Managed DentalGuard
Group Benefit Plan

Prepared For:

CHRISTIAN RESEARCH INSTITUTE

Managed Dental Care of California
a wholly owned subsidiary of Guardian

The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616. WWW.theguardian.com
Managed Dental Care of California, Inc., 6200 Canoga Avenue, Woodland Hills, CA 91367

Important Information About Managed DentalGuard: This plan provides pre-paid dental benefits through a network of participating dentists and specialists. All covered services must be provided by the member's Primary Care Dentist. Specialists' services are covered only when referred by the member's Primary Care Dentist and approved in advance by Managed Dental Care. Only those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The Managed DentalGuard plan documents are the final arbiter of coverage.

GP-1-MDG1, et al.

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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.

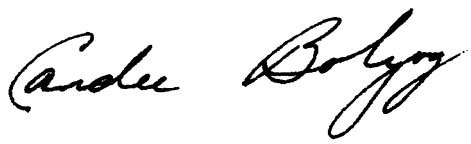
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care of California
6200 Canoga Avenue, Suite 100
Woodland Hills, California 91367
1-800-273-3330

We, MDC, certify that the *employee* named below is entitled to the benefits provided by MDC 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 Evidence of Coverage and Disclosure Form constitutes only a summary of the *plan.* The dental care *plan* contract should be consulted to determine the exact terms and conditions of coverage. This Form replaces any Evidence of Coverage and Disclosure Form previously issued under the above *plan* or under any other plan providing similar or identical benefits issued to your *employer* by MDC. A specimen copy of the *plan* contract will be furnished upon request.



President

CGP-3-MDC1

B850.0230

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," "Managed Dental Care," "MDC," "us" and "we" mean Managed Dental Care of California.

"Plan" means the MDC *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 MDC 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 MDC; or (b) by an amendment to this *plan* signed by the *planholder* and one of the listed officers of MDC.

Examination

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

Public Policy Committee

MDC maintains a Public Policy Committee comprised of at least 3 members, one participating dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee.

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures

You and your *dependents* may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your *employer;* and (b) returning the enrollment material to your *employer.* After your enrollment material has been received by MDC, *you* or your *dependents* need only contact the selected and assigned *primary care dentist's* office to obtain services.

MDC will issue *you* and each of your *dependents,* either directly or through your *employer's* representative, an MDC ID card. The ID card will show the *member's* name and the name, address and telephone number of his or her selected and assigned *primary care dentist.*

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 MDC.

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 open enrollment period which occurs after he or she has been without coverage for one full year.

When Your Coverage Starts

Your coverage starts on the date shown on the face page of this *plan* if you are enrolled when the *plan* starts. If *you* are not enrolled on this date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by MDC; 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) an adopted child; (b) a stepchild; or (c) a foster child, coverage begins on the date of placement in your home. 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. Coverage does not terminate if enrollment materials are not received within 30 days.

When Coverage Ends

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

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

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

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

(4) The date on which *you* or your *dependent* no longer reside or work in the *service area.*

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

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

(7) Immediately, if a *member:* (a) has knowingly given false information in writing on an enrollment form; or (b) has misused his or her ID card or other documents provided to obtain benefits available under this *plan;* or

(8) 30 days after written notice is sent to *you* advising that your or your *dependent's* coverage will terminate because MDC has determined that the *member's* behavior is: (a) disruptive; (b) unruly; (c) abusive; (d) unlawful; (e) fraudulent; or (f) uncooperative to the extent that the *member's* continued participation in the *plan* seriously impairs the *plan's* ability to provide services to either your *employer* or to other *members;* or (g) when MDC has determined that the *member* is not able to maintain an appropriate dentist-patient relationship. MDC will:

   (a) make a reasonable effort to resolve the problem presented by the *member,* including the use or attempted use of *member* grievance procedures;

   (b) ascertain, to the extent possible, that the *member's* behavior is not related to the use of medical services or medical illness;

   (c) document the problems, efforts and medical conditions on which the problem is based; and

   (d) provide 30 days advance written notice of termination.

Pursuant to Section 1365(b) of the Knox Keene Act, any *member* who alleges his or her enrollment has been cancelled or not renewed because of his or her health status or requirement for services may request review by the California Department of Corporations.

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 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 work 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 Insured

If *you* die while insured, 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.*

CGP-3-MDCCC B850.0361

Your Employer's Liability

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

Election of Continuation

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

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

The monthly premium will be the total rate which would have been charged for the group 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 to occur 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 dental 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 EXPENSE COVERAGE

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.* MDC 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. 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.

