim Forms

After we receive notice of claim, we will furnish claim forms for filing proof of loss within fifteen (15) days. If we do not receive notice of claim, the covered person can provide proof of loss to us:

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

Written proof of loss

1. must be furnished to us at the address shown on the ID card; and
2. should be furnished within ninety (90) days of the date the dental service or supply was provided.

If proof of loss is not received within the time requested, the claim will not be denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any event, the proof required must be sent no later than one (1) year from the ninety (90) day period, unless the covered person was legally incapacitated.

To file a claim, the covered person must obtain an itemized statement from the dental care provider and attach it to a completed American Dental Association ("ADA") claim form. The covered person may obtain an ADA claim form by contacting us at the address shown on the ID card. The itemized statement must contain the following information: (a) the date the dental service or supply was provided; (b) a description of the dental service or supply provided; (c) the amount actually charged by the provider; (d) the provider's name and address; (e) the patient's name; and (f) the covered employee's name.

Time of Payment of Claims

We will process claims for dental benefits under the Plan, or any part of such claims, within forty-five (45) days of our receipt of a properly completed claim form which:

1. establishes proof of loss; and
2. contains, as determined by us, all the information we need to pay the claim.

If a claim or any part of a claim is contested or denied, or additional information is needed, we will give written notice to the claimant within forty-five (45) days after we initially receive such claim.

This notice will identify:

1. the contested or denied portion of the claim;
2. reason(s) for the contest or denial; and/or
3. additional information needed.

We will complete the processing of the claim within sixty (60) days of receipt, at the address shown on the ID card, of the additional information we requested.

All claims will be paid, contested, or denied no later than one hundred twenty (120) days after receiving the claim form. Payment will be considered made on the date:

1. we deposit the notice of the claims processing decision in the United States mail in a properly addressed, postpaid envelope; or
2. of delivery, if not so posted.

Review Of Denied Claims

In the event we deny coverage or benefits for services or supplies listed on a claim, in whole or in part, the covered person can ask us to review the denial decision. The covered person must request such a review within sixty (60) days of receipt of the notice of the claim denial. The covered person should submit to us any additional information he or she wants us to consider during the review. We will notify the covered person of our review decision as specified under the Complaint and Grievance Procedure. The covered person may designate, in writing, an individual to represent him during the review process.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims under the Plan, we may need information, including medical information, from the dental care providers who rendered the services or supplies. A covered person must cooperate with us in obtaining information we need to process the claims, and if requested, must help us obtain such information by, among other ways, signing any release of information or other appropriate forms. A covered person's failure to fully cooperate with us may result in the denial of a claim.

Fraud, Misrepresentation or Omission in Applying for Benefits

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

Explanation of Benefits Form

All claims decisions, including denial and claims review decisions, will be given to the covered person 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 applicable benefit booklet 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 a covered person 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 CLAIMS 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 Plan. The Claims Administrator has been authorized by the plan sponsor to require acceptable proof that an individual meets and continues to meet applicable eligibility requirements under the Plan.

Employee Eligibility Class

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

1. you must be in an eligible class as determined by the participating employer;
2. you must work at least the number of hours each week as determined by the participating employer as your normal work week; and
3. you must have completed any applicable waiting period required by the participating employer.

Dependent Eligibility Class

The following individuals are eligible to apply for dependent coverage under the Plan:

1. the legal spouse of a covered employee; and
2. a child under the limiting age who is a covered employee's 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 covered 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 Plan may do so by completing the enrollment process required by the plan sponsor or other entity or person designated by the plan sponsor. You must follow the procedures established by the plan sponsor in order to enroll for coverage under the Plan.

Effective Date Of An Individual's Coverage Following Enrollment

The coverage effective date for an individual who meets the eligibility requirements, set forth in the Eligibility section, shall be the coverage effective date shown on the Schedule of Benefits.

Any individual who is eligible to enroll but who does not apply for coverage within the time period specified for completion of the enrollment process, must wait until the next annual open enrollment period to apply. Coverage will take effect on the date specified by the plan sponsor.

Changes In Coverage/Effective Date

Marital Status

Dependents eligible to enroll under your coverage, due to a change in your marital status, will be covered as of the date of marriage. The change request to add dependents to your coverage must be received within thirty (30) days after the date of the marriage.

Newborn Children

Coverage under the Plan for a newborn child will take effect from the moment of birth. If an enrollment change request is received within thirty (30) days after the date of birth, an employee contribution will not be charged for the first thirty (30) days of coverage. If we do not receive a change request within thirty (30) days after the date of birth, the applicable employee contribution may be charged 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.

