

For the Employees of

FLAGLER COUNTY SCHOOL BOARD

BlueDental Choice

Copayment Plan

Certificate Booklet

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



SCHEDULE OF BENEFITS

Contractholder:	FLAGLER COUNTY SCHOOL BOARD
Contract Number:	25-R0172-00-3
Certificate Effective Date:	September 1, 2011, or the Effective Date specified on the Employee Application, whichever is later
Plan Year:	September 1st through August 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 FCL allowance (which is a combination of the amount paid by FCL plus the specified copayment paid by the insured) plus any applicable deductible, as payment in full for covered services. The copayment fees for services provided by Participating Dentists are shown in the Participating Dentist Schedule attached to this contract.

Benefits are payable for Participating and Non-Participating Dentists as shown below. See the Provider Alternatives provision for further details.

	Participating Dentists	Non- Participating Dentists
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)

	Participating Dentists	Non- Participating Dentists
COINSURANCE PAYABLE BY FCL FOR COVERED SERVICES:		
Preventive.....	N/A	80%
Basic.....	N/A	60%
Major.....	N/A	40%

***COPAYMENT FEES FOR COVERED SERVICES:**

Prophylaxis (Cleanings)		
Adult/Child (1110, 1120).....	\$0	N/A
	See attached Participating Dentist Schedule for complete listing of services	

*Copayment fees will not apply toward the satisfaction of any deductible or coinsurance requirements under this contract.

PREVENTIVE, BASIC AND MAJOR SERVICES

Plan Year Maximum per person..... \$1,000
 (Applies to covered services provided by Participating and
 Non-Participating Dentists, combined)

ORTHODONTIA SERVICES
(Applicable to All Insureds)

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

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

**FLAGLER COUNTY SCHOOL BOARD
1769 E. MOODY BOULEVARD
BUNNELL, FLORIDA 32110**

25-R0172-00-3

**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

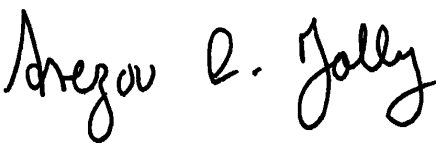
Florida Combined Life Insurance Company, Inc. (herein referred to as "FCL") has issued a group insurance contract to your employer, the contractholder. The contract is between the contractholder and FCL, and through which you are provided dental insurance coverage.

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.

50485-0802

Copayment PPO

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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 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.

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 between FCL and the insured for covered services provided by a non-participating dentist. 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.

Copayment - The amount payable by an insured for a covered service provided by a participating dentist. The copayment is expressed as a dollar amount rather than as a percentage.

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

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

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

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

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

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

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

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

Dependent - means your legal spouse and/or natural, newborn, adopted, foster, or step child(ren), or a child for whom you have been court-appointed as legal guardian or legal custodian. A child may be considered a dependent until the end of the calendar year in which the child reaches 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.

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, such dentist has agreed to accept specific copayments, plus any applicable deductible, from the insured for his or her services. The insured is responsible for the copayments and any deductible, payable directly to the participating dentist.

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.

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

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 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 for paper claims 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 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 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 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 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 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, if any, is shown on the Schedule of Benefits. This deductible must be met by an insured before benefits for covered services 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 covered services provided by a non-participating dentist will be paid at the percentage shown on the Schedule of Benefits.

Copayment

Copayments are fees payable by the insured directly to the participating dentist for covered services. Copayment fees are shown on the Participating Dentist Schedule attached to this certificate.

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 specified copayments, plus any applicable deductible, from the insured for covered services. The insured is not responsible for charges in excess of the copayments unless such charges are for services that exceed any maximum benefit limitations. The insured is responsible for the payment of all charges for non-covered services. 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. 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; and
4. Bitewing x-rays, once per plan year.

Basic

1. Palliative (emergency) treatment of an acute condition requiring immediate care;
2. Sealants for dependent children through age sixteen (16);
3. Periapical (root area) x-rays as required;
4. 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;
5. Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;
6. Repair of broken partial or complete dentures;
7. 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;
8. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
9. Routine extractions;

10. 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;
11. Tissue conditioning treatments for the upper and lower dentures, two (2) times per plan year;
12. Adjustments to the maxillary and mandibular dentures, two (2) times per plan year (six [6] months after the initial insertion of the denture);
13. 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;
14. 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);
15. Surgical removal of teeth;
16. Surgical removal of maxillary or mandibular intrabony cysts; and
17. Alveoloplasty - per quadrant.

