

Benefit Booklet
for
CITY OF HOLLYWOOD
PREMIUM PLAN

A Self-Insured Group Dental Benefit Plan

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

For Customer Service Assistance Call Toll Free: 1-877-203-9921

SCHEDULE OF BENEFITS

CITY OF HOLLYWOOD

Group Number:	25K0040
Coverage Effective Date:	January 1, 2006
Plan Year:	January 1 st through December 31 st

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

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

	<u>Participating Dentists</u>	<u>Non- Participating Dentists</u>
DEDUCTIBLE FOR PREVENTIVE SERVICES.....	None	None
INDIVIDUAL DEDUCTIBLE PER PERSON, PER PLAN YEAR FOR BASIC, MAJOR AND ORTHODONTIA SERVICES.....	\$25	\$25

SCHEDULE OF BENEFITS
(continued)

PREVENTIVE, BASIC AND MAJOR SERVICES

Plan Year Maximum per person\$2,000

Plan Percentage Payable:

	<u>Participating Dentists</u>	<u>Non- Participating Dentists</u>
Preventive	100%	80%
Basic	80%	70%
Major	50%	50%

ORTHODONTIA SERVICES (Applicable to covered dependent children to age 19.)

Orthodontia Lifetime Maximum per Dependent Child\$2,000

Plan Percentage Payable.....50%

*For the out of state Retiree Division, only, the Participating Dentists Plan Percentage Payable will apply to both Participating and Non-Participating Dentists.

**THIS BENEFIT BOOKLET DESCRIBES THE DENTAL
COVERAGE, BENEFITS, LIMITATIONS AND
EXCLUSIONS FOR THE SELF-INSURED GROUP
DENTAL BENEFIT PLAN (OR “PLAN”)
ESTABLISHED AND MAINTAINED BY:**

CITY OF HOLLYWOOD

2600 Hollywood Boulevard
Hollywood, FL 33020

The Group Dental Benefit Plan established and maintained by the above-named entity is self-insured. This means that all benefits paid under the terms of coverage are paid from funds provided by that entity. All periods of time under this benefit booklet will begin and end at 12:01 a.m. at the plan sponsor’s address.

As the claims administrator, Florida Combined Life Insurance Company, Inc. performs certain limited administrative claims processing and customer services only and does not assume any financial risk or obligation with respect to claims received for processing under this Plan.

Florida Combined Life Insurance Company, Inc. is a subsidiary of Blue Cross and Blue Shield of Florida, Inc. and an independent corporation operating under a license from the Blue Cross Blue Shield Association, that permits Florida Combined Life Insurance Company, Inc. to use the Blue Cross and Blue Shield Service Marks in the State of Florida.

GROUP DENTAL ORTHODONTIA BENEFITS

This rider is a part of the benefit booklet to which it is attached. The effective date of this rider is the later of the coverage effective date shown in the Schedule of Benefits, or the date of the amendment adding this rider to the benefit booklet. Unless amended by this rider, benefit booklet definitions, terms and provisions will apply to this rider.

1. For purposes of this rider, the following definition is added to the benefit booklet:

Orthodontia - means the branch of dentistry concerned with the interception and treatment of improper alignment of biting or chewing surfaces (malocclusion) of the teeth and their surrounding structures.

2. For purposes of this rider, the following benefit booklet provisions are amended:

A. **“Benefits”** is amended as follows:

- (i) The following is added to the first paragraph:

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

- (ii) The following is added under “Preventive” benefits:

9. Cephalometric x-rays, but only in connection with orthodontic diagnosis, and only once in any thirty-six (36) consecutive month period.

(iii) The following provision is added:

Orthodontic Services

The following is a list of covered services for orthodontic services for the correction of an existing malocclusion and its attendant sequelae through the correction of malposed teeth.

1. diagnosis, including radiographs and study models;
2. active treatment, including necessary appliances; and
3. retention treatment following active treatment.

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

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

10. Orthodontia services will be limited to the Lifetime Orthodontia Maximum shown on the Schedule of Benefits.
11. Benefits for covered orthodontia services will be payable in equal monthly amounts during the period covered by the approved treatment plan and while coverage is in effect, not to exceed thirty-six (36) months.
12. If the treatment plan for covered orthodontia services is completed in less time than specified in the approved treatment plan, we will make payment in the amount of the remainder of the liability, after we receive notice from the dentist.
13. Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with orthodontic appliance therapy.
14. Benefit payment for orthodontic services will be limited to thirty-six (36) consecutive months’ active treatment or eighteen (18) consecutive months’ retention treatment. These limits will include the number of months of such treatment received prior to commencement of this coverage.

(ii) "Exclusions" is amended as follows:

(a) Item 5. is deleted and replaced with the following:

5. Services rendered primarily for cosmetic purposes, except for orthodontic services rendered for correction of defects incurred through traumatic injuries which occurred while this rider is in force.

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SECTION I

DEFINITIONS

Adverse Benefit Determination – means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Plan with respect to a claim.

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

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

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

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

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

Deductible - means the amount of charges, up to the allowable expenses, a covered person must pay each plan year before payment for covered dental services begins. To calculate the amount to be applied towards satisfying the deductible, only allowable expenses are applied. For Example:

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

Any amounts credited by FCL towards your individual Plan Year Deductible for Covered Services incurred during the last three months of the prior Plan Year will be carried over to reduce your individual Plan Year Deductible requirement for the current Plan Year.

Dental Services Waiting Period - means, if shown in the Schedule of Benefits, the length of time as established by the Plan Sponsor before a covered person is eligible for coverage under the Plan for specific covered dental services.

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

Eligible Dependent means a Covered Plan Participant's:

1. legal spouse under a legally valid, existing marriage; or
2. natural, newborn, adopted, or step child(ren); or
3. a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian;

who meets and continues to meet all of the eligibility requirements described in the Eligibility for Coverage section in the Booklet.

