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Schedule B Indemnity Dental Plan Florida

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COMPBENEFITS INSURANCE COMPANY

P. O. Box 8236 Chicago, IL 60680-8236 (800) 342-5209

CERTIFICATE OF GROUP DENTAL INSURANCE

This certificate outlines the features of the Group Dental Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as "CompBenefits"). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

Signed for CompBenefits Insurance Company

Gerald L. Ganoni
President

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR DENTISTS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION WITH OTHER BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION.

IMPORTANT CANCELLATION INFORMATION

Please read the provision entitled Termination, found on page 15.

DEFINITIONS

You will need to know what is meant by certain terms used in this certificate. They are defined below.

"You" and "Your" mean the certificateholder.

"We", "Our" and "Us" mean CompBenefits.

"Premium Due Date" is the first day of each calendar month.

"Effective Date" means the date the Policy begins.

"Eligibility Date" means the date the employee can become insured as defined under When You Can Be Insured.

"Benefit Year" for the first policy year begins on the Effective Date and ends on the 31st of December of the same year. Thereafter, the Benefit Year will be the calendar year.

"Covered Dental Expenses" means the kinds of expenses which can apply to meet the Deductible or for which Dental Benefits can be paid. Covered Dental Expenses include only certain charges for services or supplies which do not exceed the Reimbursement Rate when ordered by a dentist for dental care and treatment. The charges for services or supplies listed in the Schedule of Benefits are the only charges that are Covered Dental Expenses.

"Covered Dental Injury'' means all damage to a covered person's mouth due to an accident caused by any sudden, unexpected impact from outside the oral cavity, and all complications arising from that damage.

"Deductible" means the dollar amount of Covered Dental Expenses that must be incurred and paid by you before benefits can be paid. The Deductible is applied chronologically by the dates on which CompBenefits receives claims for Covered Dental Expenses. If all or any portion of an insured's or member's Deductible for a calendar year is applied against Covered Dental Expenses incurred by an insured or member during the last three months of the contract period, the insured's or member's Deductible for the next ensuing contract period shall be reduced by the amount so applied.

"Dental Treatment Plan" means a dentist's report, on a form that meets CompBenefits's approval, which: (a) itemizes the dental procedures that the dentist will perform; (b) lists the charges for each procedure; and (c) is accompanied by supporting pre-operative x-rays and any other appropriate diagnostic material required by CompBenefits. Related procedures (such as cleaning, root planing, fillings and crowns) will be considered part of the same Dental Treatment Plan even if reported on different claim forms and/or on different dates of service, if they are performed within four months of one another.

"Dentist" means any dental or medical practitioner who: a) is properly licensed or certified under the laws of the state where he practices; and b) provides services which are within the scope of that license or certificate.

"Group**"** means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

"Participating Dentists Fee Schedule" is a schedule of maximum allowable charges that participating network Dentists have agreed to use when charging You or Your Dependent.

"Policy" means the Policy issued to the Policyholder.

"Policyholder" means the Group to whom the Policy has been issued.

"Reimbursement Rate" means the total dollar amount of reimbursement for a Covered Dental Expense as determined by combining actual charges and relative values of the services in the area. Factors CompBenefits considers when determining Reimbursement Rate include geographic area and actual billed rates for services provided. Upon written request, CompBenefits shall provide a general description of the methodology used to determine the frequency of determining, and the database used to determine the Reimbursement Rate.

BECOMING INSURED

Who Can Be Insured

All persons who are members of the Group can be insured. You are a member of the Group if:

1. You are an eligible employee or member of the Policyholder (defined by the Policyholder); and
2. If you are an employee of the Group, you work at least the minimum number of hours per week (defined by the Policyholder).

If You and Your spouse are members of the Group, either of You may choose to be covered for Dental Benefits:

1. as an employee; or
2. as a dependent.
   If one chooses to be covered as a dependent, the other must choose to be covered as an employee

When You Can Be Insured

You can be insured on the Effective Date if:

1. You are a member of the Group on that date; and
2. You have completed the initial waiting period, as shown in the Schedule of Benefits.

If You do not meet the above requirements on Effective Date, Your Eligibility Date will be the Premium Due Date which next follows the date You first become a member of the Group, or during any open enrollment period as may be determined and approved by CompBenefits.

