Managed DentalGuard
Group Benefit Plan

Prepared For:

FORT BEND INDEPENDENT SCHOOL DISTRICT
CLASS 0001
DENTAL DHMO PLAN

Managed DentalGuard, Inc.
a wholly owned subsidiary of Guardian

This Evidence of Coverage is intended to explain the benefits provided by this plan. It does not constitute the Group Contract. Your rights and benefits are determined in accordance with the provisions of the Group Contract, and your coverage is effective only if you are eligible for coverage and remain covered in accordance with its terms.

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CERTIFICATE OF COVERAGE

Managed DentalGuard, Inc.
14643 Dallas Parkway, Suite 100
Dallas, Texas 75254
1-888-618-2016

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

Group Policy No.	Form No.	Effective Date
Issued To		

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

Raymond J Marra

Ray Marra
Vice President, Group Products
Managed DentalGuard

CGP-3-MDG-TX-1-08 B850.1161

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call *MDG's* toll-free telephone number for information or to make a complaint at:

1-888-618-2016

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

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web:http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

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

CGP-3-MDG-TX-2-08

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Guardian's para informacion o para someter una queja al:

1-888-618-2016

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas al:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web:http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

B850.1162

GENERAL PROVISIONS

As used in this booklet:

"Employer" means the *employer* or other entity who purchased this *plan.*

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

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

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

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

Limitation of Authority

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

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

Entire Contract

The contract issued to the *planholder* by MDG, including any attachments or amendments thereto, together with the group application and certificate booklet(s), constitutes the entire contract between the parties regarding this *plan.* The *planholder* may cancel this *plan* by giving 30 days prior written notice to MDG in the event that MDG makes any material change to any provisions required to be disclosed to the *planholder* or to *plan members* pursuant to 28 TAC Chapter 11.

Incontestability

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

A group certificate may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

We may increase the premium charge to an appropriate level if we determine that the *employee* made a material misrepresentation of health status on the application. We must provide the *planholder* 31 days prior written notice of any premium rate change.

Claims Provisions

"Claim" means a first-party claim made by a *member* under this *plan* that MDG must pay directly to the *member.*

"Notice of claim" means any written notification provided to MDG by a *member* that reasonably informs MDG of the facts relating to a claim.

Not later than the 15th business day after receipt of notice of a claim, MDG will:

a. acknowledge, either orally or in writing, the receipt of the claim. Oral acknowledgments will be documented.
b. begin any investigation of the claim.
c. request all items, statements & forms that MDG reasonably believes, at the time, to be required. Additional requests for necessary information may be made during the course of the investigation of the claim.

MDG will notify the *member* in writing of acceptance or rejection of the claim not later than 15-business days after the date of receipt of all items, statements and forms requested.

If MDG notifies a *member* that the claim or part of a claim will be paid, MDG will pay the claim not later than the 5th business day after the notice has been made.

If MDG notifies a *member* that the claim is rejected, the notice will state the reasons for rejection.

If MDG is unable to accept or reject the claim within the 15 business- day period, MDG must:

a. notify the *member* within this time period. The notice must state the reasons that additional time is needed.
b. accept or reject the claim not later than the 45th day after the date such notice is provided.

If MDG is liable for a claim and does not comply with the provisions of this section, MDG also will be liable for interest on the amount of the claim at the rate of 18% per year and for reasonable attorney's fees.

Conformity With Statutes

This *plan* will be governed by the laws of the State of Texas.

Adjustment Of Premiums

The *planholder* must pay MDG the premiums due under this *plan* on each due date. The premiums will be the sum of each premium per *member* covered by this *plan.*

We may change such premiums: (a) on any date to the extent or terms of services provided to the *planholder* are changed by amendment to this *plan;* or (b) on any date our obligation under this *plan* with respect to the *planholder* is changed because of statutory or other regulatory requirements.

The *planholder* will receive written notice at least 60 days in advance of any adjustment of premiums.

Grace Period - Termination Of Plan

A grace period of 31 days, without interest charge, will be granted to the *planholder* for each premium except the first. If any premium is not paid before the end of the grace period, this *plan* automatically terminates on the last day of the month to which the grace period applies. The *planholder* will still owe *us* premiums for the month this *plan* was in effect during the grace period.

Member Eligibility And Termination Provisions

Enrollment Procedures

In order to become *members* under this *plan,* (a) *you* must reside or work in the *plan's* approved *service area,* and (b) the legal residence of any enrolled *dependent* must be (i) the same as *yours;* (ii) in the service area with the person having temporary or permanent conservatorship or guardianship of such *dependent,* including an adoptee or child who has become the subject of a suit for adoption by *you,* where *you* have legal responsibility for the health care of such *dependent;* or (iii) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

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

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

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

Open Enrollment Period

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

If, after initial enrollment, you or one of your dependents disenroll from the *plan* before the open enrollment period, the *member* may not re-enroll until the next open enrollment period.

When Your Coverage Starts

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

When Your Dependent Coverage Starts

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

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

When Coverage Ends

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

1. The end of the 31-day grace period following the period for which *your employer* last made the required premium payment.

2. If *you* are required to pay all or part of the cost of coverage but fail to do so, the end of the period for which *you* last made the required payment.

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

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

5. The date 30 days after *MDG* sends written notice to a *member* advising that his or her coverage will end because the *member* no longer resides or works in the *service area.* Such action must be taken by *MDG* uniformly and without regard to any health status-related factors of a *member.* But coverage will not end for a *dependent child* who is the subject of a medical support order.

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

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

8. The date 15 days after MDG sends written notice to a *member* advising that his or her coverage will end because the *member* has knowingly given false information or has intentionally misrepresented material fact in writing on his or her signed enrollment form, a copy of which has been furnished to the *member.*

9. The date 15 days after MDG sends written notice to a *member* advising that his or her coverage will end because the *member* has: (a) misused his or her ID card or other documents provided to obtain benefits under this *plan;* or (b) otherwise acted in an unlawful or fraudulent manner regarding *plan* services and benefits.

