EVIDENCE OF COVERAGE

Managed DentalGuard, Inc.
5850 Granite Parkway, Suite 800
Plano, Texas 75024
1-888-618-2016

The Group Dental Coverage described in this Evidence of Coverage is attached to the group Plan effective September 1, 2019. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Plan or under any other Plan providing similar or identical benefits issued to the Planholder by Us.

MANAGED DENTAL CARE PLAN

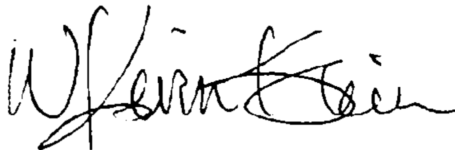
GROUP DENTAL COVERAGE

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP PLAN.

We certify that the Subscriber to whom this Evidence of Coverage is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Subscriber must: (a) satisfy all of the Plan's eligibility and Effective Date requirements; (b) be listed in Our and/or the Planholder's records as a validly covered Subscriber under the Plan; and (c) all required premium payments must have been made by or on behalf of the Subscriber.

The Subscriber is not covered by any part of the Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Planholder's records.

Planholder: GARLAND INDEPENDENT SCHOOL DISTRICT
Group Plan Number: 00562276
Effective Date: September 1, 2019



Kevin Klein, President
and Chief Executive Officer

Harris Oliner, Senior Vice President
and Corporate Secretary

B426.0005

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Managed DentalGuard, Inc.'s toll-free telephone number for information or to make a complaint at:

1-888-618-2016

You may also write MDG at:

Managed DentalGuard, Inc.
5850 Granite Parkway, Suite 800
Plano, TX 75024

You may contact the Texas Department of Insurance on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # 1 - (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim, You should contact MDG first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR PLAN: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Managed DentalGuard, Inc.'s para informacion o para someter una queja al:

1-888-618-2016

Usted tambien puede escribir a MDG:

Managed DentalGuard, Inc.
5850 Granite Parkway, Suite 800
Plano, TX 75024

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # 1 - (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene un disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse MDG primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Tejas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

B426.0007

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Applicable Benefits

This Evidence of Coverage may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

B426.0010

Limitation of Authority

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

No change in this Evidence of Coverage will be valid unless evidenced by: (a) an endorsement or rider to this Evidence of Coverage signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of Us; or (b) an amendment to this Evidence of Coverage signed by the Planholder and by one of Our officers.

Only Our President, a Vice President or a Secretary has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Plan or Evidence of Coverage is to be issued;
- Waive or alter any contract, Plan or Evidence of Coverage, or any of Our requirements;
- Bind Us by any statement or promise relating to the Plan issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Plan or waive any of its provisions.

B426.0011

Incontestability

All statements made by the Subscriber on the written enrollment application are considered representations and not warranties. The statements are considered to be truthful and are made to the best of the Subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew a Subscriber's coverage or reduce benefits unless (a) it is in a written enrollment application signed by the Subscriber; and (b) a signed copy of the enrollment application is or has been furnished to the Subscriber or the Subscriber's personal representative.

A group Evidence of Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application. For small employer coverage, the misrepresentation shall be other than a misrepresentation related to health status.

We may increase the premium charge to an appropriate level if We determine that the Subscriber made a material misrepresentation of health status on the application. We must provide the Planholder 60 days prior written notice of any premium rate change.

In the event Your coverage is rescinded, We will refund premiums paid for the periods such coverage is void. The premium paid by You will be sent to Your last known address on file with the Planholer or Us.

B426.0013

Conformity With Statutes

This Plan will be governed by the laws of the State of Texas.

B426.0017

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Enrollment Procedures

In order for You to become a Subscriber under this Evidence of Coverage, (a) You must reside or work in the Plan's approved Service Area, and (b) the legal residence of any enrolled dependent must be:

(1) the same as Your residence;

(2) in the Service Area with the person having temporary or permanent conservatorship or guardianship of such dependent, including an adoptee or child who is the subject of a suit for adoption by You, where You have legal responsibility for the health care of such dependent; or

(3) anywhere in the United States for a child whose coverage under a Plan is required by a medical support order.

You may enroll for dental coverage by:

- Completing and signing the appropriate enrollment form and any additional material required by Your Planholder.
- Returning the enrollment material to Your Planholder. Your Planholder will forward these materials to Us.

The enrollment materials require You to select a Primary Care Dentist (PCD) for each Member. After Your enrollment material has been received by Us, We will determine if a Member's selected PCD is available under Your Plan. If the PCD is available under the Plan, 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.

We will issue You and Your dependents, either directly or through Your Planholder's representative, an ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

B426.0019

Open Enrollment Period

If You do not enroll yourself or Your eligible dependents for dental coverage under this Plan within 30 days of: a) the date of becoming eligible or b) the date of a Qualifying Event, 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 Planholder and Us.

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 one full year.

B426.0021

Subscriber Eligibility

You are eligible for dental coverage if You are:

- In an eligible class of Subscribers;
- An active Full-Time Subscriber; and
- Working at least the minimum required number of hours in Your eligible class at:
  - The Planholder's place of business;
  - Some place where the Planholder's business requires You to travel; or
  - Any other place You and the Planholder have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for dental coverage if You are:

- A temporary or seasonal Subscriber; or
- The Subscriber for whom, pursuant to a collective bargaining agreement, the Planholder makes any payments to any kind of health and welfare benefit plan other than under this Evidence of Coverage.

B426.0025

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent children:

1. Who are under age 26;

   - Dependent child includes: (1) a stepchild who is dependent on You for most support and maintenance; (2) newborn child; (3) legally adopted child or foster child; (4) grandchild who is Your or Your Spouse's dependent for federal income tax purposes at the time the application for coverage of the grandchild is made; or (5) a child for whom You are court-appointed legal guardian, if the child (a) is part of Your household, and (b) is primarily dependent on You for support and maintenance. It also includes any child for whom a court-ordered decree requires You to provide dependent coverage, and any child who is the subject of a legal suit for adoption by You.

2. A mentally retarded or physically handicapped child who: (a) has reached the age limit of a dependent child: (b) is not capable of self-sustaining work: and (c) 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 age limit, and each year after that, if requested by Us. We cannot ask for this proof more than once a year.

Eligible dependent does not include anyone who is insured under this Plan as the Subscriber.

B426.0031

When Coverage Starts

Your Planholder will inform You of Your Effective Date under the dental Plan. Your coverage begins on the date:

- You and Your eligible dependent(s) are eligible for the dental Plan as stated in the Conditions Of Eligibility for Group Dental Coverage section; and
- You and Your eligible dependent(s) have enrolled in the dental Plan; and
- If Your dependent child is:
  - A newborn then coverage begins on the date of birth. Coverage will automatically be provided for the initial 31 days from birth. For coverage to continue after the 31 day period, notice must be provided and any additional premium, if any, must be received by Us within the 31 day period.
  - (a) A stepchild, or (b) a foster child then coverage begins when the child begins to reside in Your home.
  - An adopted child then coverage begins on the date the child is subject to a legal suit for adoption. Coverage will automatically be provided for the initial 31 days. For coverage to continue after the 31 day period, notice must be provided and any additional premium, if any, must be received by Us within the 31 day period.

- You must complete enrollment materials for a newborn, adopted, stepchild or foster child within 31 days of the child's coverage Effective Date.

- Required premiums have been paid.

If you not enroll by Your Effective Date, Your coverage will begin on:

- The first day of the month following the date enrollment materials are received by Us; or
- The first day of the month after the end of any waiting period Your Planholder may require; or
- The date you are eligible for the Plan based on the Planholder's eligibility rules as approved by Us.

B426.0035

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

And if:

- You were fully capable of performing Active Work for the Planholder for the minimum number of hours of the Subscriber in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Subscriber in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Evidence of Coverage placed.

B426.0037

When Your Coverage Ends

Your coverage will end on the first of the following events:

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Subscriber under this Evidence of Coverage.
- The last day of the month in which you no longer reside or work in the Service Area.
- The date 30 days after We send written notice to You advising that coverage will end because You no longer reside or work in the Service Area. Such action must be taken by Us uniformly and without regard to any health-status related factors of a Subscriber. But coverage will not end for a child who is the subject of a medical support order.
- The date the group Evidence of Coverage ends, or is discontinued for a class of Subscribers to which You belong.
- The last day of the period for which required payments are made for You.
- The end of the 31-day grace period following the period for which Your Planholder last made the required premium payment.
- If You are required to pay all or part of the cost of coverage but fail to do so, the end of the period for which You made the last required payment.
- The end of the month during which Your Planholder receives written notice from You requesting termination of coverage for You and Your dependents, or on such later date as You may request by the notice.
- 15 days after We send written notification to the Subscriber advising that his or her coverage will end because the Subscriber has knowingly given false information in writing on his or her enrollment form, misused his or her ID card or other documents to obtain benefits under this Plan, or otherwise acted in an unlawful or fraudulent manner regarding services and benefits.
- 30 days after We send written notification to the Subscriber where We have addressed the failure of the Subscriber and his or her PCD to establish a satisfactory patient-Dentist relationship, offered the Member the opportunity to select another PCD and described the changes necessary to avoid termination.
- The date 30 days after We send written notice to You advising that coverage will end because You failed to pay Patient Charges that are due.
- The date of Your misconduct, which is detrimental to the safety of Our operations and the delivery of services.
- The date You die.

- Upon Your being no longer eligible for coverage, Texas law requires that Your Planholder provide You with coverage including the payment of premiums until the end of the month in which We are notified by Your Planholder You are no longer an eligible Subscriber. This does not apply:

  1. When the 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 We receive notice from Your Planholder within the first 3 business days of the next month;
  3. If Your Planholder notifies Us at least 30 days prior to the date You are no longer eligible under the Plan;
  4. When You elect to end coverage and obtain other coverage which takes effect after termination of eligibility under the Plan and prior to the end of coverage under the 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 the 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: the date of Your death or the date You receive the last covered service under the Plan.

B426.0041

When Your Dependent Coverage Ends

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Subscriber under this Evidence of Coverage.
- The date the group Evidence of Coverage ends, or dependent coverage is discontinued for a class of Subscribers to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- The date 30 days after We send written notice to a Member advising that coverage will end because the Member no longer resides or works in the Service Area. Such action must be taken by Us uniformly and without regard to any health-status related factors of a Subscriber. But, coverage will not end for a child who is the subject of a medical support order.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.

