COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care of California
605 E. Holland Avenue, Suite 300
Spokane, WA 99218
1-800-273-3330

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

The Group Dental Coverage described in this Evidence of Coverage is attached to the group policy "Policy" effective July 1, 2010. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Policy or under any other policy providing similar or identical benefits issued to the Policyholder by Us.

Managed Dental Care ("MDC") of California is a California corporation, licensed as a Knox-Keene Heath Care Service Plan under applicable California law, whose primary purpose is to operate a dental care service plan.

MANAGED DENTAL CARE PLAN

GROUP CONTRACT FOR PREPAID DENTAL SERVICES

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHAT IT COVERS, LIMITS, AND EXCLUDES.

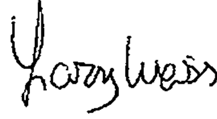
We certify that the Subscriber to whom this Evidence of Coverage is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Subscriber must: (a) satisfy all of the Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Subscriber under the Policy; 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 Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: IBEW LOCAL 18 HEALTH AND WELFARE TRUST
Group Policy Number: 00456998
Effective Date: July 1, 2010

Managed Dental Care of California

Jill M. Purcell, President



Larry Weiss, Assistant Vice President
and Controller

B425.1020

TABLE OF CONTENTS

GENERAL PROVISIONS
Applicable Benefits 1
Public Policy Committee 1
Confidentiality 1
Limitation of Authority 1
Incontestability 2
Language Assistance 2

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE
Enrollment Procedures 3
Open Enrollment Period 3
Subscriber Eligibility 3
Dependent Eligibility 4
When Coverage Starts 5
Termination of Coverage 5
When Your Dependent Coverage Ends 7

CONTINUATION OF COVERAGE
Continuation Rights 8
Uniformed Services Continuation Rights 8
Cal-COBRA Continuation Rights 8
Small Policyholder Group 12
Family Medical Leave Of Absence (FMLA) 13
Dependent Survivorship Benefit 14

DENTAL BENEFITS
How to Contact Us 15
Managed Dental Care 15
Principal Benefits and Coverages 16
Choice of Dentists 16
Changes in Dentist Participation 16
Refusal of Recommended Treatment 17
Specialty Referrals 17
Facilities 18
Emergency Dental Services 18
Out-of-Area Emergency Dental Services 19
Timely Access to Care 19
Continuity of Care - Terminated Dentist 20
Continuity of Care - Non-Contracted Dentist 21
Extended Dental Benefits 22

COORDINATION OF BENEFITS (COB)
Coordination with a Pre-Paid Dental Plan 23
Coordination with a PPO Dental Plan 24
Our Right to Certain Information 24

GRIEVANCE PROCESS
Grievances Requiring Expedited Review 28
Covered Services 30

DEFINITIONS **34**

STATEMENT OF ERISA RIGHTS **37**

TABLE OF CONTENTS (CONT.)

SCHEDULE OF BENEFITS

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - U60 G 42

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN U60 G 43

EVIDENCE OF COVERAGE AMENDATORY RIDER 62

GENERAL PROVISIONS

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.

B425.0637

Public Policy Committee

MDC maintains a Public Policy Committee composed of at least three Members, one Contracted Dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee. MDC communicates material changes affecting public policy to Members in periodic newsletters.

B425.0638

Confidentiality

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

You may contact Our customer services department by telephone at 1-800-273- 3330, or by mail to P.O. Box 2474, Spokane, WA 99210-2474 to request a copy of the Policy's confidentiality statement. The confidentiality statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

B425.1022

Limitation of Authority

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, Policy or Evidence of Coverage is to be issued;
- Waive or alter any contract, Policy or Evidence of Coverage, or any of Our requirements;
- Bind Us by any statement or promise relating to the Policy 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 Policy or waive any of its provisions.

B425.0640

Incontestability

All statements made on Your enrollment form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. No statement contained in Your enrollment form will void Your coverage or reduce Your benefits after Your coverage has been in force for two years. Within the first two years of issuance of coverage under this Policy, We may rescind Your coverage based on any fraudulent statement or intentional misrepresentation of material fact made on Your signed enrollment application.

The statements and information contained in the Your enrollment form are represented by You to be true and correct and incorporated into the Policy. You also recognize that MDC has issued the Policy in reliance on those statements and information. The Policy replaces and cancels all other contracts, if any, issued to You by Us.

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 Policyholder or Us.

B425.1023

Language Assistance

As an MDC Member, You have a right to free language assistance services, including interpretation and translation services. MDC collects and maintains Your language preferences, race, and ethnicity so that We can communicate more effectively with Our Members. If You require spoken or written language assistance or would like to inform MDC of Your preferred language, please contact Us at 1-800-273-3330. TDD/TTY for the hearing impaired is available through 1-800-947-6644.

B425.1026

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Enrollment Procedures

You may enroll for dental coverage by:

- Completing and signing the appropriate enrollment form and any additional material required by Your Policyholder.
- Returning the enrollment material to your Policyholder. Your Policyholder 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 Policy. If the PCD is available under the Policy, 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 Policyholder'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.

B425.1038

Open Enrollment Period

If You do not enroll Yourself or Your eligible dependents for dental coverage under this Policy 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 Policy's Effective Date, or at time intervals mutually agreed upon by Your Policyholder and Us.

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

If after initial enrollment You, or one of Your dependents disenroll from the Policy 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.

B425.1027

Subscriber Eligibility

You are eligible for dental coverage if You are:

- In an eligible class of Subscribers;

- The determination of who is eligible to participate and who is actually participating in the plan shall be determined by your Employer and the group contract. Coverage takes effect on the first day of the month of schedule effective date.
- Any disputes or inquires regarding your eligibility, renewal, reinstatement, and the like, should be directed by your Employer. MDC will not discriminate against any member based upon age, race, religion, national origin, sex, or sexual orientation.

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 Policyholder makes any payments to any kind of health and welfare benefit plan other than under this Evidence of Coverage.

B425.0655-R

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
  - A child who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Subscriber for support and maintenance, may remain eligible for dependent benefits past the age limit, subject to the following:
    - We will send notice to You at least 90 days prior to the limiting age and You must send Us written proof that the child is dependent upon You for support and maintenance as is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. You have 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the childs eligibility is made. We can ask for periodic proof that the childs condition continues, but We cannot ask for this proof more than once a year after the two-year period following the childs attainment of the limiting age.