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 a change request is received within thirty (30) days after the date the child was placed. You may be required to provide written proof of adoption or foster care. If a change request is received within this thirty (30)-day period, an employee contribution 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 applicable Florida law.

No employee contribution will be charged for the first thirty (30) days of coverage, if a change request is received within thirty (30) days of the date of birth or placement of the adopted newborn child.

If a change request is not received within thirty (30) days of the date of placement of an adopted or foster child or birth of a newborn, the applicable employee contribution may be charged 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 the Plan. It is your responsibility to notify the plan sponsor 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 the Plan. Proof of final adoption must be submitted to the plan sponsor. It is your responsibility to notify the plan sponsor if the adoption does not take place. Coverage for the child under the Plan will terminate 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 the Plan. It is your responsibility to notify the plan sponsor, that the foster child is no longer in your care. Coverage for the child under the Plan will terminate on the first billing date following 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 the plan sponsor or, if the plan sponsor has authorized the Claims Administrator to receive such forms, to the Claims Administrator, in accordance with the procedures established by the plan sponsor. Coverage for such dependent will terminate on the first billing date following our receipt of the change request.

Elective Termination of Coverage

If you elect to terminate your coverage or delete an eligible dependent from coverage at any time during a plan year, neither you nor your dependent can reapply for coverage under the Plan for a period of two (2) years following termination. You may reapply for coverage under the Plan during the annual open enrollment period which immediately follows the end of the two (2) year period.

Other Provisions Regarding Enrollment and Effective Date of Coverage

Rehired Employees

If you are rehired as an employee of the plan sponsor, you are considered a newly hired employee under the Plan. The provisions of this benefit booklet which apply to newly hired employees and their eligible dependents apply to you and your eligible dependents.

Prior Coverage under an Extension of Benefits

The plan sponsor’s prior insurance carrier may be required to provide certain benefits to a covered person under an extension of benefits provision contained in an insurance policy or health care plan. No payment will be made under the Plan for any claims for dental services which are paid or payable under an extension of benefits provision contained in the prior carrier's insurance policy or plan for extension of benefits after termination of the Plan.

SECTION V

THE DATE ON WHICH COVERAGE TERMINATES

Termination of Employee Coverage

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

1. the date the Plan terminates;
2. the date you fail to meet any eligibility requirement;
3. the date specified by the plan sponsor that your coverage terminates;

Termination of Dependent Coverage

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

1. the date the Plan terminates;
2. the date your coverage terminates;
3. the date the covered dependent fails to meet any eligibility requirement;
4. the date specified by the plan sponsor that dependent coverage terminates.

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 a covered dependent before benefits are payable for covered dental services.

Family Deductible Limit

The family deductible per plan year 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 covered person can contribute toward satisfaction of the family deductible per plan year is the individual deductible amount.

Plan Percentage Payable

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

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 the Claims Administrator for a predetermination of benefits prior to the start of treatment.

The main purpose of a predetermination of benefits is to provide the covered person and the dentist with an estimate of the amount of the Plan's financial liability, if any, prior to services being performed. The estimate may be provided in the form of a range of payments or average payments but, in no event, shall the Plan be bound by the estimate.

Requests for a predetermination of benefits should be submitted within thirty (30) days of the date of the initial diagnosis or exam. The covered person should submit, for review by the Claims Administrator, 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

Under the Plan, the covered person can obtain dental services from any provider of his or her choice. The amount the covered person has to pay as his or her share of expenses incurred for covered dental services, depends, in part, on the participation status of the provider from whom the covered person receives services and supplies. The following describes the arrangement used to make payment under the Plan.

Participating Dentist

Participating dentists are dentists who have signed an agreement currently in effect with us to participate in our dental network and/or a signed agreement with a third party contracted by us to participate in their network. Participating dentists have agreed to accept the lesser of the actual charge or our allowance or the contracted third party's allowance, as applicable, for covered services. The covered person is not responsible for charges in excess of the allowance. The covered person is responsible for the deductible, percentage not payable by the Plan, and the payment of charges for non-covered services, as well as charges in excess of any maximum benefit limitations. Participating dentists will file the claim for services they provide on the covered person'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 plan sponsor or any covered person.

Non-Participating Dentist

These are dentists who do NOT have a signed agreement currently in effect with us, or a third party contracted by us, to participate in either of our dental provider networks. Non-participating dentists have not agreed to accept our allowance or the contracted third party's allowance for covered dental services. The covered person is responsible for the difference between the allowance and the non-participating dentist's charge, if any. The covered person is also responsible for the non-participating deductible shown on the Schedule of Benefits, the percentage not payable by the Plan, and the payment of charges for non-covered services as well as charges in excess of any maximum benefit limitations.