- For Your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.
- Upon Your being no longer eligible for coverage, Texas law requires that Your Planholder provide You with coverage including the payment of premiums until the end of the month in which We are notified by Your Planholder You are no longer an eligible Subscriber. This does not apply;

  1. When the 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 We receive notice from Your Planholder within the first 3 business days of the next month;
  3. If Your Planholder notifies Us at least 30 days prior to the date You are no longer eligible under the Plan;
  4. When You elect to end coverage and obtain other coverage which takes effect after termination of eligibility under the Plan and prior to the end of coverage under the 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 the 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: the date of Your death or the date You receive the last covered service under the Plan.

B426.0047

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Evidence of Coverage carefully for details and discuss with Your Planholder or administrator.

B426.0051

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

B425.0071

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a Federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Plan would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Planholder for additional information.

B426.0055

COBRA Continuation Rights

If dental coverage for You or Your dependents ends, You or Your dependents may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Planholder or visit our website at www.GuardianAnytime.com.

B426.0057

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Planholder for information regarding such legally mandated leave of absence laws.

B426.0059

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Planholder's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B426.0060

Texas Continuation Rights

A Member whose dental coverage under the Plan ceases for any reason other than involuntary termination for cause and who has been continuously covered under the Plan for at least three consecutive months immediately prior to such termination, or under any prior Group Dental Plan providing similar coverage that the Plan replaces, may request dental coverage continuation.

Election of dental coverage continuation must be requested in writing by the Member to the Planholder no later than the 60th day after the later of the:

- date dental coverage would otherwise terminate; or
- date the Member is given notice by the Planholder of the right to elect to continue dental coverage.

The Member who elects to continue dental coverage must pay the Planholder no later than the 45th day after the initial election and monthly thereafter on the payment due date the contribution amount required by the Planholder, plus 2% of the coverage amount for the dental coverage under the Plan. Following the first payment made for initial coverage election, any other premium payment is considered timely if made on or before the 30th day after the date payment is due.

Group dental coverage continued may not terminate until the earliest of:

- the date the maximum continuation period provided by law would end, which is for any Member:

    - not eligible for continuation coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), nine months after the date the Member elects to continue the dental coverage; or
    - eligible for continuation coverage under COBRA, six additional months following any period of continuation coverage provided under COBRA;
- the date failure to make timely payments would terminate dental coverage;
- the date the dental coverage terminates in its entirety;
- the date the Member is or could be covered under Medicare;
- the date the Member is covered for similar benefits by another Dental Group Plan;
- the date the Member is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- the date similar benefits are provided or available to the Member under any state or federal law other than continuation coverage under COBRA.

Not later than the 30th day before the end of the continuation period described above that is applicable to the Member, the insurer must:

- notify the Member may be eligible for coverage under the Texas Health Insurance Risk Pool as provided by Chapter 1506; and
- provide to the Member the address for applying to that pool.

B426.0061

Texas Dependent Continuation Rights

This section applies only to the dental coverage provided by this Plan if coverage ends due to:

- the severance of a family relationship; or
- the retirement or death of the Subscriber.

A dependent of a Subscriber is eligible to continue dental coverage if:

- the dependent has been a member of the Plan for a period of at least one year; or
- is an infant under one year of age.

A dependent who exercises the option to continue dental coverage is not required to take and pass a physical examination as a condition to continuing coverage.

A Member covered under group continuation coverage is entitled to coverage that is identical in scope to the group dental coverage provided under this Plan. No additional exclusions that were not included in this Plan will be included in the group continuation coverage.

If the group Planholder replaces this Plan within the period described below, a Member covered under group continuation coverage may obtain group dental coverage benefits identical in scope to the group dental coverage under the replacement group plan.

The premium will not be more than the premium charged under this Plan for the dependent had the family relationship not been severed.

A Member covered under group continuation dental coverage is required to pay premiums for the group dental coverage directly to the Planholder. Premiums may be paid in monthly installments with an additional administrative fee of $5.00.

At the time this Plan is issued, the Planholder is required to give written notice of this continuation to each Member.

We require a Member to provide written notice to the Planholder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option. Written notice may be given by the Subscriber.

On receipt of notice, the group Planholder shall immediately give written notice of the continuation option to each affected Member.

On receipt of notice of the death or retirement of the Subscriber, the Planholder must immediately give written notice of the continuation option to each dependent of the Subscriber. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the Subscriber, a Member must give written notice to the Planholder of the election to exercise the continuation option. Coverage under this Plan remains in effect during the period if the Plan's premiums are paid.

If a Member does not give written notice of the election to exercise the continuation option within the time period, the option expires.

Any period of previous dental coverage under this Plan must be used in full or partial satisfaction of any required probationary or waiting periods for Member coverage.

If this Plan provides to a Member continuation rights to cover the period between the time the Subscriber, retires and or is eligible for Medicare, the same continuation rights are available to the Subscriber's dependents.

The dental coverage of a Member who exercises the continuation option operates without interruption and may not be canceled or otherwise terminated until:

- the Member fails to make a premium payment within the time required to make the payment;

- the Member becomes eligible for substantially similar coverage under another Group Dental Plan or
- the third anniversary of (a) the severance of the family relationship or (b) the retirement or death of the Subscriber.

B426.0062

DENTAL BENEFITS

This Plan will cover many of the dental expenses incurred by You and those of Your dependents who are covered under this Plan. We interpret how the Plan is to be administered. What We cover and the terms of coverage are explained below.

B426.0068

How to Contact Us

Our customer service associates can assist You with benefit coverage questions, resolving problems, selecting or changing a Dentist. A customer service associate can be reached toll free Monday through Friday at 1-888-618-2016 from 8:30 a.m. to 6:30 p.m. Central Standard Time. An automated service is also provided after hours for eligibility verification.

B426.0065

Managed Dental Care

This Plan is designed to provide quality dental care while controlling the cost of such care. To do this, the Plan requires Members to seek dental care from Contracted Dentists that belong to the Network.

The Network is made up of Contracted Dentists in the Plan's approved Service Area. A Contracted 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 current Contracted General Dentists. Each Member must be assigned to a Primary Care Dentist (PCD). The PCD will coordinate all of the Member's dental care covered by this Plan. After enrollment, a Member will receive an ID card. A Member must present this ID card or supply the Group Number and Member ID number when he or she goes to their PCD.

All dental services covered by this Plan must be coordinated by the PCD to whom the Member is assigned. What We cover is based on all the terms of this Plan. Please refer to the Schedule of Benefits for Group Dental Coverage information including Covered Dental Procedures and Patient Charges, Benefit Limitations and Exclusions.

B426.0066

A Member may choose any available Contracted General Dentist as his or her PCD. A request to change a PCD must be made to Us. Any such change will be effective the first day of the month following approval however, We may require up to 30 days to process and approve such request. All fees and Patient Charges due to the Member's current PCD must be paid in full prior to such transfer.

B425.0088

Changes in Dentist Participation

We may have to reassign a Member to a different Contracted Dentist if:

- The Member's Dentist is no longer a Contracted Dentist in the Network; or
- We take 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 Contracted Dentist.

If a Member has a dental service in progress at the time of the reassignment, We will subject to applicable law, either:

- Arrange for completion of the services by the original Dentist;
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service. If a Member has special circumstances as defined in section 843.362 of the Texas Insurance Code, a Member may be eligible for up to 90 days of continuing treatment from such Contracted Dentist after the Member's effective date of termination.
- The treating Dentist must:
  - Identify the special circumstance for which a Member needs services.
  - Request a Member be permitted to continue treatment under the Dentist's care, and
  - Agree not to seek payment from a Member for any amount for which a Member would not be responsible if the Dentist continued participation in the Network.

B426.0069

Refusal of Recommended Treatment

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

B425.0090

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

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

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a Contracted Specialist is required, the PCD must complete the specialty referral request form. At this point, the following options are available:

  (a) The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to Us. We will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Contracted Specialist to schedule an appointment.

  (b) The PCD may determine that the direct referral to the Contracted Specialist fits the referral plan guidelines. If so, the PCD will complete the specialty referral request form and provide this form to the Member and the Contracted Specialist. We will retrospectively review the direct referral upon receipt of the Contracted Specialist's claim, once the Contracted Specialist's procedures or services have been completed.

If the PCD's request for specialty referral is denied (an Adverse Determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. Refer to the Complaint and Appeal Procedures section for additional information.

If the service in question is a covered service and no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

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

A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

When specialty dental care is referred by the PCD, a Member will be referred to a Contracted Specialist for treatment. The Network includes Contracted 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 Contracted Specialist in the Plan's approved Service Area, We will refer the Member to a Non-Contracted specialist Dentist of Our choice.

B426.0071

Out of Network Services

If a covered dental procedure is not available through a Contracted Dentist or Contracted Specialist, We will, upon request from a Contracted Dentist or Contracted Specialist, allow referral to a Non-Contracted Dentist or specialist who will provide the covered services for the dental procedure where;

- A response to such request will be provided within 5 business days after receipt by Us of reasonably requested documentation for the covered dental procedure; and
- Any reimbursement for a Non-Contracted Dentist or specialist will be paid at the Non-Contracted Dentist's or Non-Contracted specialist's usual and customary rate or at an agreed rate.
- Before denying a request for out of Network services, We will provide for a review of the requested dental procedure by a specialist of the same or similar type of specialty as the Non-Contracted Dentist or specialist to whom the referral is requested.

B426.0072

Emergency Dental Services

The 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 Us for an authorization to obtain services from another Dentist. If the Member is unable to obtain a referral or authorization for Emergency Dental Services, the Member may obtain Emergency Dental Services from any Dentist. If Emergency Dental Services are performed by a Contracted General Dentist, We will reimburse the Member for the cost of covered Emergency Dental Services, less the applicable Patient Charge(s). If Emergency Dental Services are performed by a Non-Contracted specialist Dentist, the Member will be responsible for the Dentist's usual fee.

Members must submit, to Us, the following information within 60 days or as soon as reasonably possible:

- A copy of the Dentist statement for the emergency services.
- Evidence of payment.
- A brief explanation of the emergency.

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 Us, coverage is limited to the benefit for a palliative treatment (code D9110).

B426.0073

DENTAL CLAIM REIMBURSEMENT

A claim for a covered Emergency Dental Services or authorized specialty care should be sent to Us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if a Member can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. Claims may be submitted to: 21820 Burbank Blvd., Suite 200, Woodland Hills, CA 91367.

We will acknowledge receipt of a Member's claim in writing and initiate investigation within 15 business days. The Member will be requested to provide additional information, if required.

A claim submitted with all necessary information will be accepted or rejected within 15 business days of receipt. Notice of rejected claims will state the reasons for the rejection. In the event additional information is required and a determination cannot be made, a Member will receive notification within this 15-day period stating the reason for the delay.