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

B425.1046

When Coverage Starts

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

- You and Your eligible dependents are eligible for the dental Policy as stated in the Conditions Of Eligibility for Group Dental Coverage section; and
- You and Your eligible dependents have enrolled in the dental Policy; and
- Required premiums have been paid.

If you do 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 Policyholder may require; or
- The date you are eligible for the Policy based on the Policyholder's eligibility rules as approved by Us.

B425.0390

Termination of Coverage

In the event of cancellation by either Us (except in the case of fraud or deception in the use of services or facilities of MDC or knowingly permitting such fraud or deception by another) or You, We shall within 30 days return to You any pro rata portion of fees paid by You which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due.

Termination by You
You may cancel your coverage at any time during the grace period outlined below or by giving Us 31 days advance written notice. This notice must be sent to Our office. The Policyholder will owe Us all unpaid premiums for the period that coverage is in force.

Termination by MDC
We shall have the right to cancel Your coverage upon providing written notice to the Policyholder, who is required to promptly send such notice to You, in the following circumstances:

- Termination by MDC for Non-payment of Premium. We may cancel or decline to renew Your coverage for cause if the Policyholder fails to pay all premiums in accordance with the following terms and conditions:

- A grace period of 30 days, starting after the last date of paid coverage, will be allowed for outstanding premium payments. You will receive a written notice stating the start and end dates of the grace period from the Policyholder.
- If the Policyholder, or another party acting on the Policyholders behalf, makes the necessary premium payment and that payment is received on or before the last day of the grace period, We shall ensure that coverage is not cancelled or not renewed on account of non-payment of such premiums.
- If any premium with respect to the Members covered by the Policy is not paid before the end of the grace period, coverage ends with respect to all Members covered by the Policy immediately following the end of the grace period. You will receive a written notice of end of coverage no later than five (5) business days following the last day of paid coverage from the Policyholder.
- If the Policyholder give Us advance written notice of an earlier termination date during the grace period, Your coverage will end as of such earlier date.
- If Your coverage ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy was in force during the grace period.

- Termination by MDC for Intentional Misrepresentation of Material Fact by You. We may cancel or decline to renew Your coverage if We demonstrate an intentional misrepresentation of a material fact by You or the Policyholder in obtaining Your coverage. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC for Violation of Material Provision Relating to Employer Contributions or Group Participation Rates. We may cancel or decline to renew Your coverage if the Policyholder violates a material provision of the Policy relating to employer contributions or group participation rates. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC Due to Cessation of Services in the State or Withdrawal of Policy from the Market. Subject to providing 180 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the cancellation or nonrenewal is due to MDC ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this State pursuant to Health and Safety Code section 1365(a)(5). Subject to providing 90 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the MDC withdraws the health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6).

If You believe that Your coverage has been or will be improperly canceled, rescinded, or not renewed, You may file request a review by the Department of Managed Health Care, within 180 days of receipt of the notice of cancellation, pursuant to Section 1368 of the Health and Safety Code. Such request for review may be submitted directly to the Department of Managed Health Care by mail to the attention of the Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725; by phone at 1-888-466-2219/TDD 1-877-688-9891; by fax at 1-916-255- 5241; or online at www.healthhelp.ca.gov. Such review shall be in accordance with Sections 1368 and 1365(b) of the Health and Safety Code.

B425.1029

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.
- 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.

B425.0694

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 Policyholder or administrator.

B425.0695

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 Policy 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 Policyholder for additional information.

B425.0076

Cal-COBRA Continuation Rights

Important Notice: This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies to the dental benefits of this Policy. In this section, these benefits are referred to as "group dental benefits."

Under this section, a "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this Policy as: (a) an active, covered Subscriber; (b) the spouse of an active, covered Subscriber; or (c) the dependent Child of an active covered Subscriber. A child born to, or adopted by, the covered Subscriber during a continuation period is also a qualified beneficiary if the child is enrolled in the Policy as a dependent within 30 days of the child's birth or placement for adoption. Any other person who becomes covered under this Policy during a continuation period provided by this section is not a qualified beneficiary.

A qualified beneficiary will be eligible for continuation coverage without demonstrating evidence of insurability upon certain "qualifying events." "Qualifying events" are defined as: (a) the death of the covered Subscriber; (b) the termination or reduction of work hours of the covered Subscribers employment, if he or she was not terminated for gross misconduct; (c) the divorce or legal separation of the covered Subscriber from the covered Subscribers spouse; (d) the loss of dependent status by a dependent enrolled in the group Policy; and (e) the covered Subscribers eligibility for coverage under Medicare.

Conversion: Continuing the group health benefits does not stop a qualified beneficiary from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this Policy in force at the time the continuation ends.

If Your Group Health Benefits End: If Your group dental benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if You were not terminated due to gross misconduct. The continuation: (a) may cover You or any other qualified beneficiary; and (b) is subject to "When Continuation Ends."

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to the Subscribers termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

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

This extra 11 month continuation is subject to "When Continuation Ends."

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

If You Die While Insured: If You die while insured, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months subject to "When Continuation Ends."

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

If A Dependent Loses Eligibility: If a dependent child's group dental benefits end due to his or her loss of dependent eligibility as defined in this Plan, other than Your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified beneficiary. The continuation can last for up to 36 months, subject to "When Continuation Ends."

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

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

Special Medicare Rule: If You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for Your dependents. The continuation period, after Your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months from Your termination of employment or reduction of work hours; or (b) 36 months from the date of Your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

B425.0697-R

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this section must notify Your Policyholder, in writing, of: (a) Your legal divorce or legal separation from Your spouse; or (b) the loss of dependent eligibility, as defined in this Policy, of a dependent.

Such notice must be given to Your Policyholder within 60 days of either of these events. Subscriber must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the Policyholder if the Policy has contracted with the Policyholder for administrative service, within the 60-day period following the later of (1) the date that the Subscribers coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the Subscriber was sent notice of that ability to continue coverage under the group benefit plan. A qualified beneficiary electing continuation shall pay to the Policy, in accordance with the terms and conditions of the Policy Contract, which shall set forth in the notice to the qualified beneficiary, the amount of the required premium payment.

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

Your Policyholder must provide the qualified beneficiary with written notice of the necessary benefit information, premium information, enrollment forms and instructions within 14 days of: (a) the date a qualified beneficiary's group dental benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or (b) the date a qualified beneficiary notifies Your Policyholder, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a dependent child.

