Managed DentalGuard Group Benefit Plan

Prepared For:

THE TRUSTEES OF THE AFFILIATED PHYSICIANS &
EMPLOYERS MASTER TRUST
CLASS 0001
DENTAL - DHMO PLAN

Managed DentalGuard, Inc.
a wholly owned subsidiary of Guardian

CERTIFICATE OF COVERAGE

MANAGED DENTALGUARD, INC.
695 Rte 46 West, Suite 402
Fairfield, New Jersey 07004

We, Managed DentalGuard, Inc. (MDG) certify that the *employee* named below is entitled to the benefits provided by *MDG* described in this form, provided the eligibility and effective date requirements of the *plan* are satisfied.

Group Plan No.	Certificate No.	Effective Date
Issued To		

This *CERTIFICATE OF COVERAGE* replaces any *CERTIFICATE OF COVERAGE* previously issued under the above *plan* or under any other plan providing similar or identical benefits issued to the *planholder* by *MDG.*

Christopher T. Swanker

Christopher T. Swanker
Vice President, Group Dental
Managed DentalGuard, Inc.

Definitions

As used in this certificate of coverage, the terms listed below are defined as follows. These terms are italicized when used in this certificate of coverage. Defined terms are specific to a particular coverage as found within that coverage.

"Employer" means the *employer* who purchased this *plan.*

"Member" means an *employee* or a *dependent* covered by this *plan.*

"Our," "MDG," "us" and "we" mean Managed DentalGuard.

"Plan" means the MDG *plan* of group coverage purchased by your *employer.*

"You" and "your" mean an *employee* covered by this *plan.*

Limitation of Authority

No agent is authorized: (a) to alter or amend this *plan;* (b) to waive any conditions or restrictions contained in this *plan;* (c) to extend the time for paying a premium; or (d) to bind MDG by making any promise or by giving or receiving any information.

No change in this *plan* will be valid unless evidenced by: (a) an endorsement or rider to this *plan* signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of MDG; or (b) an amendment to this *plan* signed by the *planholder* and by one of the aforesaid officers of MDG.

Incontestability

This *plan* will be incontestable after two years from its effective date, except for non-payment of premiums.

No statement in any application, except a materially fraudulent statement, made by a person covered under this *plan* may be used in contesting the validity of his or her coverage or in denying a claim for loss incurred after such coverage has been in force for two years during his or her lifetime.

If this *plan* replaces the group plan of another insurer, we may rescind this *plan* based on misrepresentations made in a signed application for up to two years from this *plan's* effective date.

Examination

We have a right to have a doctor or *dentist* of our choice examine the person for whom a claim is being made under this *plan* as often as may be reasonably necessary. *We* 'll pay for all such examinations.

Enrollment Procedures

You and your *dependents* may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your *employer;* and (b) returning the enrollment material to your *employer.* Your *employer* will forward these materials to *MDG.*

The enrollment materials require *you* to select a *primary care dentist* (PCD) for each *member.* After your enrollment material has been received by *MDG, we* will determine if a *member's* selected *PCD* is available in your *plan.* if so, the selected *dentist* will be assigned to the *member* as his or her *PCD.* If a *member's* selection is not available, an alternate *dentist* will be assigned as the *PCD.* A *member* need only contact his or her assigned *PCD's* office to obtain services.

MDG will issue *you* and your *dependents,* either directly or through your *employer's* representative, an *MDG* ID card. The ID card will show the *member's* name and the name and telephone number of his or her assigned *PCD.*

Open Enrollment Period

If *you* do not enroll for dental coverage under this *plan* within 30 days of becoming eligible, *you* must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every 12 months after this *plan's* effective date, or at time intervals mutually agreed upon by your *employer* and *MDG.*

Enrollment is for a minimum of 12 consecutive months while *you* are eligible. Voluntary termination from this *plan* will only be permitted during the open enrollment period.

If, after initial enrollment, you or one of your dependents disenroll from the *plan* before the open enrollment period, the *member* may not re-enroll until the next open enrollment period which occurs after the *member* has been without coverage for 1 full year.

When Your Coverage Starts

Your coverage starts on the date shown on the face page of this *plan* if *you* are enrolled when the plan starts. If *you* are not enrolled on this date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by *MDG;* or (b) the first day of the month after the end of any waiting period your *employer* may require.

When Your Dependent Coverage Starts

Except as stated below, your *dependents* will be eligible for coverage on the later of: (a) the day *you* are eligible for coverage; or (b) the first day of the month following the date on which *you* acquire such *dependent.*

If your *dependent* is a newborn child, his or her coverage begins on the date of birth. If your *dependent* is: (a) a stepchild; or (b) a foster child, coverage begins on the date that child begins to reside in your home. If the *dependent* is an adopted child, coverage begins on the date that the child is subject to a legal suit for adoption. If a newborn child, adopted child or foster child becomes covered under this *plan, you* must complete enrollment materials for such child within 30 days of his or her effective date of coverage.

When Coverage Ends

Subject to any continuation of coverage privilege which may be available to *you* or your *dependents,* coverage under this *plan* ends when *your employer's* coverage terminates. Your and your *dependents* coverage also ends on the first to occur of:

1. The end of the period for which *you* have made your last premium payment, if *you* are required to pay any part of this *plan;*

2. The end of the month in which a *member* is no longer eligible for coverage under this *plan;*

3. The end of the month in which your *dependent* is no longer a *dependent* as defined in this *plan;*

4. The date on which *you* or your *dependent* no longer resides or works in the *service area;*

5. The end of the month during which your *employer* receives written notice from *you* requesting termination of coverage for *you* or your *dependents,* or on such later date as *you* may request by the notice;

6. The date of a *member's* entry into active military duty. But, coverage will not end if the *member's* duty is temporary. Temporary duty is duty of 31 days or less.

7. 30 days after *MDG* sends written notice to a *member* advising that his or her coverage will end because the *member* has: (a) knowingly given false information in writing on his or her enrollment form; or (b) misused his or her ID card or other documents provided to obtain benefits under this *plan;* or (c) otherwise acted in an unlawful or fraudulent manner regarding *plan* services and benefits; or

8. 30 days after *MDG* sends written notice to a *member,* where *MDG* has: (a) addressed the failure of the *member* and his or her PCD to establish a satisfactory patient-dentist relationship; (b) offered the *member* the opportunity to select another PCD; and (c) described the changes necessary to avoid termination.

However, upon no longer being eligible for coverage, Florida insurance law requires that your *employer* provide *you* with coverage including the payment of premiums until the end of the month in which *MDG* is notified by your *employer* that *you* are no longer eligible. This does not apply:

1. when this *plan* ends or *you* terminate coverage under this *plan* but remain eligible for coverage;

2. when *you* cease to be eligible within 7 days of the end of the month and *MDG* receives notice from your *employer* within the first 3 business days of the next month;

3. if your *employer* notifies *MDG* at least 30 days prior to the date *you* are no longer eligible under this plan;

4. when *you* elect to end coverage under this *plan* and obtain other coverage which takes effect after termination of eligibility under this *plan* and prior to the end of coverage under this *plan;*

5. if *you* are covered under a federal or state continuation of coverage requirement that allows *you* to pay premium and extend coverage under this *plan* after *you* leave employment or are no longer eligible;

6. when the entire premium for this coverage is paid by *you;* or

7. after the later of: your date of your death and the date *you* receive the last covered service under this plan.

Read this booklet carefully if your coverage ends. *You* may have the right to continue certain group benefits for a limited time.

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Extended Dental Expense Benefits

If a *member's* coverage ends, *we* extend dental expense benefits for him or her under this *plan* as explained below.

Benefits for orthodontic services end at the termination of the *member's* coverage under this *plan. We* extend benefits for covered services other than orthodontic services only if the procedure(s) are: (a) started before the *member's* coverage ends; and (b) are completed within 90 days after the date his or her coverage ends. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. Root canal is started when the pulp chamber is opened.

The extension of benefits ends on the first to occur of: (a) 90 days after the *member's* coverage ends; or (b) the date he or she becomes covered under another plan which provides coverage for similar dental procedures. But, if the plan which succeeds this *plan* excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the *member's* coverage ends.

We don't grant an extension if the *member* voluntarily terminates his or her coverage. And what *we* pay is based on all the terms of this Plan.

Extended Dental Expense Benefits During a Period of Total Disability:

If a Member is totally disabled on the date this Plan ends, We extend dental expense benefits for him or her under this Plan as explained below.

We only extend benefits for covered charges for dental procedures, if the procedures are: (a) In connection with a specific accident or illness incurred while the Plan was in effect; and (b) are performed within 90 days after the date the Member's insurance ends.

We don't grant an extension if the Member's coverage ends because he or she failed to make required payments to his or her Employer. And what we pay is based on all the terms of this Plan.