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

11. The date 30 days after MDG sends written notice to a *member* advising that his or her coverage will end because the *member* has failed to pay *patient charges* that are due under the *plan.*

12. The date of a *member's* misconduct, which is detrimental to safe plan operations and the delivery of services.

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

1. when this *plan* ends or *you* terminate coverage under this *plan* but remain eligible for coverage;
2. when *you* cease to be eligible within 7 days of the end of the month and MDG receives notice from your *employer* within the first 3 business days of the next month;
3. if your *employer* notifies MDG at least 30 days prior to the date *you* are no longer eligible under this plan;
4. when *you* elect to end coverage under this *plan* and obtain other coverage which takes effect after termination of eligibility under this *plan* and prior to the end of coverage under this *plan;*
5. if *you* are covered under a federal or state continuation of coverage requirement that allows *you* to pay premium and extend coverage under this *plan* after *you* leave employment or are no longer eligible;
6. when the entire premium for this coverage is paid by *you;* or
7. after the later of: your date of your death and the date *you* receive the last covered service under this plan.

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

Extended Dental Expense Benefits

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

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

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

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

YOUR CONTINUATION RIGHTS

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

An Important Notice About Continuation Rights

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

Federal Continuation Rights

Important Notice

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

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

If Your Group Dental Benefits End

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

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

Extra Continuation For Disabled Qualified Continuees

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

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

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

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

If You Die While Covered

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

If Your Marriage Ends

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

If A Dependent Loses Eligibility

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

Concurrent Continuations

If a dependent elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) your 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: (a) the dependent becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (b) you become entitled to Medicare.

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

The Qualified Continuee's Responsibilities

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

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

Your Employer's Responsibilities

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

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

Your Employer's Liability Election Of Continuation

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

Election Of Continuation

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

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

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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 *plan* on a regular basis. It includes any amount that would have been paid by your *employer.* Except as explained in the "Extra Continuation for Disabled Qualified Continuees," your *employer* may also require an additional charge of 2% of the total premium charge.

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

Grace In Payment of Premiums

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

When Continuation Ends

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

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

(b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that a disabled qualified continuee 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 the group dental benefits would otherwise end;

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

(e) the date the *plan* ends;

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

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

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

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DENTAL BENEFITS PLAN

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

Managed DentalGuard - This *Plan's* Dental Coverage Organization

Managed DentalGuard

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

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

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

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

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

Choice of Dentists

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

A *Member* with a chronic, disabling or life-threatening condition or disease may submit a request to MDG's Dental Director to use a *participating specialist* as his or her *PCD.* Such request must:
(i) include any information specified by *MDG,* including certification of the medical need; and
(ii) be signed by the *Member* and the *participating specialist* interested in serving as the *Member's PCD.*

To be eligible to serve as the *Member's PCD,* a *participating specialist* must:
(i) meet MDG's requirements for *PCD* participation; and
(ii) agree to accept the responsibility to coordinate all of the *Member's* dental care needs.

MDG compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount each month. The amount a Participating General Dentist is paid is based upon the number of *Members* who have the Dentist assigned as their PCD. *MDG* may also make minimum monthly payments, supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from *MDG.*

The *dentist* also receives compensation from *Members* who may pay an office visit charge for each office visit and a *patient charge* for specific dental services. The schedule of *patient charges* is shown in the *Covered Dental Services And Patient Charges* section of this booklet.

Changes in Dentist Participation

We may have to reassign a *Member* to a different *participating dentist* if: (a) the *Member's dentist* is no longer a *participating dentist* in the *MDG* network; or (b) *MDG* takes an administrative action which impacts the *dentist's* participation in the network. If reassignment becomes necessary, the *Member* will have the opportunity to request a change to another *participating dentist,* as set forth in the preceding section. If a *Member* has a dental service in progress at the time of the reassignment, *we* will, at *our* option and subject to applicable law, either: (a) arrange for completion of the services by the original *dentist;* or (b) make reasonable and appropriate arrangements for another *participating dentist* to complete the service. If a *Member* has "special circumstances" as defined in section 843.362 of the Texas Insurance Code, a *Member* may be eligible for up to 90 days of continuing treatment from such *participating dentist* after his or her effective date of termination.

Refusal of Recommended Treatment

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

Specialty Care Referrals

A *member's PCD* is responsible for providing all covered services. But, certain services may be eligible for referral to a *participating specialty care dentist. MDG* will pay for covered services for specialty care, less any applicable *patient charges,* when such covered services are provided in accordance with the following specialty referral process:

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

(2) When the care of a *participating specialty care dentist* is required, the *member's PCD* must contact *MDG* and request authorization.

(3) If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply to that service, the *PCD* may be asked to perform the service directly, or to provide more information.

(4) If the *PCD's* request for specialty referral is denied as not medically necessary (an adverse determination), the *PCD* and the *member* will receive a written notice along with information on how to appeal the denial to an independent review organization. (See Appeal of Adverse Determination, below, under Complaint and Appeal Procedures.)

(5) If the *PCD's* request for specialty care referral is approved, the Member will be referred to a *participating specialty care dentist* for treatment. The *member* will be instructed to contact the *participating specialty care dentist* to schedule an appointment. The *MDG* network includes *participating specialty care dentists* in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the *plan's* approved *service area.*

(6) If there is no *participating specialty care dentist* in the *plan's* approved *service area, MDG* will refer the *member* to a *non-participating specialty care dentist* of *MDG's* choice. In no event will *MDG* pay for dental care provided to a *member* by a *specialty care dentist* who was not pre-authorized by *MDG* to provide such services.

(7) A *member* who receives authorization for covered specialty care services is responsible for all applicable *patient charges* for the services provided. In no event will *MDG* pay for specialty care services that are not covered services under the *plan.*

ALL SPECIALTY CARE REFERRAL SERVICES MUST BE COVERED SERVICES UNDER THE *PLAN.* THE *PLAN'S* BENEFITS, CONDITIONS, LIMITATIONS AND EXCLUSIONS WILL DETERMINE COVERAGE IN ALL CASES. IF A REFERRAL IS MADE FOR A SERVICE THAT IS NOT A COVERED SERVICE UNDER THE *PLAN,* THE *MEMBER* MUST PAY THE ENTIRE AMOUNT OF THE *PARTICIPATING SPECIALTY CARE DENTIST'S* CHARGE FOR THAT SERVICE.