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

Managed DentalGuard
Managed Dental Care's Dental Coverage Program

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 a *member's service area.* A "*participating dentist* " is a *dentist* that has a Managed DentalGuard agreement in force with MDC.

When a *member* enrolls in this plan, he or she will get information about MDC's current *participating general dentists.* Each *member* must select 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 MDC 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* selects and is assigned to upon enrolling in 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 and *patient charges.*

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

MDC has a written plan describing how this *plan* facilitates the continuity of care for new *members* receiving services from a *non-participating dentist* during a current episode of care for an acute condition. A *member* may request a copy of MDC's written plan which includes information on how he or she may request a review under this *plan.*

Choice of Dentists

A *member* may select any available *participating general dentist* as his or her *PCD.* A request to change *PCDs* must be made to MDC at 1-800-273-3330. Any such change will be effective the first day of the month following approval. MDC 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.

MDC compensates its *participating general dentists* through a capitation agreement by which they are paid a fixed amount of money each month based upon the number of *members* that select them as their *PCD.*

MDC may also make supplemental payments on a limited number of specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from MDC. The *dentist* also receives compensation from *plan members* who may pay an office visit charge for each office visit and a defined *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.

If a *member* wishes to know more about these issues, the *member* may request additional information from the health care service plan, the *member's* provider, or the provider's medical group or independent practice association regarding this information.

Changes in Dentist Participation

MDC reserves the right to reassign *you* to a different *participating* dentist if: (a) the *dentist you* have chosen is no longer a *participating dentist* in the MDG network; or (b) MDC takes an administrative action which impacts the *dentist's* participation in the network. If this becomes necessary, *you* will have the opportunity to choose another *participating dentist.* If *you* have 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.

Specialty Referrals

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

MDC compensates its *participating specialists* the difference between their contracted fee and the *patient charge* given in the Covered Dental Services And Patient Charges section. This is the only form of compensation that *participating specialists* receive from MDC.

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

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

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

(2) When the care of a *participating specialist* is required, the *PCD* must contact MDC and request authorization.

(3) If the *PCD's* request for specialist referral is approved, MDC will notify the *member.* He or she will be instructed to contact the *participating specialist* to schedule an appointment.

(4) If the *PCD's* request for specialist referral is denied, the *PCD* and the *member* will be notified of the reason for the denial. If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply, the *PCD* may be asked to perform the service directly, or to provide additional information.

(5) If a request for specialist referral is denied and the *member* wishes to submit additional information or documentation to be considered in the evaluation of the request, he or she may submit an appeal of the determination. The appeal must be submitted to MDC within 5 business days of the original determination.

(6) A *member* who receives authorized specialty services must pay all applicable *patient charges* associated with the services provided.

When specialty dental care is authorized by MDC, a *member* will be referred to a *participating specialist* for treatment. The MDG network includes *participating specialists* in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the *member's service area.* If there is no *participating specialist* in the *member's service area,* MDC will refer the *member* to a *non-participating specialist* of *our* choice. In no event will MDC pay for dental care provided to a *member* by a specialist not pre-authorized by MDC to provide such services.

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Emergency Dental Services

The MDG network also provides for *emergency dental services* 24 hours a day, 7 days a week, to all *members.* A *member* should contact his or her selected *PCD,* who will arrange for such care. If a *member* is not able to reach his or her *PCD* in an emergency during normal business hours, he or she must call MDC's Member Services Department for instructions. If a *member* is not able to reach his or her *PCD* in an emergency after normal business hours, the *member* may seek *emergency dental services* from any *dentist.* Then, within 2 business days, he or she should call MDC to advise of the emergency claim. The *member* must submit to MDC: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her *PCD.* This must be done within 30 days. MDC will reimburse the *member* for the cost of the *emergency dental services,* less any *patient charge* which may apply.

Out-Of-Area Emergency Dental Services

If a *member* is more than 50 miles from his or her *PCD's* office, and *emergency dental services* are required, he or she should seek care from a *dentist.* Then he or she must file a claim within 30 days. He or she must present an acceptable detailed statement from the treating *dentist.* The statement must list all services provided. MDC will reimburse the *member* within 30 days for any covered *emergency dental services,* up to $50.00 per incident.

