ARGUS DENTAL & VISION, INC.
MASTERPLAN DENTAL INSURANCE
INDIVIDUAL CERTIFICATE OF COVERAGE

1. ARGUS DENTAL & VISION, INC., a dental service corporation, licensed and operating in accordance with the laws of the State of Florida, has made available a dental service plan, (hereinafter referred to as "Plan" or "ADVI"), for all individuals seeking dental care.
2. The address of the corporate office of the Plan is ARGUS DENTAL & VISION, INC., 4919 W. Laurel St., Tampa, FL 33607, and the telephone number is (877) 864-0625.
3. The Certificate of Coverage (Certificate), along with Plan's Enrollment Application and Member Guide, constitutes the entire Agreement between the parties and shall not be construed as creating any third party beneficiaries hereof.

PART I: DEFINITIONS

A. "Subscriber" means a person who meets all applicable eligibility requirements of Part II of this Certificate, and enrolls in Plan hereunder, and for whom the necessary premium has been received by the Plan.
B. "Dependent(s)" when used in this Certificate means the spouse of the Subscriber and/or unmarried children from birth to age of 19. An unmarried child who is over 19 years old but less than 26 years old, who is attending school as a part-time or full-time student and who is dependent on the Subscriber for primary support is eligible to be covered. Upon reaching the limiting age, the child is eligible for extended coverage as a dependent if the child continues to be both (1) incapable of sustaining employment by reason of mental retardation or physical handicap, and (2) chiefly dependent upon the Subscriber for support and maintenance. Children include natural children, newborn children, stepchildren, adopted and adopted newborn children.
C. "Premium" means the periodic payment that must be paid by Subscriber enrolled hereunder, and when received by Plan, Subscriber shall be entitled to receive dental service in accordance with the terms and conditions of this Certificate.
D. "Co-Payments" means the amount to be paid by Subscriber directly to a Participating Dental Provider or Participating Specialist in connection with the services set forth in Plan's Fee Schedule.
E. "Fee Schedule" is the Schedule of Subscriber benefits, which are applicable to Subscriber and are attached hereto and made a part hereof by reference.
F. "Eligibility I.D. Card" is an identification card identifying the Subscriber entitled to the benefits of Plan.
G. "Coverage" means coverage under this Certificate pertaining to a Subscriber or Dependent.
H. "Participating Dental Providers" are those licensed dentists who have agreed to provide dental services under the terms and conditions of the Plan's Fee Schedule.
I. "Participating Specialists" are those licensed dentists who are qualified specialists and who have agreed to provide specialized dental services under the terms and conditions of the Plan's Fee Schedule.
J. "Non-Participating General Dentists" and "Non-Participating Specialists" are dentists who do not provide dental services to Subscribers of this Plan.
K. "Emergency Service" is the sudden and unexpected onset of an acute condition involving severe pain, requiring immediate dental care for temporary relief of pain and suffering.
L. "Member(s)" means an eligible Subscriber or Dependent(s) enrolled in the Plan.

PART II: ELIGIBILITY

1. Persons who have applied as Subscribers, have paid the premium, and have been accepted by the Plan prior to the fifteenth (15th) day of the month are eligible for benefits beginning on the 1st day of the next month.
2. Persons who have applied as Subscribers, have paid the premium, and have been accepted by the Plan between the sixteenth (16th) day of the month and the last day of the month are eligible for benefits beginning the 1st day of the second month.

PART III: ENROLLMENT OF NEWLY ELIGIBLE DEPENDENTS

To enroll a newly eligible Dependent under a Subscriber's individual Plan, a Subscriber must notify the Plan in writing and provide documentation of the new relationship, as indicated below:

A. Marriage: The Subscriber must submit notice and documentation to the Plan within thirty (30) days after the date of marriage.
B. Newborn: The Subscriber must submit notice and documentation to the Plan within thirty (30) days after the date of birth.

C. Adopted Child: The Subscriber must submit notice and documentation to the Plan within thirty (30) days after:
   1. The date of filing a petition to adopt, if the child has been living in the Subscriber's residence as a foster child for whom the Subscriber has received foster care payments; or
   2. The birth of a newborn child, if there is a written agreement in place to adopt the child; or
   3. In all other cases, the date of the child's placement in the Subscriber's residence by a licensed placement agency (for the purpose of adoption).