Selection of a Dentist

The covered person is solely responsible for selecting his or her own dentist. All decisions that require or pertain to independent professional dental/clinical judgement or training, or the need for dental or medical services, are solely the covered person's responsibility and that of his or her treating providers. The covered person and his or her dentist are responsible for deciding what care should be rendered or received and when that care should be provided. We are only responsible for determining whether expenses incurred for dental care are covered under this Plan. In making coverage decisions, we will not be deemed to participate in or override a covered person's decisions concerning his or her health or the dental decisions of his or her medical and dental providers.

SECTION VIII

BENEFITS

The maximum benefit payable per plan year, per person is shown on the Schedule of Benefits.

The Orthodontia Lifetime Maximum benefit payable per person is shown on the Schedule of Benefits. If your plan sponsor offers more than one dental coverage option administered by the Claims Administrator, and you change from one option to another, the Plan's Lifetime Maximum benefit does not start over. This rule applies regardless of the number of times you change between dental options offered by your plan sponsor. In the event you change dental options, the Orthodontia Lifetime Maximum benefit will be the higher lifetime benefit maximum of any dental option, under which you have been enrolled.

The following describes covered dental benefits. 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 covered dependent children to age nineteen (19) years of age, one (1) times per plan year;
4. Bitewing x-rays, twice (2) per plan year;
5. Space maintainers (not made of precious metals) that replace prematurely lost teeth for covered dependent children under fourteen (14) years of age. No payment will be made for duplicate space maintainers;
6. Sealants for covered dependent children through age six (6) to age nineteen (19);
7. 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;
8. Periapical (root area) x-rays as required;
9. Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;
10. Cephalometric x-rays, but only in connection with orthodontic diagnosis, and only once in any thirty-six (36) consecutive month period.
11. Pulp vitality test; and
12. Palliative (emergency) treatment of an acute condition requiring immediate care.

Basic

1. Application of desensitizing medicaments;
2. Periodontal maintenance procedures (following active therapy) twice per plan year.
3. Repair of broken partial or complete dentures;
4. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
5. Routine extractions;
6. 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;
7. 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;

8. Adjustments to the maxillary and mandibular dentures, two (2) times per plan year (beginning six [6] months after the initial insertion of the denture);
9. Recementation of space maintainers once per plan year (must be six [6] months after the initial placement date);
10. Repair of broken crowns, inlays, onlays or bridges;
11. Surgical removal of teeth;
12. Apicoectomy (dental root surgery);
13. Gingivectomy and gingivoplasty;
14. Periodontal scaling, payable once per quadrant every twenty-four (24) months;
15. Root amputation - per root;
16. Hemisection - (including any root removal), not including root canal therapy;
17. Biopsy of soft oral tissue;
18. Alveoloplasty - per quadrant;
19. Gingival flap procedure - once per quadrant every thirty-six (36) months; and
20. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis - payable once every thirty-six (36) months; and
21. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every thirty-six (36) months.

Major

1. Clinical crown lengthening-hard tissue only, subject to dental consultant review for coverage 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 partial or complete denture or bridge by a new denture or by a new bridge, if satisfactory proof is given that:
   (a) the existing denture or bridge was inserted at least five (5) years before it is replaced; and
   (b) the existing denture or bridge is not serviceable and cannot be made serviceable. If the existing 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. Free soft tissue graft procedure, including donor site;
7. Frenulectomy;
8. Bone replacement graft - once per site every thirty-six (36) months;
9. Tissue conditioning treatments for the upper and lower dentures, two (2) times per plan year;
10. 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;
11. 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);
12. Pedicle soft tissue graft - once per site every thirty-six (36) months;

13. Guided tissue regeneration - once per site every thirty-six (36) months; and
14. Subepithelial connective tissue graft - once per site every thirty-six (36) months.
15. Surgical placement of permanent endosteal implant once per lifetime for members age sixteen (16) and over;
16. Initial insertion of prefabricated or custom abutment per implant;
17. Replacement of a prefabricated or custom abutment per implant once every five (5) years;
18. Initial insertion of abutment supported or implant supported implant crowns and bridges;
19. 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;
20. Implant maintenance twice per year; and
21. Implant repair procedures once per arch every six (6) months.

Group Dental Orthodontia Benefits

Orthodontic Services

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.