ALL SPECIALTY CARE REFERRAL SERVICES MUST BE: (A) COORDINATED BY A *MEMBER'S PCD;* AND (B) PRE-AUTHORIZED BY *MDG.* IF A *MEMBER* ELECTS SPECIALTY CARE SERVICES WITHOUT PRIOR REFERRAL BY HIS OR HER *PCD* AND APPROVAL BY *MDG,* THE *MEMBER* MUST PAY THE ENTIRE AMOUNT OF THE *PARTICIPATING SPECIALTY CARE DENTIST'S* CHARGE FOR THAT SERVICE.

MDG compensates its *participating specialty care dentists* the difference between their contracted fee and the *Patient Charge* shown in the Covered Dental Services And Patient Charges section. This is the only form of compensation that *participating specialty care dentists* receive from *MDG.*

Out-of-Network Specialty Referrals

A *member's* PCD is responsible for providing all covered services. But, certain medically necessary services may be eligible for a specialty referral to a *non-participating dentist* if: (i) the referral is requested by a *participating dentist,* and (ii) MDG determines that no *participating dentist* has the appropriate training and experience to provide the dental treatment, procedure or service required to meet the particular dental care needs of a *member.* Before MDG may deny a request for referral, a review is required by a *participating specialty care dentist* of the same or similar specialty as the type of *dentist* to whom the referral is requested.

If the request for referral is approved, MDG will refer the *member* to an appropriate *non-participating dentist* within the time appropriate to the circumstances relating to the delivery of the services and the *member's* condition, but no later than 5 working days after receipt of reasonably requested documentation.

The dental treatment, procedure or service provided by the *non-participating dentist* must otherwise be a covered service under the *plan.* A *member* who receives authorized services from a *non-participating dentist* must pay all applicable *patient charges* associated with the services provided.

ANY MEMBER WHO RECEIVES OUT-OF-NETWORK SERVICES WITHOUT PRIOR REFERRAL AND APPROVAL BY MDG IS RESPONSIBLE FOR ALL CHARGES INCURRED.

CGP-3-MDG-TX-10-D-08 B850.1170

Emergency Dental Services

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

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

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

CGP-3-MDG-TX-EM-A-08 B850.1171

Complaint Overview

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

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

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

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

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

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

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

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

1-888-618-2016
or by mail at:
P. O. Box 4391, Woodland Hills, CA 91367

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

1-888-834-2476

Complaint Process

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

Member Service Representatives document each telephone call and work with the Member to resolve their oral Complaint. The Member will be sent, within 5 days from the date of receipt of the telephone call, an acknowledgement letter and a Complaint Form to complete if the Member desires additional review.

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

MDG will review and resolve the written Complaint within 30 calendar days after the date of receipt.

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

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

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

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

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

CGP-3-MDG-TX-GRV-08 B850.1172

Complaint Committee and Peer Review Committee

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

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

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

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

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

Complaint Appeal Process

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

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

a. Representative(s) from MDG;
b. Representative(s) selected from Participating General Dentists;
c. Representative(s) selected from Participating Specialty Care Dentists (if the Complaint concerns specialty care); and
d. Representative(s) selected from Plan Members who are not MDG employees.

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

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

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

The Committee will meet within the Member's county of residence or the county where the Member normally receives dental care or at another site agreed to by the Member, or address a written appeal to the complaint appeal board.

MDG will complete the appeals process under this section within 30 calendar days after the date of the receipt of the request for appeal.

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

The Member will receive a written notice of resolution within 5 working days after the date of the Committee resolution. The resolution notice will include a written statement of the specific medical determination, clinical basis and contractual criteria used to reach the final decision. The notice shall also prominently and clearly state the toll free telephone number and address of the Texas Department of Insurance.

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

The Member may also contact the Texas Department of Insurance to file a Complaint. The Department's addresses and telephone numbers are:

P. O. Box 149104
Austin, TX 78714-9104
Telephone: 1-800-252-3439
FAX #: 1-512-475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

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

Emergency Complaints

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

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

CGP-3-MDG-TX-GRV-08 B850.1173

Documentation Database

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

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

The objectives of the logging system in the database are:

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

Documentation/Files

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

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

CGP-3-MDG-TX-GRV-08 B850.1174

Appeal Of Adverse Determination

Adverse Determination means: a determination by us or a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary or are not appropriate.

We shall permit any party whose appeal of an adverse determination is denied by us to seek review of that determination by an independent review organization assigned to the appeal as follows;

(1) We shall provide to you, your designated representative or your *dentist* information on how to appeal the denial of an adverse determination to an independent review organization;

(2) Such information must be provided by us to you, your designated representative or your *dentist* at the time of the denial of the appeal;

(3) We shall provide to you, your designated representative or your *dentist* the prescribed form;

(4) The form must be completed by you, your designated representative or your *dentist* and returned to us to begin the independent review process;

(5) In life threatening situations, you, your designated representative or your *dentist* may contact us by telephone to request the review and provide the required information.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places your health in serious jeopardy.