Eligible Dependent also includes a newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Refer to the Eligibility for Coverage section for limits on eligibility.

Employee - means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Covered Employee subsection of the Eligibility for Coverage section in the Benefit Booklet and is eligible to enroll as a Covered Employee. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee by the City of Hollywood.

Experimental or Investigational - A drug, a device, a procedure or treatment is experimental or investigational, as defined herein, if:

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

Medicare - means any coverage under Title XVIII of the Federal Social Security Act. If this Act is amended, this term will mean any coverage provided under the amended Act.

Medically Necessary - means, for coverage and payment purposes only, any services, care, or supplies received by a covered person were: 1) consistent with the symptom, diagnosis, and treatment of the covered person's condition; 2) in accordance with standards of good dental or medical practice; 3) approved by the appropriate dental or medical body or board for the condition in question; 4) not primarily for the comfort or convenience of the covered person, or dentist; 5) the most appropriate, efficient, and economical dental or medical supply, service, or level of care which could have safely been provided; and 6) not cosmetic in nature.

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

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

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

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

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

Treatment Plan - means the dentist's written report of a series of procedures and estimated charges recommended for the treatment of dental disease, defect or injury, which is prepared for a covered person as a result of an examination made by such dentist.

Usual, Reasonable and Customary Charges – means an amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar conditions in the locality where the service is performed. Payment under this contract for covered services provided by a non-participating dentist is based on usual, reasonable and customary charges.

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

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

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

SECTION II

GENERAL PROVISIONS

General Plan Provisions

Representations Made During Enrollment

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

Identification Cards

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

Extension of Benefits Upon Plan Termination

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

- a. a course of treatment or dental procedures were recommended in writing and commenced while the covered person was covered under the Plan; and
- b. the dental procedures were for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and
- c. the dental procedures were performed within ninety (90) days after the covered person's coverage terminated under the Plan, and the termination did not occur as a result of your voluntary termination of coverage.

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

The dental benefits available under this Group Dental Benefit Plan shall not duplicate any dental benefits to which the covered person is entitled, or eligible for, under state or federal government programs (e.g., Medicare, Medicaid, Champus, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of dental benefits of coverage under a prior plan or program which may be provided or required by law.

Appeal of an Adverse Determination

You, or a representative designated by you in writing, have the right to appeal an adverse benefit determination. Your written appeal must be filed with us within one hundred eighty (180) days of the original adverse benefit determination.

We will review your appeal under the following guidelines:

1. we must receive the appeal orally or in writing;
2. you may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
3. if the adverse benefit determination is based on the lack of medical necessity of a specific service or experimental, investigational or other similar limitations or exclusions, you may request at no charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the plan to the insured's circumstances;
4. during the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;
5. we may consult with appropriate dentists, as necessary; and
6. any independent medical or dental consultant who reviews your adverse benefit determination on our behalf will be identified upon request.

We will use our best efforts to review your appeal of an adverse benefit determination and notify you of our review decision within sixty (60) days of our receipt.

A covered person, or a provider acting on behalf of the covered person, who has had a claim denied as not medically necessary has the right to appeal the claim denial. The appeal may be directed to an employee of the claims administrator who is a licensed dentist responsible for medical necessity reviews. The appeal may be by telephone and the dentist will respond to the covered person within a reasonable time, not to exceed fifteen (15) business days.

Claims Processing

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

Notice of Claim

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

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

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

Claim Forms

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

1. within the time limit for filing "Proof of Loss" stated below; and
2. covering the occurrence, nature, and extent of the loss.

Proof of Loss

Written proof of loss:

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

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

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

Payment, Contest or Denial of Claims

We will pay, contest or deny a claim, or any part of a claim, within the timeframes described below.

Payment of Claims

We will use our best efforts to pay a claim or any part of a claim that establishes proof of loss and contains, as determined by us, all the information we need to pay the claim, as follows:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within forty (40) days of our receipt.

We may provide the claimant notice of payment within thirty (30) days of receipt.

If we are unable to determine if a claim or any part of a claim is payable because additional information is needed, we may contest the claim as set forth below.

Contested Claims

If a claim is contested or additional information is needed, we will use our best efforts to provide notice that the claim or any part of the claim is contested, within the following timeframes:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within thirty (30) days of our receipt.

This notice will identify:

1. the contested portion or portions of the claim;
2. the reason(s) for the contest;
3. the date we reasonably expect to notify the claimant of the decision; and
4. the additional information needed.

If we request additional information, we must receive it within forty-five (45) days of the request. Upon receipt of the requested information, we will use our best efforts to complete the processing of the claim within fifteen (15) days of receipt. If we do not receive the requested information, the claim will be processed based on the information we possess at the time, and it may be denied.

Denied Claims

If a claim is denied, we will use our best efforts to provide notice that the claim or any part of the claim is denied, within the following timeframes:

1. for an electronically filed claim, within twenty (20) days of our receipt; and
2. for a claim filed on a paper claim form, within thirty (30) days of our receipt.

This notice will identify:

1. the denied portion or portions of the claim; and
2. reason(s) for the denial.

It is the claimant's responsibility to provide all information determined by us as necessary to process a claim. If we do not receive the necessary information, the claim or any part of the claim may be denied.

Any claim that is denied is an adverse benefit determination. A claimant has the right to appeal an adverse benefit determination for a claim as specified in "Appeal of an Adverse Benefit Determination."

We will use our best efforts to pay or deny all claims within the following timeframes:

1. for an electronically filed claim, within ninety (90) days of our receipt.
2. for a claim filed on a paper claim form, within one hundred twenty (120) days after our receipt.

Processing of the claim will be considered complete on the date notice of the claim decision is deposited in the mail by us or otherwise electronically transmitted.

Any claims payment not made within the applicable timeframe shall bear simple interest at the rate specified by law.