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

Election of Continuation: To continue his or her group dental benefits, the qualified beneficiary must give Your Policyholder written notice that he or she elects to continue. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from Your Policyholder as described above. And the qualified beneficiary must pay his or her first month's premium within 45 days by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Policy, or to the Policyholder if the Policyholder has contracted with the Policy to perform the administrative services. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

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

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group Policy on a regular basis. It includes any amount that Your Policyholder would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," Your Policyholder may require an additional charge of 2% of the total premium charge. If the qualified beneficiary fails to give Your Policyholder notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

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

When Continuation Ends: A qualified beneficiary's continued group dental benefits end on the first of the following to occur:

a) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date of the qualifying event;

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

c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a dependent's eligibility, the end of the 36 month period which starts on the date of the qualifying event;

d) with respect to a dependent whose continuation is extended due to the Subscribers entitlement to Medicare, while the dependent is on continuation, the end of the 36 month period which starts on the date of the qualifying event;

e) the date Your Policyholder ceases to provide any group dental plan to any Subscriber;

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

g) the date he or she becomes covered under any other group dental plan which does not contain any pre-existing condition exclusion or limitation affecting him or her;

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

B425.0698-R

Small Policyholder Group

Applies to Members who are covered under a Policy between Us and a California small Policyholder group with two (2) through nineteen (19) eligible Subscribers.

You are eligible if You are a permanent Subscriber who is actively engaged on a full-time basis in the conduct of the business of the small Policyholder with a normal workweek of at least 30 hours, at the small Policyholder's regular places of business, and have met any statutorily authorized applicable waiting period requirements. It also includes any eligible Subscriber who obtains coverage through a guaranteed association. This does not include Subscribers who work on a part-time, temporary, or substitute basis.

Permanent Subscribers who work at least 20 hours but not more than 29 hours are deemed to be eligible Subscribers if all four of the following apply:

(1) they otherwise meet the definition of an eligible Subscriber except for the number of hours worked; (2) the Policyholder offers the Subscriber health coverage under a health benefit plan; (3) all similarly situated individuals are offered coverage under the health benefit plan; and (4) the Subscriber must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter.

In order to receive CAL-COBRA benefits for yourself and/or Dependent(s), You or Dependent(s) must provide written notice to Us within sixty (60) days of the qualifying events, except if coverage terminates due to a reduction of Subscriber work hours or termination of your employment. If Your coverage and/or coverage for Dependents will terminate due to a reduction of Your work hours or termination of Your employment, Your Policyholder must notify Us within 30 days of the qualifying event. Notice will be sent to the last known address.

If you or Dependent(s) do not notify MDC within sixty (60) days of the qualifying event(s), You and Dependents(s) will not receive Cal-COBRA benefits. Dependents may also be disqualified from receiving Cal-COBRA benefits if your Policyholder does not provide Us with notification as required by law and summarized in the Policy.

Within fourteen (14) days of receiving notification of a qualifying event, We will mail Cal-COBRA information package to the last known address of the Dependent. The package will contain premium information, enrollment forms and the disclosures necessary to formally elect Cal-COBRA continuation benefits and will be sent to the Dependents last known address.

If you and/or Dependent(s) are eligible for extended continuation coverage for twenty-nine (29) months as a result of a disability, You and/or Dependent(s) must notify Us within thirty (30) days of a determination that the Member is no longer disabled.

B425.0701-R

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 Policyholder for information regarding such legally mandated leave of absence laws.

B425.0080

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 Policyholder'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.

B425.0082

DENTAL BENEFITS

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

B425.0084

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 1-888-273-3330 from 8:00 am to 8:00 pm, Pacific Standard Time. An automated service is also provided after hours for eligibility verification.

B425.1030

Managed Dental Care

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

The Network is made up of Contracted Dentists in the Policy'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 Policy, 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 Policy. 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 Policy must be coordinated by the PCD to whom the Member is assigned. What We cover is based on all the terms of this Policy. Please refer to the Schedule of Benefits for Group Dental Coverage information including Covered Dental Procedures and Patient Charges, Benefit Limitations and Exclusions.

B425.1039

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Schedule of Benefits section of this Evidence of Coverage. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a Patient Charge. Services specifically excluded from this coverage are listed in the section titled Exclusions in the Schedule of Benefits. Please read this section carefully. Dental services performed by a Non-Contracted Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Dental Services.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF DENTIST DENTAL CARE MAY BE OBTAINED.

B425.0703

Choice of Dentists

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, at Our option and subject to applicable law, either:

- Arrange for completion of the services by the original Dentist; or
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service.

B425.0089

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

Specialty Referrals

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 policy guidelines described below.

In order for specialty services to be covered by this Policy, the referral policy 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 policy 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 Grievance Process 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 Policy'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 Policy, 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 Policy's approved Service Area. If there is no Contracted Specialist in the Policy's approved Service Area, We will refer the Member to a Non-Contracted specialist Dentist of Our choice.

B425.0091

Facilities

MDC PCD's available under the Policy Contract are listed in the Network General Dentist booklet. MDC's PCD offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if You cannot keep Your scheduled appointment, You must notify Your PCD at least 24 hours in advance or You will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet. Broken appointment fees will be waived in exigent circumstances (e.g., emergency hospitalization of Member).

You may contact MDC's Member Services Department at 1-800-273-3330 to request the Network General Dentist booklet.

B425.1040

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 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).

B425.0092

Out-of-Area Emergency Dental Services

If You are out of the area, and Emergency Dental Services are required, You should seek palliative treatment from a Dentist. You must file a claim within 180 days of service. You must present a detailed statement from the treating Dentist, which lists the services provided. MDC will reimburse you within 30 days for any covered Emergency Dental Services, less applicable Patient Charges, up to $50 per incident. This paperwork should be submitted to the address listed on page 1.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of Your condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if You are requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating Dentist, acting within the scope of the Dentist's practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on Your health.

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

- Appropriate for Your dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for You at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Contracted Dentists are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how You may obtain urgent or emergency care, including how to contact another Dentist who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the Contracted Dentist does not answer and You have an emergency, You may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any Dentist.

Telephone triage or screening services are to be provided in a timely manner appropriate for Your condition. During normal business hours, the waiting time for You to speak by telephone with a knowledgeable and competent customer service representative regarding Your questions and concerns will not exceed 10 minutes.

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

B425.1031

Continuity of Care - Terminated Dentist

The Member may request for the continuation of covered services to be rendered by a terminated Contracted Dentist when the Member is undergoing treatment from a terminated Dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current Members or 180 days from the effective date for newly covered Members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Contracted Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members.