A claim will be accepted or rejected within 45 days of that notice. Accepted claims will be paid no later than the 5th business day following notice of acceptance. If payment is subject to performance of an act by a Member, the claim will be paid no later than the 5th business day after the date the act is performed. For more information, please refer to Specialty Referrals and Emergency Dental Services.

B426.0074

Extended Dental Benefits

If a Member's coverage ends, We extend dental expense benefits for him or her under this Plan. We extend benefits for covered services other than orthodontic services only if the procedures are started before the Member's coverage ends and are completed within 90 days after the date his or her coverage ends.

- Inlays, onlays, crowns and bridges are started on the date the tooth or teeth are initially prepared.
- Dentures are started on the date the impressions are taken.
- Root canals are started on the date the pulp chamber is opened.

Coverage for orthodontic services ends upon the termination of the Member's coverage under this Plan.

The extension of benefits ends 90 days after the Member's coverage ends or the date he or she becomes covered under another plan which provides coverage for similar dental procedures, whichever occurs first. 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.

B426.0075

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) 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. Each plan is considered separately when coordinating payments.

Definitions

"Allowable expense" is a dental care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(2) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(3) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the Dentist has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Dentist's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

"Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a Non-Contracted Dentist. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the Member is responsible.

"Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

"Plan" means any of the following that provides dental expense benefits or services: (1) group or blanket insurance plans; (2) group Blue Cross plans, group Blue Shield plans or other service or prepayment plans on a group basis; (3) union welfare plans, employer plans, employee benefits plans, trusteed labor and management plans, or other plans for members of a group; (4) individual insurance contracts that pay or reimburse for the cost of dental care and (5) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other governmental program or coverage which We are not allowed to coordinate with by law. "Plan" also does not include blanket school accident-type coverage or disability income protection coverage.

"This Plan" means the part of this Plan subject to this Coordination of Benefits provision.

B426.0077

How This Provision Works: Order of Benefit Determination Rules

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its plan terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

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, unless the provisions of both plans state that the complying plan is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

(1) **Nondependent or Dependent.** A plan that covers a Member as an employee or retiree pays first, the plan that covers a Member as a dependent pays second;

(2) **Dependent Child/Parents Not Separated or Divorced.** Except for dependent children of separated or divorced parents, the following governs which plan pays first when the Member is a dependent child of an employee:

(a) The plan that covers a dependent of an employee whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of an employee whose birthday falls later in the calendar year pays second. The employee's year of birth is ignored.

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

(3) **Dependent Child/Separated or Divorced Parents.** For a dependent child of separated or divorced parents, or parents not living together (whether or not they have ever been married), the following governs which plan pays first when the Member is a dependent of an employee:

(a) If a court order makes one parent financially responsible for the health care expenses or health care coverage of the dependent child, and the plan of that parent has actual knowledge of those terms, then that parent's plan pays first;

(b) If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the order of benefit determination rules outlined in the Dependent Child/Parents Not Separated or Divorced rule will apply.

(c) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the order of benefit determination Dependent Child/Parents Not Separated or Divorced rule will apply.

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) the plan of the parent with custody of the child;

(ii) the plan of the spouse of the parent with the custody of the child;

(iii) the plan of the parent not having custody of the child; and

(iv) the plan covering the Spouse of the noncustodial parent.

(4) **Dependent Child/Non-Parents.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits determination Nondependent or Dependent rule will apply.

(5) **Dependent Child with Spouse Coverage.** For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, the order of benefits determination Longer/Shorter Length of Coverage rule will apply. However, in the event that the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plan, the order of benefits is to be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's Spouse.

(6) **Active, Retired, or Laid-off Employee.** 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 that we're coordinating with does not have a similar provision for such persons, then this rule will not apply. This rule does not apply if the Nondependent and Dependent rule can determine the order of benefits.

(7) **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, Member, subscriber, or retiree or covering the person as a dependent of an employee, Member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent and Dependent rule can determine the order of benefits.

(8) **Longer or Shorter Length of Coverage.** If the rules above 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 insured under a plan, two plans will be treated as one if the covered person was eligible under the second within 24 hours after the first plan ended. The Member's length of time covered under a 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. The start of a new plan does not include: a) a change in the amount or scope of a plan's benefits; b) a change in the entity which pays, provides or administers plan benefits; or c) a change from one type of plan to another.

(9) **Sharing Equally Between Plans.** If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

B426.0078

How This Provision Works: Coordinating Benefits

Coordination with Another Pre-Paid Dental Plan:

A Managed DentalGuard Member may also be covered under another pre-paid dental plan where Members pay only a fixed payment amount for each covered service.

For Primary Care Dentists' services, when the Primary Care Dentist participates under both pre-paid plans, the Member will never be responsible for more than the Managed DentalGuard Patient Charge.

For Participating Specialist Dentists' services, when this Plan is primary, our benefits are paid without regard to the other coverage. When this Plan is the secondary coverage, any payment made by the primary carrier is credited against the Patient Charge. In many cases the Member will have no out-of-pocket expenses.

For Emergency Dental Services outside the Service Area, when this Plan is primary, this Plan's benefits are paid without regard to the other coverage. When this Plan is the secondary coverage, this Plan pays the balance of expenses not paid by the primary plan, up to this Plan's usual benefit.

B426.0079

When a Member is covered by this Plan and a fee-for-service plan, the following rules will apply:

- For Primary Care Dentists' services, when this Plan is the primary plan, the Primary Care Dentist 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.
- For Primary Care Dentists' services, when this Plan is the secondary plan, the Primary Care Dentist 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 Specialist Dentists' services, when this Plan is the primary plan, our benefits are paid without regard to the other coverage. When this Plan is the secondary plan, 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, the Plan's benefits are paid without regard to the other coverage. When this Plan is the secondary coverage, this Plan pays the balance of expenses not paid by the primary Plan, up to this Plan's usual benefit.

B426.0080

Complaint Overview

Members are entitled: (a) to have any complaint reviewed by Us; and (b) to be provided with a resolution in a timely manner. We review each complaint in an objective, nonbiased manner and consider reaching a timely resolution a top priority.

The Member or Dentist may contact the customer 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 Our operation, including but not limited to Our 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 Member's oral or written expression of dissatisfaction or disagreement with an adverse determination.

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 medically 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.

Our customer services department and the QCL can be contacted by telephone at:

1-888-618-2016
or by mail at:
21820 Burbank Blvd., Suite 200, Woodland Hills, CA 91367

GC-DHMO-16-TX

The 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 Us. If the Member wishes to contact the Texas Department of Insurance to discuss the Independent Review process, the telephone number is:

1-888-834-2476

Complaint Process

Members make their concerns known by: (a) calling the customer services department, using the toll-free telephone number; or (b) directly contacting Us in writing.

Our customer services department document each telephone call and work with the Member to resolve their oral Complaint. The Member will be sent, within 5 business 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.

Upon receipt of a written Complaint or the Complaint Form, the QCL or QCL designee sends an acknowledgement letter to the Member within 5 business days. If a Complaint is made orally, an acknowledgement letter accompanied by a one-page complaint form that prominently and clearly states that the form must be returned to Us for prompt resolution of the Complaint.

We will review and resolve the written Complaint within 30 calendar 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. We 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 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; Contracted General Dentist and/or Contracted Specialist 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. In addition, the method by which a Member can contact the Texas Department of Insurance for additional assistance will be noted in the resolution letter.

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

The Texas Department of Insurance may review Complaint documentation during any Plan review.

We assert We are prohibited from retaliating against a group Planholder or a Member because the group Planholder or Member has filed a Complaint against Us or appealed a decision of Ours. We are 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 Us or appealed Our decision.

The Complaint Committee and the Peer Review Committee

The Dental Director or the Directors designee and/or the QCL or QCL designee, may refer Complaints 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 Peer Review Committee will meet quarterly and as needed.

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

B426.0081

Complaint Appeal Process

If the Member is not satisfied with the resolution, the Member may make a telephone or written request 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 also be asked to send the request in writing. An acknowledgement letter will be sent to the Member within 5 business days from receipt of the written request for appeal.

This Committee will meet within 30 calendar days from receipt of the written request for appeal. The Committee is composed of an equal number of:

a. Representative(s) from Us;

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

c. Representative(s) selected from Contracted Specialist Dentists (if the complaint concerns specialty care); and

d. Representative(s) selected from plan Members who are not Our 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 business days from the date of receipt of the written request for an appeal, the Member will be sent written notice:

(a) acknowledging the date the appeal was received; and

(b) giving the date and location of the Committee meeting.

The Member will also be advised that:

(a) Member may appear in person before the Committee; or through a representative, if the Member is a minor or disabled before the Committee; or

(b) address a written appeal to the Committee; and

(c) may also bring any person to the Committee meeting. But, the participation of such person is subject to Our Complaint Appeal Committee guidelines.

The Member has the right to present: (a) written or oral information; and (b) alternative expert testimony and (c) 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 or at another site agreed to by the Member, or address a written appeal to the Complaint appeal board.

We will 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 business days prior to the Committee meeting, unless the complainant agrees otherwise, We 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 business days after the date of the Committee resolution. The resolution notice will include a written statement of:

(a) the specific medical determination;

(b) clinical basis; and

(c) the contractual criteria used to reach the final decision.

The notice will also prominently and clearly state the toll free telephone number and address of the Texas Department of Insurance.

The Member will provide for his/her own expenses relating to the Committee process. We will pay for its expenses relating to the Committee process. We will pay for the expenses of Our representative(s) and representative(s) selected from Contracted General Dentists and/or Contracted Specialists Dentists and the expenses of representatives selected from Our plan members. Following the decision of the Committee, We and the Member each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Contracted Dentist. Any use of arbitration by Us or a Member is voluntary and will be conducted in compliance with the Texas Civil Practice and Remedies Code, Chapter 171.

The Member may also contact the Texas Department of Insurance to file a complaint. The Department's address and toll-free telephone number are:

P. O. Box 149104
Austin, TX 78714-9104

Telephone: (800) 252-3439
Fax # 1 - (512) 490-1007
Web; www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

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

B426.0082

Emergency Complaints

Complaints involving an emergency will be concluded in accordance with the dental immediacy of the case not more than 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 Independent Review Organization without filing an appeal. (See the Utilization Review and Utilization Appeal Processes which follows.)

Documentation Database

With Our 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 calendar days, if applicable.

We categorize complaints using the following:

- Quality of Care of Services
- Accessibility/Availability of Services
- Utilization Review or Management
- Complaint Procedures
- Physician and Provider Contracts
- Group Subscriber Contracts
- Individual Subscriber Contracts
- Marketing
- Claims Processing
- Miscellaneous

The three 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 to that a Complaint has been received and is being reviewed by the QCL or the 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 about 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.