We will investigate any allegation of improper billing by a provider, upon written notice from a covered person. If we determine that the covered person was billed for a service that was not actually performed, any payment amount will be adjusted, and if applicable, a refund will be requested. In such a case, if payment to the provider is reduced solely to the notice from the covered person, we will pay the covered person twenty (20) percent of the amount of the reduction, up to \$500.

Additional Claims Processing Provisions

Release of Information/Cooperation

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

Fraud, Misrepresentation or Omission in Applying for Benefits

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

Explanation of Benefits Form

All claims decisions, including denial and claims review decisions, will be given to the covered person in writing in an explanation of benefits form. This form may indicate:

- a. the reason(s) the claim was denied;
- b. a reference to the applicable benefit booklet provision upon which the denial is based;
- c. a description of additional material or information necessary to make the claim payable and why such material or information is necessary; and
- d. an explanation of the steps to be taken if a covered person wants a claim denial decision reviewed.

**IF YOU HAVE ANY QUESTIONS ON YOUR SUBMISSION OF
CLAIMS OR BENEFITS
CALL 1-877-203-9921**

**OR
WRITE TO**

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

SECTION III

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in the Group Dental Plan, and who meets and continues to meet the eligibility requirements described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members. No changes in the eligibility requirements will be permitted except as permitted by the City of Hollywood. Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Eligible Employee as the legal guardian or appropriate adoption documentation described in the Enrollment and Effective Date of Coverage section.

Eligibility Requirements for Covered Employees

In order to be eligible to enroll as a Covered Employee, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. The employee must be a bona fide full-time employee of the City of Hollywood (part-time employees who worked more than 1500 hours in the previous fiscal year shall be eligible at the discretion of the City of Hollywood or in accordance with any collective bargaining agreement);
2. The employee's job must fall within a job classification identified by the City of Hollywood;
3. The employee must have completed any applicable Waiting Period determined by the City of Hollywood; and
4. The employee must meet any additional eligibility requirement(s) required by the City of Hollywood.

The City of Hollywood's coverage eligibility classifications may be expanded to include:

1. retired employees and their Covered Dependents or the surviving Covered Dependents of a deceased employee or deceased retired employee as collective bargaining agreements and/or City of Hollywood policies and procedures may allow;
2. additional job classifications;

3. the Mayor and members of the City Commission;
4. Assistant City Attorney;
5. Hollywood Housing Authority and Community Redevelopment Agency active, full-time employees;
6. employees of affiliated or subsidiary companies of the City of Hollywood, and
7. other individuals as determined by the City of Hollywood.

The City of Hollywood shall have sole discretion concerning the expansion of eligibility classifications.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Employee's spouse under a legally valid existing marriage;
2. The Covered Employee's natural, newborn, adopted, or step child(ren) (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian or a child covered by a Qualified Medical Child Support Order) until the end of the Calendar Year in which the child reaches age 25, and who is:
 - a) dependent upon the Covered Employee for financial support; and
 - i. living in the household of the Covered Employee or (in the case of divorce the other parent), or a full-time or part-time student; or
 - ii. the child does not live in the household of the Covered Employee and is not enrolled as a full or part-time student because the child has not met the age requirement to begin elementary school education; or
 - b) in the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 25, as a Covered Dependent if the child is:
 - i. otherwise eligible for coverage under the Group Dental Plan;

- ii. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- iii. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 25th birthday.

This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

or

- 3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility to establish that a child meets the applicable requirements for eligibility. However, beginning at age 19, verification of Eligibility for your dependent child will be requested by FCL. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Eligible Dependent(s) will not include:

- 1. a spouse following legal separation or final decree of dissolution or divorce;
- 2. any person who is on active duty in a military service;
- 3. any person who lives outside of the United States;
- 4. any person who is enrolled as a Covered Employee or retiree under the Group Dental Plan; or
- 5. any person who is enrolled as a Covered Dependent of another Covered Employee or retiree under the Group Dental Plan.

SECTION IV

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage according to the provisions below.

Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Benefit Booklet. Neither FCL nor the City of Hollywood will have any obligation whatsoever to any individual who is not properly enrolled.

Any Employee or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage according to the provisions set forth below.

Enrollment Forms/Electing Coverage

To apply for coverage, you as the Eligible Employee must:

1. complete and submit, through the City of Hollywood, the Enrollment Form;
2. provide any additional information needed to determine eligibility, at the request of FCL or the City of Hollywood;
3. pay any required contribution; and
4. complete and submit, through the City of Hollywood, an Enrollment Form to add Eligible Dependents.

When making application for coverage, you must elect one of the types of coverage available under the City of Hollywood's program. Such types may include:

Employee Only Coverage - This type of coverage provides coverage for the Covered Employee only.

Employee and one Dependent Coverage - This type of coverage provides coverage for the Covered Employee and the employee's spouse (under a legally valid existing marriage) or one child only.

Employee and two or more Dependents Coverage - This type of coverage provides coverage for the Covered Employee and the employee's Covered Dependents.

There may be additional contribution amounts for each Covered Dependent.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later. Coverage for newly hired employees who properly enroll during the Initial Enrollment Period will be effective the first day of the first month following 30 days of active employment. Dependent coverage, if elected, will be effective concurrent with the employee's coverage effective date.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the City of Hollywood's dental benefit program. The period is established by the City of Hollywood, occurs annually, and will take place when specified by the City of Hollywood.

Special Enrollment Period is the 30-day period of time immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for coverage.

Special circumstances are described in the Special Enrollment Period subsection.

Employee Enrollment

An Eligible Employee who fails to enroll during the Initial Enrollment Period will not be covered and may only enroll under this Benefit Booklet during the next Annual Open Enrollment Period established by the City of Hollywood, or in the case of a Special Enrollment event, during the Special Enrollment Period. The Effective Date for enrollments during the Annual Enrollment Period will be the date specified by the City of Hollywood. The Effective Date for enrollments during the Special Enrollment Period will be the date of the Special Enrollment Event.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Employee. Below are special rules for certain Eligible Dependents.