When Your Insurance Begins

To be insured under this policy, You must enroll within 31 days of your Eligibility Date. If You enroll and meet the Actively At Work Requirement, Your insurance will begin at 12:01 a.m. on the Premium Due Date which is the same as or which next follows the date You enroll.

If You do not enroll within 31 days of Your Eligibility Date, You may not enroll until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

The Actively At Work Requirement

If you are an employee of the Group, to become insured under the Group Policy You must be actively at work. To be actively at work, You must:

1. be able to do the normal tasks of Your job on a full-time basis for a full work day on the day Your insurance is to begin;
2. be able to do such tasks at one of Your employer's normal places of business or at a location to which You must travel to do Your job; and
3. not be absent from work because of leave of absence or temporary layoff.

If You do not meet the above requirements, insurance will begin on the Premium Due Date which is the same as or next follows the day on which You do meet these requirements.

Insurance For Your Dependents

If You are insured by the Group Policy, You can also insure Your Eligible Dependents. If You and Your spouse are members of the Group, either of You - but not both may insure Your children who are Eligible Dependents.

Who Are Your Eligible Dependents

Your Eligible Dependents are:

1. Your spouse, if You are legally married; and
2. Your unmarried children who are:
   (a) up to the Dependent Age listed in the Schedule of Benefits; or
   (b) up to the Dependent Maximum Age listed in the Schedule of Benefits, dependent on You for support, and attending an accredited educational institute, college or university, or vocational/technical school on a full time basis; or
   (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions:
      (1) the child must have become incapable prior to his or her 19th birthday, or the Dependent Maximum Age if a full time student, and must be covered as Your Eligible Dependent when he reaches age 19, or the Dependent Maximum Age if a full time student;
      (2) the child must be chiefly dependent on You for support and maintenance;
      (3) the child must stay unmarried and in the condition described above;

(4) You must give CompBenefits written proof that the child is incapable; and
(5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof.

A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

For purposes of this Policy the following are excluded from insurance coverage: 1) a dependent child who can be insured as a member of the Group; or 2) a dependent who is on active duty with the armed forces of any country.

Coverage For Children Placed For Adoption

A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of: 1) the date of birth if a petition for adoption is filed within 31 days of the birth of such child; or 2) the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid within 31 days of such date.

When Insurance For Dependents Begins

If you have Eligible Dependents on the day you first become insured, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll for them within 31 days after they become Eligible Dependents. Your dependent coverage will begin at 12:01 a.m. on the next Premium Due Date which follows the date You enroll for dependent coverage, or the Premium Due Date after which you first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll for them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

A child born to You while You are insured will be an Eligible Dependent and will automatically be insured for 31 days following the moment of birth. If You choose to insure Your newborn, You must enroll for the child within 31 days of his date of birth or coverage for that child will terminate at the end of the 31-day period.

When Your Insurance Ends

Your insurance will end at 12:01 a.m. on the earliest of:

1. The date on which the Group Policy terminates.
2. The last day of the month which follows Your last payment to the cost of Your insurance if You stop Your payments.
3. The last day of the month which follows the date You are no longer a member of the Group.
4. The last day of the month in which Your employment terminates.
5. The day you enter into any naval, military, air force or any other armed service in any country.

When Your Dependents' Insurance Ends

Insurance for Your dependents will end at 12:01 a.m. on the earliest of:

1. the date the Group Policy ends;
2. the date the Group Policy is changed to exclude insurance for Your dependents;
3. the date Your insurance ends; or
4. the date ending the term that insurance is in force because of Your last payment to the cost of insurance for Your dependents if You stop Your payments.

Insurance for any one dependent will end on the last day of the month in which he ceases to be an Eligible Dependent.

DENTAL BENEFITS

The Dental Benefits described on the pages that follow apply to Covered Dental Expenses incurred:

1. by You while You are insured; and
2. for a dependent while You are insured for the dependent.

Benefits will be paid after Covered Dental Expenses during a Benefit Year exceed the Deductible. Covered Dental Expenses will include only those charges for treatment or services that begin and are completed while You and Your dependents are insured.

Beginning Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will begin:

1. for full dentures or partial dentures - on the date the final impression is made;
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays and other laboratory prepared restorations - on the date final preparation of the teeth is completed;
3. for root canal therapy - on the date the pulp chamber is first opened;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

CompBenefits will not pay benefits for any service which started prior to the patient being insured. If a procedure is started before the expiration of the waiting period to which that procedure is subject, no benefit will be payable, even if the procedure is completed after the expiration of the waiting period.

