ATTACHMENT F

Advantage AVN2 Dental Plan
Florida

compbenefits
vision
dental

CompBenefits Company
Agreement And Certificate of Benefits

Provided that all Contributions and Copayments required by this Certificate are paid when due, CompBenefits Company (hereinafter referred to as "Company") hereby agrees to provide Benefits to the Subscriber subject to all the provisions, definitions, limitations, and conditions of this Certificate outlined below:

Clyde E Rathmell

President

I. Definitions

A. **"Agreement and Certificate of Benefits"** (hereinafter referred to as "Certificate") is that document provided to the Subscriber that specifies Benefits and conditions of Coverage.

B. **"Benefits"** are those Dental Care Services available to the Members as stated in their Certificates.

C. **"Contributions"** are those periodic payments due Company by Subscriber to receive Benefits as provided by the Certificate.

D. **"Copayment"** is an additional fee the Participating General Dentist or Participating Specialist may charge Member when providing Dental Care Services not specified as "No Charge" in the Certificate.

E. **"Copayment Benefits"** are those Dental Care Services for which there are reduced fees which are due and payable directly by the Member to the Participating General Dentist or Participating Specialist at the time the services are rendered or in accordance with the particular payment procedures of the Participating General Dentist or Participating Specialist.

F. **"Dental Care Services"** are those services to be performed by a Participating General Dentist or Participating Specialist pursuant to the terms of the Certificate and a Participating General Dentist Agreement or a Participating Specialist Agreement.

G. **"Dental Facility"** is the location of the Participating General Dentist's or Participating Specialist's office where Members shall receive Dental Care Services.

H. **"Dependent"** means the following dependents of the Subscriber: a) the legal spouse; and b) all unmarried dependent children under nineteen (19) years of age, or under twenty-three (23) if they are full-time students in an accredited college or university and dependent on the Subscriber for primary support (unless otherwise negotiated or covered by amendment to this Certificate). The term "children" also includes: a) adopted children and b) stepchildren and foster children living with the Subscriber in a parent-child relationship.

I. **"Effective Date"** is the first day that a Member is entitled to receive Benefits designated in the Certificate.

J. **"Enrollment Fee"** is a one-time application fee for non-group contracts.

K. **"Member"** is a Subscriber and/or covered eligible Dependent of a Subscriber.

L. **"Necessary Treatment"** is that set of Dental Care Services determined by the Participating General Dentist or Participating Specialist as required to establish and maintain Member's good oral health.

M. **"No Charge Benefits"** are those Dental Care Services for which there are no additional fees due the Participating General Dentist or Participating Specialist by Member.

N. **"Participating General Dentists and Participating Specialists"** are those licensed dentists selected and contracted with Company as independent contractors to provide dental Benefits to Members.

O. **"Subscriber"** is a member in good standing for whom the necessary Contributions and Copayments have been made in payment for Dental Care Services and to whom a Certificate evidencing coverage has been issued.

P. **"Treatment Plan"** is that individual proposal by the Participating General Dentist or Participating Specialist outlining the recommended course of Member's Dental Care Services. A written copy may be requested by the Member.

Q. **"Usual Charges"** are those fees that are customarily charged for Dental Care Services by the Participating General Dentist or Participating Specialist. Said charges are not determined by Company.

II. Contributions and Copayments

It is agreed that in order for Member to be eligible for and entitled to receive Benefits provided by this Certificate, Company must receive all Contributions in advance. The Participating General Dentist or Participating Specialist must receive any Copayments in accordance with their particular payment procedure.

III. Benefits

From the Effective Date, Company agrees to provide Benefits to Members through Participating General Dentists or Participating Specialists on a No Charge or Copayment basis in accordance with the Schedule of Benefits contained in this Certificate. There is no exclusion due to pre-existing dental conditions except in those instances in which treatment has been initiated but not yet completed prior to the Effective Date.

IV. Duration of Agreement

Except under the following conditions, Company and Subscriber shall maintain this Certificate in force for a period of not less than twelve (12) months:

A. Except for nonpayment of Contributions or termination of eligibility, Company may cancel this Certificate with forty-five (45) days written notice for the following reasons:

1. When a Member commits any action of fraud or material misrepresentation in applying for or presenting any claims for benefits involving company.

2. When a Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation seriously impairs the ability of a Participating General Dentist, or Participating Specialist, to provide services to the Member and/or to other Members.

3. When a Member misuses the documents provided as evidence of benefits available pursuant to this Certificate.

4. When a Member furnishes to the Company incorrect or incomplete information for the purposes of fraudulently obtaining services.

5. When a Dental Facility is not available within the immediate geographical area of the Subscriber.

6. When reasonable efforts by the Company to establish and maintain a satisfactory patient relationship are unsuccessful or when the Member has indicated unreasonable refusal to accept necessary treatment. When a Member refuses to accept treatment from two (2) Dental Facilities, proof of unreasonable refusal shall be presumed conclusively.

7. Prior to cancellation, the Company shall make every effort to resolve the problem through its grievance procedure and to determine that the Member's behavior is not due to use of the Dental Care Services provided or mental illness.

B. Subscriber may cancel this Certificate:

1. By notifying Company in writing within thirty (30) days of the Effective Date, provided no Dental Care Services have been rendered to the Member, all Contributions paid during such thirty (30) day period (excluding Enrollment Fees) will be refunded upon written request. If Dental Care Services have been received by the Member, then any Contribution refunds shall be first applied to the Usual Charges of the Participating General Dentist or Participating Specialist.

2. If the Subscriber permanently moves from the Company service area; unless by court order, the Subscriber is required to provide Dental Care Services for a dependent child. Cancellation shall become effective on the last day of the month in which Company receives written notification. If the Subscriber seeks cancellation after the first thirty (30) days and during the first twelve (12) months of this Certificate, the Subscriber will not be entitled to any refund of Contributions.

C. Cancellation of this Certificate by Company is without prejudice to any continuous loss which commenced while this Certificate was in force. Participating General Dentists and/or Participating Specialists shall complete all dental procedures undertaken upon the Member, until the specific treatment or procedure undertaken upon the Member has been completed or for ninety (90) days, whichever is the lesser period of time. This shall apply to acute care procedures only and shall not include non-acute continuing care which would require continuing periodic treatment. This provision is applicable relative to insolvency or discontinuance of operations of the Company, and would survive termination of this Certificate.

V. Continuation of Coverage

Unless cancellation of this Certificate is made for reasons specified in IV. A. 1. Subscribers who continue to pay appropriate Contributions and Copayments will have their Certificates automatically renewed at the expiration of the first twelve (12) months. The following conditions also will apply:

A. At the attainment of the applicable age, coverage as a Dependent shall be extended if the individual is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

2. Chiefly dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to Company by the Subscriber within thirty-one (31) days of the Dependent's attainment of the limiting age and subsequently as may be required by Company, but not more frequently than once every two (2) years.

B. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that certain employers maintaining group medical and dental plans offer employees and their Dependents the opportunity to continue their coverage when such coverage ends under certain conditions.

More information about COBRA continuation can be obtained from a Subscriber's employer. COBRA does not apply to coverage maintained on any basis other than that through an employer-employee relationship.

VI. Coverage for Newborn Children and Adding Additional Dependents

A. A child born to the Subscriber while this Certificate is in force is covered under this Certificate from the moment of birth, up to thirty (30) days. If coverage is to continue, the Subscriber must notify Company within sixty (60) days from the date of birth and pay the required Contribution, if any.

B. A child placed with you for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants you conservatorship of the child; or 3) the date the child is placed with you for adoption; and additional premium, if any, is paid.

C. Additional eligible Dependents of Subscriber may be added to this Certificate upon application to Company. When Dependents of a Subscriber become ineligible, upon application they may change their status and continue their Benefits as an individual Subscriber.

VII. Conversion Provisions for Group Plans

A. Upon request, Company shall offer a converted contract to any Subscriber or covered Dependent whose group plan coverage has been terminated, and who has been continuously covered under Company for at least three (3) months immediately prior to termination. The converted contract will provide coverage and benefits similar to the terminated contract and will be similar to the contract previously in effect.

B. A Subscriber or covered Dependent shall not be entitled to have a converted contract issued to him or her if termination of his or her coverage occurred for any of the following reasons:

1. Failure to pay any required premium or Contribution.

2. Replacement of any discontinued coverage by similar coverage within thirty-one (31) days.

3. Fraud or material misrepresentation in applying for any benefits under the Certificate.

4. Disenrollment for cause as specified in IV.A.1.

5. Willful and knowing misuse of the Company identification card or Certificate by the Member.

6. Willful and knowing furnishing to Company by the Member of incorrect or incomplete information for the purpose of fraudulently obtaining coverage or benefits from Company.

7. The Subscriber has left the geographic area of Company with the intent to relocate or establish a new residence outside Company's geographic area.

C. Subject to the conditions set forth above, the conversion privilege shall also be available to:

1. The surviving spouse and/or children, if any, at the death of the Subscriber, with respect to the spouse and such children whose coverage under the Company contract terminate by reason of such death.

2. To the former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support.

3. To the spouse of the Subscriber upon termination of coverage of the spouse, while the Subscriber remains covered under a group Company contract, by reason of ceasing to be a qualified family Member under the group contract.

4. To a child solely with respect to himself or herself, upon termination of his or her coverage by reason of ceasing to be a qualified family Member under a group Company contract.

VIII. General Provisions

A. Appointments

All non-emergency Dental Care Services rendered to Member shall be on a prior appointment basis during the normal office hours of the Participating General Dentist or Participating Specialist. In order to receive Benefits, Member must make an appointment with a Participating General Dentist or a Participating Specialist, and the request for an appointment must be made after the Effective Date. When making an appointment, Member should inform Dental Facility that he or she is a Company Member.

Member may request an emergency appointment (treatment of accidental, painful, or urgent conditions) within twenty-four (24) hours of calling the Dental Facility, subject to the appropriate Copayment.

B. Emergency Care

Emergency care means treatment due to injury, accident, or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically nor physically possible for the Member to be treated by any Company Participating General Dentist or Participating Specialist. An acute periodontal abscess and an acute periapical abscess which occur under circumstances where it is not possible for the Member to be treated by any Company Participating General Dentist or Participating Specialist are examples where emergency benefits would be applicable.

1. Out-of-Area Emergency Care:

When more than one hundred (100) miles from the nearest available Company Dental Facility, Member may obtain reimbursement for expenses for Emergency Care rendered by any licensed dentist, less applicable Company copayments, up to one hundred dollars ($100) per Member per year, upon presentation of an itemized statement of emergency services from the dental office. Company must be notified of such treatment within ninety (90) days of its receipt.