Newborn Child/Adopted Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit an Enrollment Form to FCL through the City of Hollywood during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Employee prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Employee may be required to provide any information and/or documents that are deemed necessary in order to administer this provision.

If timely notice is given, no additional contribution will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child if the Covered Employee provides notice to the City of Hollywood and an Enrollment Form is received within the 60-day period of the birth of the child and any applicable contribution is paid back to the date of birth.

If the newborn is not enrolled within sixty days of the date of birth, the newborn child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Employee, there shall be no coverage for the adopted newborn child. It is your responsibility as the Covered Employee to notify the City of Hollywood within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

Note: Coverage for a newborn child of a Covered Dependent child will automatically terminate 18 months after the birth of the newborn child.

Adopted Children – To enroll an adopted Child, the Covered Employee must submit an Enrollment Form during the 30-day period immediately following the date of placement. The Effective Date for an adopted (other than an adopted newborn child) will be the date such adopted child is placed in the residence of the Covered Employee in compliance with applicable law. Any Pre-existing Condition exclusionary period will not apply to an adopted child. The Covered Employee may be required to provide any information and/or documents deemed necessary in order to properly administer this section.

In the event the City of Hollywood is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as the Covered Employee provides notice to the City of Hollywood, and we receive the Enrollment Form within 60 days of the placement. If the adopted Child is not enrolled within sixty days of the date of placement, the adopted Child will not be covered, and may only be enrolled under this Benefit Booklet during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period. For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted Child. Proof of final adoption must be submitted to FCL through the City of Hollywood if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child.

Marital Status –The Covered Employee may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered Employee must complete the Enrollment Form through the City of Hollywood and forward it to FCL. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under their group coverage. To apply for coverage, the Covered Employee must complete an Enrollment Form through the City of Hollywood and forward it to FCL. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Enrollment Form during the Annual Open Enrollment Period.

The effective date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the date established by the City of Hollywood.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee or the Eligible Dependent is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependents may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee must complete the applicable Enrollment Form and forward it to the City of Hollywood within 30 days of the date of the special enrollment event. For purposes of this Benefit Booklet, the following are the special enrollment events:

1. you lose your coverage under another group dental benefit plan (as an employee or dependent), or coverage under other dental insurance, or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:
 - a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group dental plan or dental insurance coverage was the reason for declining enrollment; and
 - b) you lost your other coverage under a group dental benefit plan or dental insurance coverage as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other dental coverage, the employer ceased offering group dental coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated.

Note: Loss of coverage for failure to pay your required contribution/premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior dental coverage) is not a qualifying event for special enrollment.

2. you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees or Eligible Dependents who do not enroll during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Plan Participant).

Other Provisions Regarding Enrollment and Effective Date of Coverage

1. Individuals who are rehired as employees of the City of Hollywood are considered newly-hired employees for purposes of this section. The provisions of the Group Dental Plan (which includes this Booklet) which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents.
2. Covered Dependents of Retirees:
 - a. Coverage for a Covered Dependent spouse or Covered Dependent child will continue as long as the retired Covered Employee is living and the retired Covered Employee and the Covered Dependent spouse or Covered Dependent child continue to meet the eligibility criteria.

- b. In the event that a retired Covered Employee dies, a Covered Dependent spouse of the deceased retired Covered Employee may be eligible to elect to continue coverage as a new Covered Employee and a Covered Dependent child may be eligible to continue coverage provided the new Covered Employee and Covered Dependent child continue to meet the eligibility criteria, as long as the Group and FCL are properly notified on a timely basis and the appropriate Premiums are paid to the Group. Eligibility for continued coverage as a surviving spouse or surviving dependent is subject to the applicable collective bargaining agreement and/or City of Hollywood policies and procedures.

SECTION V

TERMINATION OF COVERAGE

Termination of a Covered Plan Participant's Coverage

A Covered Plan Participant's coverage under this Benefit Booklet will automatically terminate at 12:01 a.m.:

1. on the date the Group Dental Plan terminates;
2. on the date the ASO Agreement between FCL and the City of Hollywood terminates;
3. on the last day of the first month that the Covered Plan Participant fails to continue to meet any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
5. on the date specified by the City of Hollywood that the Covered Plan Participant's coverage terminates.

Note: A Covered Employee may only elect to terminate their coverage or the coverage of a Covered Dependent within 30 days of a qualifying event or during an Annual Open Enrollment Period. Termination of Coverage outside of these periods is not permitted.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage under this Benefit Booklet will automatically terminate at 12:01 a.m.:

1. on the date the Group Dental Plan terminates.

Termination of Employee Coverage

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

1. on the date the Group Dental Plan terminates;
2. on the date the Administrative Services Only Agreement between FCL and the City of Hollywood terminates;

3. on the date the Covered Employee's coverage terminates for any reason except the following:
 - a) a spouse and child(ren) who are Covered Dependents of a retired Covered Employee. Coverage for the Covered Dependents of a retired Covered Employee automatically terminates when the retired Covered Employee no longer meets the eligibility requirements or no longer chooses to be covered under the Benefit Booklet.
 - b) a surviving spouse (new Covered Employee) and Covered Dependent child(ren) of a deceased retired Covered Employee. Coverage for the spouse (who has become a new Covered Employee) and Covered Dependent child(ren) automatically terminates when the spouse (1) no longer meets the Eligibility Requirements for Covered Employees; (2) dies; or (3) no longer chooses to be covered under the Benefit Booklet. Coverage for a Covered Dependent child of a surviving spouse (new Covered Employee) will automatically terminate when that Covered Dependent child no longer meets the Eligibility Requirements for Dependent(s) or no longer chooses to be covered under the Benefit Booklet or the new Covered Employee's coverage terminates.
4. on the last day of the first month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Plan Participant);
5. on the date we specify that the Covered Dependent's coverage is terminated by us for cause; or
6. on the date specified by the Group that the Covered Dependent's coverage terminates.