The newly eligible Dependent(s) enrollment will be processed by the Plan after receipt of the notice and documentation from the Subscriber. A newborn child will be covered from the moment of birth. An adopted child will be covered from the moment of placement in the residence of the Subscriber. For a newborn adopted child, coverage will begin from the moment of birth if a written agreement to adopt such child has been entered into by the Subscriber prior to the birth of the child whether or not such agreement is enforceable. However, coverage for such child is not required if the child is not ultimately adopted by the Subscriber in compliance with chapter 63, Section 636.016(11), F.S. All other Dependents who become eligible after the effective date of the Subscriber shall be covered on or before the thirtieth (30^{th}) day following processing of the notice by the Plan.

PART IV: PERIOD OF COVERAGE

The effective date and termination of coverage is set forth on the Subscriber's Eligibility I.D. Card, which shall be effective for a period of 12 months, unless the contract holder requests, in writing, a shorter contract period.

PART V: PREMIUM AND ELIGIBILITY I.D. CARD

A. Subscriber's Premium for the Plan must be received annually by the Plan no later than the close of business on the fifteenth (15^{th}) day of the month preceding the month of eligibility for benefits. Annual payments must be received at 4919 W. Laurel St., Tampa, FL 33607. If Subscriber wishes to pay Premium on a monthly basis, Subscriber agrees to allow an automatic monthly bank withdrawal draft from Subscriber's bank account.
B. If any payment to a Participating Dental Provider or Participating Specialist is delinquent, the Subscriber and/or Dependent(s) will not be entitled to receive any further benefits or treatment from any other Participating Dental Provider or Participating Specialist under the benefits provided under this Certificate, until such payments are made current while the Certificate is still in force.
C. It is specifically understood that membership fee(s), payments and other terms and conditions of the Plan with or for the benefit of Plan's Members may be changed. Plan agrees to notify Subscriber, in writing, of the nature and extent of such changes forty-five (45) days prior to the effective date of such changes.
D. GRACE PERIOD: This Certificate has a ten (10) 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, this Certificate will stay in force.

PART VI: COVERED BENEFITS

A. Services under Plan will be provided in accordance with the Plan's Fee Schedule (attached hereto and incorporated by reference), through arrangements with the Subscriber's selected Participating Dental Provider or Participating Specialist. Any procedures performed by the Participating Dental Provider or Participating Specialist that are not listed on the Plan's Fee Schedule will be rendered at the Provider's usual and customary fee minus a twenty-five percent (25%) discount. Services which, in the opinion of the Participating Dental Provider or Participating Specialist, require a Non-Participating Specialist are not subject to Plan's Fee Schedule, and fees charged by such Non-Participating Specialist will be payable by Subscriber.
B. All procedures listed may not be available by the Subscriber's selected Participating Dental Provider or Participating Specialist. In such cases, Subscriber is encouraged to discuss availability of the scheduled services with his/her Participating Dental Provider or Participating Specialist or consult with other Participating Dental Providers or Participating Specialists about the availability of specific services. The fees charged and paid by Subscriber to a Participating Dental Provider or a Participating Specialist may not exceed the charges listed in Plan's Fee Schedule. Subscriber should consult with the Participating Dental Provider or Participating Specialist to receive an estimate of treatment cost.
C. All reasonable efforts will be made to establish a satisfactory network of Participating Dental Providers and Participating Specialists within the immediate geographic area of Subscriber, however, this is not guaranteed by Plan.
D. Emergency Service will be provided for Subscriber by Subscriber's Participating Dental Provider or Participating Specialist in accordance with the terms and conditions of this Certificate and ADVI's Fee Schedule. Emergency Service rendered by a Non-Participating Dental Provider or Non-Participating Specialist is not covered under this Certificate, and the cost for same will be payable by Subscriber.
E. PRE-EXISTING CONDITIONS: Plan covers all pre-existing conditions.
F. EXTENSION OF BENEFITS: Termination of this Certificate by Plan is without prejudice to any continuous loss, which commenced while this Certificate was in force. Extension of benefits beyond the period this Certificate was in force, will be afforded to Subscriber until Subscriber's specific treatment or procedure undertaken upon has been completed or for ninety (90) days, whichever is the lesser period of time.

PART VII: DELIVERY OF BENEFITS

Once Subscriber receives his/her Eligibility I.D. Card from Plan, Subscriber may make an appointment with Subscriber's Participating Dental Provider or Participating Specialist selected from Subscriber's Participating Dental Provider Directory. When making the appointment, the chosen Participating Dental Provider or Participating Specialist must be informed that the person making the appointment is a Subscriber of Plan, the Subscriber's effective date of coverage, and the Subscriber's Eligibility I.D. Card number. Subscriber must provide at any and all dental appointments Subscriber's Eligibility I.D. Card and picture identification.