CGP-3-MDCEM B850.0193

Grievance Procedures

Member grievances are handled by MDC's Quality of Care Liaison (QCL) or a person named by him or her. The grievance process is designed to address *member* concerns quickly and satisfactorily. Grievances are classified as: (a) administrative; or (b) health care services grievances. To be responsive to *member* problems and concerns about coverage provided under this *plan,* MDC has established the grievance procedures which follow:

(1) Questions or concerns may be directed to MDC either by telephone or mail. When *member* issues or concerns are received by telephone, MDC's Member Service Representative documents the call and works with the *member* to resolve the issue. If the *member* wishes to document the complaint in writing, the QCL or a person named by him or her sends the *member* a grievance form to complete. MDC considers a grievance to be a written complaint. All written *member* issues are recorded and investigated.

(2) No later than 5 business days after the receipt of the written grievance, an acknowledgment letter is sent to the *member* indicating that a review is taking place. The usual response time for a resolution is within 30 days.

(3) Under the supervision of the QCL, supporting documentation is collected. The dental office may be asked to provide: (a) copies of relevant dental records and radiographs; and (b) statements of the dental provider or office personnel. MDC may arrange a second opinion examination, if applicable.

(4) When complete documentation is received, a resolution is determined based on objective evaluation by the QCL. Health services issues are resolved under the supervision of the Dental Director. Issues of a complex nature and/or quality of care issues may be presented to the Grievance Committee for review and resolution.

(5) If the *member* is not satisfied with the resolution, he or she may make a written Appeal within 5 days from the date of the resolution letter. Appeals will be reviewed by the Grievance Committee, and/or forwarded to the Peer Review Committee, if appropriate, for evaluation and final resolution at its next meeting. If the Grievance Committee forwards the Appeal to the Peer Review Committee, the *member* will be notified that the Appeal, with all supporting documentation, will be presented at the next quarterly Peer Review Committee meeting. The Peer Review Committee makes the final determination of the Appeal in this *plan's* Grievance Appeal process.

The Grievance Committee may be composed of: (a) the Dental Director and the QCL or persons they have named; (b) the Director of Group Dental HMO Development or a person he or she has named; (c) the Manager of Dental Product and Network Development or a person he or she has named; (d) legal counsel; and (e) Member Services Representatives.

The Peer Review Committee is composed of: (a) the Dental Director or a person he or she has named; (b) the QCL or a person he or she has named; (c) the Director of Group Dental HMO Development or a person he or she has named; and (d) representatives of the *dentist* network, including *general* and *specialist dentists.*

(6) If the *member* is not satisfied with the resolution of the Appeal, he or she, or an agent acting on behalf of the *member,* may make a written request for an additional review by a Voluntary Mediation Committee. This must be done within 5 business days of the resolution letter. This Committee will meet within 60 days of the date MDC and the *member* agree to the Voluntary Mediation process. But, more time will be permitted as necessary for extraordinary circumstances.

The Voluntary Mediation Committee may be composed of: (a) one person selected by MDC; (b) one person selected by the *member;* and (c) one person selected from the dental community, agreed to by both the *member* and MDC. This person will preside over the Committee.

The *member* will provide for his or her own expenses relating to the voluntary mediation process. This will include the expenses of the person the *member* selects. MDC will pay for its expenses relating to the voluntary mediation process. This will include the expenses of the person MDC selects. The *member* and MDC will share on an equal basis the expenses of the person who presides over the Voluntary Mediation Committee.

Following the decision of the Voluntary Mediation Committee, the *member* and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a *participating dentist.*

Please Note This information further clarifies *members'* rights under the *plan.*

The California Department of Corporations is responsible for regulating health care service plans. The Department's Health Plan Division has a toll-free telephone number **(1-800-400-8015)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY)** to contact the department. The department's Internet web site (**http://www.corp.ca.gov**) has complaint forms and instructions online. If a *member* has a grievance, he or she should first contact MDC at **(800) 273-3330** and use the grievance process described above before contacting the Health Plan Division. If a *member* needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by MDC, or a grievance that has remained unresolved for more than 60 days, the *member* may call the Health Plan Division for assistance. This *plan's* grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to a *member,* and a *member's* failure to use these processes does not preclude his or her use of any other remedy provided by law.

The Commissioner of Corporations has designated a staff member to function as an "ombudsperson" to assist *members.*

CGP-3-MDCGRV B850.0194

Covered Dental Services And Patient Charges - Plan 75 M

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

These *patient charges* are only valid for covered services rendered by *participating dentists* in the state of California.