This provision does not apply to Contracted Dentists who voluntarily leave the plan. The Member must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
605 E. Holland Avenue, Suite 300
Spokane, WA 99218

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. The terminating Dentist must accept the contracted rate for that Member's treatment and agree not to seek payment from the Member for any amounts for which the Member would not be responsible if the Dentist were still in the network. The approval of the request to continue Member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating Dentist or Member wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated Dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

B425.1032

Continuity of Care - Non-Contracted Dentist

The Member, including a newly covered Member, may request for the continuation of covered services to be rendered by the Non-Contracted Dentist when the Member is undergoing treatment from the Non-Contracted Dentist for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Contracted Dentist's Agreement or 12 months from the Effective Date of coverage for newly covered Members. The Member must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
605 E. Holland Avenue, Suite 300
Spokane, WA 99218

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the Member's dental records from the Member's Dentist in order to evaluate the request. The Dental Director (or his/her designee) will determine if the Member is eligible for continuation of care under this Policy and the California Knox-Keene Act.

The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by Policy; and
3. The potential clinical effect that a change of Dentist would have on the Member's treatment.

B425.1033

If a Member's coverage ends, We extend dental expense benefits for him or her under this Policy. 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 Policy.

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 Policy 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 Policy.

B425.0093

COORDINATION OF BENEFITS (COB)

A Member may have dental coverage through multiple plans. When that occurs, one plan is determined to be primary while the other is deemed to be secondary.

Rules to make the primary/secondary determination are:

- The plan without a coordination provision is always primary.
- If a medical plan provides coverage for the dental service, that plan is primary. This excludes Affordable Care Act (ACA) compliant plans.
- If both plans have a COB provision, the plan providing coverage to a Subscriber is primary.
- A plan that provides coverage for an active Subscriber will be primary over a retiree plan.
- If a child is covered under both parents' plans:
  - When the parents are living together, the plan of the parent whose birthday is earlier in the year is primary.
  - When the parents are separated and not living together:
    - Any applicable court order will apply.
    - With 50/50 custody situations, the plan of the parent whose birthday is earlier in the year is primary.
    - With no court order benefits will be coordinated in the following order; (1) natural parent with custody; (2) step parent with custody; (3) natural parent without custody; and (4) step parent without custody.
- When none of these rules apply, the plan that has provided coverage the longest is primary.

When We are primary, benefits are determined as if no other plan exists.

B425.0095

Coordination with a Pre-Paid Dental Plan

A Member may also be covered under another pre-paid dental plan where they pay a fixed payment amount for each covered service. When the PCD participates under both pre-paid plans, the Member will never be responsible for more than the Patient Charge.

For Contracted Specialists' services, when this Policy is secondary, 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.

B425.0097

Coordination with a PPO Dental Plan

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

- For PCD services: If this Policy is the primary plan, the PCD submits a claim to the secondary plan for the Patient Charge amount. Any payment made by the secondary carrier must be deducted from the Member's Patient Charge.
- For PCD services: If this Policy is the secondary plan, the PCD submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the Patient Charge, reducing the Member's out-of-pocket expense.
- For Contracted Specialist services: If this Policy is the primary plan, benefits are paid as usual.
- For Contracted Specialist services: If this Policy 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.

B425.0098

Our Right to Certain Information

In order to coordinate benefits, We need certain information. A Member must supply Us with as much information as he or she can. If he or she can't give Us all the information needed, We have the right to request this information from any source. If another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information, We can't be held liable for such action except as required by law.

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

B425.0099

GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison ("QCL") who processes the grievances. The QCL can be contacted at 1-800-273-3330 or by mail to P.O. Box 2474, Spokane, WA 99210-2472. The QLC hours are from 8:00 a.m. to 5:00 p.m. Pacific Time. Grievances may also be submitted on Our website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

- Administrative Services: financial, accounting, procedural matters, coverage information such as effective dates, explanations of policy and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.
- Health Services: quality of care, access, availability, standards of care, appeal of denied second opinion requests, appeals of Specialty Referral decisions, professional and ethical considerations.

A grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding MDC's operation, including but not limited, to Policy administration, denial of access to a specialty referral as services are covered at the general Dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for the lack of medical necessity will be handled by the grievance process. Where MDC cannot distinguish between an inquiry and a grievance, it shall be considered a grievance.

A grievance and a complaint are one and the same.

Coverage dispute means that a Member is not provided a covered service as a Policy benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the customer services representative documents the call and works with the Member to resolve the issue. If the issue is as an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the customer services department. All other issues that are grievances will be documented on a grievance form by the customer services representative on behalf of the Member and the grievance form will be forwarded to the Quality of Care Liaison or Designee (QCL). The Member may be sent a grievance form to complete, if requested.

When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work with the QCL and provide accommodation, according to MDC guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by MDC. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.

3. Members may file a grievance up to 180 calendar days following any incident or action that is the subject of the dissatisfaction. In the case of a grievance alleging that the Member's coverage has been or will be improperly cancelled, rescinded, or not renewed, the 180 days begins on the date indicated on the Notice of Cancellation, Rescission, or Nonrenewal.

4. No later than five (5) calendar days after receipt of the grievance, or three (3) calendar days for grievances received via the MDC website, an acknowledgment letter is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL that a review is taking place and the grievance will be responded to within 30 days from the date of MDC's receipt of the grievance in a resolution letter.

5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the Dentist or office personnel. MDC may arrange a second opinion, if appropriate.

6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 calendar days from the date of MDC's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution.

   The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his/her review of available documentation by initialing a copy of the resolution letter.

The resolution letter to the Member will detail in a clear, concise manner the reasons for MDC's response. For grievances involving the delay, denial or modification of dental care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If MDC, or one of its clinical reviewers, issues a determination delaying, denying or modifying dental care services based in whole or in part on a finding that the proposed dental care services are not a covered benefit under the Policy that applies to the Member, the letter shall clearly specify the provisions in the Policy that exclude that coverage. In the event that an MDC grievance involves the delay, modification or denial of a covered service due to medical necessity, the resolution letter will include an IMR application and a Department of Managed Health Care addressed envelope.

B425.1034

7. Within thirty (30) calendar days following receipt of a resolution letter, a Member, or Member's Designee, may also request voluntary mediation with MDC prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a Member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care. In order to initiate mediation, the Member or the Member's Designee and MDC shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

   Following the use of the voluntary mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Dentist.

8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.

9. Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) calendar days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function; for any case involving cancellation, rescission, or nonrenewal of coverage; or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.