In the event you as the Covered Plan Participant wish to delete a Covered Dependent from coverage, an Enrollment Form must be forwarded to FCL through the City of Hollywood, in accordance with the Open Enrollment Period provisions or a qualifying event.

In the event you as the Covered Plan Participant wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit an Enrollment Form to the City of Hollywood, prior to the requested termination date or within 30 days of the date the divorce is final, whichever is applicable.

Termination of an Individual's Coverage for Cause

In the event any of the following occurs, the City of Hollywood may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits; or
2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed, by or on your behalf.

SECTION VI

Domestic Partner Coverage With Continuation of Coverage Endorsement

This Endorsement is to be attached to and made a part of the current Benefit Booklet and any Endorsements attached thereto. The Benefit Booklet is amended as described below to provide coverage for a Domestic Partner of a Covered Employee (employee only).

Glossary of Terms

Domestic Partner means a person of the same or opposite sex with whom the Covered Employee (employee only) has established a Domestic Partnership.

Domestic Partnership means a relationship between a Covered Employee (employee only) and one other person of the same or opposite sex who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership; and
4. the Covered Employee has completed and submitted any required forms to the City of Hollywood and the City of Hollywood has determined that their eligibility requirements for Domestic Partnership coverage entitlement have been met.

Eligibility for Coverage

Domestic Partner Eligibility

The Covered Employee's (employee only) present Domestic Partner is eligible to apply for coverage under the Benefit Booklet.

Note: Dependent child(ren) of the Covered Employee's Domestic Partner are not eligible for coverage under the Benefit Booklet. Dependent child(ren) of the Covered Employee are eligible for coverage as set forth in the Benefit Booklet.

Domestic Partner Enrollment Forms/ Electing Coverage

When an Eligible Employee is making application for coverage for his/her Domestic Partner, the Eligible Employee must complete and submit through the City of Hollywood any required Enrollment Forms. When an Eligible Employee is electing coverage for his/her self and his/her Domestic Partner, and Employee/Spouse Coverage is available under the City of Hollywood's program, Employee/Spouse Coverage is redefined as Employee/Domestic Partner Coverage.

Representations on the Enrollment Forms and any Required Forms

We rely on the information provided by the City of Hollywood with respect to a specific Domestic Partnership and on the information individuals applying for coverage under the Benefit Booklet provide on any required Enrollment Forms to determine whether to issue this Endorsement; and to determine, along with the City of Hollywood, whether an individual is eligible for and entitled to coverage under the Benefit Booklet. All such information must be accurate, truthful, and complete, however, statements made on the Enrollment Forms and any required forms are representations and not warranties.

Any misrepresentation, omission, concealment of facts, or any incorrect statement, on any forms required for Domestic Partnership may result, in addition to any other legal right we may have, in denial of a claim, cancellation or rescission of an individual's coverage under the Benefit Booklet, if such misrepresentation, omission, concealment of facts, or incorrect statement is:

1. fraudulent;
2. material to our decision to issue this Endorsement;
- or
3. material to our decision to provide coverage under the Benefit Booklet for any individual.

Domestic Partner Enrollment Periods

An Eligible Employee may make application for an eligible Domestic Partner during the following enrollment periods and as outlined in the Benefit Booklet:

1. employee's Initial Enrollment Period;
2. Annual Open Enrollment Period;
3. Special Enrollment Period; or
4. within the 30-day period immediately following the satisfaction of the City of Hollywood's eligibility requirements of the Domestic Partnership.

Termination of a Domestic Partner's Coverage

In addition to the provisions stated in the Termination of a Covered Dependent's Coverage subsection of the Benefit Booklet, the Covered Domestic Partner's coverage under the Benefit Booklet will terminate at 12:01 a.m. on the date that the Domestic Partnership terminates or the date of death of the Covered Domestic Partner. The Covered Employee must notify the City of Hollywood within 30 days of when Domestic Partnership eligibility requirements are no longer met or within 30 days of the death of the Covered Domestic Partner.

Continuation of Coverage

Covered Domestic Partners may be entitled to an 18-month continuation of coverage. This continuation of coverage is offered through the City of Hollywood and provides for the continuation of the dental insurance coverage and/or benefits provided under the Benefit Booklet.

1. Covered Domestic Partners may elect continuation of coverage for a period not to exceed 18 months* in the case of:
 - a) termination of employment of the Covered Employee other than for gross misconduct;
 - b) reduced hours of employment of the Covered Employee;
 - c) the Covered Employee's entitlement to Medicare;
 - d) death of the Covered Employee;
 - e) dissolution of the Domestic Partnership; or
 - f) the employer files bankruptcy (subject to Bankruptcy Court Approval).

***Note:** Covered Domestic Partners are eligible for an 11 month extension of the 18 month continuation of coverage option above (to a total of 29 months) if they are disabled (as defined by the Social Security Administration (SSA)) at the time of the Covered Employee's termination, reduction in hours or within the first 60 days of continuation of coverage. Notice of the disability determination must be supplied to the City of Hollywood within 18 months of becoming eligible for continuation of coverage and no later than 60 days after the SSA's determination date.

If a Covered Domestic Partner is eligible to continue group dental insurance coverage under this Endorsement, the following conditions must be met in order for coverage to be continued hereunder:

1. The City of Hollywood must provide notice to the Covered Domestic Partner of their continuation of coverage rights within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare, the City of Hollywood must be notified by the Covered Employee, in writing, within 60 days of any of these events. The City of Hollywood's 14-day notice requirement runs from the date of receipt of such notice.
2. Continuation of coverage must be elected within 60 days of the later of:
 - a. the date that the coverage terminates; or
 - b. the date the notification of continuation of coverage rights is sent by the City of Hollywood.
3. Continuation of coverage will terminate if the Domestic Partner becomes covered under any other group dental insurance plan. However, coverage may continue if the new group dental insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect their coverage and/or benefits.
4. Continuation of coverage will terminate if the Covered Domestic Partner becomes entitled to Medicare.
5. If the Covered Domestic is totally disabled, eligible and elects to extend coverage, such extension of coverage may not continue more than 30 days after a determination by the Social Security Administration that they are no longer disabled. The City of Hollywood must be informed, by the Covered Employee, of the Social Security determination within 30 days of such determination.