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;
6. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every thirty-six (36) months;
7. Free soft tissue graft procedure, including donor site;
8. Frenulectomy;
9. Bone replacement graft - once per site every thirty-six (36) months;
10. Pedicle soft tissue graft - once per site every thirty-six (36) months;
11. Guided tissue regeneration - once per site every thirty-six (36) months;
12. Subepithelial connective tissue graft - once per site every thirty-six (36) months;
13. 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;

14. Repair of broken crowns, inlays, onlays or bridges;
15. Apicoectomy (dental root surgery);
16. Gingivectomy and gingivoplasty;
17. Periodontal maintenance procedures (following active therapy);
18. Periodontal scaling, payable once per quadrant every twenty-four (24) months;
19. Root amputation - per root;
20. Hemisection - (including any root removal), not including root canal therapy;
21. Gingival flap procedure - once per quadrant every thirty-six (36) months; and
22. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis - payable once every thirty-six (36) months.

SECTION IX

LIMITATIONS AND EXCLUSIONS

Limitations

1. Any retreatment of root canals are payable one (1) year after completion date of root canal therapy.
2. Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
3. The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
4. Sealants are limited to the first and second molars for primary teeth and the 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 maintenance procedures following active therapy is limited to two (2) times per plan year. Periodontal prophylaxis will be 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 this certificate or any schedules attached to 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.**

**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: FLAGER COUNTY SCHOOL BOARD

GROUP NUMBER: 25-R0172-00-3

AMENDMENT EFFECTIVE DATE: September 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. (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: FLAGER COUNTY SCHOOL BOARD

Group Number: 25-R0172-00-3

Amendment

Effective Date: September 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. (FCL)
P.O. BOX 40028
JACKSONVILLE, FLORIDA 32203**

CERTIFICATE AMENDMENT

Effective September 23, 2010, 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 30, who is:
 - a. Either natural, legally adopted or fostered from the date of placement in the residence, or a step-child; or
 - b. Lives with you and depends on you for more than 50% of his support.
3. A handicapped child over 30 years of age, who was insured under this certificate before reaching age 30.

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 30 if the insured policyholder gives us proof that the child is:

- a. incapable of self-sustaining employment; and
- b. chiefly dependent on the insured policyholder for support and maintenance,

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

CERTIFICATE AMENDMENT

the insurance will continue as long as the child remains handicapped, unless coverage terminates according to the Termination provision 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 30.

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.

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.

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

CERTIFICATE AMENDMENT

A handwritten signature in black ink, appearing to read "James M. Munn". The signature is fluid and cursive, with a large initial "J" and "M".

President

50164-289

2010 Dependent Age Compliance Amendment for:
Group Dental Certificates:
50383-899
50410-1199
50485-0802
50530-0603

**FLORIDA COMBINED LIFE INSURANCE
COMPANY, INC. (FCL)
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: Flagler County School Board

GROUP NUMBER: 25-R0172-00-3

AMENDMENT EFFECTIVE DATE: September 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 "Tara M. M.", written in a cursive style.

President

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

BENEFIT LEVEL	ADA CODE	DESCRIPTION OF SERVICE	INSURED PAYS \$
Preventive Services			
	120	Periodic oral evaluation	0
	140	Limited oral evaluation - problem focused	0
	145	Oral eval for patient under 3 yrs. old, counseling with primary caregiver	0
	150	Comprehensive oral evaluation	0
	180	Comprehensive periodontal evaluation – new or established patient	0
	270	Bitewing - single film	0
	272	Bitewings - two films	0
	273	Bitewings- three films	0
	274	Bitewings - four films	0
	277	Vertical Bitewings - 7-8 films	0
	1110	Prophylaxis - adult	0
	1120	Prophylaxis - child	0
	1203	Topical application of fluoride (excluding prophylaxis) - child	0
	1206	Topical fluoride varnish	0
	9310	Consultation - Per session	0
	9430	Office visit for observation (during regular scheduled hrs) no other services performed	0
Basic Services			
	210	Intraoral - complete series (including bitewings)	17
	220	Intraoral periapical - first film	4
	230	Intraoral periapical - each additional	2
	330	Panoramic film	14
	1351	Sealant - per tooth	6
	1352	Preventive resin restoration in a moderate to high carries risk patient – permanent tooth	6
	1510	Space maintainer - fixed - unilateral	47
	1515	Space maintainer - fixed - bilateral	66
	1520	Space maintainer - removable - unilateral	53