A Member is totally disabled if, due to sickness or injury, he or she cannot perform the main duties of his or her occupation. A Covered Dependent is totally disabled if, due to sickness or injury, the Covered Dependent cannot perform the normal activities of someone of the same age. The Employee must submit evidence to Us that he or she or his or her dependent is totally disabled, if We request it.

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YOUR CONTINUATION RIGHTS

You and your *dependents* may be eligible to retain coverage under this *plan* during any Continuation of Coverage period or election period, necessary for your *employer's* compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for *members*, provided the *employer* continues to certify the eligibility of the *member* and the monthly premiums for COBRA coverage for the *member* continue to be paid by or through the *planholder* pursuant to this *plan.*

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to your *employer's plan. You* must contact your *employer* to find out if: (a) your *employer* is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to *you.*

Federal Continuation Rights

Important Notice

This section applies to dental benefits only. In this section, these coverages are referred to as "group dental benefits."

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this plan as: (a) an active, covered *employee;* (b) the spouse of an active, covered *employee;* or (c) the dependent of an active, covered *employee.* Except for a child born to or adopted by a covered employee during a period of continuation, any person who becomes covered under this *plan* during a continuation provided by this section is not a qualified continuee.

If Your Group Dental Benefits End

If your group dental benefits end due to termination of employment or reduction of hours, *you* may elect to continue such benefits for up to 18 months if: (a) *you* were not terminated due to gross misconduct; (b) *you* are not covered for benefits from any other group *plan* at the time your group dental benefits under this *plan* would otherwise end; and (c) *you* are not entitled to Medicare.

The Continuation: (a) may cover *you* and any other qualified continuee; and (b) is subject to "When Continuation Ends."

Extra Continuation For Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to his or her termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give your *employer* written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; and (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your *employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends."

An additional 50% of the total premium charge also may be required from the qualified continuee by your *employer* during this extra 11 month continuation period.

If You Die While Covered

If *you* die while covered, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."

If A Dependent Loses Eligibility

If a *dependent's* group dental benefits end due to his or her loss of *dependent* eligibility as defined in this *plan,* other than your coverage ending, he or she may elect to continue such benefits. However, such *dependent* must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations

If a *dependent* elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) reduction of work hours, the *dependent* may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the *dependent* becomes eligible for 36 months of group dental benefits stated above; or (ii) *you* become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your *employer,* in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of *dependent* eligibility, as defined in this *plan,* of a *dependent.*

Such notice must be given to your *employer* within 60 days of either of these events.

Your Employer's Responsibilities

Your *employer* must notify the qualified continuee, in writing, of: (a) his or her right to continue this *plan's* group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer,* in writing, of your legal divorce or legal separation from your spouse, or the loss of *dependent* eligibility of a *dependent.*

Your Employer's Liability

Your *employer* will be liable for the qualified continuee's continued group dental benefits to the same extent as, and in place of, *us* if: (a) your *employer* fails to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group dental benefits to end; or (b) your *employer* fails to notify the qualified continuee of his or her continuation rights, as described above.

Election Of Continuation

To continue his or her group dental benefits, the qualified continuee must give your *employer* written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's premium in a timely manner.

The subsequent premiums must be paid to your *employer,* by the qualified continuee, in advance, at the times and in the manner specified by your *employer.* No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed enrolled in the group *plan* on a regular basis. It includes any amount that would have been paid by your *employer.* Except as explained in the "Extra Continuation for Disabled Qualified Continuees" an additional charge of 2% of the total premium charge may also be required by your *employer.*

If the qualified continuee: (a) fails to give your *employer* notice of his or her intent to continue; or (b) fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace In Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

When Continuation Ends

A qualified continuee's continued group dental benefits end on the first of the following:

(a) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental benefits would otherwise end;

(b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that the continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(c) with respect to continuation upon the your death, your legal divorce or legal separation, or the end of a *dependent's* eligibility, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;

(d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;

(e) the date the *plan* ends;

(f) the end of the period for which the last premium payment is made;

(g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or

(h) the date he or she becomes entitled to Medicare.

This *plan* will cover many of the dental expenses incurred by *you* and those of your *dependents* who are covered for dental benefits under this *plan. MDG* decides: (a) who is eligible for this coverage; (b) who meets the requirements for benefits to be paid; and (c) what benefits are to be paid by this *plan. We* also interpret how the *plan* is to be administered. What *we* cover and the terms of coverage are explained below. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

Managed DentalGuard - This Plan's Dental Coverage Organization

Managed DentalGuard

This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires *Members* to seek dental care from participating *dentists* that belong to the Managed DentalGuard network (*MDG* network).

The *MDG* network is made up of *participating dentists* in the *plan's* approved *service area.* A "*participating dentist* " is a *dentist* that has a participation agreement in force with *us.*

When a *Member* enrolls in this *plan,* he or she will get information about *MDG* 's current *participating general dentists.* Each *Member* must be assigned to a *primary care dentist (PCD)*from this list of *participating general dentists.* This *PCD* will coordinate all of the *Member's* dental care covered by this *plan.* After enrollment, a *Member* will receive an *MDG* ID card. A *Member* must present this ID card when he or she goes to his or her *PCD.*

All dental services covered by this *plan* must be coordinated by the *PCD* whom the *Member* is assigned to under this *plan.* what *we* cover is based on all the terms of this *plan.* Read this booklet carefully for specific benefit levels, payment rates, payment limits, conditions, exclusions and limitations and *patient charges.*

You can call the *MDG* Member Services Department if *you* have any questions after reading this booklet.

Choice of Dentists

An adult *Member* may request any available *participating general dentist* as his or her *PCD.* All dependent children of an employee must enroll with the same PCD. A request to change a *PCD* must be made to *MDG.* Any such change will be effective the first day of the month following approval; however, *MDG* may require up to 30 days to process and approve any such request. All fees and *patient charges* due to the *Member's* current *PCD* must be paid in full prior to such transfer.

Changes In Dentist Participation

We may have to reassign a *Member* to a different *participating dentist* if: (a) the *Member's dentist* is no longer a *participating dentist* in the *MDG* network; or (b) *MDG* takes an administrative action which impacts the *dentist's* participation in the network. If this becomes necessary, the *Member* will have the opportunity to request another *participating dentist.* if a *Member* has a dental service in progress at the time of the reassignment, *we* will, at *our* option and subject to applicable law, either: (a) arrange for completion of the services by the original *dentist;* or (b) make reasonable and appropriate arrangements for another *participating dentist* to complete the service.

Refusal of Recommended Treatment

A *Member* may decide to refuse a course of treatment recommended by his or her PCD or specialty care dentist. The *Member* can request and receive a second opinion by contacting Member Services. If the *Member* still refuses the recommended course of treatment, the PCD or specialty care dentist may have no further responsibility to provide services for the condition involved and the *Member* may be required to select another PCD or specialty care dentist.

Specialty Care Referrals

A Member's PCD is responsible for providing all covered services covered by this Plan. But, certain services may be eligible for referral to a Participating Specialist. MDG will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty referral services are provided in accordance with the specialty referral process described below.

MDG compensates a Participating Specialist the difference between the Specialist's contracted fee for a covered service and the Patient Charge for that service shown in the Covered Dental Services and Patient Charges section. This is the only form of compensation that a Participating Specialist receives from MDG.

ALL SPECIALTY CARE REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY MDG; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY MDG IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty services to be covered by this Plan, the referral process stated below must be followed:

(1) A Member's PCD must coordinate all dental care.

(2) When the care of a Participating Specialist is required, the Member's PCD must contact MDG and request authorization.

(3) If the PCD's request for specialty referral is approved, MDG will notify the Member. He or she will be instructed to contact the Participating Specialist to schedule an appointment.

(4) If the *PCD's* request for specialty referral is denied as not medically necessary (an adverse determination), the *PCD* and the Member will receive a written notice along with information on how to appeal the denial. (See Grievance Procedure section.)

(5) If the service in question: (a) is a service covered by this Plan; and (b) no limitations, conditions or exclusions apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

(6) A specialty referral is not a guarantee of covered services. The Plan's benefits, limitations, conditions and exclusions will determine coverage in all cases. If a referral is made for a service that is not a service covered by this Plan, the Member will be responsible for the entire amount of the Specialist's charge for that service.

(7) A Member who receives authorized specialty care services must pay all applicable Patient Charges for the services provided.

When specialty dental care is authorized by MDG, a Member will be referred to a Participating Specialist for treatment. The MDG network includes Participating Specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Plan's approved Service Area. If there is no Participating Specialist in the Plan's approved Service Area, MDG will refer the Member to a Non-Participating Specialist of MDG's choice. In no event will MDG pay for dental care provided to a Member by a Specialist not pre-authorized by MDG to provide such services, except (a) when this Plan is a secondary plan or (b) when the specialty dental care is in the case of dental emergency while the Member is out of the area. And, the Member must have the right to appeal any denial of specialty dental care.