If further information is needed regarding Subscriber's delivery of services and benefits under this Certificate, such information can be obtained by calling Plan at the telephone number contained herein.

PART VIII: RENEWAL, REINSTATEMENT, OR MODIFICATION

A. If Subscriber continues to pay the Premium, this Certificate will be automatically renewed annually and Subscriber is guaranteed by Plan to remain eligible for as long as this Certificate is in force and payment is made, subject to all applicable provisions of this Certificate.
B. Eligible Dependents, including newborn or the adopted children of the Subscriber, may be enrolled with Plan and added to this Certificate upon application. When a Dependent becomes an eligible Subscriber, upon application he/she may change status and continue his/her benefits as an individual Subscriber.

PART IX: TERMINATION AND CANCELLATION

All contracts shall be for a minimum of 12 months, unless the contract holder requests, in writing, a shorter contract period.

A. Subscriber's Coverage will cease and terminate upon the occurrence of any of the following events:
   1. The end of the period for which required Premiums are due but not paid by Subscriber;
   2. The date that a Dependent no longer satisfies the definition of Dependent contained herein;
   3. Subscriber leaves the geographical service area of Plan with the intent to relocate or establish a new residence on a permanent basis outside of Plan's geographical area.
B. In addition, if after forty-five (45) days written notice of cancellation, coverage will terminate:
   1. After reasonable efforts have been made by all parties to establish a working dentist/patient relationship and have been unsuccessful;
   2. Because of fraud, material misrepresentation, misuse of dental services, facilities or membership privileges;
   3. Because of misuse of documents provided as evidence of coverage available to Subscriber through Plan;
   4. Upon Subscriber furnishing to Plan incorrect or incomplete information for the purpose of fraudulently obtaining services.

Prior to termination or cancellation, the Plan will make all efforts to resolve the problem through the grievance procedure and must determine that the Subscriber's behavior is not due to use of the services provided or mental illness.

PART X: EXCLUSIONS AND LIMITATIONS OF BENEFITS

A. The Participating Dental Provider or Participating Specialist shall have the right to refuse treatment to a Subscriber who fails to follow a prescribed course of treatment. Some Participating Dental Providers or Participating Specialists may limit their practice to exclude some dental procedures or treatments. However, no Subscriber of Plan will be excluded from receiving benefits covered by this Plan based on race, color, creed, handicap, marital status, sex or national origin of the Subscriber or Member.
B. Services for the following are excluded from the benefits of Plan's Fee Schedule:
   1. Services which, in the opinion of the Participating General Dentist or Participating Specialist, are not necessary for the Subscriber's dental health.
   2. Cosmetic or experimental dental services, and/or procedures not generally performed in a General Dentist office.
   3. Cost of hospitalization and/or pharmaceuticals.
   4. Any services performed by a Non-Participating General Dentist or Non-Participating Specialist.
   5. Services that cannot be performed because of the general health of the Subscriber.
   6. Treatment which, in the opinion of the Participating General Dentist, must be performed by a Non-Participating Specialist.
   7. Services which are not consistent with the usual and customary services provided by the Participating General Dentist or Participating Specialist.
   8. Any dental treatment started prior to the Subscriber's effective date.
   9. Services for injuries and/or conditions which are paid or payable under Worker's Compensation or Employer Liability Laws.
   10. Treatment for cysts, neoplasms and malignancies .
   11. Services provided without cost to the Subscriber by the government or an agency thereof, or any municipality, county and other subdivisions.
   12. The cost of precious metal used in any form of dental benefits.
   13. Any procedure not specifically listed as a covered benefit in the Plan's Fee Schedule.
   14. Cost of dental care covered under any automobile, medical or no-fault or similar type insurance.
   15. Fixed bridge work is not covered.
   16. Sealants applied to baby teeth are not covered.

PART XI: RIGHT TO TRANSFER

A. Plan reserves the right to transfer Subscriber(s) to another Participating Dental Provider or Participating Specialist for any one of the following reasons:
   1. If the Subscriber's chosen Participating Dental Provider or Participating Specialist is no longer under contract with Plan to provide benefits;
   2. If the Subscriber's chosen Participating Dental Provider or Participating Specialist is determined by Plan to be unable to effectively render benefits to the Subscriber;
   3. Where reasonable efforts to establish a satisfactory dentist/patient relationship between the Subscriber and the Subscriber's chosen Participating Dental Provider or Participating Specialist has failed.