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

1525	Space maintainer - removable - bilateral	75
1555	Removal of fixed space maintainer	29
2140	Amalgam - one surface, primary / permanent	15
2150	Amalgam - two surfaces, primary / permanent	19
2160	Amalgam - three surfaces, primary / permanent	23
2161	Amalgam - four or more surfaces, primary / permanent	28
2330	Resin - one surface, anterior	20
2331	Resin - two surfaces, anterior	26
2332	Resin - three surfaces, anterior	30
2335	Resin - four or more surfaces or involving incisal angel (anterior)	32
2391	Resin - one surface, posterior-primary / permanent	22
2392	Resin - two surfaces, posterior-primary / permanent	29
2393	Resin - three surfaces, posterior-primary/permanent	37
2394	Resin - four or more surfaces, posterior-primary/permanent	38
2910	Recement inlay	11
2920	Recement crown	11
2930	Prefabricated stainless steel crown primary tooth	37
2940	Sedative filling	12
2950	Core build-up, including any pins	28
2951	Pin retention per tooth, in addition to restoration	6
5410	Adjust complete denture - maxillary (upper)	10
5411	Adjust complete denture - mandibular (lower)	10
5421	Adjust partial denture - maxillary (upper)	10
5422	Adjust partial denture - mandibular (lower)	9
5510	Replace broken complete denture base	23
5520	Replace missing or broken teeth (complete denture) - each tooth	20

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

BENEFIT LEVEL	ADA CODE	DESCRIPTION OF SERVICE	INSURED PAYS \$
Basic Services (continued)			
	5610	Repair resin denture base	21
	5620	Repair cast framework	23
	5630	Repair or replace broken clasp	20
	5640	Replace broken teeth - per tooth	18
	5650	Add tooth to existing partial denture	27
	5660	Add clasp to existing partial denture	31
	5670	Replace all teeth & acrylic on cast metal framework (upper)	75
	5671	Replace all teeth & acrylic on cast metal framework (lower)	75
	5710	Rebase complete denture (upper)	73
	5711	Rebase complete denture - (lower)	73
	5720	Rebase partial denture - (upper)	66
	5721	Rebase partial denture - (lower)	66
	5730	Reline complete maxillary denture (chairside) - (upper)	38
	5731	Reline complete mandibular denture (chairside) - (lower)	38
	5740	Reline maxillary partial denture (chairside) - (upper)	34
	5741	Reline mandibular partial denture (chairside) - (lower)	34
	5750	Reline complete maxillary denture (laboratory) - (upper)	59
	5751	Reline complete mandibular denture (laboratory) - (lower)	57
	5760	Reline maxillary partial denture (laboratory) - (upper)	53
	5761	Reline mandibular partial denture (laboratory) - (lower)	53
	5850	Tissue conditioning, maxillary (upper)	18
	5851	Tissue conditioning, mandibular (lower)	19
	6930	Recement fixed partial denture	17
	6980	Bridge repair, by report	30
	7111	Extraction corneal remnants - deciduous tooth	11
	7140	Extraction erupted tooth or exposed root	17

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

7210	Surgical removal of erupted tooth	31
7220	Removal of impacted tooth - soft tissue	39
7230	Removal of impacted tooth - partially bony	53
7240	Removal of impacted tooth - completely bony	64
7241	Removal of impacted tooth - completely bony, w/ unusual surgical complications	72
7250	Surgical removal of residual roots (cutting procedure)	32
7251	Coronectomy - intentional partial tooth removal	64
7280	Surgical access of an unerupted tooth	73
7282	Mobilization of erupted or malpositioned tooth to aid eruption	45
7283	Placement of device to facilitate eruption of impacted tooth	27
7310	Alveoloplasty, per quadrant, in conjunction with extractions	31
7311	Alveoloplasty, in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	31
7320	Alveoloplasty, per quadrant, not in conjunction with extractions	42
7321	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	42
7510	Incision and drainage of abscess - intraoral soft tissue	21
9110	Palliative (emergency) treatment of dental pain, minor procedures (not w/ sed filling)	12
9220	General anesthesia (medically necessary only)	50
9221	General anesthesia - each additional 15 minutes	19
9241	Intravenous sedation - first 30 minutes (medically necessary only)	44
9242	Intravenous sedation - each additional 15 minutes (medically necessary only)	11