Utilization Review and Utilization Appeal Processes

A copy of the Member Notification of the Utilization Review Appeals process that states an Independent Review can be requested after the first Appeal; unless the Member has a life-threatening condition or a Member who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the Plan. (See Expedited Appeals.)

Expedited Appeals: Oral notification of the Expedited Appeal decision will be made no later than 1 business day from the receipt of all necessary information, followed up by the written notification with 3 business days from the date of receipt of all necessary information.

For a Member with a life-threatening condition or a Member who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance Plan, the Member is entitled to immediately appeal to an Independent Review Organization (IRO) and is not required to comply with the internal appeal process.

The Member can contact the customer services department at:

1-888-618-2016
21820 Burbank Blvd., Suite 200,
Woodland Hills, CA 91367

The plan hours are from 8:30 a.m. to 6:30 p.m. Central Time. The Service Area is in the Central Time Zone.

B426.0133

DEFINITIONS

This section defines certain terms appearing in Your Evidence of Coverage.

B426.0083

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Planholer, at:

- One of the Planholder's usual places of business;
- Some place where the Planholder's business requires You to travel; or
- Any other place You and the Planholder have agreed on for Your work.

B426.0084

Alternative Procedure: This term means a procedure other than that recommended by the Member's Primary Care Dentist, but which in the opinion of the Primary Care Dentist also represents an acceptable treatment approach for the Member's dental condition.

B425.0103

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Us to participate in Our dental Network.

B425.0105

Contracted General Dentist: This term means a licensed dentist under contract with Us who is listed in Our directory of Contracted Dentists as a general practice dentist and who may be selected as a Primary Care Dentist by a Member.

B425.0106

Contracted Specialist: This term means a licensed Dentist under contract with Us as an endodontist, oral surgeon, orthodontist, pediatric dentist or periodontist.

B425.0107

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or Evidence of Coverage and covered by this Plan.

B426.0093

Effective Date: This term means the date the Plan goes into force and effect as stated on the cover page of the Evidence of Coverage, or any change to the Plan as requested by the Planholder and approved by Us and in force and effect as stated on cover page of the Evidence of Coverage.

B426.0094

Eligibility Date: This term means the earliest date You are eligible for coverage under this Evidence of Coverage as directed by the Planholder, and you have satisfied all requirements for coverage to begin, as required by this Evidence of Coverage.

B426.0095

Emergency Dental Service: This term means procedures administered in a Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

B426.0096

Evidence of Coverage: This term means this Evidence of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Evidence of Coverage.

B426.0097

Full-time: This term means:

You are not a Part-time Subscriber as defined by Your Planholder and You work at least the minimum required number of hours for the Subscriber in Your eligible class (but not less than 10 hours per week) at:

- Your Planholder's place of business;
- Some place where the Planholder's business requires You to travel; or
- Any other place You and Your Planholder have agreed upon for the performance of Your job.

B426.0099

Member: This term means You, if You are covered by this Plan, and any of Your covered dependents.

B426.0102

Network: this term means Managed DentalGuard, Inc. network.

B426.0104

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Us to provide dental services to Subscribers in Our benefit Plan.

B426.0105

Patient Charge: This term means the amount the Member is responsible for. Patient Charge amounts are listed under the Covered Dental Procedures and Patient Charges section of the Schedule of Benefits.

B425.0123

Plan: This term means the Group Dental Coverage described in the Plan and this Evidence of Coverage.

B426.0108

Planholder: This term means a Planholder that is offering benefits to a Member under this Plan.

B426.0109

Primary Care Dentist (PCD): This term means a Contracted General Dentist selected by a Member who is responsible for providing or arranging for a Member's dental services.

B425.0126

Prior Carrier's Group Dental Plan: This term means the Planholder's Plan of group dental coverage which was in force immediately prior to this Plan. For a Plan to be considered a Prior Plan, the Plan with Us must start immediately after the prior coverage ends.

B426.0111

Qualifying Event: This term means a specific occurrence that changes a Member's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental Plan; divorce; death of Your Spouse; termination of another dental Plan; or any other event as required by state or federal law or in accordance with Your Planholder's rules.

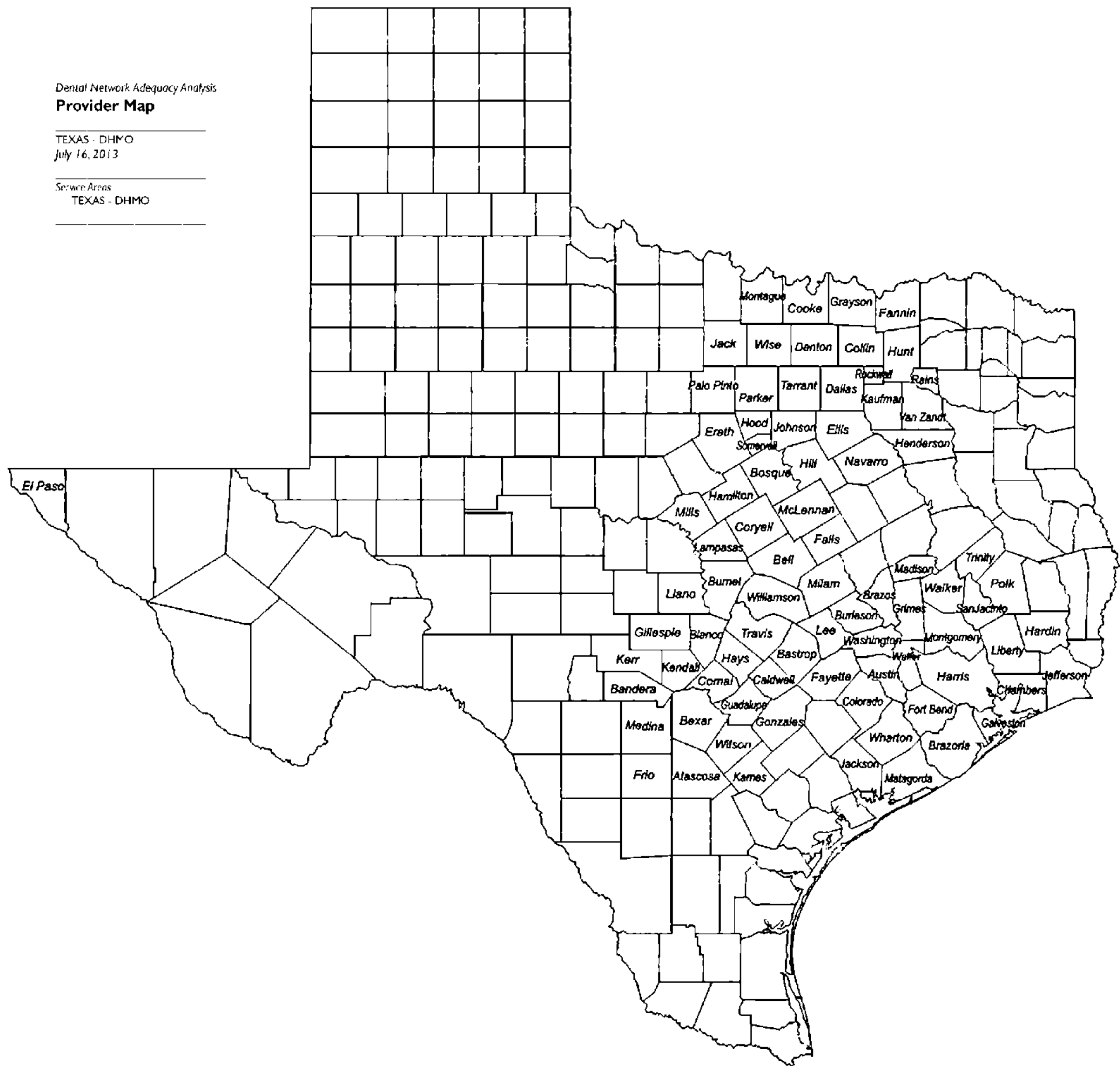
B426.0113

Service Area: This term means the geographic area in which We have arranged to provide for dental services for Members and includes:

Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Burleson, Burnet, Caldwell, Chambers, Collin, Colorado, Comal, Cooke, Coryell, Dallas, Denton, El Paso, Ellis, Erath, Falls, Fannin, Fayette, Fort Bend, Frio, Galveston, Gillespie, Gonzales, Grayson, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hays, Henderson, Hill, Hood Hunt, Jack, Jackson, Jefferson, Johnson, Kaufman, Karnes, Kendall, Kerr, Lampasas, Lee, Liberty, Llano, Madison, Matagorda, McLellan, Medina, Milam, Mills, Montague, Montgomery, Navarro, Palo Pinto, Parker, Polk, Rains, Rockwall, San Jacinto, Somervell, Tarrant. Travis, Trinity, Van Zandt, Walker, Waller, Washington, Wharton, Wilson, Williamson, and Wise counties.

Service Area Map located on the following page:

B426.0115


Dental Network Adequacy Analysis
Provider Map
TEXAS - DHMO
July 16, 2013
Service Areas
TEXAS - DHMO
El Paso
Montague
Cooke
Grayson
Fannin
Jack
Wise
Denton
Collin
Hunt
Rockwall
Rains
Palo Pinto
Parker
Tarrant
Dallas
Kaufman
Van Zandt
Erath
Hood
Somervell
Johnson
Ellis
Henderson
Hill
Navarro
Bosque
Hamilton
Mills
McLennan
Coryell
Falls
Lampasas
Bell
Trinity
Madison
Burnet
Milam
Brazos
Walker
Polk
Llano
Williamson
Grimes
San Jacinto
Burleson
Gillespie
Blanco
Travis
Lee
Washington
Montgomery
Hardin
Waller
Liberty
Kerr
Hays
Bastrop
Kendall
Comal
Caldwell
Fayette
Austin
Harris
Jefferson
Bandera
Chambers
Guadalupe
Colorado
Fort Bend
Medina
Bexar
Gonzales
Galveston
Wharton
Wilson
Brazoria
Jackson
Frio
Atascosa
Karnes
Matagorda

B426.0116

Spouse: This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B425.0132

Subscriber: This term means the member of the group determined to be eligible by the Planholder.

B426.0118

We, Us, Our and MDG: These terms mean Managed DentalGuard, Inc.

You, Your or Yourself: These terms mean the covered Subscriber.

B426.0119

GLOSSARY

ABSCESS: acute or chronic, localized inflammation, with a collection of pus, associated with tissue destruction and, frequently, swelling.

ABUTMENT: a tooth used to support a prosthesis.

ALVEOLAR: referring to the bone to which a tooth is attached.

ALVEOLOPLASTY: surgical procedure for recontouring alveolar structures, usually in preparation for a prosthesis.

AMALGAM: an alloy used in direct dental restorations.