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Emergency Dental Services

The *MDG* network also provides for *emergency dental services* 24 hours a day, 7 days a week, to all *members.* A *member* should contact his or her *PCD,* who will arrange for such care.

A *member* may require *emergency dental services* when he or she is unable to obtain services from his or her *PCD.* The *member* should contact his or her PCD for a referral to another dentist or contact *MDG* for an authorization to obtain services from another dentist. The *member* must submit to *MDG:* (a) the bill incurred as a result of the emergency; (b) evidence of payment; and (c) a brief explanation of the emergency. This should be done within 60 days or as soon as reasonably possible. If *emergency dental services* are performed by a *general dentist, MDG* will reimburse the *member* for the cost of covered *emergency dental services,* less the applicable *patient charge(s).*

When *emergency dental services* are provided by a dentist other than the *member's* assigned *PCD,* and without referral by the *PCD* or authorization by *MDG,* coverage is limited to the benefit for palliative treatment (code D9110) only.

"Emergency dental services" means only covered, bona fide emergency services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort, or to prevent the imminent loss of teeth. Services related to the initial emergency condition but not required specifically to relieve pain, discomfort, bleeding or swelling or to prevent imminent tooth loss, including services performed at the emergency visit and services performed at subsequent visits, are not considered emergency dental services.

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Complaint and Appeals Process

Complaint Overview

Members are entitled to have any complaint reviewed by MDG and be provided with a resolution in a timely manner. MDG reviews each complaint in an objective, non-biased manner and considers reaching a timely resolution a top priority.

It is generally recognized that complaints may be classified into two categories:

- Administrative Services: financial; accounting; procedural matters; coverage information, such as effective dates; explanations of Contract and Certificate of Coverage, claims, benefits and coverage; or benefit terms and definitions.
- Health Services: quality of care; access; availability; standards of care; benefits and coverage; professional and ethical considerations.

The Member or Dentist may contact the Member Services Department to review a concern or file a complaint. The Quality of Care Liaison (QCL) may be contacted to file a complaint involving an adverse determination (utilization review), to file an appeal of an adverse determination, or to request a review by an independent review organization (IRO).

"Complaint" means any dissatisfaction expressed by a Member, the Member's designated representative or the Member's Dentist, by telephone or in writing, regarding the Plan's operation, including but not limited to plan administration; procedures related to a review or appeal of an adverse determination; denial of access to a referral; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; and disenrollment decisions. This term does not include: (a) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Member; or (b) a Dentist's or Members oral or written expression of dissatisfaction or disagreement with an adverse determination.

"Complaint involving an Adverse Determination" means an appeal of an adverse determination. (See the Appeal of Adverse Determination section, below.)

"Adverse Determination" means a determination by Us or a utilization review agent that a proposed or delivered dental service, by specialty care referral, which would otherwise be covered under the Member's Plan, is or was not a medically necessary service and may result in non-coverage of the dental procedure.

"Medically necessary services", as related to Covered Services, means those dental services, requested by specialty care referral, which are: (1) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (2) consistent with nationally accepted standards of practice.

"Utilization review agent" means an entity that conducts utilization review for Us.

"Utilization review" means a system for prospective or concurrent review of the medical necessity and appropriateness of dental services being provided or proposed to be provided to a Member. The term does not include a review in response to an elective request for clarification of coverage.

Member Services and the QCL can be contacted by telephone at:

1-888-618-2016

or by mail at:

P.O. Box 4391, Woodland Hills, CA 91367.

The plan hours are from 8:30 a.m. to 6:30 p.m. Central Time. A Member may leave a message when calling after business hours, weekends, or holidays. At the time the Member is notified of an Adverse Determination, the forms required to file an appeal for an Independent Review are included with the notification letter. The Member has a right to request an Independent Review anytime after the first appeal to MDG.

Complaint Process

Members make their concerns known by either calling the MDG Member Services Department by using the toll-free telephone number or by directly contacting MDG in writing.

Member Service Representatives document each telephone call and work with the Member to resolve their oral Complaint. If a Member's concern is regarding: plan administration; the appeal of an adverse determination; denial of access to a referral; a determination that a benefit is not covered under the Plan; the denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions, the Member will be sent, within 5 days from the date of receipt of the telephone call, an acknowledgement letter and a Complaint Form to complete if the Member desires additional review.

The Complaint Form states that it must be returned to the QCL within 30 days and that the Member will receive a response to the Complaint within 15 working days from receipt of the Complaint Form.

Upon receipt of a written Complaint or the Complaint Form, the QCL or QCL designee sends an acknowledgment letter to the Member within 5 business days.

MDG will review and resolve the written Complaint within 15 working days after the date of receipt.

The QCL or QCL designee is responsible for obtaining the necessary documentation; building a case file; and researching remaining aspects of the Complaint and any additional information. MDG may arrange a second opinion, if appropriate. Upon receipt of complete documentation, a resolution is determined by the QCL or QCL designee. Any issue involving a matter of quality of care will be reviewed with the Dental Director or the Director's designee and, if needed, with the Vice President of Network Management, legal counsel, and/or the Complaint Committee and/or the Peer Review Committee.

The QCL or QCL designee is responsible for writing a resolution letter to the Member indicating the outcome of the review and the specialization of the dentists consulted, if applicable. Treatment plans and procedures; general dentist and/or specialty care dentist clinical findings and recommendations; plan guidelines, benefit information and contractual reasons for the resolution will be described, as appropriate. A copy of the Plan's appeal process will be enclosed with each resolution letter in the event the Member elects to have his or her Complaint re-evaluated.

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Complaints regarding an Adverse Determination will be handled according to the established process outlined in the Appeal of Adverse Determination section, below.)

MDG asserts it is prohibited from retaliating against a group Planholder or a Member because the group Planholder or Member has filed a Complaint against the Plan or appealed a decision of the Plan. The Plan is prohibited from retaliating against a dentist or network provider because the dentist or network provider has, on behalf of a Member, reasonably filed a Complaint against the Plan or appealed a decision of the Plan.

Complaint Committee and Peer Review Committee

At the discretion of the Dental Director or the Director's designee and/or the QCL or QCL designee, Complaints may be referred to the Complaint Committee or the Peer Review Committee for review and resolution.

The role of the Committees is to review Complaints, on a case by case basis, when the nature of the Complaint requires Committee participation and decision to reach resolution.

Once the matter has been resolved, the QCL or QCL designee will respond to the Member and will indicate in the file and the Quality Management Program (QMP) database that the matter is closed.

The Complaint Committee and the Peer Review Committee will meet quarterly and as needed.

Minutes will be compiled for each Committee Meeting and will be maintained in the office of MDG. Minutes of the meetings will be forwarded to the Quality Improvement Committee and the Board of Directors.

Complaint Appeal Process

If the Member is not satisfied with the resolution, the Member may make a telephone or written request within 30 days from the date of the resolution letter that an additional review be conducted by a "Complaint Appeal Committee." The telephone appeal request will be logged in the Member's file and the Member will be asked to send the request in writing. An acknowledgement letter will be forwarded to the Member within 5 business days from receipt of the written request.

This Committee will meet within 30 days of the date the written appeal is received. The Committee is composed of an equal number of:

a. Representative(s) from MDG;

b. Representative(s) selected from Participating General Dentists;

c. Representative(s) selected from Participating Specialty Care Dentists (if the Complaint concerns specialty care); and

d. Representative(s) selected from Plan Members who are not MDG employees.

Members of the Complaint Appeal Committee will not have been previously involved in the Complaint resolution.

A representative from the Complaint Appeal Committee panel will be selected by the panel to preside over the Committee.

Within 5 working days from the date of receipt of the written request for an appeal, the Member will be sent written notice acknowledging the date the appeal was received, and the date and location of the Committee meeting. The Member will also be advised that (s)he may either appear in person (or through a representative if the Member is a minor or disabled) before the Committee, or address a written appeal to the Committee. The Member may also bring any person to the Committee meeting (participation of said person subject to MDG's Complaint Appeal Committee guidelines). The Member has the right to present written or oral information and alternative expert testimony, and to question the persons responsible for making the prior determination that resulted in the appeal.

The Committee will meet within the Member's county of residence or the county where the Member normally receives dental care, unless another site is agreeable to the Member.

MDG will make a good faith effort to meet the Member's needs in selecting the site and shall complete the appeals process under this section within 30 calendar days after the date of the receipt of the request for appeal.

Not less than 5 working days prior to the Committee meeting unless the complainant agrees otherwise, the Plan will submit to the Member any and all documentation to be presented to the Committee, and the specialization of any dentist consulted during the investigation.

The Member will receive a written notice of resolution within 5 working days after the date of the Committee resolution. The resolution notice will include a written statement of the specific medical determination, clinical basis and contractual criteria used to reach the final decision.