2. In-Service-Area Emergency Care:

When Member is within one hundred (100) miles of any Company Dental Facility, during Company's normal business hours the Member should first contact his/her Participating General Dentist and request an emergency appointment. If his/her dentist is unable to render Emergency Care, Member should contact Company Member Services and request assistance in obtaining Emergency Care from another Company Dental Facility at that facility's usual fees less a 25% reduction.

If Emergency Care is required after Company's normal business hours, and it is not possible to contact a Company Dental Facility, Member may obtain reimbursement for expenses for Emergency Care rendered by any licensed Dentist, less applicable Company copayments, up to one hundred dollars ($100) per Member per year, upon presentation of an itemized statement of emergency services from the dental offices. Company must be notified of such treatment within ninety (90) days of its receipt.

C. Change in Contributions or Benefits

Company, at its discretion, may change the Contributions by providing Subscriber with at least thirty (30) days written notice prior to effective date of the change. Additionally, Company may increase Copayments or delete, amend, or limit any benefits under the contract upon not less than thirty (30) days prior written notice prior to the renewal of the Certificate.

D. Renewal

All Subscribers who continue to pay appropriate Contributions and Copayments will have their coverage renewed automatically, subject to all applicable provisions of this Certificate.

E. Grace Period

This contract has a thirty (30) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force. If full payment is not received within the thirty (30) day grace period, coverage will be terminated effective the first day of the grace period. Subscriber will be liable for the cost of Dental Care Services received during the grace period.

F. Reinstatement

The following guidelines shall apply to requests for reinstatement:

1. The Subscriber must submit an application for reinstatement to Company.

2. The Subscriber must remit to Company all Contributions for the period between the termination date and the reinstatement date.

Upon receipt by Company of the application and the appropriate Contributions, Company may, at its sole descretion, retroactively resume Benefits to the termination date.

G. Dental Records

Dental records concerning services rendered to Member shall remain the property of the Participating General Dentist or Participating Specialist. Member agrees that his/her dental records may be reviewed by Company as deemed necessary in compiling utilization and/or similar data. Company agrees to honor confidentiality of said data.

H. Limitations and Exclusions

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph B of this Certificate.

2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.

3. Company does not provide coverage for the following services:

   a) Cost of hospitalization and pharmaceuticals, drugs or medications.

   b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.

   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

   d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.

e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

f) Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws.

g) Treatment for cysts, neoplasms and malignancies.

h) General anesthesia.

I. Incontestability

In the absence of fraud, all statements made by the Subscriber are considered representations and not warranties during the first two years of coverage. Company may avoid providing coverage at any time if Subscriber makes a material misrepresentation in a written application.

J. Conformity with Florida Law

1. This Certificate shall be interpreted in accordance with the laws of the State of Florida and any action or claim, including arbitration, shall be brought within the State of Florida.

2. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over Company shall have the effect of amending this Certificate to conform with the minimum requirements thereof.

3. In the event any portion of this Certificate is held to be void, it shall not affect any other provisions.

K. Notices

All notices, changes, or requests by Members shall be made in writing and shall be furnished by United States Mail to Company at its address as listed below:

CompBenefits Company, P.O. Box 769729, Roswell, GA 30076,
Tel. (800) 342-5209.

L. Notice of Independent Contractor Relationship

Company assumes responsibility of fulfilling the terms of this Certificate. Participating General Dentists and Participating Specialists are independent contractors, and Company cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a Participating General Dentist or Participating Specialist, or for any damages which result from any defective or dangerous condition in or about any Dental Facility.

M. Open Enrollment for Group Plans

Company will offer group plans at least one open enrollment period every eighteen (18) months. Such open enrollment periods will be offered for as long as the group exists unless Company and the Group mutually agree to a shorter period of time than eighteen (18) months.

N. Coordination of Benefits

"Coordination of benefits" is the procedure used to pay dental care expenses when a person is covered by more than one plan. Company follows rules established by Florida law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow Florida coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Company pays for dental care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

PLANS THAT DO NOT COORDINATE

Company will pay benefits without regard to benefits paid by the following kinds of coverage.

-- Individual (not group) policies or contracts unless they contain a Coordination of Benefits Provision.
-- Medicaid
-- Group hospital indemnity plans which pay less than $100 per day
-- School accident coverage
-- Some supplemental sickness and accident policies

HOW COMPANY PAYS AS PRIMARY PLAN

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

HOW COMPANY PAYS AS SECONDARY PLAN

When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.

--We will pay only for dental care expenses that are covered by Company.
--We will pay only if you have followed all of our procedural requirements, including (care obtained from or arranged by your primary care physician, precertification, etc.).
--We will pay no more than the "allowable expenses" for the dental care involved. If our allowable expense is lower than the primary plan's, we will use the primary plan's allowable expense. That may be less than the actual bill.

WHICH PLAN IS PRIMARY?

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following which applies:

1. Non-coordinating Plan

If you have another group plan which does not coordinate benefits, it will always be primary.

2. Employee

The plan which covers you as an employee (neither laid off or retired) is always primary.

3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for dental care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention dental care, we follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the Florida Insurance Department rule on Coordination of Benefits.

4. Children & the Birthday Rule

When your children's dental care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Florida Law on Coordination of Benefits.

IX. Review and Mediation of Complaints

A. Informational Grievances

Any Member who has a grievance against Company for any matter arising out of a Subscriber Certificate or for covered Dental Care Services rendered thereunder may submit an informal oral grievance to Company. Assistance with Company's grievance procedures, including assistance with informal oral grievances, may be obtained by calling Company's Member Services Department at the address and telephone number listed below. Oral grievances shall be submitted to Company's Grievance Coordinator. Informal oral grievances shall be responded to as soon as possible by the Grievance Coordinator. If the informal oral grievance involves a dental-related matter or claim, Company's Dental Director shall be involved in resolving said grievance. The Member has the right to file a formal written grievance with Company and to grieve directly to the State of Florida Department of Financial Services, Office of Insurance Regulation.

compbenefits

ADVANTAGE - AVN2

Schedule of Benefits and Subscriber Copayments

ADA CODE	PROCEDURE	PATIENT PAYS
D0120	Periodic oral examination (limit 2 every 12 months)	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0150	Comp oral evaluation - new / established patient	$0.00
D0160	DTL&EXT oral evaluation - problem focused report	$0.00
D0170	Re-evaluation - limited problem focused	$0.00
D0180	Comp periodontal evaluation - new / est patient	$0.00
D0210	Intraoral, complete series (limit one every 3 years)	$0.00
D0220	Intraoral, periapical - first film	$0.00
D0230	Intraoral, periapical each additional film	$0.00
D0240	Intraoral, occlusal film	$0.00
D0250	Extraoral, first film	$0.00
D0260	Extraoral, each additional film	$0.00
D0270	Bitewing, single film (limit two every 12 months)	$0.00
D0272	Bitewing, two films (limit two every 12 months)	$0.00
D0274	Bitewing, four films (limit two every 12 months)	$0.00
D0277	Vertical Bitewings (limit two every 12 months)	$0.00
D0330	Panoramic film (limit one every 3 years)	$0.00
D0470	Diagnostic Casts	$0.00
D1110	Prophylaxis, adult (limit 1 every 6 months)	$0.00
D1120	Prophylaxis, child (limit 1 every 6 months)	$0.00
D1201	Topical application of fluoride child (limit 2 every 12 months)	$0.00
D1203	Topical application of fluoride - child (limit 2 every 12 months)	$0.00
D1351	Sealant, per tooth (limit 1 per tooth every 12 months for child < 13)	$0.00
D1510	Space maintainer, fixed unilateral	$0.00
D1515	Space maintainer, fixed bilateral	$0.00
D1520	Space maintainer, removable unilateral	$0.00
D1525	Space maintainer, removable bilateral	$0.00
D1550	Recementation of space maintainer	$0.00
D2140	Amalgam, one surface, primary or permanent	$0.00
D2150	Amalgam, two surfaces, primary or permanent	$0.00
D2160	Amalgam, three surfaces, primary or permanent	$0.00
D2161	Amalgam, four or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - one surface, anterior	$0.00
D2331	Resin-based composite - two surfaces, anterior	$0.00
D2332	Resin-based composite - three surfaces, anterior	$0.00
D2335	Resin compos - 4/more surfaces/ invlv incisal ang	$0.00
D2390	Resin-based composite crown anterior	$0.00
D2391	Resin-based composite - one surface, posterior	$0.00
D2392	Resin-based composite - two surfaces, posterior	$0.00
D2393	Resin-based composite - three surfaces, posterior	$0.00
D2394	Resin compos - four or more surfaces, posterior	$0.00
D2510	Inlay - metallic one surface (limit 1 per tooth every 5 years)	$313.00
D2520	Inlay - metallic two surfaces (limit 1 per tooth every 5 years)	$355.00
D2530	Inlay - metallic - 3 or more surfaces (limit 1 per tooth every 5 years)	$410.00
D2542	Onlay - metallic two surfaces (limit 1 per tooth every 5 years)	$402.00
D2543	Onlay - metallic three surfaces (limit 1 per tooth every 5 years)	$420.00
D2544	Onlay - metallic four or more surfaces (limit 1 per tooth every 5 years)	$437.00
D2610	Inlay, porcelain/ceramic - one surface (limit 1 per tooth every 5 years)	$368.00
D2620	Inlay, porcelain/ceramic - two surfaces (limit 1 per tooth every 5 years)	$389.00
D2630	Inlay, porcelain/ceramic - three or more surfaces (limit 1 per tooth every 5 years)	$414.00
D2642	Onlay, porcelain/ceramic - two surfaces (limit 1 per tooth every 5 years)	$403.00
D2643	Onlay, porcelain/ceramic - three surfaces (limit 1 per tooth every 5 years)	$434.00