ANALGESIA: loss of pain sensations without loss of consciousness.

ANESTHESIA: partial or total absence of sensation to stimuli.

ANTERIOR: refers to the teeth and tissues located towards the front of the mouth - maxillary and mandibular incisors and canines.

APEX: the tip or end of the root end of the tooth.

APICOECTOMY: amputation of the apex of a tooth.

BICUSPID: a premolar tooth; a tooth with two cusps.

BILATERAL: occurring on, or pertaining to, both sides.

BIOPSY: process of removing tissue for histologic evaluation.

BITEWING RADIOGRAPH: interproximal view radiograph of the coronal portion of the tooth.

BRIDGE: a fixed partial denture (fixed bridge) is a prosthetic replacement of one or more missing teeth cemented or attached to the abutment teeth.

CANAL: space inside the root portion of a tooth containing pulp tissue.

CARIES: commonly used term for tooth decay.

CAVITY: decay in tooth caused by caries; also referred to as carious lesion.

CEPHALOMETRIC RADIOGRAPH: a radiographic head film utilized in the scientific study of the measurements of the head with relation to specific reference points.

COMPOSITE: a tooth-colored dental restorative material.

CROWN: restoration covering or replacing the major part, or the whole of the clinical crown - (i.e., that portion of a tooth not covered by supporting tissues.)

CROWN LENGTHENING: a surgical procedure exposing more tooth for restorative purposes by apically positioning the gingival margin and removing supporting bone.

CYST: pathological cavity, containing fluid or soft matter.

DEBRIDEMENT: removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an evaluation.

DECAY: the lay term for carious lesions in a tooth; decomposition of tooth structure.

DENTURE: an artificial substitute for natural teeth and adjacent tissues.

DENTURE BASE: that part of a denture that makes contact with soft tissue and retains the artificial teeth.

DIAGNOSTIC CAST: plaster or stone model of teeth and adjoining tissues; also referred to as study model.

DISTAL: toward the back of the dental arch(or away from the midline).

ENDODONTIST: a dental specialist who limits his/her practice to treating disease and injuries of the pulp(root canal therapy) and associated periradicular conditions.

EVULSION: separation of the tooth from its socket due to trauma.

EXCISION: surgical removal of bone or tissue.

EXOSTOSIS: overgrowth of bone.

EXTRAORAL: outside the oral cavity.

FRENULECTOMY: excision of muscle fibers covered by a mucous membrane that attaches the cheek, lips and or tongue to associated dental mucosa.

GINGIVA: soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted, serving as the supporting structure for sub-adjacent tissues.

GINGIVAL CURETTAGE: the surgical procedure of scraping or cleaning the walls of a gingival pocket.

GINGIVECTOMY: the excision or removal of gingiva.

GINGIVOPLASTY: surgical procedure to reshape gingiva to create a normal, functional form.

HEMISECTION: surgical separation of a multirooted tooth so that one root and/or the overlaying portion of the crown can be surgically removed.

HISTOPATHOLOGY: the study of composition and function of tissues under pathological conditions.

IMMEDIATE DENTURE: removable prosthesis constructed for placement immediately after removal of remaining natural teeth.

IMPACTED TOOTH: an unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

IMPLANT: material inserted or grafted into tissue; dental implant-device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement.

INCISAL ANGLE: one of the angles formed by the junction of the incisal and the mesial or distal surfaces of an anterior tooth.

INLAY: an intracoronal restoration; a dental restoration made outside of the oral cavity to correspond to the form of the prepared cavity, which is then cemented into the tooth.

INTERCEPTIVE ORTHODONTIC TREATMENT: an extension of preventive orthodontics that may include localized tooth movement in otherwise normal dentition.

INTERIM PARTIAL DENTURE: a provisional removable prosthesis designed for use over a limited period of time, after which it is to be replaced by a more definitive restoration.

INTRAORAL: inside the mouth.

LABIAL: pertaining to or around the lip.

LIMITED ORTHODONTIC TREATMENT: orthodontic treatment with a limited objective, not involving the entire dentition

LINGUAL: pertaining to or around the tongue.

B426.0121

MESIAL: toward the midline of the dental arch.

METALS, CLASSIFICATION OF: The noble metal classification system is defined on the basis of the percentage of noble metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) greater than 60% (with at least 40% Au); noble Gold (Au), Palladium (Pd), and/or Platinum (Pt) greater than 25%; and predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) less than 25%.

MOLAR: teeth posterior to the premolars (bicuspids) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.

OCCLUSAL ADJUSTMENT, LIMITED: reshaping of the occlusal surfaces of teeth to create harmonious contact relationships between the upper and lower teeth; typically on a "per visit" basis.

OCCLUSAL RADIOGRAPH: an intraoral radiograph made with the film being held between the occluded teeth.

OCCLUSION: any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

ONLAY: a restoration made outside the oral cavity that replaces a cusp or cusps of the tooth, which is then cemented to the tooth.

ORAL SURGEON: a dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases of the oral regions.

ORTHODONTIST: a dental specialist whose practice is limited to the treatment of malocclusion of the teeth.

ORTHOGNATHIC: functional relationship of maxilla and mandible.

OVERDENTURE: prosthetic device that is supported by retained teeth roots.

PALLIATIVE: action that relieves pain but is not curative.

PANORAMIC RADIOGRAPH: an extraoral radiograph on which the maxilla and mandible are depicted on a single film.

PARTIAL DENTURE, REMOVABLE: a prosthetic replacement of one or more missing teeth on a framework that can be removed by the patient.

PEDIATRIC DENTIST: a dental specialist whose practice is limited to treatment of children.

PERIAPICAL: the area surrounding the end of the tooth root.

PERIODONTAL: pertaining to the supporting and surrounding tissues of the teeth.

PERIODONTAL DISEASE: inflammatory process of the gingival tissues and/or periodontal membrane of the teeth, resulting in an abnormally deep gingival sulcus, possibly producing periodontal pockets and loss of supporting alveolar bone.

PERIODONTIST: a dental specialist whose practice is limited to the treatment of periodontal diseases.

PERIRADICULAR: surrounding a portion of the root of the tooth.

PONTIC: the term used for the artificial tooth on a fixed bridge.

POST: an elongated metallic projection fitted and cemented within the prepared root canal, serving to strengthen and retain restorative material and/or a crown restoration.

POSTERIOR: refers to teeth and tissues towards the back of the mouth(distal to the canines) - maxillary and mandibular premolars and molars.

PRECISION ATTACHMENT: interlocking device, one component of which is fixed to an abutment or abutments and the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it.

PREMOLAR: see bicuspid.

PRIMARY DENTITION: the first set of teeth.

PROPHYLAXIS: scaling *and* polishing procedure performed to remove coronal plaque, calculus and stains.

PROSTHESIS, DENTAL: any device or appliance replacing one or more missing teeth and/or, if required, certain associated structures.

PROSTHODONTIST: a dental specialist whose practice is limited t the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

PULP: the blood vessels and nerve tissue that occupies the pulp chamber of a tooth.

PULP CAP: procedure in which the exposed or nearly exposed pulp is covered with a protective dressing or cement to maintain pulp vitality and/or protect the pulp from additional injury

PULP CHAMBER: the space within a tooth which contains the pulp.

PULPOTOMY: surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

QUADRANT: one of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth.

RADIOGRAPH: x-ray.

REBASE: process of refitting a denture by replacing the base material.

REIMPLANTATION, TOOTH: the return of a tooth to its alveolus.

RELINE: process of resurfacing the tissue side of a denture with new base material.

RETENTION: the phase of orthodontics used to stabilize teeth following comprehensive orthodontic treatment.

RETROGRADE FILLING: a method of sealing the root canal by preparing and filling it from the root apex.

ROOT: the anatomic portion of the tooth that is located in the alveolus (socket) where it is attached by the periodontal apparatus.

ROOT CANAL: the portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

ROOT CANAL THERAPY: the treatment of disease and injuries of the pulp and associated periradicular conditions.

ROOT PLANING: a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased tooth structure on the root surfaces and in the pocket.

SCALING: removal of plaque, calculus, and stain from teeth.

SPLINT: a device used to support, protect, or immobilize oral structures that have been loosened, replanted, fractured or traumatized.

STRESS BREAKER: that part of a tooth-borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.

STUDY MODEL: plaster or stone model of teeth and adjoining tissues; also referred to as diagnostic cast.

TEMPOROMANDIBULAR JOINT (TMJ): the connecting hinge mechanism between the mandible (lower jaw) and base of the skull (temporal bone).

TISSUE CONDITIONING: material intended to be placed in contact with tissues, for a limited period, with the aim of assisting their return to healthy condition.

UNERUPTED: tooth/teeth that have not penetrated into the oral cavity.

UNILATERAL: one-sided; pertaining to or affecting but one side.

VENEER: in the construction of crowns or pontics, a layer of tooth-colored material, usually, but not limited to, composite, porcelain, ceramic or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention; also refers to a restoration that is cemented to the tooth.

B426.0122

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GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Plan, as well as the Patient Charges, limitations, additional conditions and the exclusions. Please read the entire Evidence of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

B426.0135

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - N700I

The procedures covered by the Plan are named in this list. If a procedure is not on this list, it is not covered. All procedures must be provided by the assigned Primary Care Dentist (PCD) or by referral to a Contracted Specialist.

A Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of the Plan, including the Benefit Limitations, Additional Conditions and Exclusions.

A Member may be charged a Patient Charge for a missed appointment or a cancelled appointment if the dental office is not given at least 24 hours notice of cancellation.

The Patient Charges listed are only valid for covered procedures that are: (1) started and completed under the Plan, and (2) rendered by Contracted Dentists.