6. All contribution requirements must be met, and all other eligibility requirements in the Benefit Booklet must also be met.
7. The City of Hollywood must continue to provide group dental coverage to its employees.

Note: The continuation of coverage provided under this Endorsement is neither required by, nor subject to, the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, or any State law.

Miscellaneous

The term Eligible Dependent is modified to also include the reference to Domestic Partner when spouse is referenced.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Florida Combined Life Insurance Company, Inc. as expressed herein.

SECTION VII

Extension of Benefits During a Leave of Absence

The following language was provided by and included in this Benefit Booklet at the request of the City of Hollywood. The terms used in these paragraphs may or may not be defined herein.

Extension of Coverage Provisions

After the termination of coverage date (as determined by the Termination of Coverage section), coverage may be continued in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Disabled Dependent Children

If an already covered Dependent child attains the age which would otherwise terminate his/her status as a Dependent and:

- if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan; and
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; and
- such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his/her having attained the specified age and he/she will continue to be considered a covered Dependent under the Plan so long as he/she remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extensions of Coverage During Absence From Work

If an Employee fails to continue in active employment but is not terminated from employment (i.e., he/she is absent due to an approved leave, a temporary layoff, etc.), he/she may be permitted to continue dental care coverages for himself/herself and his/her Dependents though he/she could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis and are as outlined in the Employer's personnel policies or other Employee communications. Such documents are incorporated by reference.

Except as noted, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- the date specified in the Employer's written personnel policies or Employee communications;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of this Plan.

Extensions of Coverage During FMLA Absence

Any provisions of the Plan that provide for: (a) continuation of coverage during a leave of absence, and (b) reinstatement of coverage following a return to active service are modified by the provisions of the federal Family and Medical Leave Act of 1993, where applicable.

Continuation of Dental Coverage During Leave - An Employee's dental coverage will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- he is an eligible Employee under the terms of that Act.

The cost of dental coverage during such leave must be paid, whether entirely by the Employer or in part by the Employee and the Employer.

Reinstatement of Canceled Coverage Following Leave - Upon an Employee's return to active service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA), any terminated Plan coverage will be reinstated as of the date of the individual's return to work.

The Employee will not be required to satisfy any eligibility or benefit waiting period or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Continuation of Cafeteria Plan / Flexible Spending Account During Leave - Employees have the option of either continuing their Cafeteria Plan election, or terminating their election during FMLA absence. If continued, the employee is required to prepay or continue to pay premiums. If terminated, the Employee may reinstate their election upon return from leave.

Extension of Coverage During Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Dependent entering military service. These rights include up to 18 months of extended dental care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

Extension of Coverage for Retirees

Coverage is extended for retirees as allowed by Florida law or as contained in a collective bargaining agreement.

Extension of Coverage for a Surviving Spouse

If an employee dies, his or her spouse will have the right to continue medical and dental coverages.

SECTION VIII

YOUR OBLIGATIONS

Individual Deductible Limit

The individual deductible per person, per plan year, which is shown on the Schedule of Benefits, must be met by the covered person before benefits are payable for covered dental services.

Plan Percentage Payable

After the covered person satisfies the deductible, allowable expenses for covered dental services will be paid at the percentage shown on the Schedule of Benefits.

Predetermination of Benefits

If treatment can reasonably be expected to involve allowable expenses of more than \$500, a description of the procedures to be performed and an estimate of the dentist's charges (treatment plan) may be filed with the Claims Administrator for a predetermination of benefits prior to the start of treatment.

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

Requests for a predetermination of benefits should be submitted within thirty (30) days of the date of the initial diagnosis or exam. The covered person should submit, for review by the Claims Administrator, x-rays, a complete treatment plan, and in some cases, more substantiating material such as a study model. All predetermination of benefits will be subject to the plan year maximum.

SECTION IX

PROVIDER ALTERNATIVES

The insured has the choice of two provider alternatives which will affect how coverage is provided for dental benefits. The following describes the arrangement used to make payment under the contract.

Participating Dentist

These are dentists who have a signed agreement currently in effect with FCL to participate in our dental plan. Participating dentists have agreed to accept the lesser of the actual charge or the FCL allowance as payment in full for covered services. The insured is not responsible for charges in excess of the allowance. The insured is responsible for the deductible, coinsurance, and the payment of charges for non-covered services and charges in excess of any maximum benefit limitations. The participating dentist will file the claim on the insured's behalf and payment will be made directly to the participating dentist. A list of participating dentists will be made available to you. This list is subject to change without prior notice to, or approval of, the contractholder or certificateholder.

Non-Participating Dentist

These are dentists who do NOT have a signed agreement currently in effect with FCL to participate in our dental plan. Non-participating dentists have not agreed to accept the FCL allowance as payment in full. The insured is responsible for the difference between the FCL allowance and the non-participating dentist charge, if any, the non-participating deductible and coinsurance shown on the Schedule of Benefits, and the payment of charges for non-covered services and charges in excess of any maximum benefit limitations.

Selection of a Dentist

FCL does not have the right to select a dentist for the insured. The insured must select his or her own dentist and nothing in this plan will interfere with the relationship between the insured and any such dentist selected. In any event, FCL shall not be liable for any action on the part of any dentists, or an agent or employee of the dentist.

SECTION X

BENEFITS

The maximum benefit payable per plan year, per person is shown on the Schedule of Benefits. Payment for covered services provided by non-participating dentists will not exceed, usual, reasonable and customary charges. The following describes covered dental benefits. See the "Limitations and Exclusions" section for other limits on services.