The Member will provide for his/her own expenses relating to the Committee process. MDG will pay for its expenses relating to the Committee process. MDG will pay for the expenses of the representative(s) from MDG and representative(s) selected from Participating General Dentists and/or Participating Specialty Care Dentists and the expenses of representative(s) selected from Plan Members. Following the decision of the Committee, the Member and MDG each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a participating dentist.

Minutes will be compiled for each Committee Meeting and will be maintained in the office of MDG. Minutes of the meetings will be forwarded to the Quality Improvement Committee and the Board of Directors.

Emergency Complaints

Complaints involving an emergency will be concluded in accordance with the dental immediacy of the case and shall not exceed 24 hours from the receipt of the Complaint.

If the appeal of the emergency Complaint involves an Adverse Determination and involves a life-threatening condition, the Member or Member's Designee and Dentist may request the immediate assignment of an IRO without filing an appeal. (See the Appeal of Adverse Determination section, below.)

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Documentation/Database

With MDG's QMP database, it will be possible to track a Member's concern from the initial call through the final resolution of the issue. All steps in the resolution process may be documented in the database. Information will be accessible on groups, Members, and dentists. The database will be accessed for information for the Quality Improvement Committee, the Complaint Committee and the Credentialing Committee. The database will provide aging reports and the reasons that Complaints are not resolved within 30 days, if applicable.

"Reason Codes" will be used in the database for tracking purposes. Reason Code categories are Access, Benefits and Coverage, Claims, and Quality of Care.

The objectives of the logging system in the database are:

1. Accurate tracking of status of Complaints;
2. Accountability of the different departments/personnel involved in the resolution process; and
3. Trending of the dental providers, members and groups for appropriate follow-up.

Documentation/ Files

Each written Complaint will be logged into the database by the QCL or QCL designee on the date it was received. The Member's data management system is documented that a Complaint has been received and is being reviewed by the QCL or QCL designee. A paper file is created and labeled with the Member's name and social security number. Any subsequent follow-up information is recorded in the file by the QCL or QCL designee. The file is to be kept in the Complaint File for 3 years. The file will include all correspondence regarding the issue, copies of records, radiographs and resolution. Only when a resolution is completed can the Complaint be closed and noted as closed in the Member's file and the database. Complaint files are available for regulatory review.

The Complaint Log will be reviewed quarterly by the Quality Improvement Committee.

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The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the assigned *PCD*.

The *member* must pay the listed *patient charge*. The benefits *we* provide are subject to all the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

The *patient charges* listed in this section are only valid for covered services that are: (1) started and completed under this *plan*, and (2) rendered by *participating dentists* in the state of New Jersey.

CDT Code	Covered Services and Patient Charges - U30 G Current Dental Terminology (CDT) (c) American Dental Association (ADA)	Patient Charge
D0999	Office visit during regular hours, general dentist only	$0.00
	EVALUATIONS	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
	RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
	TESTS AND EXAMINATIONS	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00

D0470	Diagnostic casts	$0.00

DENTAL PROPHYLAXIS

D1110	Prophylaxis - adult, for the first two services in any 12-month period ++	$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period ++	$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period ++	$60.00

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period ++ =	$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period ++ =	$0.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, for the first two services in any 12- month period ++ =	$0.00
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period ++ =	$20.00

OTHER PREVENTIVE SERVICES

D1310	Nutritional counseling for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth (molars) ****	$0.00
D9999	Sealant - per tooth (non-molars) ****	$35.00

SPACE MAINTENACE (PASSIVE APPLIANCES)

D1510	Space maintainer - fixed - unilateral	$0.00
D1515	Space maintainer - fixed - bilateral	$0.00
D1525	Space maintainer - removable - bilateral	$0.00
D1550	Re-cementation of fixed space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00

ALMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT

D2330	Resin-based composite - 1 surface, anterior	$0.00
D2331	Resin-based composite - 2 surfaces, anterior	$0.00
D2332	Resin-based composite - 3 surfaces, anterior	$0.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$0.00
D2390	Resin-based composite crown, anterior	$75.00
D2391	Resin-based composite - 1 surface, posterior	$0.00

D2392	Resin-based composite - 2 surfaces, posterior	$0.00
D2393	Resin-based composite - 3 or more surfaces, posterior	$0.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$0.00

INLAY/ONLAY RESTORATIONS

D2510	Inlay - metallic - 1 surface *	$265.00
D2520	Inlay - metallic - 2 surfaces *	$320.00
D2530	Inlay - metallic - 3 or more surfaces *	$350.00
D2542	Onlay - metallic - 2 surfaces *	$350.00
D2543	Onlay - metallic - 3 surfaces *	$360.00
D2544	Onlay - metallic - 4 or more surfaces *	$370.00
D2610	Inlay - porcelain/ceramic - 1 surface	$265.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$320.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$350.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$350.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$360.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$370.00

CROWNS - SINGLE RESTORATIONS ONLY

D2740	Crown - porcelain/ceramic substrate	$395.00
D2750	Crown - porcelain fused to high noble metal *	$375.00
D2751	Crown - porcelain fused to predominantly base metal	$375.00
D2752	Crown - porcelain fused to noble metal	$375.00
D2780	Crown - 3/4 cast high noble metal *	$365.00
D2781	Crown - 3/4 cast predominantly base metal	$365.00
D2782	Crown - 3/4 cast noble metal	$365.00
D2783	Crown - 3/4 porcelain/ceramic	$365.00
D2790	Crown - full cast high noble metal *	$375.00
D2791	Crown - full cast predominantly base metal	$375.00
D2792	Crown - full cast noble metal	$375.00
D2794	Crown - titanium	$375.00

OTHER RESTORATIVE SERVICES

D2910	Recement inlay, onlay, or partial coverage restoration	$0.00
D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2930	Prefabricated stainless steel crown - primary tooth	$88.00
D2931	Prefabricated stainless steel crown - permanent tooth	$88.00
D2932	Prefabricated resin crown	$108.00
D2933	Prefabricated stainless steel crown with resin window	$108.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$115.00
D2940	Sedative filling	$0.00
D2950	Core buildup, including any pins	$100.00
D2951	Pin retention - per tooth, in addition to restoration	$18.00
D2952	Post & core in addition to crown, indirectly fabricated	$155.00
D2953	Each additional indirectly fabricated post - same tooth	$79.00
D2954	Prefabricated post and core in addition to crown	$125.00

D2957	Each additional prefabricated post - same tooth	$51.00
D2960	Labial veneer (resin laminate) - chairside	$250.00
D2970	Temporary crown (fractured tooth)	$86.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$125.00

PULP CAPPING

D3110	Pulp cap - direct (excluding final restoration)	$0.00
D3120	Pulp cap - indirect (excluding final restoration)	$0.00

PULPOTOMY

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0.00
D3221	Pulpal debridement, primary and permanent teeth	$0.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$0.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0.00

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

D3310	Root canal, anterior (excluding final restoration)	$120.00
D3320	Root canal, bicuspid (excluding final restoration)	$145.00
D3330	Root canal, molar (excluding final restoration)	$270.00
D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$75.00
D3333	Internal root repair or perforation defects	$116.00

ENDODONTIC RETREATMENT

D3346	Retreatment of previous root canal therapy - anterior	$375.00
D3347	Retreatment of previous root canal therapy - bicuspid	$425.00
D3348	Retreatment of previous root canal therapy - molar	$525.00

APICOECTOMY/PERIRADICULAR SERVICES

D3410	Apicoectomy/periradicular surgery - anterior	$240.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$270.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$320.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$116.00
D3430	Retrograde filling - per root	$72.00
D3950	Canal preparation and fitting of preformed dowel or post	$20.00

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$200.00

D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$60.00
D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$240.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$144.00
D4249	Clinical crown lengthening - hard tissue	$280.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$380.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$230.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$350.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$363.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$399.00

NON-SURGICAL PERIODONTAL SERVICE

D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$0.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$0.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$0.00

OTHER PERIODONTAL SERVICES

D4910	Periodontal maintenance, for the first two services in any 12-month period ++ #	$0.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$0.00
D4999	Periodontal maintenance, for each additional service in same 12-month period ++ =	$60.00

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5110	Complete denture - maxillary	$452.00
D5120	Complete denture - mandibular	$452.00
D5130	Immediate denture - maxillary	$492.00
D5140	Immediate denture - mandibular	$492.00

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$381.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$443.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$500.00

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$500.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$575.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$575.00

ADJUSTMENTS TO DENTURES

D5410	Adjust complete denture - maxillary	$0.00
D5411	Adjust complete denture - mandibular	$0.00
D5421	Adjust partial denture - maxillary	$0.00
D5422	Adjust partial denture - mandibular	$0.00

REPAIRS TO COMPLETE DENTURES

D5510	Repair broken complete denture base	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$36.00

REPAIRS TO PARTIAL DENTURES

D5610	Repair resin denture base	$44.00
D5620	Repair cast framework	$80.00
D5630	Repair or replace broken clasp	$56.00
D5640	Replace broken teeth - per tooth	$36.00
D5650	Add tooth to existing partial denture	$52.00
D5660	Add clasp to existing partial denture	$64.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$196.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$196.00