SECTION IX

LIMITATIONS AND EXCLUSIONS

Limitations

1. Any retreatments of root canals are 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 covered dependent children.
5. General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
6. 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.
7. Periodontal services are limited to covered persons age eighteen (18) and older.
8. Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
9. Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.
10. Orthodontia services will be limited to the Lifetime Orthodontia Maximum shown on the Schedule of Benefits.
11. 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.
12. 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 liability, after we receive notice from the dentist.
13. Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with orthodontic appliance therapy.
14. 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.

Exclusions

The following are excluded under this benefit booklet:

1. Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to an covered person's effective date of coverage, (until the covered person has been covered under the Plan for twelve [12] consecutive months), unless otherwise specified in this benefit booklet.
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, except for orthodontic services rendered for correction of defects as a result of traumatic injuries which occurred while this rider is in force.
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 total reasonable expenses that are actually incurred.
11. Services for which the covered person 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 covered person’s health or medical insurance plan, policy, or contract.
15. Services not listed in the Benefits section of this benefit booklet.
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 benefit booklet will be based on the allowance for the least costly service, procedure, or course of treatment.
17. Any additional treatment required due to the covered person’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 or after termination of coverage.
20. Services rendered after termination of the Plan, except as provided under “Extension of Benefits upon Plan 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, or alteration by a covered person, or a result of theft.
23. Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the covered person’s coverage under this benefit booklet.
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), if paid or payable under a covered person’s health or medical insurance plan, policy, or contract.
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 the replacement and/or repair of any orthodontic appliance furnished under the treatment plan or for any duplicate orthodontic device or appliance.

SECTION X

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") is a limitation of benefits for dental benefits under this Plan and is designed to avoid the duplication of payment for covered dental services. Coordination of Benefits applies when a covered person 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 the Claims Administrator.

Payment under the Plan for covered dental services depends on whether the Plan is primary, as determined in accordance with the provisions set forth below. If the Plan is primary, 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 covered person's other dental plans, programs, or policies.

In those cases where COB applies and the Plan is not primary, the payment for covered dental services, if any, will be reduced so that the combined benefits of both plans will not be more than 100% of the "total reasonable expenses" that are actually incurred by the covered person.

For purposes of this COB provision, in the event a covered person receives covered dental services from a participating dentist, “total reasonable expenses” shall mean the allowance required to be paid to the provider pursuant to the agreement the Claims Administrator has with such provider. If the primary payer's payment exceeds the allowance, no payment will be made under the Plan for such services.

The following rules shall be used to determine if the Plan is primary:

1. The dental benefits of a dental policy, plan, or program that covers the person as an employee, member, or other than as a covered 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 covered 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, 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.

   c. if the other policy or plan does not have rules that establish the same order of benefits as under this benefit booklet, the benefits under the other plan will be determined primary.

Benefits under the Plan will not be coordinated with the following types of policies:

(1) indemnity;

(2) excess insurance;

(3) specified illness or accident; or

(4) Medicare supplement.

SECTION XI

SUBROGATION

If a covered person is injured or becomes ill as a result of another person's or entity's intentional act, negligence or fault, such covered person must notify us concerning the circumstances under which he or she was injured or became ill. The covered person or his or her lawyer must notify us, by certified or registered mail, if such covered person intends to claim damages from someone for injuries or illness. If a covered person recovers money to compensate for the cost/expense services or supplies to treat his or her illness or injury, the Plan is legally entitled to recover payments made on his or her behalf to the doctors, hospitals, or other providers who treated such covered person. The legal right to recover money paid in such cases is called "subrogation." The Plan may recover the amount of any payments made on a covered person's behalf minus the Plan's pro rata share for any costs and attorney fees incurred by the covered person in pursuing and recovering damages. The Plan may subrogate against all money recovered regardless of the source of the money including but not limited to uninsured motorists coverage. Although the Plan may, but is not required to, take into consideration any special factors relating to a covered person's specific case in resolving our subrogation claim, the Plan will have the first right of recovery out of any recovery or settlement amount such covered person is able to obtain even if the covered person or his or her attorney believes that such covered person has not been made whole for his or her losses or damages by the amount of the recovery or settlement.

The covered person must do nothing to prejudice the Plan's right of subrogation hereunder and no waiver, release of liability, or other documents executed by such covered person, without notice to the claims administrator and the plan sponsor's written consent, will be binding upon the Plan.