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ADA CODE	PROCEDURE	PATIENT PAYS
D2644	Onlay, porcelain/ceramic - four or more surfaces (limit 1 per tooth every 5 years)	$461.00
D2650	Inlay - resin-based composite - one surface (limit 1 per tooth every 5 years)	$242.00
D2651	Inlay - resin-based composite - two surfaces (limit 1 per tooth every 5 years)	$288.00
D2652	Inlay - resin-based composite - three or more surfaces (limit 1 per tooth every 5 years)	$303.00
D2662	Onlay - resin-based composite - two surfaces (limit 1 per tooth every 5 years)	$263.00
D2663	Onlay - resin-based composite - three surfaces (limit 1 per tooth every 5 years)	$310.00
D2664	Onlay - resin-based composite - four or more surfaces (limit 1 per tooth every 5 years)	$332.00
D2710	Crown resin based composite indirect (limit 1 per tooth every 5 years)	$187.00
D2720	Crown - resin with high noble metal (limit 1 per tooth every 5 years)	$461.00
D2721	Crown - resin with predominantly base metal (limit 1 per tooth every 5 years)	$432.00
D2722	Crown - resin with noble metal (limit 1 per tooth every 5 years)	$441.00
D2740	Crown, porcelain/ceramic substrate (limit 1 per tooth every 5 years)	$473.00
D2750	Crown, porcelain fused to high noble metal (limit 1 per tooth every 5 years)	$466.00
D2751	Crown, porcelain fused to predom base metal (limit 1 per tooth every 5 years)	$434.00
D2752	Crown, porcelain fused to noble metal (limit 1 per tooth every 5 years)	$445.00
D2790	Crown, full cast high noble metal (limit 1 per tooth every 5 years)	$450.00
D2791	Crown, full cast predom base metal (limit 1 per tooth every 5 years)	$426.00
D2792	Crown, full cast noble metal (limit 1 per tooth every 5 years)	$434.00
D2910	Recement inlay only/part coverage restoration	$41.00
D2920	Recement crown	$42.00
D2930	Prefabricated stainless steel crown - primary tooth	$115.00
D2931	Prefabricated stainless steel crown - permanent tooth	$131.00
D2932	Prefabricated resin crown	$142.00
D2940	Sedative Filling	$44.00

ADA CODE	PROCEDURE	PATIENT PAYS
D2950	Core buildup including pins	$110.00
D2951	Pin retention - per tooth, in addition to restoration	$23.00
D2952	Cast post & core in addition to crown	$168.00
D2954	Prefabricated post & core in addition to crown	$139.00
D3220	Tx pulp-remv pulp coronal dentinocemenl junc	$75.00
D3310	Root canal - Anterior	$315.00
D3320	Root canal - Bicuspid	$385.00
D3330	Root canal - Molar	$497.00
D3346	Retreatment of previous RCT therapy, anterior	$424.00
D3347	Retreatment of previous RCT therapy, bicuspid	$500.00
D3348	Retreatment of previous RCT therapy, molar	$601.00
D3410	Apicoectomy/periradicular surgery, anterior	$361.00
D3421	Apicoectomy periradicular surgery bicuspid	$394.00
D3425	Apicoectomy periradicular surgery molar	$445.00
D3426	Apicoectomy/periradicular surgery	$148.00
D3430	Retrograde filling - per root	$109.00
D4210	Gingivect/plsty 4/> cntig/bound teeth spaces - quad (limit 1 every 12 mos.)	$358.00
D4211	Gingivect/plsty 1-3 cntig/bound teeth spaces - quad (limit 1 every 12 mos.)	$153.00
D4240	Gingivect/flp proc 4/> cntig/bound teeth spaces - quad (limit 1 every 12 mos.)	$421.00
D4241	Gingivect/flp proc 1-3 cntig/bound teeth spaces - quad (limit 1 every 12 mos.)	$217.00
D4249	Clinical crown lengthening - hard tissue	$481.00
D4260	Osseous surg 4/> contig/bound teeth spaces - quad	$680.00
D4261	Osseous surg 1-3 contig/bound teeth spaces - quad	$354.00
D4341	Prdontal scaling & root planing 4/more teeth - quad (limit 2 per quad every 12 months)	$0.00
D4342	Prdontal scaling & root planing 1-3 teeth - quad (limit 2 per quad every 12 months)	$0.00
D4355	Full Mouth Debridement to enable comprehensive evaluation and diagnosis	$0.00
D4910	Periodontal Maintenance (limit 2 every 12 months)	$0.00

ADVNAT432 (04/06)

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ADA CODE	PROCEDURE	PATIENT PAYS
D5110	Complete denture – maxillary (limit 1 every 5 years)	$642.00
D5120	Complete denture – mandibular (limit 1 every 5 years)	$642.00
D5130	Immediate denture – maxillary (limit 1 every 5 years)	$700.00
D5140	Immediate denture – mandibular (limit 1 every 5 years)	$700.00
D5211	Maxillary partial denture, resin base (limit 1 every 5 years)	$542.00
D5212	Mandibular partial denture, resin base (limit 1 every 5 years)	$629.00
D5213	Max part dentr - cast metl frmewrk w/ resin base (limit 1 every 5 years)	$709.00
D5214	Mnd part dentr - cast metl frmewrk w/ resin base (limit 1 every 5 years)	$709.00
D5410	Adjust complete denture – Maxillary	$35.00
D5411	Adjust complete denture – Mandibular	$35.00
D5421	Adjust partial denture – Maxillary	$35.00
D5422	Adjust partial denture – Mandibular	$35.00
D5510	Repair broken complete denture base	$70.00
D5520	Replace missing or broken teeth - complete denture	$59.00
D5610	Repair resin denture base	$76.00
D5620	Repair cast framework	$82.00
D5630	Repair or replace broken clasp	$100.00
D5640	Replace broken teeth - per tooth	$64.00
D5650	Add tooth to existing partial denture	$88.00
D5660	Add clasp to existing partial denture	$105.00
D5710	Rebase complete maxillary denture	$261.00
D5711	Rebase complete mandibular denture	$249.00
D5720	Rebase maxillary partial denture	$246.00
D5721	Rebase mandibular partial denture	$246.00
D5730	Reline complete maxillary denture	$147.00
D5731	Reline complete mandibular denture	$147.00
D5740	Reline maxillary partial denture	$135.00
D5741	Reline mandibular partial denture	$135.00
D5750	Reline complete maxillary denture	$196.00
D5751	Reline complete mandibular denture	$196.00
D5760	Reline maxillary partial denture	$193.00
D5761	Reline mandibular partial denture	$193.00
D5850	Tissue conditioning, maxillary	$61.00
D5851	Tissue conditioning, mandibular	$61.00

ADA CODE	PROCEDURE	PATIENT PAYS
D6210	Pontic, cast high noble metal (limit 1 every 5 years)	$431.00
D6211	Pontic, cast predominantly base metal (limit 1 every 5 years)	$404.00
D6212	Pontic, cast noble metal (limit 1 every 5 years)	$420.00
D6240	Pontic, porcelain fused to high noble metal (limit 1 every 5 years)	$426.00
D6241	Pontic, porcelain fused to predominantly base metal (limit 1 every 5 years)	$393.00
D6242	Pontic, porcelain fused to noble metal (limit 1 every 5 years)	$415.00
D6250	Pontic, resin with high noble metal (limit 1 every 5 years)	$420.00
D6251	Pontic, resin with predominantly base metal (limit 1 every 5 years)	$388.00
D6252	Pontic, resin with noble metal (limit 1 every 5 years)	$400.00
D6600	Inlay - porcelain/ceramic two surfaces (limit 1 every 5 years)	$355.00
D6601	Inlay - porcelain/ceramic three or more surfaces (limit 1 every 5 years)	$373.00
D6602	Inlay, cast high noble metal, two surfaces (limit 1 every 5 years)	$380.00
D6603	Inlay, cast high noble metal, three or more surfaces (limit 1 every 5 years)	$418.00
D6604	Inlay, cast predominantly base metal, two surfaces (limit 1 every 5 years)	$372.00
D6605	Inlay, cast predominantly base metal, three or more surfaces (limit 1 every 5 years)	$394.00
D6606	Inlay, cast noble metal, two surfaces (limit 1 every 5 years)	$366.00
D6607	Inlay, cast noble metal, three or more surfaces (limit 1 every 5 years)	$406.00
D6608	Onlay - porcelain/ceramic two surfaces (limit 1 every 5 years)	$386.00
D6609	Onlay - porcelain/ceramic three or more surfaces (limit 1 every 5 years)	$403.00
D6610	Onlay, cast high noble metal, two surfaces (limit 1 every 5 years)	$409.00
D6611	Onlay, cast high noble metal, three or more surfaces (limit 1 every 5 years)	$448.00
D6612	Onlay, cast predominantly base metal, two surfaces (limit 1 every 5 years)	$407.00
D6613	Onlay, cast predominantly base three or more surfaces (limit 1 every 5 years)	$426.00

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ADA CODE	PROCEDURE	PATIENT PAYS
D6614	Onlay, cast noble metal, two surfaces (limit 1 every 5 years)	$399.00
D6615	Onlay, cast noble metal, three or more surfaces (limit 1 every 5 years)	$414.00
D6720	Crown, resin - with high noble metal (limit 1 every 5 years)	$474.00
D6721	Crown, resin - with predom base metal - denture (limit 1 every 5 years)	$450.00
D6722	Crown, resin with noble metal (limit 1 every 5 years)	$458.00
D6740	Crown, porcelain/ceramic (limit 1 every 5 years)	$499.00
D6750	Crown, porcelain fused to high noble metal - denture (limit 1 every 5 years)	$486.00
D6751	Crown, porcelain fused to predominantly base metal (limit 1 every 5 years)	$453.00
D6752	Crown, porcelain fused to noble metal (limit 1 every 5 years)	$464.00
D6780	Crown, 3/4 cast high noble metal	$458.00
D6790	Crown, full cast high noble metal - denture (limit 1 every 5 years)	$469.00
D6791	Crown, full cast predominantly base metal - denture (limit 1 every 5 years)	$445.00
D6792	Crown, full cast noble metal - denture (limit 1 every 5 years)	$461.00
D6930	Recement fixed partial denture (limit 1 every 5 years)	$57.00
D6970	Cast post & core add fix part denture retainer (limit 1 every 5 years)	$157.00
D6972	Prefab post & core add fix part denture retain (limit 1 every 5 years)	$128.00
D6973	Core buildup for retainer including any pins (limit 1 every 5 years)	$103.00
D7111	Extraction of coronal remnants, deciduous tooth	$0.00
D7140	Extraction, erupted tooth or exposed root	$0.00
D7210	Surgical removal of erupted tooth rqr elev flp & remv bone	$108.00
D7220	Removal of impacted tooth soft tissue	$135.00
D7230	Removal of impacted tooth - partially bony	$179.00
D7240	Removal of impacted tooth completely bony	$211.00
D7241	Removal of impacted tooth - compl bony w/unusual surgical complications	$265.00

ADA CODE	PROCEDURE	PATIENT PAYS
D7250	Surgical removal of residual tooth roots	$114.00
D7310	Alveoloplasty conjunc w/extractions per quadrant	$125.00
D7311	Alveoloplasty conjunc xtract 1-3 teeth/spaces quad	$97.00
D7320	Alveoloplasty not in conjunc w/extractions - quad	$181.00
D7321	Alveoloplasty not conjunc xtract 1-3 teeth/spaces quad	$153.00
D7510	Incision and drainage of abscess, intraoral soft tissue	$120.00
D7520	Incision and drainage of abscess, extraoral soft tissue	$570.00
D7960	Frenulectomy separate procedure	$111.00
D7970	Excision of hyperplastic tissue, per arch	$272.00
D9110	Palliative treatment of dental pain - minor procedure	$45.00
D9241	IV conscious sedation/analgesia - First 30 minutes	$144.00
D9242	IV conscious sedation/analgesia - each additional 15 minutes	$60.00
D9310	Consultation	$96.00
D9951	Occlusal adjustment, limited	$58.00
D9952	Occlusal adjustment, complete	$326.00