CGP-3-MDGADV B850.0469

Covered Dental Services And Patient Charges - Plan U40 G

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

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

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

CDT Code	Covered Services and Patient Charges - U40 G Current Dental Terminology (CDT) © American Dental Association (ADA)	Patient Charge
D0999	Office visit during regular hours, general dentist only	$0.00
	EVALUATIONS	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
	RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
	TESTS AND EXAMINATIONS	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00

D0470	Diagnostic casts	$0.00

DENTAL PROPHYLAXIS

D1110	Prophylaxis - adult, for the first two services in any 12-month period [1, 2]	$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period [1, 2]	$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period [1, 2]	$60.00

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period [1, 3]	$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period [1, 3]	$0.00
D1206	Topical fluoride (prophylaxis not included) - child, for the first two services in any 12-month period [1, 3]	$12.00
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period [1, 3]	$20.00

OTHER PREVENTIVE SERVICES

D1310	Nutritional instruction for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth (molars) [4]	$10.00
D9999	Sealant - per tooth (non-molars) [4]	$35.00

SPACE MAINTENACE (PASSIVE APPLIANCES)

D1510	Space maintainer - fixed - unilateral	$65.00
D1515	Space maintainer - fixed - bilateral	$110.00
D1525	Space maintainer - removable - bilateral	$110.00
D1550	Re-cementation of fixed space maintainer	$15.00
D1555	Removal of fixed space maintainer	$20.00

ALMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	Amalgam - 1 surface, primary or permanent	$8.00
D2150	Amalgam - 2 surfaces, primary or permanent	$12.00
D2160	Amalgam - 3 surfaces, primary or permanent	$14.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$17.00

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT

D2330	Resin-based composite - 1 surface, anterior	$20.00
D2331	Resin-based composite - 2 surfaces, anterior	$25.00
D2332	Resin-based composite - 3 surfaces, anterior	$30.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$50.00
D2391	Resin-based composite - 1 surface, posterior	$35.00
D2392	Resin-based composite - 2 surfaces, posterior	$40.00

D2393	Resin-based composite - 3 or more surfaces, posterior	$45.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$50.00

INLAY/ONLAY RESTORATIONS [6]

D2510	Inlay - metallic - 1 surface [5]	$180.00
D2520	Inlay - metallic - 2 surfaces [5]	$230.00
D2530	Inlay - metallic - 3 or more surfaces [5]	$235.00
D2542	Onlay - metallic - 2 surfaces [5]	$235.00
D2543	Onlay - metallic - 3 surfaces [5]	$240.00
D2544	Onlay - metallic - 4 or more surfaces [5]	$245.00
D2610	Inlay - porcelain/ceramic - 1 surface	$180.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$230.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$235.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$235.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$240.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$245.00

CROWNS - SINGLE RESTORATIONS ONLY [6]

D2740	Crown - porcelain/ceramic substrate	$270.00
D2750	Crown - porcelain fused to high noble metal [5]	$250.00
D2751	Crown - porcelain fused to predominantly base metal	$250.00
D2752	Crown - porcelain fused to noble metal	$250.00
D2780	Crown - 3/4 cast high noble metal [5]	$240.00
D2781	Crown - 3/4 cast predominantly base metal	$240.00
D2782	Crown - 3/4 cast noble metal	$240.00
D2783	Crown - 3/4 porcelain/ceramic	$240.00
D2790	Crown - full cast high noble metal [5]	$250.00
D2791	Crown - full cast predominantly base metal	$250.00
D2792	Crown - full cast noble metal	$250.00
D2794	Crown - titanium	$250.00

OTHER RESTORATIVE SERVICES

D2910	Recement inlay, onlay, or partial coverage restoration	$20.00
D2915	Recement cast or prefabricated post and core	$20.00
D2920	Recement crown	$20.00
D2930	Prefabricated stainless steel crown - primary tooth	$60.00
D2931	Prefabricated stainless steel crown - permanent tooth	$60.00
D2932	Prefabricated resin crown	$90.00
D2933	Prefabricated stainless steel crown with resin window	$90.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$100.00
D2940	Sedative filling	$15.00
D2950	Core buildup, including any pins	$50.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post & core in addition to crown, indirectly fabricated	$95.00
D2953	Each additional indirectly fabricated post - same tooth	$29.00
D2954	Prefabricated post and core in addition to crown	$85.00
D2957	Each additional prefabricated post - same tooth	$19.00
D2960	Labial veneer (resin laminate) - chairside	$235.00
D2970	Temporary crown (fractured tooth)	$75.00

D2971	Additional procedures to construct new crown under existing partial denture framework	$125.00

PULP CAPPING

D3110	Pulp cap - direct (excluding restoration)	$10.00
D3120	Pulp cap - indirect (excluding restoration)	$10.00

PULPOTOMY

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$30.00
D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$30.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$37.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00

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

D3310	Root canal, anterior (excluding final restoration)	$95.00
D3320	Root canal, bicuspid (excluding final restoration)	$160.00
D3330	Root canal, molar (excluding final restoration)	$170.00
D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$95.00
D3333	Internal root repair or perforation defects	$80.00

ENDODONTIC RETREATMENT

D3346	Retreatment of previous root canal therapy - anterior	$310.00
D3347	Retreatment of previous root canal therapy - bicuspid	$370.00
D3348	Retreatment of previous root canal therapy - molar	$445.00

APICOECTOMY/PERIRADICULAR SERVICES

D3410	Apicoectomy/periradicular surgery - anterior	$135.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$145.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$155.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$80.00
D3430	Retrograde filling - per root	$35.00
D3950	Canal preparation and fitting of preformed dowel or post	$20.00

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$80.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$45.00

D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$190.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$114.00
D4249	Clinical crown lengthening - hard tissue	$170.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$255.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$155.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$185.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$205.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$225.00

NON-SURGICAL PERIODONTAL SERVICE

D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$30.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$18.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$35.00

OTHER PERIODONTAL SERVICES

D4910	Periodontal maintenance, for the first two services in any 12-month period [1, 2]	$30.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$25.00
D4999	Periodontal maintenance, for each additional service in same 12-month period [1, 2]	$60.00

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5110	Complete denture - maxillary	$345.00
D5120	Complete denture - mandibular	$345.00
D5130	Immediate denture - maxillary	$345.00
D5140	Immediate denture - mandibular	$345.00

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$310.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$310.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$355.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$355.00

D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$430.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$430.00

ADJUSTMENTS TO DENTURES

D5410	Adjust complete denture - maxillary	$20.00
D5411	Adjust complete denture - mandibular	$20.00
D5421	Adjust partial denture - maxillary	$20.00
D5422	Adjust partial denture - mandibular	$20.00

REPAIRS TO COMPLETE DENTURES

D5510	Repair broken complete denture base	$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$35.00