Right of Reimbursement

If any payment under this Plan is made to a covered person or on his or her behalf with respect to any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, the Plan will have a right to be reimbursed by such covered person (out of any settlement or judgment proceeds recovered which include payment for medical expenses) one dollar ($1.00) for each dollar paid under the terms of this Plan minus a pro rata share for any costs and attorney fees incurred in pursuing and recovering such proceeds.

The Plan's right of reimbursement will be in addition to any subrogation right or claim available to it, and the covered person must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement hereunder. A covered person or his or her lawyer must notify the claims administrator, by certified or registered mail, if such covered person intends to claim damages from someone for injuries or illness. A covered person must do nothing to prejudice the Plan's right of reimbursement hereunder and no waiver, release of liability, or other documents executed by such covered person, without notice to us and the plan sponsor's written consent, will be binding upon us.

SECTION XII

COBRA CONTINUATION OF COVERAGE

A Federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to the plan sponsor. If COBRA applies to the plan sponsor, you or your covered dependents may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper contribution.

You must contact the plan sponsor to determine if you or your covered dependents are entitled to COBRA continuation of coverage. The plan sponsor is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all covered persons of their rights under COBRA. The Claims Administrator is neither responsible, nor liable, for the failure of the plan sponsor or any covered person to meet the requirements of COBRA and/or the Group Dental Benefit Plan.

A summary of COBRA rights and the general conditions for a covered person's qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the plan sponsor are met by the purchase of the Group Dental Benefit Plan; the duty to meet such obligations remains with the plan sponsor.

The following is a summary of what covered persons may elect if 1) COBRA applies to the plan sponsor and 2) you or your covered dependents are eligible for continuation of coverage:

1. The covered employee and covered dependents may elect to continue their coverage for a period not to exceed eighteen (18) months* in the case of:
   a. termination of employment of the covered employee other than for gross misconduct; or
   b. reduced hours of employment of the covered employee.

***Note:** The covered employee and covered dependents are eligible for an eleven (11) month extension of the eighteen (18) month COBRA continuation option above (to a total of twenty-nine [29] months) if you or your covered dependent is totally disabled (as defined by the Social Security Administration [SSA]) at the time of your termination, reduction in hours or within the first sixty (60) days of COBRA continuation coverage. The covered person must supply notice of the disability determination to the plan sponsor within eighteen (18) months of becoming eligible for continuation coverage and no later than sixty (60) days after the SSA's determination date.

2. The covered employee's covered dependent(s) may elect to continue their coverage for a period not to exceed thirty-six (36) months in the case of:
   a. the covered employee's entitlement to Medicare;
   b. divorce or legal separation of the covered employee;
   c. death of the covered employee;
   d. the plan sponsor filing bankruptcy (subject to bankruptcy court approval); or
   e. a dependent child ceasing to be an eligible dependent under the terms of the plan sponsor's coverage. The dependent child may elect the thirty-six (36) month extension.

Children born to or placed for adoption with the covered employee during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

If you or your covered dependents are eligible to continue coverage under the Plan pursuant to COBRA, the following conditions must be met:

1. The plan sponsor must notify the covered persons of their continuation of coverage rights under COBRA within fourteen (14) days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a covered dependent child to meet eligibility requirements, you or your covered dependent must notify the plan sponsor, in writing, within sixty (60) days of any of these events. The plan sponsor's fourteen (14)-day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue coverage under the Plan within sixty (60) days of the later of:
   a. the date that the coverage terminates; or

b. the date the notification of continuation of coverage rights is sent by the plan sponsor.

3. COBRA coverage will terminate if you or your covered dependents become covered under any other group dental plan or policy. However, COBRA coverage may continue if the new policy or plan coverage contains exclusions or limitations due to a pre-existing condition that would affect the continuant's coverage.
4. COBRA coverage will terminate upon entitlement to Medicare coverage.
5. If a covered person is totally disabled and eligible and elects to extend continuation of coverage, the covered person may not continue such extension coverage more than thirty (30) days after a determination by the Social Security Administration that the covered person is no longer disabled. The covered person must inform the plan sponsor of the Social Security determination within thirty (30) days of such determination.

   Note: For purposes of this section, you will be considered "totally disabled" only if you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a physician. A covered dependent is totally disabled only if he or she is unable to perform those normal day-to-day activities which he or she would otherwise perform and he or she requires regular care and attendance by a physician.
6. In order for continuation of coverage to apply, all contribution or requirements must be met, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in this benefit booklet.
7. The plan sponsor continues to provide group dental coverage to its employees.

An election by a covered employee or covered dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that covered employee or covered dependent spouse, unless otherwise specified in the election form.

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 Plan 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 plan sponsor.