DENTURE REBASE PROCEDURES

D5710	Rebase complete maxillary denture	$160.00
D5711	Rebase complete mandibular denture	$160.00
D5720	Rebase maxillary partial denture	$160.00
D5721	Rebase mandibular partial denture	$160.00

DENTURE RELINE PROCEDURES

D5730	Reline complete maxillary denture (chairside)	$88.00
D5731	Reline complete mandibular denture (chairside)	$88.00
D5740	Reline maxillary partial denture (chairside)	$88.00
D5741	Reline mandibular partial denture (chairside)	$88.00
D5750	Reline complete maxillary denture (laboratory)	$120.00
D5751	Reline complete mandibular denture (laboratory)	$120.00
D5760	Reline maxillary partial denture (laboratory)	$120.00
D5761	Reline mandibular partial denture (laboratory)	$120.00

INTERIM PROSTHESIS

D5820	Interim partial denture (maxillary)	$175.00

D5821	Interim partial denture (mandibular)	$175.00

OTHER REMOVABLE PROSTHETIC SERVICES

D5850	Tissue conditioning, maxillary	$36.00
D5851	Tissue conditioning, mandibular	$36.00

FIXED PARTIAL DENTURE PONTICS ###

D6210	Pontic - cast high noble metal *	$350.00
D6211	Pontic - cast predomniantly base metal	$350.00
D6212	Pontic - cast noble metal	$350.00
D6214	Pontic - titanium	$350.00
D6240	Pontic - porcelain fused to high noble metal *	$350.00
D6241	Pontic - porcelain fused to predominantly base metal	$350.00
D6242	Pontic - porcelain fused to noble metal	$350.00
D6245	Pontic - porcelain/ceramic	$360.00

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS ###

D6600	Inlay - porcelain/ceramic, - 2 surface	$320.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$350.00
D6602	Inlay - cast high noble metal, - 2 surfaces *	$320.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces *	$350.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$320.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$350.00
D6606	Inlay - cast noble metal, 2 surfaces	$320.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$350.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$350.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$360.00
D6610	Onlay - cast high noble metal, 2 surfaces *	$350.00
D6611	Onlay - cast high noble metal, 3 or more surfaces *	$360.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$350.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$360.00
D6614	Onlay - cast noble metal, 2 surfaces	$350.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$360.00
D6624	Inlay - titanium	$320.00
D6634	Onlay - titanium	$350.00

FIXED PARTIAL DENTURE RETAINERS - CROWNS ###

D6740	Crown - porcelain/ceramic	$395.00
D6750	Crown - porcelain fused to high noble metal *	$375.00
D6751	Crown - porcelain fused to predominantly base metal	$375.00
D6752	Crown - porcelain fused to noble metal	$375.00
D6780	Crown - 3/4 cast high noble metal *	$365.00
D6781	Crown - 3/4 cast predominantly base metal	$365.00
D6782	Crown - 3/4 cast noble metal	$365.00
D6783	Crown - 3/4 porcelain/ceramic	$365.00
D6790	Crown - full cast high noble metal *	$375.00
D6791	Crown - full cast predominantly base metal	$375.00
D6792	Crown - full cast noble metal	$375.00

D6794	Crown - titanium	$375.00

OTHER FIXED PARTIAL DENTURE SERVICES

D6930	Recement fixed partial denture	$36.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$155.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$125.00
D6973	Core buildup for retainer, including any pins	$100.00
D6976	Each additional cast post - same tooth	$79.00
D6977	Each additional prefabricated post - same tooth	$51.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment plan ###	$125.00

EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth	$0.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0.00

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30.00
D7220	Removal of impacted tooth - soft tissue	$114.00
D7230	Removal of impacted tooth - partially bony	$140.00
D7240	Removal of impacted tooth - completely bony	$160.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$200.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35.00
D7261	Primary closure of a sinus perforation	$250.00

OTHER SURGICAL PROCEDURES

D7280	Surgical access of an unerupted tooth	$250.00
D7283	Placement of device to facilitate eruption of impacted tooth	$50.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$60.00
D7286	Biopsy of oral tissue - soft	$50.00
D7288	Brush biopsy - transepithelial sample collection	$65.00

ALEVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$125.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$65.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$150.00

D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$105.00

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$289.00

EXCISION OF BONE TISSUE

D7471	Removal of lateral exostosis (maxilla or mandible)	$204.00
D7472	Removal of torus palatinus	$283.00
D7473	Removal of torus mandibularis	$283.00

SURGICAL INCISION

D7510	Incision and drainage of abscess - intraoral soft tissue	$25.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30.00

OTHER REPAIR PROCEDURES

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$133.00
D7963	Frenuloplasty	$163.00

UNCLASSIFIED TREATMENT

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
D9120	Fixed partial denture sectioning	$15.00
D9215	Local anesthesia	$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes +++	$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes +++	$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes +++	$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes +++	$75.00

PROFESSIONAL CONSULTATION

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$0.00

PROFESSIONAL VISITS

D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00

MISCELLANEOUS SERVICES

D9951	Occlusal adjustment - limited	$10.00
D9971	Odontoplasty, 1-2 teeth	$10.00
D9972	External bleaching - per arch	$165.00
	Broken Appointment	$25.00

++ The *patient charges* for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first two services in any 12-month period. For each additional service in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable patient charge.

\# Routine prophylaxis or periodontal maintenance procedure - One of the covered periodontal maintenance procedures may be performed by a *participating specialty care periodontist* if done within three to six months following completion of approved, active periodontal therapy by a *participating specialty care periodontist.* Active periodontal therapy includes periodontal scaling and root planning or periodontal osseous surgery.

= Fluoride treatment - a total of 4 services in any 12- month period.

**** Sealants are limited to permanent teeth up to the 16th birthday.

* If high noble metal is used, there will be an additional patient charge for the actual cost of the high noble metal.

The *patient charge* for these services is per unit.

+++ Procedure codes D9220, D9221, D9241 and D9242 are limited to a *participating specialty care oral surgeon.* Additionally, these services are only covered in conjunction with other covered surgical services.

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Covered Dental Services And Patient Charges - Plan U30 G

CDT Codes	Covered Services and Patient Charges	Patient Charge	Orthodontics In Progress
	Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition **		
D8080	Comprehensive orthodontic treatment of the adolescent dentition **	Child: $2500.00 Adult: $2800.00	*** ***
D8090	Comprehensive orthodontic treatment of the adult dentition **		
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250.00	***
D8670	Periodic orthodontic treatment visit	$0.00	***
D8680	Orthodontic retention	$400.00	***
	Broken Appointment	$25.00	***

Current Dental Terminology (CDT) (c) American Dental Association (ADA)

** Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above and employee or spouse. A Member's age is determined on the date of banding.

*** Treatment in progress: Orthodontic Treatment - Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are listed on the Plan Schedule and were started but not completed prior to the Member's eligibility to receive benefits under this plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. In this situation retention services would also be at 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this plan, the Patient Charge for orthodontic retention is equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover Treatment-in- Progress section.

+ + Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan Booklet and the Manual.

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General Guidelines For Alternative Procedures

There may be a number of accepted methods of treating a specific dental condition. When a *member* selects an *alternative procedure* over the service recommended by the *PCD,* the *member* must pay the difference between the *PCD's* usual charges for the recommended service and the *alternative procedure.* He or she will also have to pay the applicable *patient charge* for the recommended service.

When the *member* selects a posterior composite restoration as an alternative procedure to a recommended amalgam restoration, the *alternative procedure* policy does not apply.

When the *member* selects an extraction, the *alternative procedure* policy does not apply.

When the *PCD* recommends a crown, the *alternative procedure* policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The *member* must pay the applicable *patient charge* for the crown actually placed.

The *plan* provides for the use of noble, high noble and base metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, *you* will pay an additional amount for the actual cost of the high noble metal. In addition, *you* will pay the usual *patient charge* for the inlay, onlay, crown or fixed bridge. The total *patient charges* for high noble metal may not exceed the actual lab bill for the service.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *member* with a treatment *plan* in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

General Guidelines For Alternative Treatment By The PCD

There may be a number of accepted methods for treating a specific dental condition. In all cases where there are more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *member* with a written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the *member* should pay, and to fully document informed consent.

- If any of the recommended alternate services are selected by the *member* and not covered under the *plan,* then the *member* must pay the *PCD's* usual charge for the recommended alternate service.
- If any treatment is specifically not recommended by the *PCD* (i.e., the *PCD* determines it is not an appropriate service for the condition being treated), then the *PCD* is not obliged to provide that treatment even if it is a covered service under the *plan.*
- *Members* can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the *PCD or Specialty Care Dentist.*

Crowns, Bridges And Dentures

A crown is a covered service when it is recommended by the *PCD.* The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan.* The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by reline, rebase or repair. Construction of new dentures may not exceed one each in any 5-year period from the date of previous placement under the *plan.* Immediate dentures are not subject to the 5-year limitation.