Preventive

1. Two (2) routine oral examinations per plan year;
2. Prophylaxis (cleaning, scaling and polishing of teeth), two (2) times per plan year;
3. Topical application of fluoride in conjunction with prophylaxis for covered dependent children under fourteen (14) years of age, two (2) times per plan year;
4. Periapical (root area) x-rays as required;
5. Complete mouth x-rays or panoramic x-rays (once in any thirty-six [36] consecutive month period.) Panoramic x-ray will be considered a complete mouth x-ray and subject to the same limit;
6. Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;
7. Bitewing x-rays, once per plan year; and
8. Periodontal maintenance procedures (following active therapy).

Basic

1. Palliative (emergency) treatment of an acute condition requiring immediate care;
2. Application of desensitizing medicaments;
3. Sealants for covered dependent children through age sixteen (16);
4. Repair of broken partial or complete dentures;
5. Space maintainers (not made of precious metals) that replace prematurely lost teeth for covered dependent children under fourteen (14) years of age. No payment will be made for duplicate space maintainers;

Basic (continued)

6. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
7. Routine extractions;
8. Endodontics, including pulpotomy (removal of the soft tissue in a decayed tooth), and root canal treatment. No payment will be made for root canal therapy until treatment is completed. Treatment is considered to be completed on the date the canals are sealed;
9. General anesthesia given in a dentist's office, for services that are: (a) performed by a person qualified to administer general anesthesia; (b) billed by such dentist; and (c) in connection with covered dental services. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation. The allowance for the administration of a local infiltration or block anesthetic in connection with other covered dental services is included in the allowance for those covered dental services;
10. Tissue conditioning treatments for the upper and lower dentures, two (2) times per plan year;
11. Adjustments to the maxillary and mandibular dentures, two (2) times per plan year (six [6] months after the initial insertion of the denture);
12. Recementation of space maintainers once per plan year (must be six [6] months after the initial placement date);
13. Replacement of core build up, if satisfactory proof is provided that at least five (5) years have passed since the date of service when the procedure was performed;
14. Relining and rebasing of immediate dentures if more than six (6) months after the insertion of an initial or replacement denture (not more than one relining or rebasing in any thirty-six [36] consecutive month period);
15. Repair of broken crowns, inlays, onlays or bridges;
16. Surgical removal of teeth;
17. Apicoectomy (dental root surgery);

Basic (continued)

18. Gingivectomy and gingivoplasty;
19. Periodontal scaling, payable once per quadrant every twenty-four (24) months;
20. Root amputation - per root;
21. Hemisection - (including any root removal), not including root canal therapy;
22. Alveoloplasty - per quadrant;
23. Gingival flap procedure - once per quadrant every thirty-six (36) months;
24. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis - payable once every thirty-six (36) months;
25. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every thirty-six (36) months;
26. Free soft tissue graft procedure, including donor site;
27. Frenulectomy;
28. Bone replacement graft - once per site every thirty-six (36) months;
29. Pedicle soft tissue graft - once per site every thirty-six (36) months;
30. Guided tissue regeneration - once per site every thirty-six (36) months;
31. Subepithelial connective tissue graft - once per site every thirty-six (36) months; and
32. Clinical crown lengthening-hard tissue only, subject to dental consultant review for coverage approval and pricing; office notes are required for review.

Major

1. Replacement of cast post and core along with prefabricated post and core procedures, if satisfactory proof is given that at least five (5) years has passed since the date of service when the procedure was performed;
2. Initial insertion of crowns, bridges (including pontics and abutment crowns, inlays and onlays);
3. Initial insertion of partial or complete dentures (including any adjustments during the six [6] month period following insertion); and

Major (continued)

4. Replacement of an existing crown, partial or complete denture or bridge by a new crown, new denture or by a new bridge, if satisfactory proof is given that:
 - (a) the existing crown, denture or bridge was inserted at least five (5) years before it is replaced; and
 - (b) the existing crown, denture or bridge is not serviceable and cannot be made serviceable. If the existing crown, denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable.

SECTION XI

LIMITATIONS AND EXCLUSIONS

Limitations

1. Any retreatments of root canals are payable one (1) year after completion date of root canal therapy.
2. Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
3. The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
4. Sealants are limited to the first and second molars for primary teeth and the bicuspid and molars for the permanent teeth of covered dependent children.
5. General anesthesia and intravenous sedation are payable only if given in connection with covered surgical procedures.
6. Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered as the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.
7. Periodontal services are limited to covered persons age eighteen (18) and older.
8. Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.

Exclusions

The following are excluded under this benefit booklet:

1. Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to a covered person's effective date of coverage, (until the covered person has been covered under the Plan for twelve [12] consecutive months), unless otherwise specified in this benefit booklet.
2. Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
3. Charges for services or supplies when billed by other than a dentist.
4. Benefits for services rendered by a member of your family, (your spouse and the child[ren], brothers, sisters and parents of either you or your spouse).
5. Services rendered primarily for cosmetic purposes.
6. Charges incurred for failure to keep a dental appointment.
7. Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
8. Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone - lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
9. Experimental or investigational treatment.
10. Dental services received or rendered:
 - (a) through or in a veteran's hospital or government facility due to a service connected disability;
 - (b) which are covered and paid under Worker's Compensation or similar law; or
 - (c) which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the total reasonable expenses that are actually incurred.
11. Services for which the covered person incurs no charge.

Exclusions (continued)

12. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
13. Local anesthesia when billed separately by a dentist.
14. Any services paid or payable under the covered person's health or medical insurance plan, policy, or contract.
15. Services not listed in the Benefits section of this benefit booklet.
16. Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this benefit booklet will be based on the allowance for the least costly service, procedure, or course of treatment.
17. Any additional treatment required due to the covered person's failure to follow instructions, or lack of cooperation with the dentist.
18. Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
19. Services rendered before the effective date of coverage.
20. Services rendered after termination of the Plan, except as provided under "Extension of Benefits upon Plan Termination."
21. Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
22. Any denture or bridge replacement made necessary by reason of loss, or alteration by a covered person, or a result of theft.

