

For the Employees of

**City of Venice
(HIGH PLAN)**

BlueDental Choice

Certificate Booklet

For Customer Service Assistance: 1-877-203-9921



Voluntary PPO Plus
(51+ lives)

SCHEDULE OF BENEFITS

Contractholder:	City of Venice (HIGH PLAN)
Contract Number:	25-Y0146-00-7
Certificate Effective Date:	January 1, 2011, or the Effective Date specified on the Employee Application, whichever is later
Plan Year:	January 1st through December 31st

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

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.

	<u>Participating Dentists</u>	<u>Non- Participating Dentists</u>
DEDUCTIBLE FOR PREVENTIVE SERVICES	None	None
INDIVIDUAL DEDUCTIBLE PER PERSON, PER PLAN YEAR FOR BASIC AND MAJOR SERVICES	\$50	\$50
FAMILY DEDUCTIBLE PER PLAN YEAR FOR BASIC AND MAJOR SERVICES	\$150	\$150

SCHEDULE OF BENEFITS

(continued)

	<u>Participating Dentists</u>	<u>Non- Participating Dentists</u>
PREVENTIVE, BASIC AND MAJOR SERVICES		
Plan Year Maximum per person	\$1,000	
Coinsurance Payable By FCL:		
Preventive	100%	90%
Basic	80%	70%
Major	50%	40%

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

Coinsurance Payable by FCL.....	50%
Orthodontia Lifetime Maximum per person	\$1,000

**THIS CERTIFICATE PROVIDES INSURANCE FOR THE EMPLOYEES
AND DEPENDENTS, IF APPLICABLE, OF:**

**CITY OF VENICE
401 WEST VENICE AVENUE
VENICE, FLORIDA 34285**

25-Y0146-00-7

**THE EMPLOYEE SHALL BE GIVEN A COPY OF THE GROUP
ENROLLMENT APPLICATION.**

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:

31. 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:

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.

B. “**Limitations and Exclusions**” is amended as follows:

(i) The following is added under “Limitations”:

11. Orthodontia services will be limited to the Lifetime Orthodontia Maximum shown on the Schedule of Benefits.
12. 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.
13. 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.
14. Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with orthodontic appliance therapy.

15. 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.



President

**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**

**This Certificate Contains A
Deductible Provision**

FOR CUSTOMER SERVICE ASSISTANCE: 1-877-203-9921

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

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. The allowance for participating dentists is determined and established solely by FCL 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, reasonable 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.

DEFINITIONS (Continued)

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 age twenty-five (25) if that child: (1) depends on you for support; and (2) is living in your household, or is a full-time or part-time student.

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.

DEFINITIONS (Continued)

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 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. 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.

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, Reasonable 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, reasonable 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 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 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

Written proof of loss

1. must be furnished to us at our home office; and
2. should be furnished within ninety (90) days of the date the dental benefit was provided.

If proof of loss is not sent 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 insured 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 a 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

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."

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 employee of FCL who is a licensed dentist 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 1-877-203-9921**

**OR
WRITE TO**

**FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.
DENTAL ADMINISTRATOR
P.O. BOX 100135, Columbia, SC 29202**

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 thirty (30) 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 thirty (30) 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 thirty (30) 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 thirty (30)-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 thirty (30) days of the date of birth or placement of the adopted newborn child.

If we do not receive a change request within thirty (30) 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.

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, you may not reapply for such terminated coverage for a period of two (2) years following the termination. You may reapply for such terminated coverage during the annual open enrollment period following this two (2) year period.

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 due date of the first premium that is not paid.

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 due date of the first premium that is not paid.

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 to participate in our dental plan. Participating dentists have agreed to accept the lesser of the actual charge or the FCL allowance 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. Non-participating dentists have not agreed to accept the FCL allowance as payment in full. The insured is responsible for the difference between the FCL allowance 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. Payment for covered services provided by non-participating dentists will not exceed, usual, reasonable 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).

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;

Basic (continued)

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);

Basic (continued)

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 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;

Major (continued)

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; and
12. Subepithelial connective tissue graft - once per site every thirty-six (36) months.

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 bicuspid 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 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 insureds 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.

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.

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.

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. (FCL)
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203**

CERTIFICATE AMENDMENT

The Certificate of Insurance and any amendments attached thereto, to which this Certificate Amendment is attached is changed as follows.

Section IV, Enrollment and Effective Date of Coverage:

The Elective Termination of Coverage provision is deleted in its entirety.

All other benefits, provisions, conditions, limitations, exceptions, or other terms of the certificate remain unchanged.