ORTHODONTICS

D8070/D8080	Comprehensive Orthodontic Treatment of the transitional adult dentition. Comprehensive Orthodontic Treatment of the transitional adolescent dentition Children up to 19 years of age Up to 24 months of routine orthodontic treatment for Class I and Class II cases	
	Consultation	$0.00
	Evaluation	$35.00
	Records/Treatment Planning	$250.00
	Orthodontic Treatment	$2,100.00
D8090	Comprehensive Orthodontic Treatment of the transitional adult dentition Comprehensive Orthodontic Treatment of the transitional adolescent dentition Children up to 19 years of age Up to 24 months of routine orthodontic treatment for Class I and Class II cases	
	Consultation	$0.00
	Evaluation	$35.00
	Records/Treatment Planning	$250.00
	Orthodontic Treatment	$2,300.00
D8680	Retention	$450.00

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NOTE

1. Your Participating General Dentist and Participating Specialty office visit co-payment amounts, if applicable, are shown on your I.D. card. Your office visit co-payment is applicable for all dates of service and is in addition to the co-payment amounts listed for covered services.
2. Co-payment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialty dentist.
3. Not all Participating Dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
4. Unlisted covered procedures are available at the Participating Dentist's usual fee less 20%.
5. If you should need to see a specialty dentist (i.e. Endodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialty dentist.

LIMITATIONS AND EXCLUSIONS

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph B of the Certificate.
2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. Company does not provide coverage for the following services:
   a) Cost of hospitalization and pharmaceuticals, drugs or medications.
   b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
   d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.
   e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.
   f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.
   g) Treatment for cysts, neoplasms and malignancies.
   h) General anesthesia.

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NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60-days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (770) 998-8936 or toll free at (800) 342-5209.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record that is related to your treatment. This information is necessary to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

Payment: We may use or disclose your health information in order to process claims or make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim to us for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided to our organization through contracts with third-party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Communication with Family or Friends: Our service professionals, using their best judgement, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fund Raising: We may contact you as part of a fundraising effort.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, we may disclose health information about you as required by military command.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Protective Services for the President, National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement: We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.

Inmates: We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.

Lawsuits and Disputes: We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Plan Sponsors: We may disclose health information about you to your plan sponsor to carry out plan administration functions that the plan sponsor performs upon certification by the plan sponsor that the plan documents have been amended as set forth under HIPAA regulations.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at 100 Mansell Court E., Suite 400, Roswell, GA 30076.

Right to Request Restrictions. You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction.

Right to Receive Confidential Communications. You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you in a designated record set. A "designated record set" is a group of records that we maintain such as enrollment, payment, and claims adjudication record systems. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend. You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspection as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period.

Right to Obtain a Paper Copy. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

CompBenefits
Attn: Privacy Officer
100 Mansell Court East, Suite 400
Roswell, GA 30076

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

CompBenefits

CS150 Dental Plan
Florida

THE COMPBENEFITS FAMILY OF COMPANIES

CompBenefits Company • CompDent • CompBenefits Insurance Company
CompBenefits Dental, Inc. • American Dental Plan of North Carolina, Inc.
National Dental Plans, Inc. • OHS of Alabama, Inc. • American Dental Plan of Georgia, Inc.
Texas Dental Plans, Inc. • Ultimate Optical, Inc. • VisionCare Plus • Primary Plus

CompBenefits Company

A Prepaid Limited Health Service Organization Licensed Under Section 636 of the Florida Insurance Code.

Agreement And Certificate of Benefits

Provided that all Contributions and Copayments required by this Certificate are paid when due, CompBenefits Company (hereinafter referred to as "Company") hereby agrees to provide Benefits to the Subscriber subject to all the provisions, definitions, limitations, and conditions of this Certificate outlined below:

Clyde E Rathmell

President

I. Definitions

A. **"Agreement and Certificate of Benefits"** (hereinafter referred to as "Certificate") is that document provided to the Subscriber that specifies Benefits and conditions of Coverage.

B. **"Benefits"** are those Dental Care Services available to the Members as stated in their Certificates.

C. **"Contributions"** are those periodic payments due Company by Subscriber to receive Benefits as provided by the Certificate.

D. **"Copayment"** is an additional fee the Participating General Dentist or Participating Specialist may charge Member when providing Dental Care Services not specified as "No Charge" in the Certificate.

E. **"Copayment Benefits"** are those Dental Care Services for which there are reduced fees which are due and payable directly by the Member to the Participating General Dentist or Participating Specialist at the time the services are rendered or in accordance with the particular payment procedures of the Participating General Dentist or Participating Specialist.

F. **"Dental Care Services"** are those services to be performed by a Participating General Dentist or Participating Specialist pursuant to the terms of the Certificate and a Participating General Dentist Agreement or a Participating Specialist Agreement.

G. **"Dental Facility"** is the location of the Participating General Dentist's or Participating Specialist's office where Members shall receive Dental Care Services.

H. **"Dependent"** means the following dependents of the Subscriber: a) the legal spouse; and b) all unmarried dependent children under nineteen (19) years of age, or under twenty-three (23) if they are full-time students in an accredited college or university and dependent on the Subscriber for primary support (unless otherwise negotiated or covered by amendment to this Certificate). The term "children" also includes: a) adopted children and b) stepchildren and foster children living with the Subscriber in a parent-child relationship.

I. **"Effective Date"** is the first day that a Member is entitled to receive Benefits designated in the Certificate.

J. **"Enrollment Fee"** is a one-time application fee for non-group contracts.

K. **"Member"** is a Subscriber and/or covered eligible Dependent of a Subscriber.

L. **"Necessary Treatment"** is that set of Dental Care Services determined by the Participating General Dentist or Participating Specialist as required to establish and maintain Member's good oral health.

M. **"No Charge Benefits"** are those Dental Care Services for which there are no additional fees due the Participating General Dentist or Participating Specialist by Member.

N. **"Participating General Dentists and Participating Specialists"** are those licensed dentists selected and contracted with Company as independent contractors to provide dental Benefits to Members.

O. **"Subscriber"** is an individual in good standing for whom the necessary Contributions and Copayments have been made in payment for Dental Care Services and to whom a Certificate evidencing coverage has been issued.

P. **"Treatment Plan"** is that individual proposal by the Participating General Dentist or Participating Specialist outlining the recommended course of Member's Dental Care Services. A written copy may be requested by the Member.

Q. **"Usual Charges"** are those fees that are customarily charged for Dental Care Services by the Participating General Dentist or Participating Specialist. Said charges are not determined by Company.

II. Contributions and Copayments

It is agreed that in order for Member to be eligible for and entitled to receive Benefits provided by this Certificate, Company must receive all Contributions and Enrollment Fees (where applicable) in advance. The Participating General Dentist or Participating Specialist must receive any Copayments in accordance with their particular payment procedure.

III. Benefits

From the Effective Date, Company agrees to provide Benefits to Members through Participating General Dentists or Participating Specialists on a No Charge or Copayment basis in accordance with the Schedule of Benefits contained in this Certificate. There is no exclusion due to pre-existing dental conditions except in those instances in which treatment has been initiated but not yet completed prior to the Effective Date.

IV. Duration of Agreement

Except under the following conditions, Company and Subscriber shall maintain this Certificate in force for a period of not less than twelve (12) months:

A. Company may cancel this Certificate with forty-five (45) days written notice:

1. (a) When a Member commits any action of fraud or misrepresentation involving Company.

(b) When a Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation seriously impairs the ability of Company, the Participating General Dentist, or the Participating Specialist to provide services to the Member and/or to other Members.

(c) When a Participating General Dentist is not available within the immediate geographical area of the Subscriber.

(d) When reasonable efforts by Company to establish and maintain a satisfactory dentist/patient relationship are unsuccessful or when Member has indicated unreasonable refusal to accept Necessary Treatment. When a Member refuses to accept treatment from two (2) Participating General Dentists or Participating Specialists, proof of unreasonable refusal shall be presumed conclusively.

2. Prior to cancellation, Company shall make every effort to resolve the problem through its grievance procedure and to determine that the Member's behavior is not due to use of the Dental Care Services provided or to mental illness.

3. If cancellation is effected by Company, all excess Contributions received by Company (excluding Enrollment Fees) over Usual Charges will be returned to Subscriber. Whenever cancellation is effected by Company because a Participating General Dentist is not available within the immediate geographical area of the Subscriber, then the Enrollment Fee (if any) also will be refunded.

4. Cancellation of this Certificate by Company is without prejudice to any continuous loss which commenced while this Certificate was in force. Participating General Dentists and/or Participating Specialists shall complete all dental procedures undertaken upon the Member, until the specific treatment or procedure undertaken upon the Member has been completed or for ninety (90) days, whichever is the lesser period of time. This shall apply to acute care procedures only and shall not include non-acute continuing care which would require continuing periodic treatment.

B. Subscriber may cancel this Certificate:

1. By notifying Company in writing within thirty (30) days of the Effective Date. Provided no Dental Care Services have been rendered to the Member, all Contributions (excluding Enrollment Fees) will be refunded upon written request. If Dental Care Services have been received by the Member, then any Contribution refunds shall be first applied to the Usual Charges of the Participating General Dentist or Participating Specialist.

2. If the Subscriber permanently moves from the Company service area. Cancellation shall become effective on the last day of the month in which written notification is received by Company.

3. If the Subscriber seeks cancellation after the first thirty (30) days and during the first twelve (12) months of this Certificate, the Subscriber will not be entitled to any premium refund. Additionally, Company Participating General Dentists and Participating Specialists, at their discretion, shall have

the right to collect from the Member their Usual Charges less any Copayments previously paid by the Member.

V. Continuation of Coverage

Unless cancellation of this Certificate is made for reasons specified in IV. A. 1. (a), (b), (c), or (d), Subscribers who continue to pay appropriate Contributions and Copayments will have their Certificates automatically renewed at the expiration of the first twelve (12) months. The following conditions also will apply:

A. At the attainment of the applicable age, coverage as a Dependent shall be extended if the individual is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

2. Chiefly dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to Company by the Subscriber within thirty-one (31) days of the Dependent's attainment of the limiting age and subsequently as may be required by Company, but not more frequently than annually after the two-year period following the Dependent's attainment of the limiting age.

B. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that certain employers maintaining group medical and dental plans offer employees and their Dependents the opportunity to continue their coverage when such coverage ends under certain conditions.