Exclusions (continued)

23. Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the covered person's coverage under this benefit booklet.
24. General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
25. Charges for nitrous oxide.
26. Charges for labial veneers.
27. Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or lower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), if paid or payable under a covered person's dental or medical insurance plan, policy, or contract.
28. Prescribed drugs, premedication or analgesia.
29. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues).
30. Charges for oral hygiene, plaque control, or diet instruction.
31. Duplicate or temporary dentures, crowns or bridges.

SECTION XII

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") is a limitation of benefits for dental benefits under this Plan and is designed to avoid the duplication of payment for covered dental services. Coordination of Benefits applies when a covered person is covered under other dental plans, programs, or policies providing dental benefits which contain a COB provision or are required by law to contain a COB provision. Such other dental plans, programs, or policies may include, but are not limited to:

1. any group or individual dental insurance, group type self-insurance dental, dental maintenance organization dental plan, or other dental plan, program, or policy; or
2. any group or individual dental plan, program, or policy underwritten or administered by the Claims Administrator.

Payment under the Plan for covered dental services depends on whether the Plan is primary, as determined in accordance with the provisions set forth below. If the Plan is primary, payment for dental benefits, if any, will not be reduced due to the existence of other coverage and will be made without regard to the covered person's other dental plans, programs, or policies.

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

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

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

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

However, if the person is also a Medicare beneficiary, and as a result of the rule established under the Social Security Act of 1965, as amended, Medicare is secondary to the dental plan covering the person as a dependent of an active covered employee, the order in which dental benefits are payable will be determined as follows:

- a. first, dental benefits of a plan that covers a person as an employee, member, or subscriber;
 - b. second, dental benefits of a plan of an active employee that covers a person as a dependent;
 - c. third, Medicare Benefits.
2. Except as stated in paragraph 3, when two or more dental policies, plans, or programs cover the same child as a dependent of different parents:
 - a. the dental benefits of the dental policy, plan, or program of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the dental policy, plan, or program of the parent whose birthday, excluding year of birth, falls later in the year; but
 - b. if both parents have the same birthday, the dental benefits of the dental policy, plan, or program which has covered the parent for the longest are determined before those of the dental policy, plan, or program which has covered the parent for the shorter period of time.

However, if one of the plans does not have a provision which is based on the birthday of the parent, but instead on the gender, and this results in each dental policy, plan, or program determining its benefits before the other, the dental policy, plan, or program which does not have a provision which is based on a birthday will determine the order of dental benefits.

3. If two or more dental policies, plans, or programs cover a dependent child of divorced or separated parents, dental benefits for the child are determined in this order:
 - a. first, the dental policy, plan, or program of the parent with custody of the child;
 - b. second, the dental policy, plan, or program of the spouse of the parent with custody of the child; and
 - c. third, the dental policy, plan, or program of the parent not having custody of the child.

However, if the specific terms of a court decree makes one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the dental benefits of the dental policy, plan, or program of that parent has actual knowledge of those terms, the dental benefits of that dental policy, plan, or program are determined first. This does not apply with respect to any claim determination period or dental plan, policy, or program year during which any dental benefits are actually paid or provided before that entity has the actual knowledge.

4. The dental benefits of a dental policy, plan, or program which covers a person as an employee other than as a laid-off or retired employee, or as a dependent of such a person, are determined before those of a dental policy, plan, or program which covers that person as a laid off or retired employee or as a dependent of such a person. If the other dental policy, plan, or program is not subject to this rule, and if, as a result, the dental policies, plans, or programs do not agree on the order of dental benefits, this paragraph shall not apply.
5. If none of the above rules determine the order of dental benefits, the dental benefits of the policy, plan, or program which has covered the employee, member, the longest period of time are determined before those of the other dental policy, plan, or program.

If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group dental plan, the following order of benefits applies:

- a. first, the dental plan which covers the person as an employee, or as the employee's dependent;
- b. second, the coverage purchased under the dental plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

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

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

- (1) indemnity;
- (2) excess insurance;
- (3) specified illness or accident; or
- (4) Medicare supplement.

SECTION XIII

SUBROGATION

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

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

Right of Reimbursement

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

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

SECTION XIV

COBRA CONTINUATION OF COVERAGE

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

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

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

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

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

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

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

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

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

1. The plan sponsor must notify the covered persons of their continuation of coverage rights under COBRA within fourteen (14) days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a covered dependent child to meet eligibility requirements, you or your covered dependent must notify the plan sponsor, in writing, within sixty (60) days of any of these events. The plan sponsor's fourteen (14) day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue coverage under the Plan within sixty (60) days of the later of:
 - a. the date that the coverage terminates; or
 - b. the date the notification of continuation of coverage rights is sent by the plan sponsor.
3. COBRA coverage will terminate if you or your covered dependents become covered under any other group dental plan or policy. However, COBRA coverage may continue if the new policy or plan coverage contains exclusions or limitations due to a pre-existing condition that would affect the continuant's coverage.
4. COBRA coverage will terminate upon entitlement to Medicare coverage.

5. If a covered person is totally disabled and eligible and elects to extend continuation of coverage, the covered person may not continue such extension coverage more than thirty (30) days after a determination by the Social Security Administration that the covered person is no longer disabled. The covered person must inform the plan sponsor of the Social Security determination within thirty (30) days of such determination.

Note: For purposes of this section, you will be considered “totally disabled” only if you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a physician. A covered dependent is totally disabled only if he or she is unable to perform those normal day-to-day activities which he or she would otherwise perform and he or she requires regular care and attendance by a physician.

6. In order for continuation of coverage to apply, all contribution or requirements must be met, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in this benefit booklet.
7. The plan sponsor continues to provide group dental coverage to its employees.

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Plan shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the plan sponsor.