Completion Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will be completed:

1. for dentures and partial dentures - on the date the final completed appliance is inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient; and
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays, and other laboratory prepared restorations - on the date that the appliance is permanently cemented in place; for all other services, on the date the service is performed.

3. for root canal therapy - on the date the canals are permanently filled;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

Waiting Periods

Benefits for certain services are payable only after a person has satisfied a waiting period. Waiting periods are identified in the Schedule of Benefits.

Benefits Payable

Based on your Plan design, Benefits are payable at either a) the lesser of the Reimbursement Rates or actual charges incurred by You or Your dependents for Covered Dental Expenses, or b) the lesser of the Scheduled Benefits or actual charges incurred by You or Your dependents for Covered Dental Expenses. To receive benefits, the expenses incurred must exceed the Deductible. The expenses used to meet the Deductible must be incurred within a Benefit Year. When the Deductible is met, CompBenefits will pay benefits for expenses incurred during the rest of the Benefit Year. The amount of the benefits will be equal to the insured percentage of the Covered Dental Expenses or the Scheduled Benefits for the Covered Dental Expenses that are more than the Deductible. The insured percentages or Scheduled Benefits that apply to Covered Dental Expenses are shown in the Schedule of Benefits. No benefits are payable for expenses listed in the section headed "Exclusions". The maximum benefit which will be paid is explained in the section headed "Maximum Benefits".

Estimate of Benefits

If Covered Dental Expenses for a procedure are expected to be more than $200, CompBenefits recommends You send to CompBenefits a Dental Treatment Plan for the procedure before treatment begins. The Dental Treatment Plan should be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials as requested by CompBenefits. CompBenefits will notify You and Your dentist of the benefits payable based upon the Dental Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If You and Your dentist decide on a more expensive method of treatment than that predetermined by CompBenefits, We will not pay the excess amount. The maximum Covered Dental Expense to be considered for payment will be the most economical procedure, determined by CompBenefits, to accomplish a professionally satisfactory result.

Maximum Benefits

The total amount of Dental Benefits that will be paid for one person for expenses (other than orthodontic expenses) incurred in a Benefit Year will not be more than the Maximum Annual Payment shown in the Schedule of Benefits.

Benefits After Insurance Ends

If a procedure (other than orthodontic treatment) starts for You or a dependent and it has not been completed when Dental Benefits end, You or Your dependent will be entitled to benefits for Covered Dental Expenses incurred for that procedure during the three months just after the insurance ends.

Orthodontic Benefits (If Applicable)

* This is an optional benefit that is only available if purchased by the Policyholder. Orthodontic plan benefits shall only be provided for Dependents 18 years of age or younger. See Schedule of Benefits to determine if You are covered for this benefit.

The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances, incurred in any Benefit Year, will not be more than the Orthodontic Annual Maximum if an Orthodontic Annual Maximum is shown in the Schedule of Benefits. The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances during the entire time insured will not be more than the Orthodontic Lifetime Maximum shown in the Schedule of Benefits. Orthodontic treatment will begin on the date the bands or appliance(s) are first inserted. Any other treatment that can be completed on the same day as performed will be considered started and completed on the actual date that the treatment is performed.

Orthodontic benefits are paid in equal quarterly installments over the course of the entire Dental Treatment Plan. The benefit payment schedule will be calculated by:

1. determining the total benefit payable for the orthodontic treatment plan;
2. defining the amount of the initial payment as 25% of the total benefit; and
3. divide the 75% balance of the total benefit by the number of quarters that the orthodontic treatment will continue to determine the amount which will be paid for each subsequent quarter of treatment.

The first installment will be payable as of the date on which the orthodontic appliances are first installed. The subsequent quarterly benefit payments will be made for as long as the insurance remains in force provided that You submit proof to CompBenefits that treatment continues.

Major Restorative Limitations

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. a denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy, however, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
2. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture

if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;

3. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
4. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
5. the replacement of teeth up to the normal complement of 32.

Exclusions

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;

10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
18. charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, CompBenefits will determine the amount. CompBenefits will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors;
19. orthodontic plan benefits for persons 19 years of age or older.

COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but
(b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, dental care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans; and 3) medical benefits coverage in group, group type, and individual automobile "no-fault" type contracts or group or group-type automobile "fault" contracts. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" is the part of the Group Policy that provides Dental Benefits.