It is possible that a given employer is exempt from COBRA, particularly if there are less than 20 employees at all times during the calendar year.

More information about COBRA continuation can be obtained from a Subscriber's employer. COBRA does not apply to coverage maintained on any basis other than that through an employer-employee relationship.

VI. Coverage for Newborn Children and Adding Additional Dependents

A. A child born to the Subscriber, or covered family member, while this Certificate is in force is covered under this Certificate from the moment of birth, up to thirty-one (31) days. If coverage is to continue, the Subscriber must notify Company within the thirty-one (31) day period and pay the required Contribution, if any. Coverage is for the same Benefits and under the same terms and conditions applicable for Dependent children. Adoptive children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the adoptive home or from the moment of birth if a written agreement to adopt is entered into by Subscriber prior to birth.

B. Additional eligible Dependents of Subscriber may be added to this Certificate upon application to Company. When Dependents of a Subscriber become ineligible, upon application they may change their status and continue their Benefits as an individual Subscriber.

VII. Conversion Provisions for Group Plans

A. Company shall offer a converted contract to any Subscriber or covered Dependent whose group plan coverage has been terminated, and who has been

continuously covered under Company for at least three (3) months immediately prior to termination. The converted contract will provide coverage and benefits similar to the terminated contract and will be similar to the non-group or group contract previously in effect.

B. A Subscriber or covered Dependent shall not be entitled to have a converted contract issued to him or her if termination of his or her coverage occurred for any of the following reasons:

1. Failure to pay any required premium or Contribution.

2. Replacement of any discontinued coverage by similar coverage within thirty-one (31) days.

3. Fraud or material misrepresentation in applying for any benefits under the Company contract.

4. Disenrollment for cause as specified in IV.A.1.

5. Willful and knowing misuse of the Company identification or Member handbook or Certificate by the Member.

6. Willful and knowing furnishing to Company by the Member of incorrect or incomplete information for the purpose of fraudulently obtaining coverage or benefits from Company.

7. The Subscriber has left the geographic area of Company with the intent to relocate or establish a new residence outside Company's geographic area.

C. Subject to the conditions set forth above, the conversion privilege shall also be available to:

1. The surviving spouse and/or children, if any, at the death of the Subscriber, with respect to the spouse and such children whose coverages under the Company contract terminate by reason of such death.

2. To the former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support.

3. To the spouse of the Subscriber upon termination of coverage of the spouse, while the Subscriber remains covered under a group Company contract, by reason of ceasing to be a qualified family Member under the group contract.

4. To a child solely with respect to himself or herself, upon termination of his or her coverage by reason of ceasing to be a qualified family Member under a group Company contract.

VIII. General Provisions

A. Dental Facility Selection

1. Members shall be entitled to select the Dental Facility of their choice from a listing of Dental Facilities provided at the time of original enrollment.

2. Members shall be entitled to transfer from one Dental Facility to another upon written request and provided all Contributions and Copayments are currently

paid. Transfers are limited to one (1) per calendar year per Member.

3. Company reserves the right to transfer Members to another Dental Facility for the following reasons:

   (a) If chosen Dental Facility is no longer under contract with Company to provide Benefits.

   (b) If chosen Dental Facility is determined by Company to be unable to effectively render Benefits to the Member.

   (c) If efforts to establish a satisfactory dentist/patient relationship between Member and a Participating General Dentist or Participating Specialist have failed.

   (d) If Member has unreasonably refused to accept Necessary Treatment from a particular Participating General Dentist, then a transfer will be made in order to obtain a second Necessary Treatment opinion.

B. Appointments

All non-emergency Dental Care Services rendered to Member shall be on a prior appointment basis during the normal office hours of the Participating General Dentist or Participating Specialist. In order to receive Benefits, Member must make an appointment with a Participating General Dentist or a Participating Specialist, and the request for an appointment must be made after the Effective Date. When making an appointment, Member should inform Dental Facility that he or she is a Company Member.

Member may request an emergency appointment (treatment of accidental, painful, or urgent conditions) within twenty-four (24) hours of calling the Dental Facility, subject to the appropriate Copayment.

C. Emergency Care

Emergency care means treatment due to injury, accident, or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically nor physically possible for the Member to be treated by any Company Participating General Dentist or Participating Specialist. An acute periodontal abscess and an acute periapical abscess which occur under circumstances where it is not possible for the Member to be treated by any Company Participating General Dentist or Participating Specialist are examples where emergency benefits would be applicable.

1. Out-of-Area Emergency Care:

When more than one hundred (100) miles from the nearest available Company Dental Facility, Member may obtain reimbursement for expenses for Emergency Care rendered by any licensed dentist, less applicable Company copayments, up to one hundred dollars ($100) per Member per year, upon presentation of an itemized statement of emergency services from the dental office. Company must be notified of such treatment within ninety (90) days of its receipt.

2. In-Service-Area Emergency Care:

When Member is within one hundred (100) miles of any Company Dental Facility, during Company's normal business hours the Member should first contact his/her Participating General Dentist and request an emergency appointment. If his/her dentist is unable to render Emergency Care, Member should contact Company Member Services and request assistance in obtaining Emergency Care from another Company Dental Facility at that facility's usual fees less a 25% reduction.

If Emergency Care is required after Company's normal business hours, and it is not possible to contact a Company Dental Facility, Member may obtain reimbursement for expenses for Emergency Care rendered by any licensed Dentist, less applicable Company copayments, up to one hundred dollars ($100) per Member per year, upon presentation of an itemized statement of emergency services from the dental offices. Company must be notified of such treatment within ninety (90) days of its receipt.

D. Change in Contributions or Copayments

Company, at its discretion, may change the Contributions and/or Benefits by providing Subscriber with forty-five (45) days written notice prior to the Effective Date of the change. Changes in Contributions and Benefits will not be made to individual Certificates but will be made only on a class of Certificates. Subscriber shall have the right to cancel the Certificate, without penalty, if Subscriber does not wish to continue coverage because of proposed change.

E. Renewal

All Subscribers who continue to pay appropriate Contributions and Copayments will have their coverage renewed automatically, subject to all applicable provisions of this Certificate.

F. Grace Period

This contract has a thirty (30) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force. If full payment is not received within the thirty (30) day grace period, coverage will be terminated effective the first day of the grace period. Subscriber will be liable for the cost of Dental Care Services received during the grace period.

G. Reinstatement

The following guidelines shall apply to requests for reinstatement:

1. The Subscriber must submit an application for reinstatement to Company.

2. The Subscriber must remit to Company all Contributions for the period between the lapse Effective Date (previous last day of eligible coverage) and the reinstatement date.

Upon receipt by Company of the application and the appropriate Contributions, Company will notify Subscriber of the Effective Date of resumption of Benefits.

H. Dental Records

Dental records concerning services rendered to Member shall remain the property of the Participating General Dentist or Participating Specialist. Member agrees that his/her dental records may be reviewed by Company as deemed necessary in compiling utilization and/or similar data. Company agrees to honor confidentiality of said data.

I. Limitations and Exclusions

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph C of this Certificate.

2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.

3. Company does not provide coverage for the following services:

a) Cost of hospitalization and pharmaceuticals, drugs or medications.

b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.

c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.

e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

f) Services for injuries and conditions which are paid under Workers' Compensation or Employers' Liability laws.

g) Treatment for cysts, neoplasms and malignancies.

h) General anesthesia.

J. Incontestability

In the absence of fraud, all statements made by the Subscriber are considered representations and not warranties during the first two years of coverage. Company may avoid providing coverage at any time if Subscriber makes a fraudulent statement in a written application.

K. Conformity with Florida Law

1. This Certificate shall be interpreted in accordance with the laws of the State of Florida and any action or claim, including arbitration, shall be brought within the State of Florida.

2. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over Company shall have the effect of amending this Certificate to conform with the minimum requirements thereof.

3. In the event any portion of this Certificate is held to be void, it shall not affect any other provisions.

L. Notices

All notices, changes, or requests by Members shall be made in writing and shall be furnished by United States Mail to Company at its address as listed on the face page of this Certificate.

M. Notice of Independent Contractor Relationship

Company assumes responsibility of fulfilling the terms of this Certificate. Participating General Dentists and Participating Specialists are independent contractors, and Company cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a Participating General Dentist or Participating Specialist, or for any damages which result from any defective or dangerous condition in or about any Dental Facility.

N. Open Enrollment for Group Plans

Company will offer group plans at least one open enrollment period of not less than thirty (30) days every eighteen (18) months. Such open enrollment periods will be offered for as long as the group exists unless Company and the Group mutually agree to a shorter period of time than eighteen (18) months.

O. Insurance Department

The address and telephone number of the Florida Insurance Department are as follows:

200 E. Gaines Street, Tallahassee, FL 32399; Consumer Hotline (800) 342-2762.

IX. Review and Mediation of Complaints

A. Informational Grievances

Any Member who has a grievance against Company for any matter arising out of a Subscriber Certificate or for covered Dental Care Services rendered thereunder may submit an informal oral grievance to Company. Assistance with Company's grievance procedures, including assistance with informal oral grievances, may be obtained by calling Company's Member Services Department at the address and telephone number listed on the face page of this Certificate. Oral grievances shall be submitted to Company's Grievance Coordinator. Informal oral grievances shall be responded to as soon as possible by the Grievance Coordinator. If the informal oral grievance involves a dentally-related matter or claim, Company's Dental Director shall be involved in resolving said grievance. The Member has the right to file a

formal written grievance with Company and to appeal to the State of Florida Department of Insurance.

B. Submission of Formal Grievances

Any Member who has a grievance against Company for any matter arising out of a Subscriber Certificate or for covered Dental Care Services rendered thereunder may submit a formal written statement of the grievance to Company. Such written statement shall be specifically identified as a grievance, shall be submitted to Company within one (1) year from occurrence of the events upon which the grievance is based, and shall contain a statement of the action requested, the Member's name, address, telephone number, Member number, signature and the date. The statement should be sent to the Company's Grievance Coordinator at Company's address as listed on the face page of this Certificate. More information on and assistance with Company's grievance procedures may be obtained by calling Company's Member Services Department at Company's telephone number as listed on the face page of this Certificate.

C. Response to Formal Grievances

Company's Grievance Panel shall meet once a month to review written grievances submitted. If the Grievance Panel requires further information from the Member, then the Member may be asked to appear before the Grievance Panel. The Grievance Panel shall render a decision and communicate such decision, in writing, to the grievant within ten (10) days after the Grievance Panel's meeting. If the grievance involves a dentally-related matter or claim, Company's Dental Director shall be involved in resolving said grievance. If the grievance involves denial of benefits or services, the written decision shall reference the specific provisions of this Certificate upon which the denial is based. All grievances shall be processed within sixty (60) days by Company. However, if the grievance involves collection of information from outside Company's service area, an additional thirty (30) days will be allowed for processing.