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

BENEFIT LEVEL	ADA CODE	DESCRIPTION OF SERVICE	INSURED PAYS \$
Major Services			
	2510*	Inlay – metallic, one surface	221
	2520*	Inlay - metallic, two surfaces	239
	2530*	Inlay - metallic, three or more surfaces	257
	2542*	Onlay - metallic, two surfaces	239
	2543*	Onlay - metallic, three or more surfaces (not payable in conj w/2510, 2520, 2530)	297
	2544*	Onlay - metallic, four or more surfaces (not payable in conj w/2510, 2520, 2530)	306
	2610*	Inlay – porcelain/ceramic, one surface	222
	2620*	Inlay - porcelain/ceramic, two surfaces	241
	2630*	Inlay - porcelain/ceramic, three or more surfaces	261
	2642*	Onlay - porcelain/ceramic, two surfaces	273
	2643*	Onlay - porcelain/ceramic, three surfaces	312
	2644*	Onlay - porcelain/ceramic, four or more surfaces	325
	2710*	Crown - resin (laboratory)	148
	2740*	Crown - porcelain/ceramic substrate	324
	2750*	Crown - porcelain fused to high noble metal	315
	2751*	Crown - porcelain fused to predominantly base metal	289
	2752*	Crown - porcelain fused to noble metal	302
	2790*	Crown - (full cast) - high noble metal	301
	2791*	Crown - (full cast) - predominantly base metal	268
	2792*	Crown - (full cast) - noble metal	285
	2952	Cast post and core in addition to crown	113
	2954	Prefabricated post and core, in addition to crown	74
	2980	Crown repair, by report	53
	3220	Therapeutic pulpotomy (excluding final restoration)	47

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

3310	Root Canal - Anterior (excluding final restoration)	196
3320	Root Canal - Bicuspid (excluding final restoration)	231
3330	Root Canal - Molar (excluding final restoration)	305
3346	Root Canal - Retreatment - anterior, by report	256
3347	Root Canal - Retreatment - bicuspid, by report	296
3348	Root Canal - Retreatment - molar, by report	358
3410	Apicoectomy/periradicular surgery - anterior	188
3421	Apicoectomy/periradicular surgery - bicuspid (first root)	227
3425	Apicoectomy/periradicular surgery - molar (first root)	235
3426	Apicoectomy/periradicular surgery - (each additional root)	84
3430	Retrograde filling - per root	46
3450	Root amputation - per root	120
3920	Hemisection (including any root removal), not including root canal therapy	105
4210	Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant	142
4211	Gingivectomy or gingivoplasty, one to three contiguous teeth or tooth bounded spaces per quadrant	47
4240	Gingival flap procedure, including root planing – four or more contiguous teeth per quadrant	158
4241	Gingival flap procedure, including root planing - 1 - 3 teeth or tooth bounded spaces per quadrant	150
4249	Clinical crown lengthening - hard tissue, once per tooth per lifetime	212
4260	Osseous surgery (including flap entry and closure) – 4 or more contiguous teeth per quadrant	322

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
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	4261	Osseous surgery (including flap entry and closure) - 1-3 contiguous teeth per quadrant	277
	4263	Bone replacement graft - first site in quadrant	120
	4264	Bone replacement graft - each additional site in quadrant	77
	4266	Guided tissue regeneration - resorbable barrier, per site	130
	4270	Pedicle soft tissue graft procedure	225
	4271	Free soft tissue graft procedure (including donor site surgery)	236
	4273	Subepithelial connective tissue graft procedure (inc. donor site surgery)	280

BENEFIT LEVEL	ADA CODE	DESCRIPTION OF SERVICE	INSURED PAYS \$
Major Services (continued)			
	4275	Soft Tissue allograft per tooth every 36 months	221
	4276	Combined connective tissue & double pedicle graft per tooth, per site every 36 months	265
	4341	Perio scaling & root planing – 4 or more teeth per quad payable once every 24 months	61
	4342	Periodontal scaling & root planing 1-3 teeth per quadrant once per quad every 24 months	46
	4355	Full mouth debridement to enable comprehensive periodontal evaluation & diagnosis	34
	4910	Periodontal maintenance procedures following active therapy	34
	5110	Complete denture - maxillary (upper)	382
	5120	Complete denture - mandibular (lower)	382
	5130	Immediate denture - maxillary (upper)	418
	5140	Immediate denture - mandibular (lower)	418
	5211*	Upper partial - resin base (inc. any conventional clasps, rests, & teeth)	296
	5212*	Lower partial - resin base (inc. any conventional clasps, rests, & teeth)	303