"Primary Plan''/"Secondary Plan''. The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means a necessary, reasonable and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Benefit Year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

This Plan determines its order of benefits using the first of the following rules which applies:

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce

(further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

(1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans". The benefits of This Plan will be reduced when the sum of:

(a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and

(b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made;

exceeds those Allowable in a Claim Determination Period. In that case, the benefits

of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. CompBenefits has the right to decide which facts are needed. CompBenefits may get needed facts from, or give them to, any other organization or person. CompBenefits need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

7. OVERPAYMENTS.

If the amount of the payments made by CompBenefits are more than should have paid under this provision, CompBenefits may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) insurance companies or other organizations providing benefits under another Plan.

NOTICE OF CONTINUATION OF GROUP DENTAL COVERAGE RIGHTS (COBRA)

If You are member of an employer Group with 20 or more employees and Your insurance terminates in accordance with the other terms of the Policy, You may elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under the Policy, and if such insurance is terminating due to any of the following Qualified Events:

1) Termination of Your employment (for reasons other than gross misconduct).
2) Reduction of work hours including lay-off.
3) Death of the insured person.
4) Divorce or legal separation.
5) A child ceases to be a dependent as defined in this Policy.
6) The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

However, no continuation of coverage will be provided if You are covered under another group dental care plan coincident with or prior to any of the above events occurring. Continuation of insurance will be retroactive to the date of termination. The maximum continuation of coverage period with respect to a reason described above is:

1) 18 months with respect to 1 or 2 above. If You are disabled as determined under Title II or XVI of the Social Security Act, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months.
2) 36 months with respect to 3, 4 or 5 above.
3) With respect to 6 above, lifetime coverage for You, whereas Your Eligible Dependents will be covered until the earlier of a) Your death; or, b) Death of the Eligible Dependent.

If, while insurance is being continued, further events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days. It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of: a) the date of the Qualifying Event; b) the date of the loss of coverage; or c) the date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates: 1) The end of the maximum continuation of coverage period; 2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; 3) Your becoming covered under another group dental care plan as an employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group dental plan; 4) Discontinuance of this Dental Care Benefit Provision; 5) The date Your employer ceases to provide any group dental plan.

GENERAL PROVISIONS

Representations and Warranties

In the absence of fraud, all statements made by the Policyholder or by an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or You, a copy of which

has been furnished to the Policyholder or You or Your beneficiary.

Premium Rates

All premiums are payable in advance for coverage under the Policy in accordance with the premium rate schedules of CompBenefits in effect for each Premium Due Date. Premiums are payable to CompBenefits or Our authorized agent and must be paid by the Policyholder from the Policyholder's funds or from funds contributed by You, or from both. Premiums may be increased for a contract period on the anniversary date of the contract. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 60 days prior to the anniversary of the contract period.

Grace Period

Unless the Policy is terminated, a grace period of 31 days is allowed for payment of each premium due after the first premium. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will be entitled to collect all pro rata premiums then unpaid for the period any coverage under the Policy remained in force during such grace period.

Termination

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination. This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

How to Claim Benefits

You can get the forms You need for claiming benefits from the Policyholder. We will furnish said forms to the Policyholder. If the forms are not furnished before the expiration of ten working days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within 90 days of the date of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. When making a claim for Dental Benefits You must give proof of each

charge. It is important that You have copies of bills for all charges. The bills must be itemized to show the service for which each charge is made. You may have benefits paid directly to dentists. To do so, fill out and sign the claim form telling CompBenefits to pay Your benefits this way.

Notice and Proof of Claim

Written notice of dental treatment must be given to Us within one year after the date when such dental treatment occurred. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 8236, Chicago, IL 60680-8236, or to any authorized agent of Us, with information sufficient to identify the insured, shall be deemed notice to Us. Failure to give notice within that time shall neither invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

Benefits will be paid upon receipt of written proof on standard dental claim forms acceptable to CompBenefits. CompBenefits may also accept as proof of a claim, notification in any format that is commonly accepted in the industry at the time the claim is made. The proof must describe the event for which the claim is made. Proof of loss due to hospital confinement must be given to CompBenefits within 90 days after the end of the period for which the claim is made. CompBenefits will have the right, at its own expense, to examine the person whose injury or sickness is the basis of a claim, when and so often as it may reasonably require while a claim is pending.