10. MDC shall keep all copies of grievances, and the responses to grievances, for a period of five years.

11. MDC's Secretary, who is an officer of the plan, or designee, has primary responsibility for MDC's grievance system.

12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by MDC and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.

13. MDC asserts that there is no discrimination against a Member (including cancellation of the contract) solely on the grounds that the Member filed a complaint.

    The Department of Managed Health Care may contact MDC's Quality Management Staff regarding urgent grievances every business day from 8:00 am to 5:00 pm by calling 1-800-273-3330. For urgent grievances received from the Department of Managed Health Care during business hours, MDC will respond within 30 minutes. For urgent grievances after business hours, The Department of Managed Health Care should contact MDC's staff in the following order:

14. Dental Director/Plan Officer Responsible for Grievances at 1-310-908-1917, Quality of Care Liaison at 1-818-437-4177, and President at 1-207-210-8727. For urgent grievance calls received after hours, the above listed personnel will respond to the Department of Managed Health Care within one (1) hour after initial contact. Within one (1) business day of receipt of the Department of Managed Health Care's notice of acceptance of a proper complaint related to the cancellation, rescission, or nonrenewal of a Member's coverage, MDC shall respond and provide the Department of Managed Health Care with a copy of all information MDC used to makes its termination of coverage determination and all other relevant information necessary for the Department of Managed Health Care's review.

Grievances Requiring Expedited Review

MDC will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but are not limited to, procedures administered in a hospital, 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, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Policy.

MDC shall also conduct expedited review of grievances concerning the cancellation, rescission, or nonrenewal of coverage.

When MDC has notice of a grievance requiring expedited review, the grievance process requires MDC to immediately inform Members in writing of their right to notify the Department of Managed Health Care of the grievance. MDC also will provide Members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. MDC shall consider the Member's medical condition when determining the response time for an expedited grievance.

If the Member files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, MDC shall continue to provide coverage to the Member pursuant to the terms of the Member's Policy while the grievance is pending with MDC and/or the Department of Managed Health Care.

The following grievance disclosure will be on all Member correspondence:

Disclosure:

With respect to certain actions that impact You and Your coverage, Managed Dental Care or Your Employer will provide You with notice:

- When premium has not been paid and Your coverage is in force due solely to the Policy's Grace Period;
- When this Policy or Your coverage under this Policy is rescinded due to certain contractual provisions; or
- When this Policy is terminated for any other reason as may be allowed by the Policy.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll- free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

You may also access grievance forms at Managed Dental Care's website at **www.manageddentalcare.net.** Click on the "GRIEVANCE FORM" Portal box or may be obtained by contacting MDC's Customer Care Team at (800) 273- 3330 .

Note: Free language assistance services are available for You and Your dependents to assist with Your dental needs. Please contact Managed Dental Care's Member Services Department at 1-800-273-3330, Your assigned network general dentist or Your network specialist (for Managed Dental Care's approved specialty care) if English is not Your or Your dependents preferred spoken or written language.

Nota: Los servicios gratuitos de ayuda con el idioma estan disponibles para usted y sus dependientes para ayudarle con sus necesidades dentales. Si el inglis no es el idioma preferido de usted o sus dependientes, por favor comunmquese a nuestro Departamento de Servicios para Miembros al 1-800-273- 3330, su dentista general de red asignada o su especialista de red (para una atencisn especializada de Managed Dental Care).

B425.1035

Covered Services

MDC covers diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, fixed prosthodontics, oral surgery, orthodontics and adjunctive general as well as specialist and Emergency Dental Services. Covered services will be provided as necessary for a Member's dental health consistent with professionally recognized standards of practice, subject to the limitations and exclusions described in connection with each category of covered services.

Covered services include:

DIAGNOSTIC

- Clinical Oral Evaluations
- Radiographs (X-rays)
- Tests and Examinations

* A complete list of covered diagnostic services is listed in the Schedule of Benefits.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed in the Schedule of Benefits.

RESTORATIVE

- Amalgam (silver fillings)
- Resin Based Composite (white fillings)
- Inlays
- Onlays

- Crowns
- Other Restorative Services

* A complete list of covered restorative services is listed in the Schedule of Benefits.

ENDODONTICS

- Pulp Capping
- Pulpotomy
- Endodontic Therapy (root canals)
- Endodontic Retreatment
- Apicoectomy/Periradicular Services

* A complete list of covered endodontic services is listed in the Schedule of Benefits.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed in the Schedule of Benefits.

PROSTHODONTICS
(Removable)

- Complete Dentures
- Partial Dentures
- Adjustments to Dentures
- Repairs
- Rebase
- Reline

* A complete list of covered prosthodontics (removable) services is listed in the Schedule of Benefits.

IMPLANT SERVICES

- Abutment Supported
- Implant/Abutment Supported Removable Dentures
- Implant/Abutment Supported Fixed Dentures
- Abutment Supported Retainers

* A complete list of covered implant services is listed in the Schedule of Benefits

PROSTHODONTICS
(Fixed)

- Fixed Partial Denture Pontics
- Fixed Partial Denture Retainers - Crowns

* A complete list of covered prosthodontics (fixed) services is listed in the Schedule of Benefits.
Note: Treatment which requires the services of a Prosthodontist are not covered.

ORAL SURGERY

- Surgical Extractions
- Other Surgical Procedures
- Alveoloplasty
- Surgical Excision of Intra-Osseous Lesions
- Surgical Incision

* A complete list of covered oral surgery services is listed in the Schedule of Benefits.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed in the Schedule of Benefits.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed in the Schedule of Benefits.

A list of the services covered by this Policy, including Patient Charges is provided in the section Schedule of Benefits.

Exclusions and limitations will apply to some of the services. Refer to the Benefit Limitations, Additional Conditions and Exclusions sections of the Schedule of Benefits.

B425.1037

DEFINITIONS

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

B425.0712

Act: This term means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

B425.0713

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

Code: This term means the California Health and Safety Code.

B425.0714

Combined Evidence of Coverage and Disclosure Form: This term means this booklet issued to You, which summarizes the essential terms of this Policy.

B425.0724

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 Policy.

B425.0715

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

B425.0716

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

B425.0718

Emergency Dental Service: This term means services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort or to prevent the imminent loss of teeth.

B425.0113

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

B425.0720

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

B425.0118

Network: This term means The Managed Dental Care network.

B425.0120

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 Policy.