B426.0136

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N700I

CDT CODE **Current Dental Terminology (CDT) © American Dental Association (ADA)**

CDT CODE	COVERED DENTAL PROCEDURES	PATIENT CHARGE
	D0100-D0999 DIAGNOSTICS	
D0999	Office visit during regular hours, General Dentist only	$5
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0171	Re-evaluation - post-operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	$210
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$225
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$225
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	$250
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0

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
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination preparation and transmission of written report	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0

D1000-D1999 PREVENTIVE

D1110	Prophylaxis - adult, for the first two procedures in any 12 month period	$0
D1120	Prophylaxis - child, for the first two procedures in any 12 month period	$0
D1999	Prophylaxis - adult or child, for each additional procedure in the same 12 month period (maximum of 2 additional in the same 12 month period)	$35
M1110	Prophylaxis - One additional prophylaxis in any 12 month period will be covered at no charge for Members who: (a) are pregnant and in their 2nd or 3rd trimester; (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis.	$0
D1206	Topical application of fluoride varnish, for the first two procedures in any 12 month period	$0
D1208	Topical application of fluoride - excluding varnish, for the first two procedures in any 12 month period	$0
D2999	Topical fluoride each additional procedure in same 12 month period	$20
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth - molars	$0
D9999	Sealant - per tooth - non-molars	$35
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$0
D1353	Sealant repair - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cement or re-bond space maintainer	$0
D1555	Removal of fixed space maintainer	$0

B425.0223

D2000-D2999 RESTORATIVE

Code	Procedure	Charge
D2140	Amalgam - one surface, primary or permanent, including polishing	$0
D2150	Amalgam - two surfaces, primary or permanent, including polishing	$0
D2160	Amalgam - three surfaces, primary or permanent, including polishing	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior, primary or permanent, including polishing	$0
D2331	Resin-based composite - two surfaces, anterior, primary or permanent, including polishing	$0
D2332	Resin-based composite - three surfaces, anterior, primary or permanent, including polishing	$0
D2335	Resin-based composite - four or more surfaces or involving incisal angle, (anterior), primary or permanent, including polishing	$0
D2390	Resin-based composite crown, anterior	$75
D2391	Resin-based composite - one surface, posterior, including polishing	$0
D2392	Resin-based composite - two surfaces, posterior, including polishing	$0
D2393	Resin-based composite - three surfaces, posterior, including polishing	$0
D2394	Resin-based composite - four or more surfaces, posterior, including polishing	$0
D2510	Inlay - metallic - one surface**	$265
D2520	Inlay - metallic - two surfaces **	$345
D2530	Inlay - metallic - three or more surfaces**	$375
D2542	Onlay - metallic - two surfaces **	$375
D2543	Onlay - metallic - three surfaces**	$380
D2544	Onlay - metallic - four or more surfaces**	$400
D2610	Inlay - porcelain/ceramic - one surface	$265
D2620	Inlay - porcelain/ceramic - two surfaces	$350
D2630	Inlay - porcelain/ceramic - three or more surfaces	$375
D2642	Onlay - porcelain/ceramic - two surfaces	$375
D2643	Onlay - porcelain/ceramic - three surfaces	$380
D2644	Onlay - porcelain/ceramic - four or more surfaces	$390
D2650	Inlay - resin-based composite - one surface	$275
D2651	Inlay - resin-based composite - two surfaces	$300
D2652	Inlay - resin-based composite - three or more surfaces	$325
D2662	Onlay - resin-based composite - two surfaces	$300
D2663	Onlay - resin-based composite - three surfaces	$325
D2664	Onlay - resin-based composite - four or more surfaces	$350
D2710	Crown - resin-based composite (indirect)	$225
D2712	Crown - 3/4 resin-based composite (indirect)	$225
D2720	Crown - resin with high noble**	$250
D2721	Crown - resin with predominantly base noble	$250
D2722	Crown - resin with noble metal	$250
D2740	Crown - porcelain/ceramic substrate	$425
D2750	Crown - porcelain fused to high noble metal**	$395
D2751	Crown - porcelain fused to predominantly base metal	$395
D2752	Crown - porcelain fused to noble metal	$395
D2780	Crown - 3/4 cast high noble metal**	$385

Code	Procedure	Charge
D2781	Crown - 3/4 cast predominantly base metal	$385
D2782	Crown - 3/4 cast noble metal	$385
D2783	Crown - 3/4 porcelain/ceramic	$385
D2790	Crown - full cast high noble metal**	$395
D2791	Crown - full cast predominantly base metal	$395
D2792	Crown - full cast noble metal	$395
D2794	Crown - titanium	$395
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$0
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$108
D2930	Prefabricated stainless steel crown - primary tooth	$88
D2931	Prefabricated stainless steel crown - permanent tooth	$88
D2932	Prefabricated resin crown	$108
D2933	Prefabricated stainless steel crown with resin window	$108
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$115
D2940	Protective restoration	$0
D2941	Interim therapeutic restoration - primary dentition	$0
D2949	Restorative foundation for an indirect restoration	$0
D2950	Core buildup, including any pins when required	$100
D2951	Pin retention - per tooth, in addition to restoration	$18
D2952	Post and core in addition to crown, indirectly fabricated	$155
D2953	Each additional indirectly fabricated post - same tooth	$65
D2954	Prefabricated post and core in addition to crown	$125
D2955	Post removal	$100
D2957	Each additional prefabricated post - same tooth	$55
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300
D2962	Labial veneer (porcelain laminate) - laboratory	$375
D2971	Additional procedures to construct new crown under existing partial denture framework	$125
D2980	Crown repair necessitated by restorative material failure	$100
D2981	Inlay repair necessitated by restorative material failure	$80
D2982	Onlay repair necessitated by restorative material failure	$75
D2983	Veneer repair necessitated by restorative material failure	$80
D2990	Resin infiltration of incipient smooth surface lesions	$0

D3000-D3999 ENDODONTICS

Code	Procedure	Charge
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0

Code	Procedure	Charge
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$120
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$140
D3330	Endodontic therapy, molar (excluding final restoration)	$220
D3331	Treatment of root canal obstruction; non-surgical access	$60
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$75
D3333	Internal root repair or perforation defects	$116
D3346	Retreatment of previous root canal therapy - anterior	$375
D3347	Retreatment of previous root canal therapy - bicuspid	$425
D3348	Retreatment of previous root canal therapy - molar	$525
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root restoration, etc.)	$36
D3352	Apexification/recalcification - interim medication replacement	$25
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root restoration, etc.)	$84
D3410	Apicoectomy - anterior	$240
D3421	Apicoectomy - bicuspid (first root)	$270
D3425	Apicoectomy - molar (first root)	$320
D3426	Apicoectomy - (each additional root)	$116
D3427	Periadicular surgery without apicoectomy	$270
D3430	Retrograde filling - per root	$72
D3450	Root amputation - per root	$140
D3920	Hemisection (including any root removal), not including root canal therapy	$135
D3950	Canal preparation and fitting of preformed dowel or post	$20

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D4000-D4999 PERIODONTICS

Code	Procedure	Charge
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$200
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$60
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$42
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$240
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$144
D4245	Apically positioned flap	$250
D4249	Clinical crown lengthening - hard tissue	$280
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$380
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$230
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$108

Code	Procedure	Charge
D4266	Guided tissue regeneration - resorbable barrier, per site	$225
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	$225
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$350
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position.	$395
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$375
D4276	Combined connective tissue and double pedicle graft, per tooth	$425
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$360
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$205
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	$240
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	$261
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$0
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$60
D4910	Periodontal maintenance	$0
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0
D4921	Gingival irrigation - per quadrant	$35
D4999	Periodontal maintenance, for each additional procedure in same 12 month period (maximum of 2 additional in the same 12 month period)	$60

D5000-D5899 PROSTHODONTICS - REMOVABLE

Code	Procedure	Charge
D5110	Complete denture - maxillary	$452
D5120	Complete denture - mandibular	$452
D5130	Immediate denture - maxillary	$492
D5140	Immediate denture - mandibular	$492
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$443
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$443

Code	Procedure	Charge
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$500
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$500
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth	$465
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth	$465
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$525
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$525
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$575
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$575
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$245
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5510	Repair broken complete denture base	$40
D5520	Replace missing or broken teeth - complete denture (each tooth)	$36
D5610	Repair resin denture base	$44
D5620	Repair cast framework	$85
D5630	Repair or replace broken clasp - per tooth	$56
D5640	Replace broken teeth - per tooth	$36
D5650	Add tooth to existing partial denture	$52
D5660	Add clasp to existing partial denture - per tooth	$64
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$196
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$196
D5710	Rebase complete maxillary denture	$160
D5711	Rebase complete mandibular denture	$160
D5720	Rebase maxillary partial denture	$160
D5721	Rebase mandibular partial denture	$160
D5730	Reline complete maxillary denture (chairside)	$88
D5731	Reline complete mandibular denture (chairside)	$88
D5740	Reline maxillary partial denture (chairside)	$88
D5741	Reline mandibular partial denture (chairside)	$88
D5750	Reline complete maxillary denture (laboratory)	$120
D5751	Reline complete mandibular denture (laboratory)	$120
D5760	Reline maxillary partial denture (laboratory)	$120
D5761	Reline mandibular partial denture (laboratory)	$120
D5810	Interim complete denture (maxillary)	$418
D5811	Interim complete denture (mandibular)	$418
D5820	Interim partial denture (maxillary)	$195
D5821	Interim partial denture (mandibular)	$195

D5850	Tissue conditioning, maxillary	$36
D5851	Tissue conditioning, mandibular	$36

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D6000-D6199 IMPLANT SERVICES

D6010	Surgical placement of implant body: endosteal implant	$1,050
D6011	Second stage implant surgery	$0
D6055	Connecting bar - implant supported or abutment supported	$450
D6056	Prefabricated abutment - includes modification and placement	$225
D6057	Custom fabricated abutment - includes placement	$350
D6058	Abutment supported porcelain/ceramic crown	$725
D6059	Abutment supported porcelain fused to metal crown (high noble metal)**	$725
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$645
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$685
D6062	Abutment supported cast metal crown (high noble metal)**	$695
D6063	Abutment supported cast metal crown (predominantly base metal)	$645
D6064	Abutment supported cast metal crown (noble metal)	$685
D6065	Implant supported porcelain/ceramic crown	$725
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)**	$725
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)**	$725
D6068	Abutment supported retainer for porcelain/ceramic FPD	$725
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)**	$725
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$645
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$685
D6072	Abutment supported retainer for cast metal FPD (high noble metal)**	$725
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$550
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$685
D6075	Implant supported retainer for ceramic FPD	$725
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)**	$725
D6077	Implant supported retainer for cast FPD (titanium, titanium alloy, or high noble metal)**	$705
D6092	Re-cement or re-bond implant/abutment supported crown	$40
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$60
D6094	Abutment supported crown (titanium)	$650

Code	Procedure	Charge
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant, surfaces, including flap entry and closure	$115
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$225
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	$125
D6104	Bone graft at time of implant placement	$125
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$990
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$990
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$925
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$925
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$2,375
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$2,375
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$1,420
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$1,420
D6190	Radiographic/surgical implant index, by report	$175
D6194	Abutment supported retainer crown for FPD (titanium)	$625

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D6200-D6999 PROSTHODONTICS - FIXED