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
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5213*	Upper partial - cast metal framework w/ resin dent bases (inc clasps,rests,teeth)	420
5214*	Lower partial - cast metal framework w/ resin dent bases (inc clasps,rests,teeth)	420
5225	Maxillary partial denture-flex base (incl. clasps,rests, teeth)	420
5226	Mandibular partial dental-flex base (incl. clasps, rests, teeth)	420
6010	Surgical placement of implant body: endosteal implant	512
6053	Implant/Abutment supported removable denture: completely edentulous arch	378
6054	Implant/Abutment supported removable denture: partially edentulous arch	378
6056	Prefabricated abutment - includes placement	112
6057	Custom abutment - includes placement	161
6058	Abutment supported porcelain/ceramic crown	294
6059	Abutment supported porcelain fused to metal crown (high noble metal)	290
6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	274
6061	Abutment supported porcelain fused to metal crown (noble metal)	280
6062	Abutment supported cast metal crown (high noble metal)	279
6063	Abutment supported cast metal crown (predominantly base metal)	240
6064	Abutment supported cast metal crown (noble metal)	252
6065	Implant supported porcelain/ceramic crown	289
6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	282
6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	274
6068	Abutment supported retainer for porcelain/ceramic FPD	294

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
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6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	290
6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	274
6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	280
6072	Abutment supported retainer for cast metal FPD (high noble metal)	286
6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	259
6074	Abutment supported retainer for cast metal FPD (noble metal)	279
6075	Implant supported retainer for ceramic FPD	289
6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	282
6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	271
6078	Implant/abutment supported fixed denture for completely edentulous arch	390
6079	Implant/abutment supported fixed denture for partially edentulous arch	269
6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	24
6090	Repair implant supported prosthesis/by report	83
6092	Recement implant/abutment supported crown	23
6093	Recement implant/abutment supported fixed partial denture	36
6094	Abutment supported crown - (titanium)	230

**Florida Combined Life Insurance Company, Inc.
BlueDental Choice Copayment (PPO) Plan
Participating Dentist Schedule**

BENEFIT LEVEL	ADA CODE	DESCRIPTION OF SERVICE	
Major Services (continued)			
	6095	Repair implant abutment, by report	65
	6100	Implant removal, by report	120
	6194	Abutment supported retainer crown for FPD	235
	6210*	Pontic - cast high noble metal	306
	6211*	Pontic - cast predominantly base metal	263
	6240*	Pontic - porcelain fused to high noble metal	316
	6241*	Pontic - porcelain fused to predominantly base metal	288
	6242*	Pontic - porcelain fused to noble metal	302
	6245*	Pontic - porcelain/ceramic	299
	6545	Retainer - cast metal for resin bonded fixed prosthesis	123
	6600	Inlay porcelain - ceramic - two surfaces	241
	6601	Inlay porcelain - ceramic - three or more surfaces	261
	6606	Inlay - cast noble metal - two surfaces	239
	6607	Inlay - cast noble metal - three or more surfaces	257
	6608	Onlay - porcelain / ceramic - two surfaces	273
	6609	Onlay - porcelain / ceramic - three or more surfaces	312
	6615	Onlay - cast noble metal - three or more surfaces	297
	6720	Crown - resin with high noble metal	299
	6721	Crown - resin with predominantly base metal	250
	6722	Crown - resin with noble metal	277
	6740	Crown - porcelain/ceramic	350
	6750	Crown - porcelain fused to high noble metal	315
	6751	Crown - porcelain fused to predominantly base metal	288
	6752	Crown - porcelain fused to noble metal	302
	6790	Crown - full cast high noble metal	301

**Florida Combined Life Insurance Company, Inc.
 BlueDental Choice Copayment (PPO) Plan
 Participating Dentist Schedule**

	6791	Crown - full cast predominantly base metal	266
	6792	Crown - full cast noble metal	280
	7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	98
	7963	Frenuloplasty	112

* Including routine post delivery care