B425.0121

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

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

B425.0721

Policyholder: This term means an Employer that is offering benefits to a Member under this Policy.

B425.0125

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

B425.0127

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 Policy; divorce; death of Your Spouse; termination of another dental Policy; or any other event as required by state or federal law or in accordance with Your Policyholder's rules.

B425.0129

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

B425.0131

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, state law or local law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B425.1050

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

B425.0133

We, Us, Our and MDC: These terms mean Managed Dental Care of California.

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

B425.0722

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 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 and Qualified Domestic Relations 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.

B425.0167

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 dental or medical 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 professional 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.

B425.0168

Managed Dental Care of California
605 E. Holland Avenue, Suite 300
Spokane, WA 99218
1-800-273-3330

GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Policy, as well as the Patient Charges, Benefit Limitations, Additional Conditions and the Exclusions. Please read the entire Certificate of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

B425.1051

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - U60 G

The procedures covered by the Policy 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 Policy, including the Benefit Limitations, Additional Conditions and Exclusions.

A Member may be charged a Patient Charge for a broken 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 Policy, and (2) rendered by Contracted Dentists.

B425.1112

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	$0.00
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D1000 - D1999	**DENTAL PROPHYLAXIS**	
D1110	Prophylaxis - adult, for the first two services in any 12-month period	$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period	$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period	$60.00
D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period	$0.00
D1206	Topical fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	$0.00

Code	Procedure	Charge
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period	$20.00
D1310	Nutritional instruction for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth (molars)	$0.00
D9999	Sealant - per tooth (non-molars)	$35.00
D1510	Space maintainer - fixed - unilateral	$0.00
D1515	Space maintainer - fixed - bilateral	$0.00
D1525	Space maintainer - removable - bilateral	$0.00
D1550	Re-cementation of fixed space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00
D2000 - D2999	**RESTORATIVE**	
D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$0.00
D2331	Resin-based composite - 2 surfaces, anterior	$0.00
D2332	Resin-based composite - 3 surfaces, anterior	$0.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$0.00
D2390	Resin-based composite crown, anterior	$0.00
D2391	Resin-based composite - 1 surface, posterior	$0.00
D2392	Resin-based composite - 2 surfaces, posterior	$0.00
D2393	Resin-based composite - 3 or more surfaces, posterior	$0.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$0.00
D2510	Inlay - metallic - 1 surface	$60.00
D2520	Inlay - metallic - 2 surfaces	$75.00
D2530	Inlay - metallic - 3 or more surfaces	$75.00
D2542	Onlay - metallic - 2 surfaces	$80.00
D2543	Onlay - metallic - 3 surface	$80.00
D2544	Onlay - metallic - 4 or more surfaces	$80.00
D2610	Inlay - porcelain/ceramic - 1 surface	$60.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$75.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$75.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$80.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$80.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$80.00
D2740	Crown - porcelain/ceramic substrate	$100.00
D2750	Crown - porcelain fused to high noble metal	$95.00
D2751	Crown - porcelain fused to predominantly base metal	$95.00
D2752	Crown - porcelain fused to noble metal	$95.00
D2780	Crown - 3/4 cast high noble metal	$85.00
D2781	Crown - 3/4 cast predominantly base metal	$85.00
D2782	Crown - 3/4 cast noble metal	$85.00
D2783	Crown - 3/4 porcelain/ceramic	$85.00
D2790	Crown - full cast high noble metal	$95.00
D2791	Crown - full cast predominantly base metal	$95.00
D2792	Crown - full cast noble metal	$95.00

Code	Procedure	Charge
D2794	Crown - titanium	$95.00
D2910	Recement inlay, onlay, or partial coverage restoration	$0.00
D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2930	Prefabricated stainless steel crown - primary tooth	$10.00
D2931	Prefabricated stainless steel crown - permanent tooth	$10.00
D2932	Prefabricated resin crown	$20.00
D2933	Prefabricated stainless steel crown with resin window	$20.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$20.00
D2940	Sedative filling	$0.00
D2950	Core buildup, including any pins	$20.00
D2951	Pin retention - per tooth, in addition to restoration	$0.00
D2952	Post & core in addition to crown, indirectly fabricated	$30.00
D2953	Each additional indirectly fabricated post - same tooth	$10.00
D2954	Prefabricated post and core in addition to crown	$25.00
D2957	Each additional prefabricated post - same tooth	$8.00
D2960	Labial veneer (resin laminate) - chairside	$40.00
D2970	Temporary crown (fractured tooth)	$15.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$125.00
D3000 - D3999	**ENDODONTICS**	
D3110	Pulp cap - direct (excluding restoration)	$0.00
D3120	Pulp cap - indirect (excluding restoration)	$0.00
D3220	Therapeutic pulpotomy (excluding final restoration) - Removal of pulp coronal to the dentinocemental junction and application of medicament	$10.00
D3221	Pulpal debridement, primary and permanent teeth	$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$10.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$15.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$15.00
D3310	Root canal, anterior (excluding final restoration)	$70.00
D3320	Root canal, bicuspid (excluding final restoration)	$80.00
D3330	Root canal, molar (excluding final restoration)	$140.00
D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair or perforation defects	$40.00
D3346	Retreatment of previous root canal therapy - anterior	$80.00
D3347	Retreatment of previous root canal therapy - bicuspid	$95.00
D3348	Retreatment of previous root canal therapy - molar	$150.00
D3410	Apicoectomy/periradicular surgery - anterior	$90.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$95.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$40.00
D3430	Retrograde filling - per root	$15.00

Code	Procedure	Charge
D3950	Canal preparation and fitting of preformed dowel or post	$20.00
D4000 - D4999	**PERIODONTICS**	
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$60.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$20.00
D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$105.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$35.00
D4249	Clinical crown lengthening - hard tissue	$85.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$155.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$95.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$100.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$110.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$120.00
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$25.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$15.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15.00
D4910	Periodontal maintenance, for the first two services in any 12-month period	$15.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$0.00
D4999	Periodontal maintenance, for each additional service in same 12-month period	$60.00
D5000 - D5999	**PROSTHODONTICS - REMOVABLE**	
D5110	Complete denture - maxillary	$110.00
D5120	Complete denture - mandibular	$110.00
D5130	Immediate denture - maxillary	$110.00
D5140	Immediate denture - mandibular	$110.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$90.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$90.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$130.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$130.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$140.00