D. Appeal of Decision

If the Member is dissatisfied with the decision of the Grievance Panel, the Member may request reconsideration by the Grievance Panel and may request a personal appearance before the Grievance Panel. Such requests for reconsideration must be made within sixty (60) days after receipt of the Grievance Panel's initial written decision. In addition, a Member has the right to appeal to the State of Florida Department of Insurance.

X. Entire Agreement

This Certificate constitutes the entire agreement between the parties.

XI. Agreement Language

Whenever the context hereof requires, the gender of all words shall include the masculine, feminine and neuter, and the number of all words shall include the singular and plural.

CompBenefits

CS 150

Schedule of Benefits and Subscriber Copayments

ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS		
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$15.00
9430	Office Visit (normal hours)	$5.00
9440	Office Visit (after regularly scheduled hours)	$35.00
9999	Emergency visit during regularly scheduled hours, by report	$20.00
9999	Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broken appointment. No charge will be made due to emergencies.	$10.00
DIAGNOSTIC		
120	Periodic oral evaluation	NO CHARGE
140/150/160	Limited/Comprehensive oral evaluation	NO CHARGE
180	Comprehensive periodontal evaluation - new or established patient	$10.00
210	X-Ray Intraoral - complete series including bitewings	NO CHARGE
220	X-Ray Intraoral - periapical - first film	NO CHARGE
230	X-Ray Intraoral - periapical - each additional film	NO CHARGE
270	X-Ray Bitewing - single film	NO CHARGE
272	X-Ray Bitewings - two films	NO CHARGE
274	Bitewings - four films	NO CHARGE
330	Panoramic film	NO CHARGE
460	Pulp vitality tests	NO CHARGE
470	Diagnostic casts	NO CHARGE
PREVENTIVE CARE		
1110/1120	Prophylaxis-adult/child- routine (once every 6 months)	NO CHARGE
1110/1120	Prophylaxis-adult/child-(additional)	$20.00
1201	Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	NO CHARGE
1203	Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	NO CHARGE
1330	Oral hygiene instruction	NO CHARGE
1351	Sealant - per tooth	$10.00
1510	Space Maintainer - fixed - unilateral	$45.00 + LAB
1515	Space Maintainer - fixed - bilateral	$45.00 + LAB
1520	Space Maintainer - removable - unilateral	$85.00 + LAB
1525	Space Maintainer - removable - bilateral	$85.00 + LAB
1550	Recementation of space maintainer	$10.00
RESTORATIVE		
2140	Amalgam - one surface, primary or permanent	NO CHARGE
2150	Amalgam - two surfaces, primary or permanent	NO CHARGE
2160	Amalgam - three surfaces, primary or permanent	NO CHARGE
2161	Amalgam - four or more surfaces, primary or permanent	NO CHARGE
2940	Sedative filling	$15.00
2999	Sedative base (under fillings), by report.	NO CHARGE
RESIN RESTORATION		
2330	Resin - one surface, anterior	$35.00
2331	Resin - two surfaces, anterior	$40.00
2332	Resin - three surfaces, anterior	$50.00
2391	Resin - based composite - one surface, posterior	$60.00
2392	Resin - based composite - two surfaces, posterior	$80.00
2393	Resin - based composite - three surfaces, posterior	$100.00
2394	Resin - based composite - four or more surfaces, posterior.	$120.00
2510	Inlay - metallic - one surface	$95.00

ADA CODE	PROCEDURE	PATIENT PAYS
2520	Inlay - metallic - two surfaces	$105.00
2530	Inlay - metallic - three or more surfaces	$130.00

CROWN & BRIDGE

2740	Crown - porcelain/ceramic substrate	$280 + LAB
2750*	Crown - porcelain fused to high noble metal	$280.00
2751	Crown - porcelain fused to predominantly base metal	$280.00
2752*	Crown - porcelain fused to noble metal	$280.00
2790*	Crown - full cast high noble metal	$280.00
2791	Crown - full cast predominantly base metal	$280.00
2792*	Crown - full cast noble metal	$280.00
2910	Recement inlay	$15.00
2920	Recement crown	15.00
2930	Prefabricated stainless steel crown - primary tooth	$75.00
2950	Core buildup, including any pins	$45.00
2951	Pin retention - per tooth	$15.00
2952	Cast post and core in addition to crown	$90.00 + LAB
2953	Each additional cast post - same tooth	$90.00 + LAB
2954	Prefabricated post and core in addition to crown	$90.00
2962	Labial veneer (porcelain laminate) - laboratory	$280 + LAB

ENDODONTICS

3220	Therapeutic pulpotomy	$35.00
3221	Pulpal debridement, primary and permanent teeth	$100.00
3310	Root canal therapy - anterior (excluding final restoration)	$100.00
3320	Root canal therapy - bicuspid (excluding final restoration)	$200.00
3330	Root canal therapy - molar (excluding final restoration)	$250.00
3410	Apicoectomy/periradicular surgery - anterior	$125.00

PERIODONTICS (Gum treatment)

4210	Gingivectomy/gingivoplasty 4+ teeth per quad	$125.00
4211	Gingivectomy/gingivoplasty 1-3 teeth per quad	$40.00
4260	Osseous surgery, 4+ teeth, per quad	$350.00
4261	Osseous surgery, 1-3 teeth, per quad	$350.00
4271	Free soft tissue graft procedure (inc. donor site surgery)	$225.00
4341	Periodontal scaling and root planing 4+ teeth per quad	$50.00
4342	Periodontal scaling and root planing 1-3 teeth per quad	$50.00
4355	Full mouth debridement to enable eval and diagnosis	$45.00
4381	Localized delivery of chemotherapeutic agents (per tooth)	$45.00
4910	Periodontal maintenance	$50.00

PROSTHODONTICS

5110	Complete denture - maxillary	$300.00 + LAB
5120	Complete denture - mandibular	$300.00 + LAB
5130	Immediate denture - maxillary	$300.00 + LAB
5140	Immediate denture - mandibular	$300.00 + LAB
5211	Maxillary partial denture - resin base	$300.00 + LAB
5212	Mandibular partial denture - resin base	$300.00 + LAB
5213	Maxillary partial denture - cast metal framework, resin denture bases	$300.00 + LAB
5214	Mandibular partial denture - cast metal framework, resin denture bases	$300.00 + LAB
5410	Adjust complete denture - maxillary	$15.00
5411	Adjust complete denture - mandibular	$15.00
5421	Adjust partial denture - maxillary	$15.00
5422	Adjust partial denture - mandibular	$15.00

REPAIRS TO PROSTHETICS

5510	Repair broken complete denture base	15.00 + LAB
5520	Replace missing or broken teeth - complete denture (each tooth)	$15.00 + LAB
5610	Repair resin denture base	$15.00 + LAB
5630	Repair or replace broken clasp	$15.00 + LAB

ADA CODE	PROCEDURE	PATIENT PAYS
5640	Replace broken teeth - per tooth	$15.00 + LAB
5650	Add tooth to existing partial denture	$30.00 + LAB
5730	Reline complete maxillary denture (chairside)	$50.00
5731	Reline complete mandibular denture (chairside)	$50.00
5740	Reline maxillary partial denture (chairside)	$50.00
5741	Reline mandibular partial denture (chairside)	$50.00
5750	Reline complete maxillary denture (laboratory)	$35.00 + LAB
5751	Reline complete mandibular denture (laboratory)	$35.00 + LAB
5760	Reline maxillary partial denture (labratory)	$35.00 + LAB
5761	Reline mandibular partial denture (laboratory)	$35.00 + LAB
5850	Tissue conditioning - maxillary	$30.00
5851	Tissue conditioning - mandibular	$30.00

PROSTHODONTICS (Fixed)

6210*	Pontic - cast high noble metal	$280.00
6211	Pontic - cast predominantly base metal	$280.00
6212*	Pontic - cast noble metal	$280.00
6240*	Pontic - porcelain fused to high noble metal	$280.00
6241	Pontic - porcelain fused to predominantly base metal	$280.00
6242*	Pontic - porcelain fused to noble metal	$280.00
6750*	Crown - porcelain fused to high noble metal	$280.00
6751	Crown - porcelain fused to predominantly base metal	$280.00
6752*	Crown - porcelain fused to noble metal	$280.00
6790*	Crown - full cast high noble metal	$280.00
6791	Crown - full cast predominantly base metal	$280.00
6792*	Crown - full cast noble metal	$280.00
6930	Recement fixed partial denture (per unit)	$10.00

EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY

7111	Coronal remnants, deciduous tooth	NO CHARGE
7140	Extraction, erupted tooth or exposed root	NO CHARGE
7210	Surgical removal of erupted tooth	$40.00
7220	Removal of impacted tooth - soft tissue	$50.00
7230	Removal of impacted tooth - partially bony	$70.00
7240	Removal of impacted tooth - completely bony	$85.00
7250	Surgical removal of residual tooth roots	$35.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	$35.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	$70.00
7510	Incision and drainage of abscess - intraoral	$25.00

ORTHODONTICS

8070/8080 Comprehensive orthodontic treatment of the transitional/adolescent dentition. Children up to 19 years of age. Up to 24 months of routine (full-banded) .... orthodontic treatment for Class I and Class II cases

Consultation	NO CHARGE
Evaluation	$35.00
Records/Treatment Planning	$250.00
Orthodontic Treatment	$1,800.00

8090 Comprehensive orthodontic treatment of the adult dentition. Adults 19 years of age and over. Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases

Consultation	NO CHARGE
Evaluation	$35.00
Records/Treatment Planning	$250.00
Orthodontic Treatment	$2,000.00

8680	Retention	$450.00

ADJUNCTIVE GENERAL SERVICES

9215	Local anesthesia	NO CHARGE
9230	Analgesia (nitrous oxide - per 15 minutes)	$15.00
9450	Case presentation, detailed and extensive treatment planning	NO CHARGE
9951	Occlusal adjustment - limited	$25.00
9952	Occlusal adjustment - complete	$150.00

*** THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL. THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED $125 PER UNIT AND $75 PER UNIT FOR SEMI-PRECIOUS METAL.**

NOTE:

1. NOT ALL PARTICIPATING DENTISTS PERFORM ALL LISTED PROCEDURES, INCLUDING AMALGAMS. PLEASE CONSULT YOUR DENTIST PRIOR TO TREATMENT FOR AVAILABILITY OF SERVICES.

2. UNLISTED PROCEDURES ARE AT THE DENTIST'S USUAL FEE LESS 25%.

3. WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL $50.00 PER UNIT.

SPECIALIST SERVICES

Should you need a specialist, (i.e., Endodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist. Copayment amounts are applicable when treatment is performed by Participating Specialists.. Benefits for procedures not listed on the schedule, that are performed by a Participating Specialist, are available at the Participating Specialist's usual and customary fee less 25%.