REPAIRS TO PARTIAL DENTURES

D5610	Repair resin denture base	$45.00
D5620	Repair cast framework	$80.00
D5630	Repair or replace broken clasp	$60.00
D5640	Replace broken teeth - per tooth	$35.00
D5650	Add tooth to existing partial denture	$45.00
D5660	Add clasp to existing partial denture	$45.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$160.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$160.00

DENTURE REBASE PROCEDURES

D5710	Rebase complete maxillary denture	$125.00
D5711	Rebase complete mandibular denture	$125.00
D5720	Rebase maxillary partial denture	$125.00
D5721	Rebase mandibular partial denture	$125.00

DENTURE RELINE PROCEDURES

D5730	Reline complete maxillary denture (chairside)	$65.00
D5731	Reline complete mandibular denture (chairside)	$65.00
D5740	Reline maxillary partial denture (chairside)	$65.00
D5741	Reline mandibular partial denture (chairside)	$65.00
D5750	Reline complete maxillary denture (laboratory)	$120.00
D5751	Reline complete mandibular denture (laboratory)	$120.00
D5760	Reline maxillary partial denture (laboratory)	$120.00
D5761	Reline mandibular partial denture (laboratory)	$120.00

INTERIM PROSTHESIS

D5820	Interim partial denture (maxillary)	$95.00
D5821	Interim partial denture (mandibular)	$95.00

OTHER REMOVABLE PROSTHETIC SERVICES

D5850	Tissue conditioning, maxillary	$30.00
D5851	Tissue conditioning, mandibular	$30.00

FIXED PARTIAL DENTURE PONTICS [6]

D6210	Pontic - cast high noble metal [5]	$230.00
D6211	Pontic - cast predomniantly base metal	$230.00
D6212	Pontic - cast noble metal	$230.00
D6214	Pontic - titanium	$230.00
D6240	Pontic - porcelain fused to high noble metal [5]	$230.00
D6241	Pontic - porcelain fused to predominantly base metal	$230.00
D6242	Pontic - porcelain fused to noble metal	$230.00
D6245	Pontic - porcelain/ceramic	$240.00

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS [6]

D6600	Inlay - porcelain/ceramic, - 2 surface	$230.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$235.00
D6602	Inlay - cast high noble metal, - 2 surfaces [5]	$230.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces [5]	$235.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$230.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$235.00
D6606	Inlay - cast noble metal, 2 surfaces	$230.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$235.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$235.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$240.00
D6610	Onlay - cast high noble metal, 2 surfaces [5]	$235.00
D6611	Onlay - cast high noble metal, 3 or more surfaces [5]	$240.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$235.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$240.00
D6614	Onlay - cast noble metal, 2 surfaces	$235.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$240.00
D6624	Inlay - titanium	$230.00
D6634	Onlay - titanium	$235.00

FIXED PARTIAL DENTURE RETAINERS - CROWNS [6]

D6740	Crown - porcelain/ceramic	$270.00
D6750	Crown - porcelain fused to high noble metal [5]	$250.00
D6751	Crown - porcelain fused to predominantly base metal	$250.00
D6752	Crown - porcelain fused to noble metal	$250.00
D6780	Crown - 3/4 cast high noble metal [5]	$240.00
D6781	Crown - 3/4 cast predominantly base metal	$240.00
D6782	Crown - 3/4 cast noble metal	$240.00
D6783	Crown - 3/4 porcelain/ceramic	$240.00
D6790	Crown - full cast high noble metal [5]	$250.00
D6791	Crown - full cast predominantly base metal	$250.00
D6792	Crown - full cast noble metal	$250.00
D6794	Crown - titanium	$250.00

OTHER FIXED PARTIAL DENTURE SERVICES

D6930	Recement fixed partial denture	$15.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$95.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$85.00
D6973	Core buildup for retainer, including any pins	$55.00
D6976	Each additional cast post - same tooth	$29.00
D6977	Each additional prefabricated post - same tooth	$19.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment [6]	$125.00

EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10.00

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

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30.00
D7220	Removal of impacted tooth - soft tissue	$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	$90.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35.00
D7261	Primary closure of a sinus perforation	$250.00

OTHER SURGICAL PROCEDURES

D7280	Surgical access of an unerupted tooth	$130.00
D7283	Placement of device to facilitate eruption of impacted tooth	$40.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$70.00
D7286	Biopsy of oral tissue - soft	$65.00
D7288	Brush biopsy - transepithelial sample collection	$65.00

ALEVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$25.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$70.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	$49.00

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$85.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$160.00

EXCISION OF BONE TISSUE

D7471	Removal of lateral exostosis (maxilla or mandible)	$125.00
D7472	Removal of torus palatinus	$125.00
D7473	Removal of torus mandibularis	$125.00

SURGICAL INCISION

D7510	Incision and drainage of abscess - intraoral soft tissue	$40.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$44.00

OTHER REPAIR PROCEDURES

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$95.00
D7963	Frenuloplasty	$152.00

UNCLASSIFIED TREATMENT

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$15.00
D9120	Fixed partial denture sectioning	$10.00
D9215	Local anesthesia	$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes [7]	$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes [7]	$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes [7]	$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes [7]	$75.00

PROFESSIONAL CONSULTATION

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$30.00

PROFESSIONAL VISITS

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

MISCELLANEOUS SERVICES

D9951	Occlusal adjustment - limited	$20.00
D9971	Odontoplasty, 1-2 teeth	$20.00
D9972	External bleaching - per arch	$165.00
	Broken Appointment	$25.00

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

[2] Routine prophylaxis or periodontal maintenance procedure - a total of 4 services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a participating periodontal Specialist if done within 3 to 6 months following completion of approved, active periodontal therapy (periodontal scaling and root planning or periodontal osseous surgery) by a participating periodontal Specialist. Active periodontal therapy includes periodontal scaling and root planning or periodontal osseous surgery.

[3] Fluoride treatment - a total of 4 services in any 12- month period.

[4] Sealants are limited to permanent teeth up to the 16th birthday.