The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6 months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture.

Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the *PCD.*

Multiple Crown/Bridge Unit Treatment Fee

When a *member's* treatment plan includes 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the *member* will be responsible for the *patient charge* for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

Pediatric Specialty Services

If, during a *PCD* visit, a *member* under age 8 is unmanageable, the *PCD* may refer the *member* to a *Participating Pediatric Specialty Care Dentist* for the current treatment plan only. Following completion of the approved pediatric treatment plan, the *member* must return to the *PCD* for further services. If necessary, *we* must first authorize subsequent referrals to the *participating specialty care dentist.* Any services performed by a *Pediatric Specialty Care Dentist* after the *member's* 8th birthday will not be covered, and the *member* will be responsible for the *Pediatric Specialty Care Dentist's* usual fees.

Second Opinion Consultation

A *member* may wish to consult another *dentist* for a second opinion regarding services recommended or performed by: (a) his or her *PCD;* or (b) a *participating specialty care dentist* through an authorized referral. To have a second opinion consultation covered by *us, you* must call or write Member Services for prior authorization. *We* only cover a second opinion consultation when the recommended services are otherwise covered under the *plan.*

A Member Services Representative will help *you* identify a *participating dentist* to perform the second opinion consultation. *You* may request a second opinion with a *non-participating general dentist* or *specialty care dentist.* the Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting *dentist.* the second opinion consultation shall have the applicable *patient charge* for code D9310.

Third opinions are not covered unless requested by *us.* If a third opinion is requested by the *member,* the *member* is responsible for the payment. Exceptions will be considered on an individual basis, and must be approved in writing by *us.*

The *plan's* benefit for a second opinion consultation is limited to $50.00. If a *participating dentist* is the consultant *dentist, you* are responsible for the applicable *patient charge* for code D9310. If a *non-participating dentist* is the consultant *dentist, you* must pay the applicable *patient charge* for code D9310 and any portion of the *dentist's* fee over $50.00.

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Noble and High Noble Metals

The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the *member* will be responsible for the *patient charge* for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

General Anesthesia / IV Sedation

General anesthesia / IV sedation - General anesthesia or IV sedation is limited to services provided by a *Participating Oral Surgery Specialty Care Dentist.* Not all *Participating Oral Surgery Specialty Care Dentists* offer these services. The *member* is responsible to identify and receive services from a *Participating Oral Surgery Specialty Care Dentist* willing to provide general anesthesia or IV sedation. The *member's* patient charge is shown in the Covered Dental Services and Patient Charges section.

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Orthodontic Treatment

Orthodontic Treatment

The *plan* covers orthodontic services as shown in the Covered Dental Services and Patient Charges section. Coverage is limited to one course of treatment per *member. We* must preauthorize treatment, and treatment must be performed by a *Participating Orthodontic Specialty Care Dentist.*

The *plan* covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, the *member* will be responsible for each additional month of treatment, based upon the *Participating Orthodontic Specialty Care Dentist's* contracted fee.

Except as described under Treatment in Progress - Orthodontic Treatment and Treatment in Progress - Takeover Benefit for Orthodontic Treatment, orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the *plan.* If a *member's* coverage terminates after the fixed banding appliances are inserted, the *Participating Orthodontic Specialty Care Dentist* may prorate his or her usual fee over the remaining months of treatment. The *member* is responsible for all payments to the *Participating Orthodontic Specialty Care Dentist* for services after the termination date. Retention services are covered at the Patient Charge shown in the Plan Schedule's section only following a course of comprehensive orthodontic treatment started and completed under this *plan.*

If a *member* transfers to another *Orthodontic Specialty Care Dentist* after authorized comprehensive orthodontic treatment has started under this *plan,* the *member* will be responsible for any additional costs associated with the change in *Orthodontic Specialty Care Dentist* and subsequent treatment.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the *member's* responsibility. The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan.* Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the *member's* responsibility.

If a *member* has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the *plan* provides the standard orthodontic benefit. The *member* will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the *Participating Orthodontic Specialist Dentist's* usual fee.

Treatment In Progress

1. Treatment in Progress A *member* may choose to have a *participating dentist* complete an inlay, onlay, crown, fixed bridge, denture, or root canal, or orthodontic treatment procedure which: (1) is listed in the *Covered Dental Services and Patient Charges* Section; and (2) was started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* The *member* is responsible to identify, and transfer to, a *participating dentist* willing to complete the procedure at the *patient charge* described in this section.

Restorative Treatment Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the member's eligibility to receive benefits under this plan, have a patient charge equal to 85% of the Participating General Dentist's usual fee. (There is no additional charge for high noble metal.)

Endodontic Treatment Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are shown in the Covered Dental Services and Patient Charges section that were started but not completed prior to the member's eligibility to receive benefits under this plan may be covered if the member identifies a Participating General or Specialty Care Dentist who is willing to complete the procedure at a patient charge equal to 85% of Participating Dentist's usual fee.

Orthodontic Treatment

Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are listed on the Covered Dental Services and Patient Charges section and were started but not completed prior to the member's eligibility to receive benefits under this plan may be covered if the member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment, including retention, at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover Treatment-in-Progress section.

2. Treatment in Progress - Takeover Benefit for Orthodontic Treatment

The Treatment in Progress - Takeover Benefit for Orthodontic Treatment provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another dental pre-paid plan with the current treating orthodontist, after this Plan becomes effective.

A Member may be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment only if:

- the Member was covered by another dental pre-paid plan just prior to the effective date of This Plan and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with a participating network orthodontist under the prior dental pre-paid plan;
- the Member has such orthodontic treatment in progress at the time This Plan becomes effective;
- the Member continues such orthodontic treatment with the treating orthodontist;
- the Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental pre-paid plan; and
- a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form, completed by the treating orthodontist, is submitted to us within 6 months of the effective date of This Plan.

The benefit amount will be calculated based on: (i) the number of remaining months of comprehensive orthodontic treatment; and (ii) the amount by which the Member's payment responsibility has increased as a result of the treating orthodontist's raised fees, up to a maximum benefit of $500 per Member.

The Member will be responsible to have the treating orthodontist complete a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form and submit it to us. The Member has 6 months from the effective date of This Plan to have the Form submitted to us in order to be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment. We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under This Plan is terminated.

This benefit is only available to Members that were covered under the prior dental pre-paid plan and are in comprehensive orthodontic treatment with a participating network orthodontist when This Plan becomes effective with us. It will not apply if the comprehensive orthodontic treatment was started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another orthodontist. This benefit applies to Members of new Plans only. It does not apply to Members of existing Plans. And it does not apply to persons who become newly eligible under the Group after the effective date of This Plan.

The benefit is only available to Members in comprehensive orthodontic treatment (D8070, D8080 or D8090). It does not apply to any other orthodontic services. Additionally, we will only cover up to a total 24 months of comprehensive orthodontic treatment.

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Limitations On Benefits For Specific Covered Services

NOTE: Time limitations for a service are determined from the date that service was last rendered under this *plan.*

The codes below in parentheses refer to the CDT Codes as shown in the Covered Dental Services and Patient Charges section.

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis: D1203, D1204, D1206, D2999) or periodontal maintenance procedure (D4910, D4999) - a total of four (4) services in any twelve (12)-month period. One of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D2999) four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to 1 in any 2-year period on or after the 40th birthday.
- Full mouth x-rays - 1 set in any 3-year period.
- Bitewing x-rays - 2 sets in any 12-month period.
- Panoramic x-rays - 1 set in any 3-year period.
- Sealants - limited to permanent teeth, up to the 16th birthday - 1 per tooth in any 3-year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) - a total of 1 service per quadrant or area in any 3-year period.

- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) - a total of 1 service per area in any 3-year period.
- Periodontal scaling and root planning (D4341, D4342) - 1 service per quadrant or area in any 12-month period.
- Emergency dental services when more than 50 miles from the PCD's office - limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the member's assigned PCD, and without referral by the PCD or authorization by MDG - limited to the benefit for palliative treatment (code D9110) only.
- Reline of a complete or partial denture - 1 per denture in 12-month period.
- Rebase of a complete or partial denture - 1 per denture in any 12-month period.
- Second Opinion Consultation - when approved by us, a second opinion consultation will be reimbursed up to $50.00 per treatment plan.

Exclusions

We won't pay for:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any *histopathological* examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the *participating dentist* is not necessary for maintaining or improving the *member's* dental health, or (b) which is solely for cosmetic purposes.
- Precision attachments, stress breakers, magnetic retention or *overdenture* attachments.