Code	Procedure	Charge
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$140.00
D5410	Adjust complete denture - maxillary	$5.00
D5411	Adjust complete denture - mandibular	$5.00
D5421	Adjust partial denture - maxillary	$5.00
D5422	Adjust partial denture - mandibular	$5.00
D5510	Repair broken complete denture base	$0.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0.00
D5610	Repair resin denture base	$0.00
D5620	Repair cast framework	$0.00
D5630	Repair or replace broken clasp	$0.00
D5640	Replace broken teeth - per tooth	$0.00
D5650	Add tooth to existing partial denture	$0.00
D5660	Add clasp to existing partial denture	$0.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$0.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$0.00
D5710	Rebase complete maxillary denture	$0.00
D5711	Rebase complete mandibular denture	$0.00
D5720	Rebase maxillary partial denture	$0.00
D5721	Rebase mandibular partial denture	$0.00
D5730	Reline complete maxillary denture (chairside)	$0.00
D5731	Reline complete mandibular denture (chairside)	$0.00
D5740	Reline maxillary partial denture (chairside)	$0.00
D5741	Reline mandibular partial denture (chairside)	$0.00
D5750	Reline complete maxillary denture (laboratory)	$0.00
D5751	Reline complete mandibular denture (laboratory)	$0.00
D5760	Reline maxillary partial denture (laboratory)	$0.00
D5761	Reline mandibular partial denture (laboratory)	$0.00
D5820	Interim partial denture (maxillary)	$45.00
D5821	Interim partial denture (mandibular)	$45.00
D5850	Tissue conditioning, maxillary	$0.00
D5851	Tissue conditioning, mandibular	$0.00
D6200 - D6999	**PROSTHODONTICS - FIXED**	
D6210	Pontic - cast high noble metal	$90.00
D6211	Pontic - cast predomniantly base metal	$90.00
D6212	Pontic - cast noble metal	$90.00
D6214	Pontic - titanium	$90.00
D6240	Pontic - porcelain fused to high noble metal	$90.00
D6241	Pontic - porcelain fused to predominantly base metal	$90.00
D6242	Pontic - porcelain fused to noble metal	$90.00
D6245	Pontic - porcelain/ceramic	$90.00
D6600	Inlay - porcelain/ceramic, - 2 surface	$75.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$75.00
D6602	Inlay - cast high noble metal, - 2 surfaces	$75.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces	$75.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$75.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$75.00

Code	Procedure	Charge
D6606	Inlay - cast noble metal, 2 surfaces	$75.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$75.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$80.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$80.00
D6610	Onlay - cast high noble metal, 2 surfaces	$80.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$80.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$80.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$80.00
D6614	Onlay - cast noble metal, 2 surfaces	$80.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$80.00
D6624	Inlay - titanium	$75.00
D6634	Onlay - titanium	$75.00
D6740	Crown - porcelain/ceramic	$100.00
D6750	Crown - porcelain fused to high noble metal	$95.00
D6751	Crown - porcelain fused to predominantly base metal	$95.00
D6752	Crown - porcelain fused to noble metal	$95.00
D6780	Crown - 3/4 cast high noble metal	$85.00
D6781	Crown - 3/4 cast predominantly base metal	$85.00
D6782	Crown - 3/4 cast noble metal	$85.00
D6783	Crown - 3/4 porcelain/ceramic	$85.00
D6790	Crown - full cast high noble metal	$95.00
D6791	Crown - full cast predominantly base metal	$95.00
D6792	Crown - full cast noble metal	$95.00
D6794	Crown - titanium	$95.00
D6930	Recement fixed partial denture	$0.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$30.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$25.00
D6973	Core buildup for retainer, including any pins	$20.00
D6976	Each additional cast post - same tooth	$10.00
D6977	Each additional prefabricated post - same tooth	$8.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment	$125.00

Code	Procedure	Charge
D7000 - D7999	**ORAL AND MAXILLOFACIAL SURGERY**	
D7111	Extraction, coronal remnants - deciduous tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$35.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$70.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$85.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40.00
D7261	Primary closure of a sinus perforation	$250.00
D7280	Surgical access of an unerupted tooth	$90.00

Code	Procedure	Charge
D7283	Placement of device to facilitate eruption of impacted tooth	$35.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$45.00
D7286	Biopsy of oral tissue - soft	$40.00
D7288	Brush biopsy - transepithelial sample collection	$65.00
D7310	Alveoplasty in conjunction with extractions - 4 or more Teeth or tooth spaces, per quadrant	$35.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$16.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$45.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	$30.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$60.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$110.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$75.00
D7472	Removal of torus palatinus	$75.00
D7473	Removal of torus mandibularis	$75.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$25.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$60.00
D7963	Frenuloplasty	$100.00
D8000 - D8999	**ORTHODONTICS**	
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1500.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$2800.00
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention	$400.00
D9000 - D9999	**ADJUNCTIVE GENERAL SERVICES**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
D9120	Fixed partial denture sectioning	$15.00
D9215	Local anesthesia	$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes	$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$75.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$30.00

GC-SCH-DHMO-U-20-CA

D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9951	Occlusal adjustment - limited	$0.00
D9971	Odontoplasty, 1-2 teeth	$10.00
D9972	External bleaching - per arch	$165.00
	Broken Appointment	$25.00

PLAN U60 G

B425.1086

BENEFIT LIMITATIONS

This section lists the dental benefits and procedures Members are allowed to obtain through the Policy 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.

NOTICE: Any benefit that includes an age restricted limitation will be subject to an exception based on medical necessity.

B425.1017

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

- 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.
- 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.

B425.1088

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).
- 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, up to age 16, once per tooth in 36 months.

B425.1089

Fixed Partial Dentures (Bridges)& Other Restorations

- Fixed partial dentures (bridges), inlays, onlays & veneers: Covered when recommended by the PCD. The replacement of a 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 Policy.
- 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 anterior, bicuspid and molar teeth when recommended by the PCD.
- The Policy 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.

B425.1090-R

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.

B425.1091

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 Policy.
- Immediate dentures are not subject to the 5-year replacement limitation.

B425.0152

Oral and Maxillofacial Surgery

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

B425.0154

Orthodontics

- The Policy 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 comprehensive orthodontic treatment 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 Policy 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 Policy.

- If a Member transfers to another orthodontist Contracted Specialist after authorized comprehensive orthodontic treatment has started under the Policy, 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 Policy.

- The Policy 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 Policy 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.

B425.1092

Adjunctive General Services

- Deep sedation/general anesthesia and IV 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 or IV sedation. The Member's Patient Charge is shown in the Covered Dental Procedures and Patient Charges section.