Legal Action

No legal action shall be brought to recover on a claim prior to the end of 60 days after proof of loss has been filed. No such action shall be brought at all unless brought within six years from the end of the time in which proof of loss is required.

Conformity with State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time of Payment of Claims

Indemnities payable under this Certificate for any loss, other than loss for which this Certificate provides periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by CompBenefits or by any agent duly authorized by CompBenefits to accept such premium without requiring in connection

therewith an application for reinstatement shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the insured and CompBenefits shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Time Limit on Certain Defenses

After this policy has been in force for a period of two (2) years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application.

Participating Provider Networks, if applicable

Certain plans offered by CompBenefits feature different levels of benefits based upon You utilizing a participating network dentist. Participating dentists have agreed to charge You or Your eligible Dependents based on a Participating Dentists Fee Schedule. Benefits payable to non-participating dentists may be based on either the Reimbursement Rate or the Participating Dentists Fee Schedule. Non-participating dentists may bill You for the balance of their charges. Please check Your Schedule of Benefits to determine if Your plan features a participating network option. If it does, please refer to the list of participating network Dentists prior to making an appointment.

AMENDMENT

The Certificate of Group Dental Insurance ("Certificate") is hereby amended as follows.

The terms and conditions of that certain Certificate are hereby confirmed in their entirety with the exception that to the extent the terms and conditions of this Amendment are in conflict with the terms and conditions of the Certificate, the terms of this Amendment shall govern.

1. The following is added to Page one (1) of the Certificate:

   If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (800) 342-5209.

2. The provision "Who Are Your Eligible Dependents" is hereby deleted in its entirety and replaced with the following:

   Who Are Your Eligible Dependents

   Your Eligible Dependents are:

   1. Your spouse, if You are legally married; and
   2. Your children: (a) up to the Dependent Age listed in the Schedule of Benefits; or (b) up to the Dependent Maximum Age listed in the Schedule of Benefits if the child is dependent upon You for support and is living with You or is a full-time or part-time student; or (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions: (1) the child must have become incapable prior to his or her 19th birthday, or the end of the calendar year in which the child reaches the Dependent Maximum Age if the child is dependent upon You for support and is living with You or is a full-time or part-time student; (2) the child must be chiefly dependent on You for support and maintenance; (3) the child must stay in the condition described above; (4) You must give CompBenefits written proof that the child is incapable within 31 days after his or her coverage would end; and (5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof. A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

   For purposes of this Policy the following are excluded from insurance coverage:
   1. a dependent child who can be insured as a member of the Eligible Group; or
   2. a dependent who is on active duty with the armed forces of any country.

3. The provision "Coverage For Children Placed For Adoption" is hereby deleted in its entirety and replaced with the following:

Coverage For Children Placed For Adoption

A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of: 1. the date of birth if a petition for adoption is filed within 60 days of the birth of such child; or 2. the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3. the date the child is placed with You for adoption.

4. The provision "When Insurance For Dependents Begins" is hereby deleted in its entirety and replaced with the following:

When Insurance For Dependents Begins

If you have Eligible Dependents on the day you first become insured, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll for them within 31 days after they become Eligible Dependents. Your dependent coverage will begin on the next Premium Due Date which follows the date You enroll for dependent coverage, or the Premium Due Date after which you first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll for them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

A child born to You or a covered Dependent while insured will be an Eligible Dependent and will automatically be insured for 60 days following the moment of birth. If You choose to insure the newborn, You must enroll the child within 60 days of his date of birth or coverage for that child will terminate at the end of the 60-day period. The coverage for a newborn child of a covered Dependent terminates 18 months after the birth of the newborn child.

5. The provision "Exclusions " is hereby amended as follows:

Exclusions

Benefits will not be paid for:

17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are received under any workers' compensation act or similar law; or

6. The provision "Termination" is hereby amended as follows:

Termination

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination. This section does not apply to a termination for nonpayment of premium by the Policyholder.

If cancellation is due to nonpayment of premium a notice of termination will be mailed to the Policyholder prior to 45 days after the date the premium is due. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

7. The provision "Legal Action" is hereby deleted in its entirety and replaced with the following:

Legal Action

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

8. The following provision is hereby added as follows:

Information regarding performance outcomes and financial data published by the Florida Agency for Health Care Administration is available electronically on the Internet at http://www.floridahealthstat.com. A link to this site is also available by visiting the CompBenefits web site at http://www.CompBenefits.com.