Code	Procedure	Charge
D6205	Pontic - indirect resin based composite	$125
D6210	Pontic - cast high noble metal**	$350
D6211	Pontic - cast predominantly base metal	$350
D6212	Pontic - cast noble metal	$350
D6214	Pontic - titanium	$350
D6240	Pontic - porcelain fused to high noble metal**	$350
D6241	Pontic - porcelain fused to predominantly base metal	$350
D6242	Pontic - porcelain fused to noble metal	$350
D6245	Pontic - porcelain/ceramic	$375
D6250	Pontic - resin with high noble metal**	$275
D6251	Pontic - resin with predominantly base metal	$275
D6252	Pontic - resin with noble metal	$275
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$350
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$370
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$350
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$375
D6602	Retainer inlay - cast high noble metal, two surfaces**	$350
D6603	Retainer inlay - cast high noble metal, three or more surfaces**	$380

Code	Procedure	Charge
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$350
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$380
D6606	Retainer inlay - cast noble metal, two surfaces	$350
D6607	Retainer inlay - cast noble metal, three or more surfaces	$380
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$400
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$380
D6610	Retainer onlay - cast high noble metal, two surfaces**	$400
D6611	Retainer onlay - cast high noble metal, three or more surfaces **	$380
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$400
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$380
D6614	Retainer onlay - cast noble metal, two surfaces	$400
D6615	Retainer onlay - cast noble metal, three or more surfaces	$380
D6624	Retainer inlay - titanium	$350
D6634	Retainer onlay - titanium	$375
D6710	Retainer crown - indirect resin based composite	$200
D6720	Retainer crown - resin with high noble metal **	$250
D6721	Retainer crown - resin with predominantly base metal	$250
D6722	Retainer crown - resin with noble metal	$250
D6740	Retainer crown - porcelain/ceramic	$395
D6750	Retainer crown - porcelain fused to high noble metal **	$395
D6751	Retainer crown - porcelain fused to predominantly base metal	$395
D6752	Retainer crown - porcelain fused to noble metal	$395
D6780	Retainer crown - 3/4 cast high noble metal **	$365
D6781	Retainer crown - 3/4 cast predominantly base metal	$365
D6782	Retainer crown - 3/4 cast noble metal	$365
D6783	Retainer crown - 3/4 porcelain/ceramic	$365
D6790	Retainer crown - full cast high noble metal **	$375
D6791	Retainer crown - full cast predominantly base metal	$375
D6792	Retainer crown - full cast noble metal	$375
D6794	Retainer crown - titanium	$375
D6930	Re-cement or re-bond fixed partial denture	$30
D6940	Stress breaker	$100
D6980	Fixed partial denture repair necessitated by restorative material failure	$70
D6999	Multiple crown and fixed partial denture retainers (bridge) treatment plan - per unit, six or more	$125

D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY

Code	Procedure	Charge
D7111	Extraction - coronal remnants - deciduous tooth	$0
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$30
D7220	Removal of impacted tooth - soft tissue	$100
D7230	Removal of impacted tooth - partially bony	$85
D7240	Removal of impacted tooth - completely bony	$150

Code	Procedure	Charge
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35
D7251	Coronectomy - intentional partial tooth removal	$140
D7260	Oroantral fistula closure	$200
D7261	Primary closure of a sinus perforation	$250
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$100
D7280	Surgical access of an unerupted tooth	$250
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$250
D7283	Placement of device to facilitate eruption of impacted tooth	$55
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$80
D7286	Incisional biopsy of oral tissue - soft	$55
D7287	Exfoliative cytological sample collection	$40
D7288	Brush biopsy - transepithelial sample collection	$65
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$50
D7310	Alveoloplasty, in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100
D7311	Alveoloplasty, in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7320	Alveoloplasty, not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$150
D7321	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$120
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$289
D7471	Removal of lateral exostosis (maxilla or mandible)	$204
D7472	Removal of torus palatinus	$283
D7473	Removal of torus mandibularis	$283
D7485	Surgical reduction of osseous tuberosity	$204
D7510	Incision and drainage of abscess - intraoral soft tissue	$30
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$40
D7520	Incision and drainage of abscess - extraoral soft tissue	$45
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$50
D7953	Bone replacement graft for ridge preservation - per site	$226
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$133
D7963	Frenuloplasty	$163
D7970	Excision of hyperplastic tissue - per arch	$72
D7971	Excision of pericoronal gingiva	$60
D7972	Surgical reduction of fibrous tuberosity	$122

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D8000-D8999 ORTHODONTICS

Code	Procedure	Charge
D8010	Limited orthodontic treatment of the primary dentition	$700
D8020	Limited orthodontic treatment of the transitional dentition	$700
D8030	Limited orthodontic treatment of the adolescent dentition	$700

Code	Procedure	Charge
D8040	Limited orthodontic treatment of the adult dentition	$700
D8050	Interceptive orthodontic treatment of the primary dentition	$900
D8060	Interceptive orthodontic treatment of the transitional dentition	$900
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,895
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,895
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,195
D8660	Pre-orthodontic treatment examination to monitor growth and development (includes treatment plan, records, evaluation and consultation)	$250
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$400
D8681	Removable orthodontic retainer adjustment	$0

B425.0178

D9000-D9999 ADJUNCTIVE GENERAL SERVICES

Code	Procedure	Charge
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$19
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for deep sedation or general anesthesia	$55
D9223	Deep sedation/general anesthesia - each 15 minute increment	$98
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$40
D9248	Non-intravenous conscious sedation	$75
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$50
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$10
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$15
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$45
D9942	Repair and/or reline occlusal guard	$7
D9951	Occlusal adjustment - limited	$12
D9952	Occlusal adjustment - complete	$100
D9971	Odontoplasty, 1-2 teeth; includes removal of enamel projections	$14
D9972	External bleaching - per arch - performed in office	$165

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D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$99
D9986	Missed appointment	$25
D9987	Cancelled appointment	$25

** The Plan provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.

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BENEFIT LIMITATIONS

This section lists the dental benefits and procedures Members are allowed to obtain through the Plan when the procedures are necessary for their dental health, consistent with professionally recognized standards of practice, subject to the Benefit Limitations, Additional Conditions and Exclusions listed below.

B426.0182

General

- Emergency Dental Services when more than fifty (50) miles from the PCD 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 Us: Limited to the benefit for palliative treatment (D9110) only.

B425.0142

Diagnostic

- Office visit Patient Charges that are the Member's responsibility after the group Plan has been in effect for three full years, will be paid to the PCD by Us.
- One intraoral complete series of radiographic images and one panoramic radiographic image: Limited to 1 each in 36 months.
- Bitewing radiographic images: Limited to 2 sets in 12 months.
- 2D oral/facial photographic image: Limited to 1 in 12 months.
- Caries susceptibility tests: Limited to 1 in 24 months.
- Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Limited to 1 in 24 months for persons age 40 or older.
- Accession of tissue is covered only when performed in conjunction with a tooth-related biopsy, when performed by a Contracted Dentist.
- One cone beam CT (D0364, D0365, D0366 or D0367): Limited to 1 in 12 months. Covered only when performed in conjunction with a covered surgical placement of an implant and when performed in the office of a Contracted Dentist.

B426.0184

Preventive

- Prophylaxis (D1110 or D1120) or periodontal maintenance (D4910): Limited to 2 in 12 months. One of the covered periodontal maintenance may be performed by a periodontist Contracted Specialist if done within 3 to 6 months following completion of approved periodontal scaling and root planing or osseous surgery by a periodontist Contracted Specialist. Members are eligible to receive 2 additional prophylaxes or periodontal maintenance in the same 12 months at the Patient Charge of D1999 (for prophylaxes) or D4999 (for periodontal maintenance).

  One additional prophylaxis will be covered at no charge for Members in any 12 month period who: (a) are pregnant in their 2nd or 3rd trimester; or (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis. Verification of the condition must be provided by the Member with a doctor's note to the PCD.

- Fluoride treatment: Limited to 2 in 12 months. Members are eligible to receive 2 additional fluoride treatments in the same 12 months at the Patient Charge of D2999.

- Sealants or preventive resin restoration: Limited to permanent teeth that are free from occlusal restorations, up to age 16, once per tooth in 36 months.

- Sealant Repair: Limited to 1 per tooth in 12 months.

B425.0147

Crowns & Fixed Partial Dentures (Bridges)

- Crowns, fixed partial dentures (bridges), inlays, onlays & veneers: Covered when recommended by the PCD. The replacement of a crown, fixed partial denture (bridge), inlay, onlay or veneer is limited to once in 5 years based on the original placement date while covered under the Plan.

- Multiple crown and fixed partial denture (bridge) unit treatment plan: When a Member's treatment plan includes 6 or more covered units of crown and/or fixed partial denture (bridge) to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or fixed partial denture (bridge), plus an additional charge per unit (D6999), as shown in the Covered Dental Procedures and Patient Charges section.

- Porcelain crowns and/or porcelain fused to metal crowns: Covered on all permanent adult teeth when recommended by the PCD.

- The Plan provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.

- In the event a covered indirect restoration (inlays, onlays, crowns and fixed partial dentures - bridges) is recommended and the Member elects to have a porcelain/ceramic substrate indirect restoration made using a CAD/CAM machine in one appointment, in lieu of a laboratory processed porcelain/ceramic substrate indirect restoration (more than one appointment), the Member will be responsible for a fee of $500 in addition to the listed Patient Charge for such porcelain/ceramic substrate indirect restoration. Please note that the one-appointment porcelain/ceramic substrate indirect restoration may not be available at all Contracted General Dentist locations.

B426.0192

Endodontics

- Root amputation, per root: Limited to once per tooth.
- Hemisection: Limited to once per tooth.

B425.0149

Periodontics

- Gingival flap procedure or osseous surgery: Limited to 1 procedure per quadrant in 36 months.
- Tissue grafts: Limited to 1 procedure per tooth/site in 36 months.
- Periodontal scaling and root planing: Limited to once per quadrant in 12 months.
- Bone replacement grafts: Limited to once per site in 10 years when the tooth is present.
- Guided tissue regeneration: Limited to once per site in 10 years when the tooth is present or when done in conjunction with a covered surgical implant placement and simultaneous bone graft associated with the implant placement site.

B425.0150

Prosthodontics

- Reline and rebase of a complete or partial denture: Limited to once per denture in 12 months.
- The benefit for dentures includes all post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures includes follow-up care for 6 months but does not include rebasing or relining procedures or a complete new denture.
- Replacement of dentures: Covered when recommended by the PCD and only if the existing denture cannot be made satisfactory by reline, rebase or repair. The replacement of a denture is limited to once in 5 years based on the original placement date while covered under the Plan.
- Immediate dentures are not subject to the 5-year replacement limitation.

B426.0194

Implants and Implant/Abutment Supported Prosthetics

- Implants: Covered when recommended by the PCD. Patient Charge includes treatment plan, local anesthetic and post-surgical care. Limited to no more than once for the same tooth position in 10 years. The number of implants is limited to 2 per 12 months, per arch, after 12 months of coverage.