COMPBENEFITS FAMILY OF COMPANIES
CompBenefits Company
CompDent
CompBenefits Insurance Company
CompBenefits Dental, Inc.
American Dental Plan of North Carolina, Inc.
National Dental Plans, Inc.
OHS of Alabama, Inc.
American Dental Plan of Georgia, Inc.
Texas Dental Plans, Inc.
Ultimate Optical, Inc.
VisionCare Plan
Primary Plus

Limitations and Exclusions

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph C of the Certificate.

2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.

3. Company does not provide coverage for the following services:

   a) Cost of hospitalization and pharmaceuticals, drugs or medications.

   b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.

   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

   d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.

   e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

   f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.

   g) Treatment for cysts, neoplasms and malignancies.

   h) General anesthesia.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60-days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (770) 998-8936 or toll free at (800) 342-5209.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record that is related to your treatment. This information is necessary to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

Payment: We may use or disclose your health information in order to process claims or make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim to us for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided to our organization through contracts with third-party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Communication with Family or Friends: Our service professionals, using their best judgement, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fund Raising: We may contact you as part of a fundraising effort.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, we may disclose health information about you as required by military command.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Protective Services for the President, National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement: We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.

Inmates: We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.

Lawsuits and Disputes: We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Plan Sponsors: We may disclose health information about you to your plan sponsor to carry out plan administration functions that the plan sponsor performs upon certification by the plan sponsor that the plan documents have been amended as set forth under HIPAA regulations.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at 100 Mansell Court E., Suite 400, Roswell, GA 30076.

Right to Request Restrictions. You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction.

Right to Receive Confidential Communications. You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you in a designated record set. A "designated record set" is a group of records that we maintain such as enrollment, payment, and claims adjudication record systems. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend. You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspection as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period.

Right to Obtain a Paper Copy. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

CompBenefits
Attn: Privacy Officer
100 Mansell Court East, Suite 400
Roswell, GA 30076

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Questions & Answers DHMO

Thank you for selecting a CompBenefits dental plan. You and your family can look forward to receiving affordable care as well as good dental health. CompBenefits' benefits are designed to encourage preventive care which will keep your teeth and gums free of dental disease. When you receive care from one of our Participating General Dentists or Participating Specialists, simply consult your Schedule of Benefits to determine the amount you will pay for a specified procedure. This amount is referred to as a "copayment" or "surcharge".

From time to time, you may have questions about your dental benefits. We have anticipated what some of those questions may be and have provided the answers for you below. Understanding how your new dental program works will allow you to get the best care possible for both you and your family. Please take a moment now to read through this brochure and learn more about your dental plan.

Where can I receive benefits?

Benefits are provided by Participating General Dentists and Participating Specialists. The Participating General Dentist you have selected is printed on your Certificate of Dental Benefits. If you have not already chosen a Participating General Dentist, please contact Member Services in order to do so.

Please note that some Participating General Dentists may have more than one office. Please be sure to go only to the physical office location you choose. Each month, your dentist will receive a list with your name on it. It is a good idea for you to check with your dentist's office staff to be sure your name is on their list before you receive services.

How do I obtain a dental appointment?

Simply call your selected Participating General Dentist and make an appointment. Please take a moment to confirm the effective date of your coverage, which is printed on your Certificate of Dental Benefits. If you receive your Certificate of Benefits prior to your effective date, please wait until your effective date to make an appointment.

How do I obtain a list of Participating Dentists?

Simply call Member Services. We will be happy to mail one to you.

What should I do if I need to cancel my appointment?

If you need to cancel an appointment, please call your Participating General Dentist at least 24 hours before your appointment. Dentists work on an appointment basis and need to know your change of plans. If you break an appointment without giving 24-hour notice to your Participating General Dentist's office, you may be charged for a broken appointment at the rate shown on your Schedule of Benefits.

When I go to my selected Participating General Dentist, what treatment will I receive?

Your Participating General Dentist will evaluate your total dental needs. The two of you will then agree on a treatment plan to correct any existing problems and get you started on a program of good oral hygiene to help keep your teeth healthy and sound. Be sure you understand the recommended treatment plan and any associated charges. You may request a written copy of your treatment plan.

Your dentist is a dental care professional. Please do not ask him or her to provide only the "no charge" benefits and neglect treatment which is in the best interest of your own oral health. If you have any questions about your treatment plan, discuss them with your Participating General Dentist. If you have questions regarding your Schedule of Benefits, contact Member Services.

What if I want a second opinion?

You may get a second opinion from one of our Participating General Dentists at the cost indicated on your Schedule of Benefits. Simply call a Participating General Dentist and let the receptionist know that you'd like a second opinion appointment. Be sure to indicate that you are a member. The dentist will evaluate your situation and discuss it with you. If any services are rendered, you will be responsible for the cost.

What do I do if I need emergency treatment?

Call your Participating General Dentist and request an emergency appointment for the treatment of accidental, painful or urgent conditions. Your Schedule of Benefits shows the copayment for emergency appointments. This copayment is in addition to any copayment for treatment.

If your Participating General Dentist is not available, contact Member Services. We will help you locate another Participating General Dentist who can provide emergency care.

Consult your Certificate of Benefits for specific information regarding "out-of-area" emergency care.

Can I go to any Specialist of my choice?

Your benefits are available only from Participating General Dentists and Participating Specialists. Your Participating General Dentist will provide most, if not all, of the care you need. In the event specialist care is required, your Participating General Dentist may make a recommendation. Depending on your plan's specific provisions, an authorized referral from your Participating General Dentist may be required before seeking specialty care. Please read your plan's Certificate of Benefits carefully for specific guidance about accessing specialty care.

What should I do if I have a change of address?

Simply notify Member Services by phone or letter if your address or telephone number changes.

What are my charges if a procedure is not on my Schedule of Benefits?

A few services are specifically listed as exclusions on your Schedule of Benefits. You do not have any benefits for those services. Any service that is not specifically excluded may be available at a discount from Participating General Dentists' Usual and Customary Fees. Please refer to your Schedule of Benefits for the exact discount applicable to your plan.

What is the difference between Prophylaxis and Periodontal Prophylaxis?

Prophylaxis (ADA code #1110) is a routine cleaning. It includes scaling and polishing of teeth with normal periodontium (gum attachment and bone support).

Periodontal Maintenance Procedures (ADA code #4910) are maintenance procedures which are often necessary for those patients who have treatment for periodontal problems such as gum disease or pyorrhea and require follow up care.

Periodic maintenance treatment following active therapy is not the same as routine cleaning. It is a more extensive scaling process. There is a scheduled copayment for this procedure.

May I change from one Participating General Dentist to another?

Yes. You may change your Participating General Dentist by simply calling Member Services. If you request a change by the 15th of the month, it will become effective on the first of the following month. You may be precluded from transferring if you have a balance owed to your current dentist. Please read your plan's Certificate of Benefits for details on dental facility transfer limitations.

Is your dental plan a dental insurance plan?

Our plan is not an insurance plan. It is a Prepaid Dental Plan which makes benefits available from selected Participating General Dentists and Participating Specialists.

You enjoy benefits without deductibles, pre-existing conditions, or maximum benefit limitations. You, as the patient, pay your dentist the copayment amount stated in your Schedule of Benefits. The financial arrangements for making these copayments are strictly between the dentist and the patient. There are no claim forms to be filed.

What will I pay for a crown or a bridge?

The amount you pay depends on the type of crown or bridge which your Participating General Dentist recommends for you. The copayment on your Schedule of Benefits may not include the price of gold. If your crown or bridge includes gold, there may be an additional charge.

How do I transfer my dental records?

Dental records are the property of the Participating General Dentists or the Specialists. As a patient, you may request that a copy of your dental records be forwarded to your new Participating General Dentist's office, however, we cannot do this for you. Please note that there may be a charge to you for copies of dental records, including X-rays.

What happens if I am covered by dental insurance in addition to my coverage?

We typically will be your primary coverage. However, you may want to file your "out-of-pocket" expenses with your other carrier. Please contact your other plan for information about how they would like you to submit your "out-of-pocket" expenses.

What if I have other questions?

We have a qualified staff trained to answer your questions. Please contact us for further information.

Contact Member Services for:

- ❒ Name of Participating General Dentist
- ❒ Change of Participating General Dentist
- ❒ List of Participating Dentists
- ❒ Explanation of benefits
- ❒ Change of address
- ❒ New Certificate of Benefits & ID Cards

Contact Account Services for:

- ❒ Billing/payment questions
- ❒ Continuation of coverage
- ❒ Continuation of coverage for dependents who have reached the maximum age limit
- ❒ Policy reinstatement
- ❒ Dependent addition
- ❒ Dependent deletion
- ❒ Change of name
- ❒ Cancellation of coverage
- ❒ Effective date of policy

CompBenefits Member Services
1.800.342.5209

www.compbenefits.com

Elite Preferred 720 Dental Plan
Florida

compbenefits
vision
dental

CXZH04

COMPBENEFITS INSURANCE COMPANY

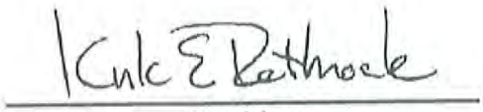
P. O. Box 8236 Chicago, IL 60680-8236 (800) 342-5209

CERTIFICATE
OF
GROUP DENTAL INSURANCE

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

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

Signed for CompBenefits Insurance Company



President

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

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION.

IMPORTANT CANCELLATION INFORMATION

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

DEFINITIONS

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

"You" and "Your" mean the certificateholder.

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

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

"Effective Date" means the date the Policy begins.

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

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

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

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

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

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

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

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

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

"Policy" means the Policy issued to the Policyholder.

