CompBenefits Company
Agreement And Certificate of Benefits

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

President

I. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Contributions and Copayments

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

III. Benefits

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

IV. Duration of Agreement

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

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

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

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

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

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

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

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

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

B. Subscriber may cancel this Certificate:

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

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

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

V. Continuation of Coverage

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

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

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

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

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

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

VI. Coverage for Newborn Children and Adding Additional Dependents

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

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

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

VII. Conversion Provisions for Group Plans

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

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

1. Failure to pay any required premium or Contribution.

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

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

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

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

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

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

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

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

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

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

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

VIII. General Provisions

A. Appointments

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

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

B. Emergency Care

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

1. Out-of-Area Emergency Care:

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

2. In-Service-Area Emergency Care:

When Member is within one hundred (100) miles of any Company Dental Facility, during Company's normal business hours the Member should first contact his/her Participating General Dentist and request an emergency appointment. If his/her dentist is unable to render Emergency Care, Member should contact Company Member Services Department at (800) 342-5209 and request assistance in obtaining Emergency Care from another Company Dental Facility at that Facility's usual fees less a 25 % reduction.

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

C. Change in Contributions or Benefits

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

D. Renewal

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

E. Grace Period

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

F. Reinstatement

The following guidelines shall apply to requests for reinstatement:

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

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

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

G. Dental Records

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

H. Limitations and Exclusions

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

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

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

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

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

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

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

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

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

   g) Treatment for cysts, neoplasms and malignancies.

   h) General anesthesia.

I. Incontestability

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

J. Conformity with Florida Law

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

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

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

K. Notices

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

American Dental Plan, Inc., P. O. Box 769729, Roswell, GA 30076, Tel. (800) 342-5209

L. Notice of Independent Contractor Relationship

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

M. Open Enrollment for Group Plans

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

N. Coordination of Benefits

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

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

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

PLANS THAT DO NOT COORDINATE

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

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

HOW COMPANY PAYS AS PRIMARY PLAN

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

HOW COMPANY PAYS AS SECONDARY PLAN

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

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

WHICH PLAN IS PRIMARY?

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

1. Non-coordinating Plan

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

2. Employee

The plan which covers you as an employee (neither laid off nor retired) is always primary.

3. Children (Parents Divorced or Separated)

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

4. Children & the Birthday Rule

When your children's dental care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and

your spouse's birthday is in March, your plan will be primary for all of your children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. Other Situations

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

IX. Review and Mediation of Complaints

A. Informational Grievances

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

B. Submission of Formal Grievances

Any Member who has a grievance against Company for any matter arising out of a Subscriber Certificate or for covered Dental Care Services rendered thereunder may submit a formal written statement of the grievance to Company. Such written statement shall be specifically identified as a grievance, shall be submitted to Company within one (1) year from occurrence of the events upon which the grievance is based, and shall contain a statement of the action requested, the Member's name, address, telephone number, Member number, signature and the date. The statement should be sent to the Company's Grievance Coordinator at 5775 Blue Lagoon Drive, Suite 400 Miami, FL 33126. More information on and assistance with Company's grievance procedures may be obtained by calling Company's Member Services Department number (800) 342-5209.

C. Response to Formal Grievances

The Grievance Coordinator will investigate the grievance, gather all of the relevant facts review the case with the appropriate parties and respond in writing to the Member and the Participating General Dentist or Participating Specialist, if appropriate, within ten (10) days of completion of the review. If the grievance involves a dental related matter or claim, the Company's Dental Director shall be involved in the resolution. If it involves denial of benefits or services, the written decision shall state the specific provisions of this Certificate upon which the denial is based. All grievances shall be processed within sixty (60) days, however, if the grievance involves collection of information from outside the Plan's service area, an additional thirty (30) days will be allowed for processing.

D. Appeal of Decision

If the Member is dissatisfied with the formal grievance decision the Member may request reconsideration by the Grievance Panel and may request a personal appearance before the Grievance Panel. Such requests for reconsideration must be made within sixty (60) days after receipt of the written decision. In addition, a Member always has the right to grieve directly to the State of Florida Department of Financial Services, Office of Insurance Regulation, anytime.

E. Contact Information

CompBenefits Company
5775 Blue Lagoon Drive, Suite 400
Miami, FL 33126
Att: Member Services Department
or call, toll free at (800) 342-5209

Florida Department of Financial Services
Office of Insurance Regulation
Consumer Assistance
200 East Gaines Street
Tallahassee, FL 32399-032
or call toll free Consumer Hotline at (800) 342-2762

X. Entire Agreement

This Certificate constitutes the entire agreement between the parties.

XI. Agreement Language

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