B. The Subscriber has the right to change his/her Participating Dental Provider or Participating Specialist at any time if Subscriber does not owe any fees or payments due to the Subscriber's current Participating Dental Provider or Participating Specialist. Plan benefits will be suspended until all payments due to the Subscriber's current Participating Dental Provider or Participating Specialist are paid in full. All dental records of Subscriber concerning services performed shall remain the property of the Participating Dental Provider or Participating Specialist.

PART XII: ASSIGNMENT

Subscriber may not assign this Certificate or his/her rights hereunder, nor delegate Subscriber's duties hereunder.

PART XIII: CONFORMITY WITH STATE LAWS

A. This Certificate will be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with the laws of the State of Florida. Any action or claim, including arbitration, will be brought forth within Hillsborough County, Florida.

B. Any statute, act, ordinance, rule or regulation of any governmental authority with jurisdiction over the Plan will have the effect of amending this Certificate to conform to the minimum requirements of these regulations.

C. The invalidity or unenforceability of any section or subsection of this Certificate, shall not affect the validity or enforceability of the remaining sections or subsections hereof.

PART XIV: ATTORNEYS' FEES

If either party brings an action to enforce the terms of this Certificate, the prevailing party shall be entitled to recover from the non-prevailing party all costs and expenses of such action, including but not limited to, reasonable attorneys' fees, whether in settlement, at trial, or on appeal.

PART XV: COMPLAINTS AND GRIEVANCES

Informal Grievances: Any Member who has a grievance against ADVI for any matter arising from a Subscriber Certificate or for covered services rendered hereunder may submit an informal oral grievance to ADVI. Assistance with ADVI's grievance procedures, including assistance with informal oral grievances, may be obtained by calling ADVI's Member Services Department at (877) 864-0625. Oral grievances shall be submitted to ADVI's Grievance & Appeals Department. Informal oral grievances shall be responded to as soon as possible by the Grievance Coordinator. If the informal oral grievance involves a medical-related matter or claim, a dentist shall be involved in resolving said grievance. The Member has the right to file a formal written grievance with ADVI and to appeal to the State of Florida Department of Financial Services.

Submission of Formal Grievances: Any Member who has a grievance against ADVI for any matter arising out of the Certificate or covered services rendered hereunder may submit a formal written statement of the grievance to ADVI. Such written statement shall be specifically identified as a grievance and shall be submitted to ADVI within sixty (60) days from the date of the occurrence. The written grievance shall contain a statement of action requested by the Member; the Member's name, address, telephone number, member number; the name of the Subscriber's Participating General Dentist or Participating Specialist; and the Subscriber's signature and the date. The statement should be sent to ADVI's Grievance Coordinator at ADVI's address as set forth herein. More information on ADVI's grievance procedures may be obtained by calling ADVI's Member Services Department at ADVI's telephone number set forth above.

Response to Formal Grievances: ADVI will confirm receipt of the Member's grievance, in writing, within five (5) business days. ADVI will resolve the grievance and communicate the resolution, in writing, within thirty (30) days. The timeframe may be extended up to thirty (30) days if the Member asks for an extension or the Plan documents that additional information is needed and the delay is in the Member's interest. A grievance is not considered formal until the Plan receives a written summary from the Member.

Expedited Grievances: ADVI will confirm receipt of the Member's expedited grievance, orally, within twenty-four (24) hours. ADVI will resolve the expedited grievance within seventy-two (72) hours and will communicate the resolution orally and in writing to the Member.

Appeal of Decision: If the action taken by the Plan is not satisfactory to the Member, the Member may appeal the matter to the Plan within thirty (30) days after receiving notice of the resolution. The Member's request for an appeal must be submitted to the Plan, in writing, and should be directed to Argus Dental & Vision, Inc., Grievance Department, 4919 W. Laurel St., Tampa, FL 33607. The Plan will resolve all appeals and communicate the resolution, in writing, within thirty (30) days. If the Member is dissatisfied with the appeal decision, the Member has the right to appeal to the State of Florida Department of Financial Services.

PART XVI: SUBSCRIBER PREMIUM

	MONTHLY*	ANNUAL
Individual	$8.95	$107.40
Individual +1	$14.35	$172.20
Family	$21.55	$258.60

*For monthly premiums, your account will be debited or charged the monthly premium stated plus a $1 monthly service charge.

ARGUS DENTAL & VISION, INC.

Jeremy Earp
National Practice Leader

Date