In the event of any inconsistencies between the provisions of this amendment and the provisions in the certificate, the provisions in this amendment shall control to the extent necessary to effectuate the intent of FCL as expressed herein.

Signed for the Florida Combined Life Insurance Company, Inc., at Jacksonville, Florida.



President

**FLORIDA COMBINED LIFE INSURANCE
COMPANY, INC. (FCL)
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203**

AMENDMENT

The Group Dental Benefits Certificate to which this amendment is attached is changed as follows:

The following service listed under Basic in **SECTION VIII – BENEFITS** is moved to Preventive.

- Sealants for dependent children through age sixteen (16)

Nothing herein contained shall be held to vary, alter, waive or extend any of the provisions, conditions, limitations, exceptions, or other terms of the policy to which this amendment is attached other than as herein stated.

Policyholder: City of Venice
(HIGH PLAN)

Group Number: 25-Y0146-00-7

Amendment
Effective Date: January 1, 2011

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



President

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

AMENDMENT

The Group Dental Benefits Certificate to which this amendment is attached is changed as follows:

The following services listed under Basic in **SECTION VIII - BENEFITS** are moved to Preventive.

- Periapical (root area) x-rays as required;
- 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.
- Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;

Nothing herein contained shall be held to vary, alter, waive or extend any of the provisions, conditions, limitations, exceptions, or other terms of the certificate to which this amendment is attached other than as herein stated.

POLICYHOLDER: City of Venice
(HIGH PLAN)

GROUP NUMBER: 25-Y0146-00-7

AMENDMENT

EFFECTIVE DATE: January 1, 2011

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



President

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

AMENDMENT

The Group Dental Benefits Certificate to which this amendment is attached is changed as follows:

A. The following services listed under Preventive in **SECTION VIII – BENEFITS** are covered as follows:

- Prophylaxis (cleaning, scaling and polishing of teeth), four (4) times per plan year.

B. The following services listed under Limitations in **SECTION IX – LIMITATIONS AND EXCLUSIONS** are covered as follows:

- Periodontal prophylaxis is limited to four (4) 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 four (4) times per plan year.

Nothing herein contained shall be held to vary, alter, waive or extend any of the provisions, conditions, limitations, exceptions, or other terms of the certificate to which this amendment is attached other than as herein stated.

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



President

POLICYHOLDER: City of Venice
(HIGH PLAN)

POLICY NUMBER: 25-Y0146-00-7

AMENDMENT EFFECTIVE DATE: January 1, 2011

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

CERTIFICATE AMENDMENT

The Group Dental Benefits Certificate to which this amendment is attached is changed as follows:

The following are added to SECTION VIII, BENEFITS, subsection Major.

13. Surgical placement of permanent endosteal implant once per lifetime for members age 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.
19. Implant repair procedures once per arch every 6 months.

Nothing herein contained shall be held to vary, alter, waive or extend any of the provisions, conditions, limitations, exceptions, or other terms of the policy to which this amendment is attached other than as herein stated.

POLICYHOLDER: City of Venice
(HIGH PLAN)

GROUP NUMBER: 25-Y0146-00-7

AMENDMENT EFFECTIVE DATE: January 1, 2011

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

A handwritten signature in black ink, appearing to read "Jaron M. M...", is positioned above the title "President".

President

**FLORIDA COMBINED LIFE INSURANCE COMPANY, INC. (FCL)
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203**

CERTIFICATE AMENDMENT

The Certificate of Insurance and any amendments attached thereto, to which this Certificate Amendment is attached is changed as follows.

The definition for Dependent is deleted in its entirety and is replaced with the following:

Dependent, if Dependent coverage is included, will include:

1. Your spouse, if not legally separated from you.
2. Any child, until the end of the calendar year in which that child reaches age 26. After the end of the calendar year in which that child reaches age 26, the child will only be covered according to the terms in items 3a, 3b and 3c below. The term "child" also includes a legally adopted child or foster child, from the date of placement in the residence or step-child.
3. 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.

If a child between the ages 27 and 30 is provided coverage under your certificate after the end of the calendar year in which the child reached age 26 and coverage for that child is subsequently terminated, the child is not eligible to be covered again under your certificate unless the child was

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CERTIFICATE AMENDMENT

continuously covered by other like coverage without a gap in that coverage of more than 63 days.

4. A handicapped child over 26 years of age, who was insured under this certificate before reaching age 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.

All other benefits, provisions, conditions, limitations, exceptions, or other terms of the certificate remain unchanged.

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CERTIFICATE AMENDMENT

In the event of any inconsistencies between the provisions of this amendment and the provisions in the certificate, the provisions in this amendment shall control to the extent necessary to effectuate the intent of FCL as expressed herein.