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

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

BECOMING INSURED

Who Can Be Insured

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

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

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

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

When You Can Be Insured

You can be insured on the Effective Date if:

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

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

When Your Insurance Begins

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

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

The Actively At Work Requirement

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

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

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

Insurance For Your Dependents

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

Who Are Your Eligible Dependents

Your Eligible Dependents are:

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

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

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

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

Coverage For Children Placed For Adoption

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

When Insurance For Dependents Begins

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

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

When Your Insurance Ends

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

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

When Your Dependents' Insurance Ends

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

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

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

DENTAL BENEFITS

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

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

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

Beginning Date for Treatment or Service

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

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

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

Completion Date for Treatment or Service

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

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

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

Waiting Periods

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

Benefits Payable

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

Estimate of Benefits

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

Maximum Benefits

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

Benefits After Insurance Ends

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

Orthodontic Benefits (If Applicable)

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

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

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

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

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

Major Restorative Limitations

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

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

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

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

Exclusions

Benefits will not be paid for:

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

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

COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

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

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

2. DEFINITIONS.

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

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

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

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

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

3. ORDER OF BENEFIT DETERMINATION RULES.

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

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

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

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

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

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

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

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

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

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

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

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

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

4. EFFECT ON THE BENEFITS OF THIS PLAN.

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

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

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

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

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

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

6. FACILITY OF PAYMENT.

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

7. OVERPAYMENTS.

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

NOTICE OF CONTINUATION OF GROUP DENTAL COVERAGE RIGHTS (COBRA)

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

Representations and Warranties

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

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

Premium Rates

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

Grace Period

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

Termination

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

How to Claim Benefits

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

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

Notice and Proof of Claim

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

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

Legal Action

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

Conformity with State Statutes

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

Time of Payment of Claims

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

Reinstatement

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

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

Time Limit on Certain Defenses

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

Participating Provider Networks, if applicable

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

AMENDMENT

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

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

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

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

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

   Who Are Your Eligible Dependents

   Your Eligible Dependents are:

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

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

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

Coverage For Children Placed For Adoption

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

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

When Insurance For Dependents Begins

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

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

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

Exclusions

Benefits will not be paid for:

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

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

Termination

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

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

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

Legal Action

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

8. The following provision is hereby added as follows:

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

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

Signed for CompBenefits Insurance Company

Kirk E Rathrock

President

SCHEDULE OF BENEFITS
Indemnity Plan

Waiting Period for Type I Services:	None
Waiting Period for Type II Services:	None
Waiting Period for Type III Services:	None
Waiting Period for Type IV Services:	Not Applicable
Dependent Age:	26
Dependent Maximum Age:	26
Annual Deductible	$50 per person, Max 3 per family, Waived for Type I
Maximum Annual Payment	$1,000

	In-Network	Out-of-Network
Type I - Diagnostic and Preventive Services	**100%**	**100%**
Type II - Basic Restorative Services	**80%**	**80%**
Type III - Major Services	**50%**	**50%**

Note: When using an out-of-network provider, benefits are payable based on the Participating Dentist's Fee Schedule.

SCHEDULE OF BENEFITS
Indemnity Plan

Type I - Diagnostic and Preventive

D0120	Periodic Oral Evaluation	Limit 1 per 6 month period
D0140	Limited Oral Evaluation – problem focused	Limit 1 per 6 month period
D0150	Comprehensive Oral Evaluation – new or established patient	Limit 1 per 2 year period
D0180	Comprehensive periodontal evaluation – new or established patient	Limit 1 per 2 year period
D0210	Intraoral – Complete Series, including bitewings	Limit 1 per 3 year period
D0220	Intraoral Periapical x-rays	Limit 4 per 12 month period unless in conjunction with operative procedure
D0230	Intraoral Periapical x-rays, each additional film	
D0240	Intraoral Occlusal	Limit 2 films per 12 month period
D0250, D0260	Extraoral x-rays	Limit 2 films per 12 month period
D0270-D0274	Bitewing x-rays	Limited to 1 set in any 12 month period
D0330	Panoramic film	Limit 1 per 3 year period
D1110, D1120	Prophylaxis	Limit 1 per 6 month period
D1201, D1203	Topical Application of Fluoride, per tooth	Limit 1 per 12 month period; limited to children under age 16
D1351	Sealant, per tooth	Limit 1 per 3 year period; limited to children under age 16 for non carious molars only
D1510-D1550	Space Maintainers	Limited to children under age 16

Type II - Basic Restorative Services

D2140-D2161	Amalgam Restorations	Current amalgam must have been in place for 24 months
D2330-D2335	Composite Resin Restorations-anterior	Current composite resin must have been in place for 24 months
D2391-D2394	Composite Resin Restorations-posterior	Current composite resin must have been in place for 24 months
D3220	Therapeutic Pulpotomy	
D3230	Pulpal therapy anterior, primary tooth	
D3240	Pulpal therapy posterior, primary tooth	
D3310-D3330	Root Canal Therapy	Limit 1 per tooth
D3346-D3348	Root Canal Therapy - retreatment-by report	Limit 1 per tooth
D3351-D3353	Apexification	
D3410-D3426	Apicoectomy	
D3430	Retrograde Filling	
D3450	Root Amputation	
D3920	Hemisection	
D7111	Coronal remnants, deciduous tooth	
D7140	Extraction, erupted tooth or exposed root elevation and/or forceps removal	

Type II - Basic Restorative Services (cont.)

D7210	Surgical Extractions - except removal of impacted teeth	
D7220	Surgical removal of impacted tooth - soft tissue	
D7230	Surgical removal of impacted tooth - partially bony	
D7240	Surgical removal of impacted tooth - completely bony	
D7250	Surgical removal of residual tooth roots cutting procedure	
D7260	Oral Antral Fistula Closure	
D7261	Primary closure of a sinus perforation	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	
D7272	Tooth transplantation	
D7281	Surgical Exposure of impacted or unerupted tooth to aid eruption.	
D7285, D7286	Biopsy of oral tissue	
D7310, D7320	Alveoloplasty	
D7340, D7350	Vestibuloplasty	
D7410, D7411	Excision of benign lesion	
D7450, D7451	Removal of benign odontogenic cyst or tumor	
D7471	Removal of exostosis maxilla or mandible	
D7510, D7520	Incision and Drainage	
D7530, D7540	Removal of foreign body	
D7960	Frenectomy	
D7970	Excision of Hyperplastic tissue - per arch	
D7971	Excision of pericoronal gingiva	
D7980	Sialolithotomy	
D7981	Excision of Salivary Gland, by report	
D7982	Sialodochoplasty	
D7983	Closure of Salivary Fistula	
D9110	Palliative emergency treatment of dental pain	
D9220, D9221	Deep sedation/general anesthesia	Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by Us

Type III - Major Services

D2510, D2520, D2530, D2543 D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664	Inlays and Onlays	Replacements allowed only if more than 5 years have passed since the last placement of the inlay, onlay and/or crown
D2710, D2721, D2740 D2750-D2752 D2790-D2792	Crowns	Replacements allowed only if more than 5 years have passed since the last placement of the inlay, onlay and/or crown. For patients under 16 years of age, benefit is limited to plastic and stainless steel crowns
D2910	Re-Cement Inlays	

Type III - Major Services (cont.)

D2920	Re-Cement Crowns	
D2930-D2933	Stainless Steel Crowns, Resin Crowns	
D2950	Core Build-up including any pins	
D2951	Pin Retention – per tooth, in addition to restoration	
D2952	Cast Post and Core, in addition to crown	
D2954	Prefabricated Post and Core, in addition to crown	
D2980	Crown Repair, by report	
D4210, D4211	Gingivectomy or gingivoplasty	Per Quadrant - Limit 1 per 36 months
D4240, D4241	Gingival Flap Procedure including root planing	Per Quadrant - Limit 1 per 36 months
D4249	Clinical crown lengthening - hard tissue	Per Quadrant - Limit 1 per 36 months
D4260, D4261	Osseous Surgery	Per Quadrant - Limit 1 per 36 months
D4263	Bone replacement graft - first site in quadrant	Per Quadrant - Limit 1 per 36 months
D4264	Bone replacement graft - each additional site in Quadrant	Per Quadrant - Limit 1 per 36 months
D4266	Guided tissue regeneration - resorbable barrier - per site, per tooth	Per Quadrant - Limit 1 per 36 months
D4267	Guided tissue regeneration – nonresorbable barrier – includes membrane removal, per site - per tooth	Per Quadrant - Limit 1 per 36 months
D4270	Pedicle Soft Tissue Graft	Per Quadrant - Limit 1 per 36 months
D4271	Free soft tissue graft including donor site surgery	Per Quadrant - Limit 1 per 36 months
D4273	Subepithelial connective tissue graft procedure	Per Quadrant - Limit 1 per 36 months
D4274	Distal or proximal wedge, procedure when not performed in conjunction with surgical procedures in the same anatomical	Per Quadrant - Limit 1 per 36 months
D4320, D4321	Provisional Splinting	Limit 1 per 12 month period
D4341, D4342	Periodontal Scaling and Root Planing, per quadrant	Limit 1 per 24 month period
D4355	Full Mouth Debridement	Limit 1 per 24 month period
D4910	Periodontal Maintenance	
D5110-D5140	Complete Dentures removable	Replacements allowed only if more than 5 years have passed since the last placement of the inlay, onlay and/or crown.
D5211, D5212, D5213, D5214.	Partial Dentures removable	
D5281		
D5410-D5422	Denture Adjustments	Limit 3 once denture is 6 months old
D5510, D5520, D5610, D5620, D5630, D5640	Repairs to full and partial dentures	Limit 1 per 12 months
D5650	Add tooth to existing partial denture to replace newly extracted functioning natural tooth	
D5660	Add clasp to existing partial denture	
D5710-D5761	Relining Dentures, Rebasing Dentures	
D5850, D5851	Tissue Conditioning - maxillary or mandibular	
D6100	Removal of implant, by report	
D6211, D6241, D6251	Fixed Partial Dentures non-precious metal pontics, crown abutments, and metallic retainers; benefits for the	

Type III - Major Services (cont.)

D6602-D6607	replacement of an existing fixed bridge are payable
D6610-D6615	only if the existing bridge is more than 5 years old
D6545	Cast Metal Retainer for resin bonded fixed partial denture
D6721	
D6751, D6780,	
D6791	
D6930	Re-Cement fixed partial denture
D6970-D6972	Post and Core in conjunction with a fixed partial denture
D6973	Core Buildup for Retainer including any pins
D6980	Fixed partial denture repair, by report area.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60-days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (770) 998-8936 or toll free at (800) 342-5209.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record that is related to your treatment. This information is necessary to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

Payment: We may use or disclose your health information in order to process claims or make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim to us for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided to our organization through contracts with third-party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Communication with Family or Friends: Our service professionals, using their best judgement, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fund Raising: We may contact you as part of a fund-raising effort.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, we may disclose health information about you as required by military command.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Protective Services for the President, National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement: We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.

Inmates: We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.

Lawsuits and Disputes: We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Plan Sponsors: We may disclose health information about you to your plan sponsor to carry out plan administration functions that the plan sponsor performs upon certification by the plan sponsor that the plan documents have been amended as set forth under HIPAA regulations.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at 100 Mansell Court E., Suite 400, Roswell, GA 30076.

Right to Request Restrictions. You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction.

Right to Receive Confidential Communications. You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you in a designated record set. A "designated record set" is a group of records that we maintain such as enrollment, payment, and claims adjudication record systems. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend. You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspection as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period.

Right to Obtain a Paper Copy. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

CompBenefits
Attn: Privacy Officer
100 Mansell Court East, Suite 400
Roswell, GA 30076

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.