- Bone replacement graft for ridge preservation, per site or bone graft at time of implant placement: Covered when done in conjunction with a covered surgical placement of an implant in the same site, limited to a total of one per tooth/site, per lifetime.

- Radiographic/surgical implant index, by report: Limited to once per arch in 12 months.

- Debridement, osseous contouring of a peri-implant defect and bone graft for repair of peri-implant defect associated with the treatment of defects surrounding a single implant: Limited to no more than once per implant, per lifetime.

- Implant/abutment supported crowns and fixed partial denture retainers (bridges): Covered when recommended by the PCD and when done in conjunction with a covered surgical placement of an implant.

  The replacement of an implant/abutment supported crown and fixed partial denture retainer (bridge) is not covered within 10 years of the original placement date under the Plan.

  The lan provides for the use of noble metal. When high noble metal (including gold) is used, the Member will be responsible for the Patient Charge of the implant/abutment supported crown and fixed partial denture retainer (bridge) plus an additional charge for the actual cost of the high noble metal per implant/abutment.

- Multiple implant/abutment supported crown and fixed partial denture retainers (bridge) unit treatment plan: When a Member's treatment plan includes 6 or more covered units of implant/abutment supported crown and fixed partial denture retainers (bridges) to restore or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of implant/abutment supported crown and fixed partial denture retainers (bridges), plus an additional charge per unit as shown in the Covered Dental Procedures and Patient Charges section (D6999).

- Implant/Abutment supported fixed and removable dentures: Covered when recommended by the PCD and when done in conjunction with a covered surgical placement of an implant.

- In the event a covered implant supported indirect restoration (crowns and fixed partial dentures - bridges) is recommended and the Member elects to have an implant supported porcelain/ceramic substrate indirect restoration made using a CAD/CAM machine in one appointment, in lieu of a laboratory processed porcelain/ceramic substrate indirect restoration (more than one appointment), the Member will be responsible for a fee of $500 in addition to the listed Patient Charge for such porcelain/ceramic substrate indirect restoration. Please note that the one-appointment porcelain/ceramic substrate indirect restoration may not be available at all Contracted General Dentist locations.

- The replacement of an implant/abutment supported fixed or removable denture is not covered within 10 years of the original placement under the Plan.

- Implant placement on Members who are less than 19 years old will be reviewed on an individual case basis, in order to determine if the treatment is appropriate. Medical proof (i.e. Carpal Index) of skeletal growth cessation should be included in any predetermination for these procedures.

B426.0195

Oral and Maxillofacial Surgery

- Routine post-operative office visits and care: Included in the surgical procedure.

B425.0154

Orthodontics

- The Plan covers orthodontic procedures as listed under Covered Dental Procedures and Patient Charges. Coverage is limited to one course of comprehensive treatment per Member. Treatment must be preauthorized and be performed by an orthodontist Contracted Specialist.
- The listed Patient Charge for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. If treatment is necessary beyond 24 months, the Member will be responsible for each additional month of treatment, based upon the orthodontist Contracted Specialist's contract.
- Orthodontic procedures are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Plan except as described under the Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
- If a Member's coverage terminates after the fixed banding appliances are inserted, the Member is responsible for any additional charges incurred for the remaining orthodontic treatment. The orthodontist Contracted Specialist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the orthodontist Contracted Specialist for procedures after the termination date.
- Retention procedures are covered at the Patient Charge shown in the Covered Dental Procedures and Patient Charges section. They are covered only if following a course of comprehensive orthodontic treatment started and completed under the Plan.
- If a Member transfers to another orthodontist Contracted Specialist after authorized comprehensive orthodontic treatment has started under the Plan, the Member will be responsible for any additional costs associated with the change in orthodontist Contracted Specialist 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 procedures are covered only following a course of comprehensive orthodontic treatment covered under the Plan.

- 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 orthodontist Contracted Specialist's usual fee.

B426.0197

Adjunctive General Services

- Deep sedation/general anesthesia, IV sedation, nitrous oxide, non-intravenous conscious sedation: Limited to procedures provided by an oral surgeon Contracted Specialist. Not all oral surgeon Contracted Specialists offer these procedures. The Member is responsible for identifying and receiving procedures from an oral surgeon Contracted Specialist who is willing to provide deep sedation/general anesthesia, IV sedation, nitrous oxide or non-intravenous conscious sedation. The Member's Patient Charge is shown in the Covered Dental Procedures and Patient Charges section.

- Occlusal guard: Limited to 1 in 5 years. Covered only if performed by the PCD.

- Repair and/or reline of occlusal guard: Limited to 1 in 24 months if performed more than 24 months after initial fabrication and delivery.

- Occlusal adjustment - limited: Limited to a total of 2 visits, per lifetime.

B425.0156

ADDITIONAL CONDITIONS

B425.0157

Alternative Procedure Policy

There may be a number of accepted methods of treating a specific dental condition. In all cases where there is more than one course of treatment (procedure) available, a full disclosure of all the treatment options must be given to the Member before treatment is initiated. This PCD-presented document should include a written treatment plan, as well as the cost of each treatment option, in order to minimize the potential for confusion over what the Member should pay, and to fully document the informed consent of the treatment recommended.

When a Member selects an Alternative Procedure over the procedure recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended procedure and the Alternative Procedure chosen by the Member. The Member will also have to pay the applicable Patient Charge for the recommended procedure.

If any of the Alternative Procedures that are selected by the Member are not covered under the Plan, the Member must pay the PCD's usual fee for the Alternative Procedure.

If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not an appropriate procedure for the condition being treated), the PCD is not obliged to provide that treatment even if it is a covered procedure under the Plan.

Members can request and receive a second opinion by contacting Our Member Services department in the event they have questions regarding the recommendations of the PCD or Contracted Specialist.

B426.0200

Exceptions to Alternative Procedure Policy

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.

B425.0159

Second Opinion Consultation

A Member may wish to consult another Dentist for a second opinion regarding procedures recommended or performed by the Member's PCD or Contracted Specialist through a referral. To have a second opinion consultation covered by Us, the Member must call or write Our Member Services department for prior authorization. We only cover a second opinion consultation when the recommended procedures are covered under the Plan.

A Member Services associate will help identify a Contracted Specialist to perform the second opinion consultation. The second opinion consultation will include the applicable Patient Charge for code D9310.

The Plan's benefit for a second opinion consultation is limited to $50.00. If a Contracted Specialist is the consulting Dentist, the Member is responsible for the applicable Patient Charge for code D9310. If a Non-Contracted Dentist is the consulting Dentist, the Member must pay the applicable Patient Charge for code D9310 and any portion of the Dentist's fee over $50.00.

The Member Services associate will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting Dentist.

B426.0202

Third Opinion Consultation

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.

B425.0161

Treatment in Progress-Takeover Benefit for Orthodontic Treatment Provision

This provision provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another Dental HMO plan with the current/original treating orthodontist, after the Plan becomes effective. A Member may be eligible for this provision if all of these conditions are met:

- The Member was covered by another dental HMO plan just prior to the Effective Date of the Plan and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior dental plan. This benefit applies to Members who are eligible for coverage on the Effective Date of the Plan and enroll for such coverage within 30 days. It does not apply to persons who become newly eligible for coverage after the Effective Date of the Plan.
- The Member has such orthodontic treatment in progress at the time the Plan becomes effective.
- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- A "Treatment in Progress - Takeover Benefit for Orthodontic Treatment" form, completed in its entirety by the treating orthodontist, is submitted to Us within 6 months of the Effective Date of the Plan.

The benefit amount will be calculated based on the prior dental HMO carrier's pro-rated remaining benefit balance; up to a maximum benefit of $1,200 per Member. The Member is responsible for the Dentist's original comprehensive treatment fee and Patient Charges under the original contract and financial agreement made between the Member and the Dentist. The Member is responsible for any increase in fee as a result of the takeover process. Additionally, the Plan will only cover up to a total of 24 months of comprehensive orthodontic treatment.

B426.0204

EXCLUSIONS

We will not pay benefits for:

- Treatment needed due to an on-the-job or job-related injury or a condition for which benefits are payable by Worker's Compensation, occupational disease law or similar laws, whether or not the Member claims his or her rights to such benefits.
- Dental procedures performed in a hospital, surgical center, or related hospital fees.
- Any treatment of congenital and/or developmental malformations. This does not apply for congenital defects for a newborn child which will be treated on the same basis as any other illness or injury for which dental treatment may apply. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
- 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.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatments or appliances requested, recommended or performed: (a) which in the opinion of the Contracted Specialist or Contracted General Dentist are not necessary for maintaining or improving the Member's dental health, or (b) which are solely for cosmetic purposes, except for bleaching.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or is considered by the American Dental Association (ADA) 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 specialist procedures or treatment which can be routinely provided by the PCD, or by a specialist without a direct referral from the PCD or a pre-authorization by Us.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits for such treatment.
- Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; (4) splint or stabilize teeth for periodontal reasons; or (5) improve cosmetic appearance, except for bleaching.
- Any procedure, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

- Dental procedures, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's selected and assigned PCD, unless previous written authorization was provided by the Us.
- 2D cephalometric radiographic images except when performed as part of an orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Treatment which requires the procedures of a prosthodontist.
- Treatment or Procedures which requires the services of a pediatric dentist Contracted Specialist, after the Member's 9th (ninth) birthday.
- Consultations for non-covered procedures.
- Any procedure or treatment not specifically listed in the Covered Dental Procedures and Patient Charges section.
- Any procedure associated with the placement or removal, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered procedures as a result of the presence of a dental implant.
- Any covered procedure, regardless of specialty, that was started, but not completed, prior to the Member's eligibility to receive benefits under the Plan except as described under Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
- 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 performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to, root canal therapy to facilitate overdentures.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under limited, interceptive or comprehensive orthodontic treatment or correct or control harmful habits.
- Any procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.

- Replacement or repair of orthodontic appliances lost or damaged.
- Accident injury. An accident injury is defined as damage to the hard and/or soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) functions will be covered at the amount as shown in the Covered Dental Procedures and Patient Charges section.

B426.0205

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Dental benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

If you have questions about this section, see your plan administrator.

Dental Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

B405.0447

Definitions

"Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing For Initial Benefit Determination

The Benefit Determination period begins when a claim is received. Guardian will make a Benefit Determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse Benefit Determination must be provided.

Guardian will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a Benefit Determination due to a claimant s failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the Adverse Benefit Determination;

- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan’s claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan s review procedures and the time limits applicable to such procedures, including a statement of the claimant s right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person’s subordinate;
- In deciding an appeal based upon a dental or medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person’s subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant s claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

B405.0448