- The use of: (a) intramuscular sedation,(b) oral sedation, or (c) inhalation sedation, including but not limited to *nitrous oxide*.
- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
- Any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD*, or (b) treatment by a specialist without a referral from the *PCD* and approval from *us*.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for *periodontal* reasons (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the *temporomandibular joint (TMJ)*.
- Dental services, other than covered *Emergency Dental Services,* which were performed by any *dentist* other than the *member's* assigned *PCD,* unless *we* had provided written authorization.
- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a *Prosthodontist.*
- Treatment which requires the services of a *Pediatric Specialty Care Dentist,* after the *member's* 8th birthday.
- Consultations for non-covered services.
- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.
- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.

- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress - Restorative Treatment. (Inlays, onlays crowns or fixed bridges are (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are (a) started when the impressions are taken, and (b) completed when the denture is delivered to the *member.)*

- Root canal treatment started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Endodontic treatment. (Root canal treatment is: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)

- Orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress - Orthodontic Treatment and Treatment in Progress - Takeover Benefit for Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the *plan* as *Emergency Dental Services.*

- *Root canal* treatment started by a *non-participating dentist. Root canal* treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the *plan* as *Emergency Dental Services.*

- Extractions performed solely to facilitate *orthodontic* treatment.

- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.

- *Orthognathic* surgery (moving of teeth by surgical means) and associated incremental charges.

- Clinical crown lengthening (D4249) performed in the presence of *periodontal* disease on the same tooth.

- Procedures performed to facilitate non-covered services, including but not limited to: (a) *root canal* therapy to facilitate *overdentures, hemisection* or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.

- Any endodontic, *periodontal,* crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the *member.*
- Orthodontic services.

GLOSSARY

This Glossary defines the italicized terms appearing in this booklet.

Alternative Procedure means a service other than that recommended by the *member's PCD.* But, in the opinion of the *PCD,* such procedure is also an acceptable treatment for the *member's* dental condition.

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Certificate Of Coverage means this booklet issued to *you,* which summarizes the essential terms of this *plan.*

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Dentist means any dental practitioner who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan.*

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Dependent means a person listed on your enrollment form who is any of the following:

1. your legal spouse.

   Your legal spouse includes a partner to a civil union when that union is in accordance with New Jersey Law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Any reference in this plan to legal divorce or legal separation shall also mean the dissolution of a civil union. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

2. your or your spouse's dependent child who is less than 26 years of age.

   The term *"dependent child"* as used in this *plan* will include any: (a) stepchild; (b) newborn child; (c) legally adopted child; (d) child for whom *you* are court-appointed legal guardian; or (e) proposed adoptive child, during any waiting period prior to the formal adoption if the child: (i) is a part of your household, and (ii) is primarily dependent on *you* for support and maintenance. The term also includes any child for whom a court-ordered decree requires *you* to provide *dependent* coverage.

3. A *dependent child* who has a mental or physical handicap or developmental disability, and who: (1) has reached the upper age limit of a *dependent child;* (2) is unmarried or unpartnered; (3) is not capable of self-sustaining work; and (4) depends primarily on *you* for support and maintenance. *You* must furnish proof of such lack of capacity and dependence to *us* within 31 days after the child reaches the limiting age, and each year after that, on *our* request.

4. Your domestic partner, subject to the conditions below. For a domestic partner to be considered an eligible *dependent* under this *plan*, both you and your domestic partner must:

   - have a common residence and be jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, as shown by at least one of the following:
     - a joint deed, mortgage agreement or lease;
     - a joint bank account;
     - designation of one of the domestic partners as a primary beneficiary in the other's will;
     - designation of one of the domestic partners as a primary beneficiary in the other's life insurance policy or retirement plan; or
     - joint ownership of a motor vehicle.
   - agree to be jointly responsible for each other's basic living expenses during the domestic partnership.
   - not be in a marriage recognized by New Jersey law or be a member of another domestic partnership.
   - not be related by blood or affinity up to and including the fourth degree of consanguinity.
   - be at least 18 years of age.
   - have chosen to share each other's lives in a committed relationship of mutual caring.
   - have terminated any prior registered domestic partnership in accordance with New Jersey law; and
   - not have been in a domestic partnership that was terminated less than 180 days prior to the current domestic partnership, unless the earlier partner died.

   Before coverage may become effective, you must provide us with satisfactory written confirmation of the domestic partnership.

   Your domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

   You must provide us with written notification if the domestic partnership terminates. The domestic partnership will terminate if: (a) you and your domestic partner no longer meet the requirements for coverage; (b) you and your opposite sex domestic partner enter into a marriage that is recognized by New Jersey law; or (c) the Superior Court of New Jersey adjudges that the domestic partnership is terminated.

   Your domestic partner and his or her children will not be eligible for continuation of dental coverage under the "Federal Continuation Rights" section of this plan, unless you are also eligible for and elect continuation.

   As used in this provision:

   "Basic living expenses" means the cost of basic food and shelter, and any other cost, including, but not limited to, the cost of health care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

"Have a common residence" means that two persons share the same place to live in the state of New Jersey, or share the same place to live in another jurisdiction when at least one of the persons is a member of a State-administered retirement system, regardless of whether or not: the legal right to possess the place is in both of their names; one of both persons have additional places to live; or one person temporarily leaves the shared place of residence to reside elsewhere, on either a short-term or long-term basis, for reasons that include, but are not limited to, medical care, incarceration, education, a sabbatical or employment, but intends to return to the shared place of residence.

"Jointly responsible" means that each domestic partner agrees to provide for the other partner's basic living expenses if the other partner is unable to provide for himself.

The term *"dependent"* does not include a person who is also covered as an *employee* for benefits under any dental plan which the *planholder* offers, including this one.

CGP-3-MDG-DEF4-DMST-10-NJ B850.1310-R

Emergency Dental Services mean only covered, bona fide emergency services which are reasonably necessary to: (a) relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort; or (b) prevent the imminent loss of teeth. Services related to the initial emergency condition that are not bona fide emergency services, as described above, are not considered *emergency dental services.* This includes: (a) services performed at the emergency visit; and (b) services performed at later visits.

CGP-3-MDG-DEF5-NJ B850.0717-R

Employee or You means the person to whom this booklet is issued: (a) who meets your *employer's* eligibility requirements; and (b) for whom monthly payments are made by your *employer.*

CGP-3-MDG-DEF6-NJ B850.0718-R

Employer Or Planholder means the *employer* or other entity: (a) with whom or to whom this *plan* is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its *members.*

CGP-3-MDG-DEF7-NJ B850.0719-R

Member means *you* and any of your eligible *dependents:* (a) as defined under the eligibility requirements of this *plan;* and (b) as determined by your *employer,* who are actually enrolled in and eligible to receive benefits under this *plan.*

CGP-3-MDG-DEF8-NJ B850.0720-R

Non-Participating Dentist means any *dentist* that does not have an MDG participation agreement in force with *us* to provide dental services to *members.*

CGP-3-MDG-DEF9-NJ B850.0721-R

Participating Dentist means a *dentist* who has an MDG participation agreement in force with *us.* This term includes any hygienist and technician recognized by the dental profession who assists and acts under the supervision of a *participating dentist.*

CGP-3-MDG-DEF10-NJ B850.0722-R

Participating General Dentist means a *dentist* who has an MDG participation agreement in force with *us:* (a) who is listed in MDG's directory of *participating dentists* as a general practice *dentist;* and (b) who may be selected as a *PCD* by a *member* and assigned by MDG to provide or arrange for a *member's* dental services.

CGP-3-MDG-DEF11-NJ B850.0723-R

Participating Specialist means a *dentist* who has an MDG participation agreement in force with *us* as an: (a) Endodontist; (b) Pediatric Specialist; (c) Periodontist; (d) Orthodontist; or (e) Oral Surgeon.

CGP-3-MDG-DEF12-NJ B850.0724-R

Patient Charge means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this *plan*. Such amount is the patient's portion of the cost of covered dental services.

CGP-3-MDG-DEF13-NJ B850.0726-R

Plan means the MDG *plan* of group dental benefits described in this booklet.

CGP-3-MDG-DEF14-NJ B850.0727-R

Primary Care Dentist (PCD) means a dental office location: (a) at which one or more *participating general dentists* provide *covered services* to *members;* and (b) which has been selected by a *member* and assigned by MDG to provide and arrange for his or her dental services.

CGP-3-MDG-DEF15-NJ B850.0728-R

Service Area means the geographic area in which *we* are licensed to provide dental services for *members*.

CGP-3-MDG-DEF16-NJ B850.0729-R

We, Us, Our And MDG mean Managed DentalGuard, Inc.

CGP-3-MDG-DEF17-NJ B850.0730-R

CERTIFICATE AMENDMENT

Your Certificate of Coverage is amended as described below.

1. The following reference to civil union partners will be included under the "Important Notice" heading of the Federal Continuation Rights section: Under federal law, "marriage" means a legal union between one man and one woman as husband and wife, and "spouse" refers to a person of the opposite sex who is a husband or wife. This plan will allow an active, covered employee's civil union partner and that partner's dependent children to continue group health benefits under this provision only when: (a) the employer consents; and (b) that employee elects such continuation coverage.