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

[6] The *patient charge* for these services is per unit.

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

Covered Dental Services And Patient Charges - Plan U40 G

CDT Code	Covered Services and Patient Charges - U40 G Current Dental Terminology (CDT) © American Dental Association (ADA)	Patient Charge
	ORTHODONTICS [8, 10]	
D8070	Comprehensive orthodontic treatment of the transitional dentition [9, 11]	Child: $2500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition [9, 11]	Child: $2500.00
D8090	Comprehensive orthodontic treatment of the adult dentition [9, 11]	Adult: $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
	Broken Appointment	$25.00

[8] The orthodontic *patient charges* are valid for authorized services started and completed under this *plan* and rendered by a *participating orthodontic specialty care dentist* in the state of Texas.

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

[10] Limited to one course of comprehensive orthodontic treatment per *member.*

[11] Comprehensive orthodontic treatment is limited to 24 months of continuous treatment.

Additional Conditions On Covered Services

General Guidelines For Alternative Procedures

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

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

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

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

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

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

General Guidelines For Alternative Treatment

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

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

Crowns, Bridges And Dentures

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

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

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

Multiple Crown/Bridge Unit Treatment Fee

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

Pediatric Specialty Services

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

Second Opinion Consultation

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

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

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

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

Noble and High Noble Metals

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

General Anesthesia / IV Sedation

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

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Orthodontic Treatment

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

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

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

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

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

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

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

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Treatment In Progress

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

Restorative Treatment

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

Endodontic Treatment

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

Orthodontic Treatment

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

Treatment in Progress - Takeover Benefit for Orthodontic Treatment

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

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

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

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

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

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

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

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

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

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

- Routine cleaning (prophylaxis) or periodontal maintenance procedures, which are not medically necessary - a total of 4 services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within 3 to 6 months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to 1 in any 2-year period (or any 12-month period, if the Plan has been in effect for less than one year) on or after the 40th birthday.
- Full mouth x-rays - 1 set in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- Bitewing x-rays - 2 sets in any 12-month period.
- Panoramic x-rays - 1 set in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- Sealants - limited to permanent teeth, up to the 16th birthday - 1 per tooth in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) - a total of 1 service per quadrant or area in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) - a total of 1 service per area in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- Periodontal scaling and root planing (D4341, D4342) - 1 service per quadrant or area in any 12-month period.
- Emergency dental services when more than 50 miles from the PCD's office - limited to a $50.00 reimbursement per incident.

- Emergency dental services when provided by a dentist other than the member's assigned PCD, and without referral by the PCD or authorization by MDG - limited to the benefit for palliative treatment (code D9110) only.
- Reline of a complete or partial denture - 1 per denture in 12-month period.
- Rebase of a complete or partial denture - 1 per denture in any 12-month period.
- Second Opinion Consultation - when approved by us, a second opinion consultation will be reimbursed up to $50.00 per treatment plan.

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Exclusions

We will not cover:

- Any condition for which benefits of any nature are recovered, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any *histopathological* examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the *participating dentist* is not necessary for maintaining or improving the Member's dental health; or (b) which is solely for cosmetic purposes.
- Precision attachments, stress breakers, magnetic retention or *overdenture* attachments.
- The use of: (a) intramuscular sedation; (b) oral sedation; or (c) inhalation sedation, including but not limited to *nitrous oxide.*
- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.

- Replacement or repair of prosthetic appliances due to the neglect of the Member.
- Any Member request for: (a) specialist services or treatment which can be routinely provided by the *PCD,* or (b) treatment by a specialist without a referral from the *PCD* and approval from *us.* This exclusion will not apply to *Emergency Dental Services.*
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely: (a) to alter vertical dimension; (b) to replace tooth structure lost due to attrition or abrasion; (c) to splint or stabilize teeth for *periodontal* reasons; or (d) except as described in the Orthodontic Treatment section, to realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the *temporomandibular joint (TMJ).*
- Dental services, other than covered *Emergency Dental Services,* which were performed by any *dentist* other than the Member's assigned *PCD,* unless *we* had provided written authorization.
- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a *Prosthodontist.*
- Treatment which requires the services of a *Pediatric Specialty Care Dentist,* after the Member's 8th birthday.
- Consultations for non-covered services.
- Any procedure not specifically listed as a covered service.

CGP-3-MDG-TX-EXCL-08 B850.1213

- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this *plan,* except as described under Treatment in Progress- Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be: (a) 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 plan, 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.)
- Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the plan as Emergency Dental Services.
- Root canal treatment started by a non-participating dentist. (Root canal treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the plan as Emergency Dental Services.
- Orthodontic treatment started prior to the Member's eligibility to receive benefits under this plan, except as described under Treatment in Progress-Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

CONVERTING THIS GROUP DENTAL PLAN

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

If Your Group Dental Benefits End: If your group dental benefits end for any reason, *you* can obtain a converted policy. But *you* must have been covered by this *plan* for at least 3 consecutive months immediately prior to the date your group dental benefits end. The converted policy will cover *you* and those of your eligible *dependents* whose group dental benefits end.

If *You* Die While Covered: If *you* die while covered, after any applicable continuation period has ended, your then covered spouse can convert. The converted policy will cover the spouse and those of your *dependent* children whose group benefits end. If the spouse is not living, each *dependent* child whose group dental benefits end may convert for himself or herself.

If Your Marriage Ends: If your marriage ends by legal divorce or annulment, and if your former spouse is dependent on *you* for financial support, your former spouse can convert. The converted policy will cover your former spouse and those of your *dependent* children whose group dental benefits end.

When A Dependent Loses Eligibility: When a covered *dependent* stops being an eligible *dependent,* as defined in this *plan,* he or she may convert. The converted policy will only cover the *dependent* whose group benefits end.

How and When to Convert: To convert, the applicant must apply to Us in writing and pay the required premium. He or she has 31 days after his or her group dental benefits end to do this. We don’t ask for proof of insurability. The converted policy will take effect on the date the applicant’s group dental benefits end. If the applicant is a minor or incompetent, the person who cares for and supports the applicant may apply for him or her.