B425.1093

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 Policy, 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 Policy.

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.

B425.0158

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 Policy.

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.

B425.0727

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

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

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

- Orthodontic Treatment: Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Policy may be covered if the Member identifies a Contracted Specialist who is willing to complete the treatment at a Patient Charge equal to 85% of the Contracted Specialist's usual fee. In this situation, the Patient Charge for retention services would also be equal to 85% of the Contracted Specialist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this Policy, the Patient Charge for orthodontic retention is equal to 85% of the Contracted Specialist's usual fee.

B425.1094

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 Policy 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 Policy and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior Dental Policy.
- This benefit applies to Members of new Policies only. It does not apply to Members of existing Policies and it does not apply to persons who become newly eligible under the Group after the Effective Date of this Policy.
- The Member has such orthodontic treatment in progress at the time the Policy becomes effective.
- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- The Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental HMO plan.
- We will only cover up to a total of 24 months of comprehensive orthodontic treatment.
- 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 Policy.

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

We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under this Policy is terminated.

The benefit will not apply if the comprehensive orthodontic treatment started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another orthodontist. The benefit does not apply to any other orthodontic services.

B425.1096

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.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
- Any histopathological examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any 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.
- Precision attachments, stress breakers, magnetic retention or overdenture attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
- Any procedure or treatment method 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.

GC-SCH-DHMO-U-20-CA

- 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 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 8th (eighth) 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.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Policy, except as described under Treatment in Progress Restorative Treatment. Inlays, onlays, crowns or fixed bridges are (a) considered to be started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken; and (b) completed when the denture is delivered to the Member.
- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Policy, except as described under Treatment in Progress - Endodontic Treatment. Root canal treatment is considered to be (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.
- Inlay, onlays, crowns, fixed bridges or dentures started by a Non-Contracted Dentist. Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. This exclusion will not apply to services that are started and which were covered under the Policy as Emergency Dental Services.
- Root canal treatment started by a Non-Contracted Dentist. Root canal treatment is considered to be started when the pulp chamber is opened. This exclusion will not apply to services that were started and which were covered under the Policy as Emergency Dental Services.
- Extractions performed solely to facilitate orthodontic treatment.

- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under comprehensive orthodontic treatment or to correct or control harmful habits.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances lost or damaged.

B425.1098

EVIDENCE OF COVERAGE AMENDATORY RIDER

This Rider amends the Evidence of Coverage as follows and is effective on 01/20/2022.

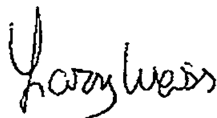
The Emergency Dental Services provision is replaced with the following:

Emergency Dental Services

The MDC Network also provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. You should contact Your selected PCD, who will arrange for such care. If You are not able to reach Your PCD in an emergency during normal business hours, You must call MDC's Member Services Department for instructions. If You are not able to reach Your PCD in an emergency after normal business hours, You may seek Emergency Dental Services from any Dentist. MDC will reimburse You for the cost of the Emergency Dental Services, less any Patient Charge which may apply. You should present a statement from the treating Dentist. You must file a claim within 180 days of service. This should be submitted to the address listed on page 1.

This Rider is part of the Evidence of Coverage. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Evidence of Coverage.

Managed Dental Care of California



Jill M. Purcell, President

Larry Weiss, Assistant Vice President and Controller

B425.1210

GC-A-DHMO-EDS-21-CA

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN U60	**Deductibles**	**Lifetime Maximums**	**Professional Services**			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Bitewings Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			No Charge	Prophylaxis - $0 - $60; Flouride - $0 - $20; Sealants - $0 - $35; Space Maintainers - $0	Amalgam - $0; Resin - $0; Crowns - $85 - $100; Inlays & Onlays - $60 - $80; Labial Veneer - $40; Miscellaneous Restorative Services - $0 - $125	Pulp Cap - $0; Pulpotomy - $10 - $15; Root Canals - $70 - $140; Retreatments - $80 - $150; Apicoectomy - First Root - $90 - $100; Each Additional Root - $40; Retrograde Filling - Per Root - $15; Canal Preparation - $20

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Cont.)	**Deductibles**	**Lifetime Maximums**	**Professional Services (Continued)**			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Compre-hensive Orthodontic Treatment Per Member	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, Up To 16th Birthday, One Per Tooth In Any 3-Year Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

MDC U60 0308

B850.1076-R

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Continued)	**Professional Services (Continued)**				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Services (Continued)	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Crown Lengthening; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor Excision Of Bone Tissue	Comprehensive Treatment; Retention; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia General Anesthesia Intravenous Conscious Sedation/ Analgesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - $20 - $60; Gingival Flap Procedure - $35 - $105; Osseous Surgery - $95 - $155; Scaling & Root Planing - $15 - $25; Soft Tissue Graft - $100 - $120; Crown Lengthening - $85; Miscellaneous Periodontal Services $0 - $15	Complete Denture $110; Immediate Denture - $110; Rebase - $0; Interim Partial - $45; Partial Denture - $90 - $140; Reline - $0; Repair - $0; Tissue Conditioning - $0; Denture Adjustment - $5	Extractions - Coronal Total/ Remnants/ Erupted Exposed Root - $10; Surgical Removal - $35; Removal Of Impacted Tooth - $50 - $85; Alveoloplasty - $16 - $45; Removal of Cyst/ Tumor - $60 - $110; Excision Of Bone Tissue - $75; Surgical Incision - $25 - $30; Other Surgical Procedures - $35 -$90; Other Repair Procedures - $60 - $100;	To Age 18 - $1500; Over Age 18 - $2800; Retention - $400; Treatment Plan And Records - $250.00	Office Visit - $0 - $10; After Hours Office Visit - $50; Palliative Treatment - $0; Local Anesthesia - $0; General Anesthesia/ Conscious Sedation - $75 - $95; External Bleaching - $165; Miscellaneous Services - $0 - $34

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Continued)	**Professional Services (Continued)**				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations (Continued)	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member’s Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/ Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

B850.1080

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDC U60 0308

B850.1078

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Cont.)	**Outpatient Services**	**Hospitalization Service**	**Emergency Health Coverage**		**Ambulance Services**	**Prescription Drug Services**
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to $50 Reimbursement Per Incident	Not Covered*	Not Covered*

U60 (Cont.)	**Durable Medical Equipment**	**Mental Health Services**	**Chemical Dependency Services**	**Home Health Services**	**Other**
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDC U60 0308

B850.1079