It is agreed and acknowledged that this Amendment shall be effective upon receipt of this Amendment.

Signed for CompBenefits Insurance Company

Gerald L. Ganoni
President

Plan Design Summary

Initial Waiting Period for Insurance: None
Waiting Period for Type I Services: None
Waiting Period for Type II Services: None
Waiting Period for Type III Services: None
Dependent Age: 26
Dependent Maximum Age: 26
Annual Deductible: $0 per person; max 3 per family; waived for Type I
Maximum Annual Payment: $1,000

TYPE I: PREVENTIVE DENTAL SERVICES

The maximum charge for TYPE I Dental Services which may be included in Covered Dental Expenses will be the Scheduled Benefit shown below.

PROCEDURE	MAXIMUM REIMBURSEMENT
Periodic oral examination—established patient[1]	$23.00
Limited oral evaluation—problem focused[1]	$31.00
Oral evaluation for a patient under three years of age and counseling with primary caregiver[1]	$31.00
Comprehensive oral evaluation - new or established patient[1]	$31.00
Comprehensive periodontal evaluation - new or established patient[1]	$31.00
X-ray intraoral—complete series of radiographic images (once per three year period)	$61.00
X-ray intraoral—periapical, first radiographic image	$13.00
X-ray intraoral—periapical, each additional radiographic image	$13.00
X-rays intraoral—occlusal radiographic image	$16.00
Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$22.00
Extra-oral posterior dental radiographic image[1]	$32.00
X-ray bitewing—single radiographic image[1]	$20.00
X-ray bitewings—two radiographic images[1]	$25.00
Bitewings – three radiographic images[1]	$32.00

TYPE I: PREVENTIVE DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Bitewings—four radiographic images[1]	$32.00
Panoramic radiographic image (covered once per three year period)	$47.00
Collection of microorganisms for culture & sensitivity	$36.00
Prophylaxis—adult[1]	$38.00
Prophylaxis—child[1]	$36.00
Topical application of fluoride varnish (Covered twice per 12 consecutive months for a dependent child under 16)	$31.00
Topical application of fluoride – excluding varnish (Covered twice per 12 consecutive months for a dependent child under 16)	$31.00
Sealant—per tooth (Covered once per 12 consecutive months for a dependent child under age 13)	$13.00
Space maintainer—fixed, unilateral	$160.00
Space maintainer—fixed, bilateral	$216.00
Space maintainer—removable, unilateral	$202.00
Space maintainer—removable, bilateral	$220.00
Re-cement or re-bond space maintainer	$27.00
Incisional biopsy of oral tissue-hard (bone, tooth)	$90.00
Incisional biopsy of oral tissue-soft	$61.00
Palliative (emergency) treatment of dental pain—minor procedure	$29.00

TYPE II: BASIC DENTAL SERVICES

The maximum charge for TYPE II Dental Services which may be included in Covered Dental Expenses will be the Scheduled Benefit shown below.

Amalgam—one surface, primary or permanent[2]	$19.00
Amalgam—two surfaces, primary or permanent[2]	$29.00
Amalgam—three surfaces, primary or permanent[2]	$36.00

[1] Covered twice per 12 consecutive months

[2] Multiple restorations on one surface will be covered as a single filling

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Amalgam—four or more surfaces, primary or permanent[2]	$46.00
Resin based composite—one surface, anterior[3]	$24.00
Resin based composite—two surfaces, anterior[3]	$36.00
Resin based composite—three surfaces, anterior[3]	$49.00
Resin based composite—four or more surfaces or involving incisal angle (anterior)[3]	$46.00
Resin based composite—one surface, posterior[3]	$19.00
Resin based composite—two surfaces, posterior[3]	$29.00
Resin based composite—three surfaces, posterior[3]	$36.00
Resin based composite—four or more surfaces, posterior[3]	$36.00
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$19.00
Re-cement or re-bond crown	$19.00
Protective restoration (Covered as separate procedure if no other service, except X-rays, rendered during the visit)	$20.00
Core buildup, including any pins when required	$58.00
Pin retention—per tooth, in addition to restoration	$27.00
Therapeutic pulpotomy (excluding final restoration)	$33.00
Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$33.00
Endodontic therapy, anterior tooth (excluding final restoration)	$259.00
Endodontic therapy, premolar tooth (excluding final restorations)	$317.00
Endodontic therapy, molar tooth (excluding final restorations)	$389.00
Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$73.00
Apexification/recalcification—interim medication replacement (includes any necessary radiographs)	$73.00
Apexification/recalcification—final visit (includes any necessary radiographs)	$73.00
Apicoectomy—anterior	$114.00
Apicoectomy—premolar (first root)	$114.00
Apicoectomy—molar (first root)	$114.00
Apicoectomy (each additional root)	$114.00
Retrograde filling—per root	$42.00