Signed for the Florida Combined Life Insurance Company, Inc., at Jacksonville, Florida.

A handwritten signature in black ink, appearing to read "Tom Men".

50164-289
Compliance Amendment for:

26/30 Dependent Age
City of Venice Group Dental

FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.

P.O. BOX 40028

JACKSONVILLE, FLORIDA 32203

The Group Dental Benefits Contract and Certificate to which this rider is attached is changed, for purposes of this rider, by adding the following new benefit:

Plan Year Maximum Rollover Benefit

A Rollover Benefit is a portion of a member's un-used Plan Year Maximum that may be carried over to the next Plan Year, thereby increasing the next Plan Year Maximum amount, provided the following conditions are met:

1. the member is an active member of the plan on the last day of the plan year;
2. the member submits at least one (1) claim for a covered service during a Plan Year;
3. the member's total claims paid during a Plan Year do not exceed the Yearly Threshold Amount, as stated in the table below; and
4. the Accumulated Rollover Maximum has not been reached.

Plan's Annual Maximum Benefit Amount	Yearly Threshold Amount	Available Rollover Amount to use Next year/beyond	Accumulated Rollover Maximum
\$500 - \$749	\$200	\$150	\$500
\$750 - \$999	\$300	\$200	\$500
\$1,000 - \$1,249	\$500	\$350	\$1,000
\$1,250 - \$1,499	\$600	\$450	\$1,250
\$1,500 - \$1,999	\$700	\$500	\$1,250
\$2,000 - \$2,499	\$800	\$600	\$1,500
\$2,500 - \$2,999	\$900	\$700	\$1,500
\$3,000 or more	\$1,000	\$750	\$1,500

Beginning with the second (2nd) plan year of coverage under the Certificate, a member's Plan Year Maximum, as shown on the Schedule of Benefits, may be increased by the amount shown on the table above if all the above listed conditions are met. If coverage under this Rider is first provided during a partial Plan Year, the Rollover Benefit will be calculated as if coverage was provided for a full Plan Year.

Here's an example of how the Rollover Benefit works.

Plan Year	One (1)	Two (2)	Three (3)	Four (4)
Plan Year Maximum shown on the schedule of benefits	\$1,000	\$1,000	\$1,000	\$1,000
Accumulated Rollover Amount credit from prior year	\$0	\$350	\$700	\$700
Adjusted Plan Year Maximum	\$1,000	\$1,350	\$1,700	\$1,700
Covered Service received	Yes	Yes	No	
Total Claims Paid during Plan Year	\$275	\$480	\$350	
Rollover Amount	\$350	\$350	\$0	
Accumulated Rollover Amount	\$350	\$700	\$700	

The Rollover Amount can be accumulated from one Plan Year to the next, up to the Accumulated Rollover Maximum, unless:

1. the member's total claims paid during a Plan Year exceed the Yearly Threshold Amount (in this instance, there will be no additional Rollover Amount for that Plan Year), or
2. no claims for covered services are incurred during a Plan Year (in this instance, there will be no additional Rollover Amount for that Plan Year).

If total claims paid during any one Plan Year exceed the Plan Year Maximum shown on the schedule of benefits, the excess amount will be deducted from the Accumulated Rollover Amount available for that Plan Year. No additional Rollover Amount will be earned for that Plan Year and the Accumulated Rollover Amount available for the next Plan Year will be reduced by the amount deducted for the excess claim amount.

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To properly calculate the Rollover Amount, claims should be submitted in a timely manner, as described in the Certificate.

Rollover Amounts are not available for the following expenses related to a member's dental services:

1. deductibles;
2. coinsurance;
3. co-payments;
4. balance billed amounts; or
5. orthodontic benefits.

When Your Plan Year Maximum Rollover Benefit Ends

You will lose your right to any annual rollover benefit (or accumulated rollover maximum benefit) when you lose eligibility for coverage in your group's dental plan. The accumulated rollover benefit can be used only while you are enrolled in your group's dental plan and while your group continues to offer the Plan Year Maximum Rollover Benefit. This means that if you change from one group's dental plan to another group's dental plan, or if your group dental plan is terminated, you lose your right to any rollover benefit that has not been used.

Nothing herein contained shall be held to vary, alter, waive or extend any of the provisions, conditions, limitations, exceptions, or other terms of the Certificate to which this rider is attached other than as herein stated.

Signed for the Florida Combined Life Insurance Company, Inc., at Jacksonville, Florida, on the later of: (1) the effective date of the Policy and Certificate; or (2) the date of a Policy Amendment adding this Rider.



President