The Converted Plan: The applicant may convert to the individual dental insurance policy we normally issue for conversion at the time he or she applies. The policy will be renewable. The converted policy will comply with the laws of the State of Texas when he or she applies.

Restrictions:

(1) A *member* can’t convert if his or her group dental benefits end because *you* have failed to make the required payments.

(2) A *member* can’t convert if his or her discontinued coverage is replace by similar coverage within 31 days.

(3) A *member* can’t convert if his or her coverage ends for any of the reasons listed under numbers (7) or (8) of the WHEN COVERAGE ENDS section of this booklet.

CGP-3-MDGCNV B850.0525

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

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

CGP-3-MDGD1 B850.0526

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

CGP-3-MDGD2 B850.0527

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

CGP-3-MDGD3 B850.0528

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

1. your legal spouse;
2. your dependent children who are under age 26.

   The term "dependent child" as used in this plan includes any: (a) stepchild; (b) newborn child; (c) legally adopted child; (d) unmarried grandchild who is your or your spouse's dependent for federal income tax purposes at the time application for coverage of the grandchild is made; or (e) child for whom you are court-appointed legal guardian, if the child; (i) is not married; (ii) is a part of your household, and (iii) is primarily dependent on you for support and maintenance. The term also includes any child for whom a court-ordered decree requires you to provide dependent coverage, and any child who is the subject of a legal suit for adoption by the employee.
3. a mentally retarded or physically handicapped child who: (a) has reached the upper age limit of a dependent child; (b) is not married; (c) is not capable of self-sustaining work; and (d) depends primarily on you for support and maintenance. You must furnish proof of such lack of capacity and dependence to MDG within 31 days after the child reaches the limiting age, and each year after that, if requested by MDG.

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

CGP-3-MDG-D4-TX-10 B850.1309

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

CGP-3-MDGD5-TX B850.0535

Employee or You means a person: (a) who meets your *employer's* eligibility requirements; and (b) for whom your *employer* makes monthly payments under this *plan.*

CGP-3-MDGD6 B850.0536

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

CGP-3-MDGD7 B850.0537

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

CGP-3-MDGD8 B850.0538

Non-Participating Dentist means any *dentist* who is not under contract with MDG to provide dental services to *members.*

CGP-3-MDG-DEF9 B850.0539

Participating Dentist means a *dentist* under contract with MDG. This term includes any hygienist and technician recognized by the dental profession who assists and acts under the supervision of such *dentist.*

CGP-3-MDGD10 B850.0540

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

CGP-3-MDGD11 B850.0541

Participating Specialty Care Dentist means a *dentist* under contract with MDG as an: (a) *endodontist;* (b) *pediatric specialty care dentist;* (c) *periodontist;* (d) *oral surgeon;* or (e) *orthodontist.*

CGP-3-MDGD12B-TX B850.0544

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

CGP-3-MDGD13 B850.0545

Plan means the MDG group *plan* for dental services described in this booklet.

CGP-3-MDGD14 B850.0546

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

CGP-3-MDGD15 B850.0547

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

CGP-3-MDG-D16-TX-08 B850.1219

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

CGP-3-MDGD17-TX B850.0549

COORDINATION OF BENEFITS

Applicability

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

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

As used here:

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

(1) group or blanket insurance plans;

(2) group service or prepayment plans on a group basis;

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

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

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

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

How This Provision Works: The Order Of Benefits

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

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

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

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

(2) Except for *dependent* children of separated or divorced parents, the following governs which *plan* pays first when the *member* is a *dependent* child of an *employee* :

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

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

(3) For a dependent child of separated or divorced parents, the following governs which *plan* pays first when the member is a dependent of an *employee:*

(a) When a court order makes one parent financially responsible for the health care expenses of the dependent child, then that parent's *plan* pays first;

(b) If there is no such court order, then the *plan* of the natural parent with custody pays before the *plan* of the stepparent with custody; and

(c) The *plan* of the stepparent with custody pays before the *plan* of the natural parent without custody.

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

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

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

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

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

CGP-3-MDG-COB B850.0550

How This Provision Works: Coordination of Benefits

Coordination With Another Pre-Paid Dental Plan

A member may also be covered under another pre-paid dental *plan* where members pay only a fixed payment amount for each covered service.

For a PCD's services, when the PCD participates under both pre-paid plans, the member will never be responsible for more than the MDG patient charge.

For participating specialty care dentists' services and emergency dental services within the service area, when this *plan* is primary, our benefits are paid without regard to the other coverage. When this *plan* is the secondary coverage, any payment made by the primary carrier is credited against the patient charge. In many cases, the member will have no out- of-pocket expenses.

For emergency dental services outside the service area, when this *plan* is primary, this *plan's* benefits are paid without regard to the other coverage. When this *plan* is the secondary *plan,* this *plan* pays the balance of expenses not paid by the primary *plan,* up to this *plan's* usual benefit.

Coordination With An Indemnity Or PPO Dental Plan

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

For a PCD's services, when this *plan* is the primary *plan,* the PCD submits a claim to the secondary *plan* for the patient charge amount. Any payment made by the secondary *plan* must be deducted from the member's payment.

For a PCD's services, when this *plan* 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 credited against the patient charge, reducing the member's out-of-pocket expense.

For specialist dentists' services and emergency dental services within the service area, when this *plan* is the primary *plan,* our benefits are paid without regard to the other coverage. When this *plan* is the secondary *plan,* any payment made by the primary carrier is credited against the patient charge, reducing the member's out-of-pocket expense.

For emergency dental services outside the service area, when this *plan* is primary, this *plan's* benefits are paid without regard to the other coverage. When this *plan* is the secondary *plan,* this *plan* pays up to $50.00 for such services not paid by the primary *plan.*

Our Right To Certain Information

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

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

Subrogation

MDG receives any rights of recovery allowed by Texas law acquired by a member against any person or organization for negligence or any willful act resulting in illness or injury covered by MDG benefits, but only to the extent of the cost to MDG of providing such covered services. Upon receiving such services from MDG, the member is considered to have assigned such rights of recovery to MDG and to have agreed to give MDG any reasonable help required to secure the recovery.