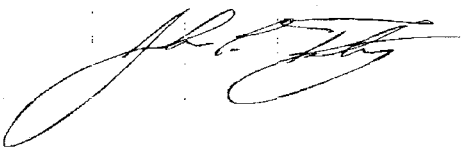
2. The following references to civil union partners, domestic partners And same-sex relationships from other jurisdictions will be included under the term "Dependent" in the Definitions section:

The term "spouse" as used in this plan includes a partner to a civil union when such union is in accordance with New Jersey law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Any reference in this plan to legal divorce or legal separation shall also mean the dissolution of a civil union.

The term "spouse" as used in this plan also includes a partner to a domestic partnership when such partnership is in accordance with and recognized by New Jersey law. We treat the domestic partner as a spouse in marriage, and the domestic partnership as a marriage. Any reference in this plan to legal divorce or legal separation shall also mean the dissolution of a domestic partnership.

The plan recognizes same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.



John Foley
Vice President, Group Dental

CGP-3-A-MDG-CU-NJ-09

B850.1225-R

Applicability

This Coordination of Benefits provision applies when a *member* has dental coverage under more than one plan.

When a *member* has dental coverage from more than one plan, this *plan* coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated.

As used here:

"Plan" means any of the following that provides dental expense benefits or services:

(1) group or blanket insurance plans;

(2) union welfare plans, employer plans, employee benefits plans, trusteed labor and management plans, or other plans for members of a group; and

(3) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other government program or coverage which *we* are not allowed to coordinate with by law. Plan also does not include blanket school accident-type coverage.

"This *plan*" means the part of this *plan* subject to this provision.

How This Provision Works: The Order of Benefits

We apply this provision when a *member* is covered by more than one plan. When this happens *we* consider each plan separately when coordinating payments.

In applying this provision, one of the plans is called the primary plan. A secondary plan is one which is not a primary plan. The primary plan pays first, ignoring all other plans. If a *member* is covered by more than one secondary plan, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that secondary plan.

If a plan has no coordination provision, it is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

(1) A plan that covers a *member* as an *employee* pays first, the plan that covers a *member* as a *dependent* pays second;

(2) Except for *dependent* children of separated or divorced parents, the following governs which plan pays first when this *plan* and another plan cover the same child as a *dependent:*

(a) The benefits of the plan of the parent whose birthday falls earlier in the calendar year pays first. The plan that covers a *dependent* child of the parent whose birthday falls later in the calendar year pays second; but

(b) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the other plan.

(c) If the benefits of the plan with which we're coordinating does not have a similar provision, then (b) will not apply and the other plan's coordination provision will determine the order of benefits.

"Birthday" refers only to month and day in a calendar year, not the year in which the parent was born.

CGP-3-MDG-COB1-NJ B850.0731-R

(3) For a *dependent* child of separated or divorced parents, benefits for that child are determined in this order:

(a) first, the plan of the parent with custody of the child;

(b) then, the plan of the spouse of the parent with custody of the child;

(c) finally, the plan of the parent not having custody of the child; and

(d) if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) A plan that covers a *member* as an active *employee* or as a *dependent* of such *employee* pays first. A plan that covers a person as a laid-off or retired *employee* or as a *dependent* of such *employee* pays second.

If the plan with which we're coordinating does not have a similar provision for such persons, then (4) will not apply.

If rules (1), (2), (3) and (4) don't determine which plan pays first, the plan that has covered the person for the longer time pays first.

To determine the length of time a *member* has been covered under a plan, two plans will be treated as one if the *member* was eligible under the second within 24 hours after the first plan ended.

The *member's* length of time covered under one plan is measured from his or her first date of coverage under the plan. If that date is not readily available, the date the *member* first became a *member* of the group will be used.

How This Provision Works: Coordination of Benefits

Coordination With An Indemnity Or PPO Dental Plan

When a *member* is covered by this plan and a fee-for-service plan, the rules which follow will apply:

For *PCDs'* services:

- when this *plan* is primary, the *PCD* submits a claim to the secondary plan for the *patient charge* amount. Any payment made by the secondary carrier must be deducted from the *member's* payment.
- when this *plan* is secondary, the *PCD* submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the *patient charge,* reducing the *member's* out-of-pocket expense.

For *participating specialists'* services and *emergency dental services* within the *service area:*

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, any payment made by the primary carrier is credited against the *patient charge,* reducing the *member's* out-of-pocket expense.

For *emergency dental services* outside the *service area:*

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, *we* pay for covered services not paid by the primary plan, up to $50.00, after payment of any *patient charge* which may apply.

Coordination With A Pre-Paid Dental Plan

A *member* may also be covered under a pre-paid dental plan where *members* pay only a fixed payment amount for each covered service. This *plan* does not coordinate benefits with another pre-paid dental plan.

Our Right To Certain Information

In order to coordinate benefits, *we* need certain information. A *member* must supply *us* with as much of that information as he or she can. If he or she can't give *us* all the information *we* need, *we* have the right to get this information from any source. If another insurer needs information to apply its coordination provision, *we* have the right to give that insurer such information. If *we* give or get information under this section, *we* can't be held liable for such action except as required by law.

When payments that should have been made by this *plan* have been made by another plan, *we* have the right to repay that plan. If *we* do so, we're no longer liable for that amount. If *we* pay out more than *we* should have, *we* have the right to recover the excess payment.

This section will be used to determine a *member's* benefits under this *plan* when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily injury sustained by a *member* as a result of an accident caused by an automobile or by an object propelled by or from an automobile; a) while occupying, entering, leaving, or using an automobile; or b) as a pedestrian.

"Allowable Expenses" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by: a) this *plan;* b) PIP; or c) OSAIC.

"Eligible Expenses" means that portion of the expense incurred for treatment of an injury which is covered under this *plan* without the application of cash deductibles and encounter fees, if any, or coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance plan other than PIP. PIP refers specifically to provisions for medical expense coverage.

"PIP" means personal injury protection coverage provided as part of an automobile insurance plan issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination Of Primary Or Secondary Coverage

This *plan* provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the *member* under this *plan.* This election is made by the named insured under a PIP plan. Such election affects that person's family members who are not themselves named insureds under another automobile plan. This *plan* may be primary for one *member,* but not for another *member* if that *member* has separate automobile *plans* and has made different selections regarding primacy of health coverage.

This *plan* is secondary to OSAIC, unless the OSAIC contains provisions which makes it secondary or excess to the planholder's *plan.* In that case this *plan* will be primary.

If there is a dispute as to which *plan* is primary, this *plan* will pay benefits as if it were primary.

Benefits This Plan Will Pay If It Is Primary To PIP Or OSAIC

If this *plan* is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms. The rules of the Coordination of Benefits section of this *plan* will apply if:

- the *member* is insured under more than one insurance *plan;* and
- such insurance *plans* are primary to automobile insurance coverage.

Benefits This Plan Will Pay If It Is Secondary To PIP Or OSAIC

If this *plan* is secondary to PIP or OSAIC the actual benefits payable will be the lesser of: a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying cash deductibles and encounter fees; or b) the benefits that would have been paid if this *plan* had been primary.

STATEMENT OF ERISA RIGHTS

As a participant, *you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all *plan* participants shall be entitled to:

(a) Examine, without charge, all *plan* documents, including contracts, collective bargaining agreements and copies of all documents filed by the *plan* with the U.S. Department of Labor, such as detailed annual reports and *plan* descriptions. The documents may be examined at the *plan* Administrator's office and at other specified locations such as worksites and union halls.

(b) Obtain copies of all *plan* documents and other *plan* information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

(c) Receive a summary of the *plan's* annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people, called "fiduciaries," who are responsible for the operation of your benefit *plan*. They have a duty to operate the *plan* prudently and in the interest of *plan* participants and beneficiaries. Your *employer* may not fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, *you* must receive a written explanation of the reason for the denial. *You* have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, *you* may file suit in a federal court if *you* request materials from the *plan* and do not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay *you* up to $110.00 a day until *you* receive them (unless the materials were not sent because of reasons beyond the Administrator's control.) If your claim for benefits is denied in whole or in part, or ignored, *you* may file suit in a state or federal court. If *plan* fiduciaries misuse the *plan's* money, or discriminate against *you* for asserting your rights, *you* may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If *you* lose, the court may order *you* to pay: for example, if it finds your claim is frivolous. If *you* have any questions about your *plan, you* should contact the Plan Administrator. If *you* have any questions about this statement or about your rights under ERISA, *you* should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

We agree to duly investigate and endeavor to resolve any and all complaints received from *members* with regard to the nature of professional services rendered. Any inquiries or complaints shall be made to *us* by writing or calling *us* at the address and telephone indicated in this booklet.