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Root amputation—per root (not covered in conjunction with procedure D3920)	$62.00
Hemisection (including any root removal), not including root canal therapy	$62.00
Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4]	$82.00
Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4]	$22.00
Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4]	$92.00
Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4]	$92.00
Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)	$153.00
Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)	$153.00
Pedicle soft tissue graft procedure (Covered once per 12 consecutive months)	$92.00
Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft (Covered once per 12 consecutive months)	$102.00
Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site (Covered once per 12 consecutive months)	$102.00
Provisional splinting—intracoronal	$29.00
Provisional splinting—extracoronal	$29.00

[2] Multiple restorations on one surface will be covered as a single filling

[3] Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations

[4] Only one of these procedures is covered per area of the mouth.

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Periodontal scaling and root planing – four or more teeth per quadrant[5]	$23.00
Periodontal scaling and root planing – one to three teeth per quadrant[5]	$23.00
Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit[5]	$49.00
Periodontal maintenance (covered only after active periodontal therapy)[5]	$32.00
Repair broken complete denture base, mandibular[6]	$42.00
Repair broken complete denture base, maxillary[6]	$42.00
Replace missing or broken teeth—complete denture (each tooth)[6]	$42.00
Repair resin partial denture base, mandibular[6]	$42.00
Repair resin partial denture base, maxillary[6]	$42.00
Repair cast partial framework, mandibular[6]	$42.00
Repair cast partial framework, maxillary[6]	$42.00
Repair or replace broken clasp—per tooth[6]	$49.00
Replace broken teeth—per tooth[6]	$30.00
Add tooth to existing partial denture[6]	$58.00
Add clasp to existing partial denture—per tooth[6]	$62.00
Rebase complete maxillary denture[6]	$122.00
Rebase complete mandibular denture[6]	$122.00
Rebase maxillary partial denture[6]	$122.00
Rebase mandibular partial denture[6]	$122.00
Re-cement or re-bond fixed partial denture (per unit)	$26.00
Extraction, coronal remnants – primary tooth	$23.00
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$23.00
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$42.00
Removal of impacted tooth—soft tissue	$58.00
Removal of impacted tooth—partially bony	$73.00
Removal of impacted tooth—completely bony	$98.00
Surgical removal of residual tooth roots (cutting procedure)	$46.00

TYPE II: BASIC DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$76.00
Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	$82.00
Alveoloplasty in conjunction with extractions— four or more teeth or tooth spaces, per quadrant	$35.00
Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$35.00
Alveoloplasty not in conjunction with extractions— four or more teeth or tooth spaces, per quadrant	$40.00
Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$40.00
Vestibuloplasty – ridge extension (second epithelialization)	$62.00
Vestibuloplasty – ridge extension (incl tissue procedures)	$122.00
Incision and drainage of abscess— intraoral soft tissue	$36.00
Incision and drainage of abscess – extraoral soft tissue	$55.00
Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$53.00
Excision hyperplastic tissue—per arch	$62.00
Deep sedation/general anesthesia – first 15 minute[7]	$54.00
Deep sedation/general anesthesia – each subsequent 15 minute increment[7]	$49.00
Therapeutic parenteral drug, single administration	$19.00
Occlusal adjustment – limited[8]	$23.00
Occlusal adjustment – complete[8]	$59.00

[5] Covered twice per area of the mouth per 12 consecutive months.

[6] Covered only if repairs/adjustments more than 1 year after the initial insertion.

[7] Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by the company.

[8] Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment.

TYPE III: MAJOR DENTAL SERVICES

The maximum charge for TYPE III Dental Services which may be included in Covered Dental Expenses will be the Scheduled Benefit shown below.