MDG may recover its share of attorney's fees and court costs only if MDG aids in the collection of damages from a third party.

CGP-3-MDG-TX-SUBR-08 B850.1220

STATEMENT OF ERISA RIGHTS

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

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

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

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

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

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

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

TECHNICAL DENTAL TERMS

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

ABUTMENT a tooth used to support a prosthesis.

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

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

AMALGAM an alloy used in direct dental restorations.

ANALGESIA loss of pain sensations without loss of consciousness.

ANESTHESIA partial or total absence of sensation to stimuli.

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

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

APICOECTOMY amputation of the apex of a tooth.

BICUSPID a premolar tooth; a tooth with two cusps.

BILATERAL occurring on, or pertaining to, both sides.

BIOPSY process of removing tissue for histologic evaluation.

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

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

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

CARIES commonly used term for tooth decay.

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

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

COMPOSITE a tooth-colored dental restorative material

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

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

CYST pathological cavity, containing fluid or soft matter.

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

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

DENTURE an artificial substitute for natural teeth and adjacent tissues.

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

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

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

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

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

EXCISION surgical removal of bone or tissue.

EXOSTOSIS overgrowth of bone.

EXTRAORAL outside the oral cavity.

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

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

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

GINGIVECTOMY the excision or removal of gingiva.

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

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

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

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

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

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

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

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

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

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

INTRAORAL inside the mouth.

LABIAL pertaining to or around the lip.

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

LINGUAL pertaining to or around the tongue.

MESIAL toward the midline of the dental arch.

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

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

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

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

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

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

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

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

ORTHOGNATHIC functional relationship of maxilla and mandible.

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

PALLIATIVE action that relieves pain but is not curative.

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

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

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

PERIAPICAL the area surrounding the end of the tooth root.

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

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

CGP-3-MDGTERMS B850.0555

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

PERIRADICULAR surrounding a portion of the root of the tooth.

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

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

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

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

PREMOLAR see bicuspid.

PRIMARY DENTITION the first set of teeth.

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

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

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

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

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

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

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

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

RADIOGRAPH x-ray.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CGP-3-MDGTERMS B850.0556

CERTIFICATE AMENDMENT

Certain provisions of the Dental Benefits Plan section of your Certificate of Coverage are amended as follows:

1. **The Covered Dental Services and Patient Charges Section,** the 3rd paragraph is hereby deleted and the following paragraph is added:

   The patient charges listed in the Covered Dental Services and Patient Charges Section are only for covered services that are: (1) started and completed under this plan, and (2) rendered by participating dentists in the State of Texas.

2. **The Additional Conditions on Covered Services Section is amended by adding the following:**

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

   Inlays, onlays, crowns, fixed bridges, or dentures which: (1) are listed in the Covered Dental Services and Patient Charges Section; and (2) were started but not completed prior to the member's eligibility to receive benefits under this plan have a patient charge equal to 85% of the participating general dentist's usual fee (there is no additional patient charge for high noble metal or dental lab service). Inlays, onlays, crowns or fixed bridges are: (a) started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented. Dentures are (1) started when the impressions are taken; and (2) completed when the denture is delivered to the patient.

   Root canal treatment procedures which: (1) are listed in the Covered Dental Services and Patient Charges Section; and (2) were started but not completed prior to the member's eligibility to receive benefits under this plan have a patient charge equal to 85% of the participating general dentist's or participating endodontic specialty care dentist's usual fee. Root canal treatment is: (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.

   Please refer to the Covered Dental Services and Patient Charges Section to determine if your plan covers orthodontic treatment. If it does, then this paragraph applies to your plan. Orthodontic treatment procedures which: (1) are listed in the Covered Dental Services and Patient Charges Section: and (2) were started but not completed prior to the member's eligibility to receive benefits under this plan have a patient charge equal to 85% of the participating orthodontic specialty care dentist's usual fee. Retention services are covered at the patient charge shown in the Covered Dental Services and Patient Charges Section only following a course of comprehensive orthodontic treatment started and completed under this plan. When comprehensive orthodontic treatment is started prior to the member's eligibility to receive benefits under this plan, the patient charge for orthodontic retention is equal to 85% of the participating orthodontic specialty care dentist's usual fee. Comprehensive orthodontic treatment is started when the teeth are banded.

3. The **Exclusions Section** is amended by deleting the following exclusions:

   We won't pay for:

   - inlays, onlays, crowns or fixed bridges started (as defined above) by a non-participating dentist. This will not apply to covered emergency dental services.
   - root canal treatment started (as defined above) by a non- participating dentist. This does not apply to covered emergency dental services.

4. The **Exclusions Section** is amended by adding the following exclusion:

   - We won't pay for inlays, onlays, crowns, fixed bridges or root canal treatment started (as defined) by a non-participating dentist while the member is covered under this plan. This does not apply to covered emergency dental services.

5. The **Complaint and Appeal Procedures** Section is amended as follows:

   The second paragraph under **Re-Evaluation** is amended by deleting the following sentence: "But, more time will be permitted as necessary for extraordinary circumstances."

Except as stated in this amendment, nothing contained in this amendment changes or affects any other terms of this Certificate of Coverage.

Raymond J Marra

Ray Marra
Vice President, Group Products
Managed DentalGuard, Inc.

CGP-3-MDGTX-AMND-02 B850.0736

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information(PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian(using the information supplied below), or on our Web site at: www.GuardianLife.com/PrivacyPolicy

What is Protected Health Information (PHI):

PHI is individually identifiable information(including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage(including medical, dental, vision and LTC coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information

about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

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Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. A breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding(e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- Guardian may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an

inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).

- We may disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0047

Your Rights with Regard to Your Protected Health Information (PHI): Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation,(ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of the disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing. Your request must state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list(e.g., paper, electronically).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply(except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

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Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it(ii) if we do not maintain the PHI at issue(iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457

B998.0049

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com


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