PROCEDURE	MAXIMUM REIMBURSEMENT
Diagnostic casts	$24.00
Inlay—metallic, one surface	$92.00
Inlay—metallic, two surfaces	$127.00
Inlay—metallic, three or more surfaces	$137.00
Inlay—porcelain/ceramic, one surface	$42.00
Inlay—porcelain/ceramic, two surfaces	$84.00
Inlay—porcelain/ceramic, three or more surfaces	$125.00
Crown—resin based composite, indirect	$82.00
Crown—resin with high noble metal	$157.00
Crown—resin with predominantly base metal	$137.00
Crown—resin with noble metal	$143.00
Crown—porcelain/ceramic	$153.00
Crown—porcelain fused to high noble metal	$288.00
Crown—porcelain fused to predominantly base metal	$147.00
Crown—porcelain fused to noble metal	$153.00
Crown—full cast high noble metal	$281.00
Crown—full cast predominantly base metal	$132.00
Crown—full cast noble metal	$143.00
Prefabricated stainless steel crown—primary tooth	$35.00
Prefabricated stainless steel crown—permanent tooth	$35.00
Post and core in addition to crown, indirectly fabricated	$58.00
Prefabricated post and core in addition to crown	$42.00
Complete denture—maxillary	$207.00
Complete denture—mandibular	$207.00
Immediate denture—maxillary	$217.00
Immediate denture—mandibular	$217.00
Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	$127.00
Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	$127.00

TYPE III: MAJOR DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$233.00
Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$215.00
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$127.00
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$127.00
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$233.00
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$215.00
Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	$46.00
Adjust complete denture—maxillary[9]	$13.00
Adjust complete denture—mandibular[9]	$13.00
Adjust partial denture—maxillary[9]	$13.00
Adjust partial denture—mandibular[9]	$13.00
Reline complete maxillary denture (chairside)[10]	$52.00
Reline complete mandibular denture (chairside)[10]	$52.00
Reline maxillary partial denture (chairside)[10]	$42.00
Reline mandibular partial denture (chairside)[10]	$42.00
Reline complete maxillary denture (laboratory)[10]	$76.00
Reline complete mandibular denture (laboratory)[10]	$76.00
Reline maxillary partial denture (laboratory)[10]	$66.00

[9] Covered only once per 12 consecutive months and only if done more than one year after the initial insertion of the denture.

[10] Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2-year period.

TYPE III: MAJOR DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Reline mandibular partial denture (laboratory)[10]	$66.00
Pontic—cast high noble metal	$281.00
Pontic—cast predominantly base metal	$132.00
Pontic—cast noble metal	$143.00
Pontic—porcelain fused to high noble metal	$288.00
Pontic—porcelain fused to predominantly base metal	$147.00
Pontic—porcelain fused to noble metal	$153.00
Pontic—resin with high noble metal	$157.00
Pontic—resin with predominantly base metal	$137.00
Pontic—resin with noble metal	$143.00
Retainer inlay—cast high noble metal, two surfaces[11]	$127.00
Retainer inlay—cast high noble metal, three or more surfaces[11]	$137.00
Retainer inlay—cast predominantly base metal, two surfaces[11]	$127.00
Retainer inlay—cast predominantly base metal, three or more surfaces[11]	$137.00

TYPE III: MAJOR DENTAL SERVICES (CONT.)

PROCEDURE	MAXIMUM REIMBURSEMENT
Retainer inlay—cast noble metal, two surfaces[11]	$127.00
Retainer inlay—cast noble metal, three or more surfaces[11]	$137.00
Retainer crown—resin with high noble metal[11]	$157.00
Retainer crown—resin with predominantly base metal[11]	$137.00
Retainer crown—resin with noble metal[11]	$143.00
Retainer crown—porcelain fused to high noble metal[11]	$288.00
Retainer crown—porcelain fused to predominantly base metal[11]	$147.00
Retainer crown—porcelain fused to noble metal[11]	$153.00
Retainer crown—3/4 cast high noble metal[11]	$147.00
Retainer crown—full cast high noble metal[11]	$281.00
Retainer crown—full cast predominantly base metal[11]	$137.00
Retainer crown—full cast noble metal[11]	$143.00

[10] Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2-year period.

[11] Bridge retainers – initial placement of replacement.

Notice of Non-Discrimination. Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc. provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us as well as provides free language assistance services to people whose primary language is not English, including qualified sign language interpreters and written information in other formats.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services, contact Humana Inc. and its subsidiaries at **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members or residents: You may also call the California Department of Insurance toll-free hotline number, **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m., Eastern time. Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

These notices are available at **www.humana.com/legal/non-discrimination-disclosure** and **www.humana.com/legal/multi-language-support**.