MDG Codes+	Description of Service	Patient Charge
	Appointments and Diagnostic Services	
0101	Office Visit - during regular hours - participating general dentist only	$5.00
0102	Broken Appointment (without 24 hours' notice)	$25.00
0120, 0140, 0150	Oral evaluation	No Charge
0460	Pulp vitality tests	No Charge
0470	Diagnostic casts	No Charge
9310	Consultation (by dentist other than practitioner providing treatment)	No Charge
9430	Office visit for observation - regular hours - no other service performed	No Charge
9440	Emergency office visit - after regularly scheduled office hours	$50.00
	Radiographs	
0210	Intraoral - complete series (including bitewings)	No Charge
0220, 0230, 0240	Intraoral - periapical or occlusal - single film	No Charge
0270, 0272, 0274	Bitewings	No Charge
0330	Panoramic film	No Charge
	Preventive Services & Space Maintenance	
1110, 1120	Prophylaxis	No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child	No Charge
1310	Nutritional counseling for control of dental diseases	No Charge
1330	Oral hygiene instruction	No Charge
1351	Sealant - per tooth	No Charge
1510	Space maintainer - fixed - unilateral	No Charge
1515	Space maintainer - fixed - bilateral	No Charge
1550	Recementation of space maintainer	No Charge
	Restorative	
2110	Amalgam - one surface - primary	No Charge
2120	Amalgam - two surfaces - primary	No Charge
2130	Amalgam - three surfaces - primary	No Charge
2131	Amalgam - four or more surfaces - primary	No Charge
2140	Amalgam - one surface - permanent	No Charge
2150	Amalgam - two surfaces - permanent	No Charge
2160	Amalgam - three surfaces - permanent	No Charge
2161	Amalgam - four or more surfaces - permanent	No Charge
2210	Silicate cement - per restoration	No Charge

2330	Resin/composite - one surface, anterior	No Charge
2331	Resin/composite - two surfaces, anterior	No Charge
2332	Resin/composite - three surfaces, anterior	No Charge
2335	Resin/composite - four or more surfaces or incisal angle, anterior	No Charge
2336	Composite resin crown, anterior - primary	No Charge
2380	Resin/composite - one surface, posterior - primary	No Charge
2381	Resin/composite - two surfaces, posterior - primary	No Charge
2382	Resin/composite - three or more surfaces, posterior - primary	No Charge
2385	Resin/composite - one surface, posterior - permanent	No Charge
2386	Resin/composite - two surfaces, posterior - permanent	No Charge
2387	Resin/composite - three or more surfaces, posterior - permanent	No Charge

Crown, Bridge & Other Cast Restorations

2510	Inlay - metallic - one surface*	$60.00
2520, 6520	Inlay - metallic - two surfaces*	$75.00
2530, 6530	Inlay - metallic - three or more surfaces*	$75.00
2543, 6543	Onlay - metallic - three surfaces*	$80.00
2544, 6544	Onlay - metallic - four or more surfaces*	$80.00
2702	Crown supporting existing partial denture - in addition to crown	$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	$125.00
2740	Crown - porcelain/ceramic substrate	$100.00
2750, 2751, 2752	Crown - porcelain fused to metal*	$95.00
2790, 2791, 2792	Crown - full cast metal*	$90.00
2810, 6780	Crown - 3/4 cast metallic*	$95.00
6210, 6211, 6212	Pontic - cast metal*	$90.00
6240, 6241, 6242	Pontic - porcelain fused to metal*	$95.00
6750, 6751, 6752	Crown - abutment - porcelain fused to metal*	$95.00
6790, 6791, 6792	Crown - abutment - full cast metal*	$90.00

Other Restorative Services

2910, 2920, 6930	Recementation inlay, crown, bridge	No Charge
2930, 2931	Prefabricated stainless steel crown	$10.00
2932	Prefabricated resin crown	$20.00
2940	Sedative filling	No Charge
2950, 6973	Core buildup, including any pins	$20.00
2951	Pin retention - per tooth, in addition to restoration	No Charge
2952, 6970	Cast post & core	$30.00
2954, 6972	Prefabricated post & core	$25.00
2960	Labial veneer (laminate) - chairside	$40.00

Endodontics

3110, 3120	Pulp cap	No Charge
3220	Therapeutic pulpotomy	$10.00
3310	Root canal - anterior	$70.00
3320	Root canal - bicuspid	$80.00
3330	Root canal - molar	$140.00
3346	Root canal - retreatment - anterior	$80.00
3347	Root canal - retreatment - bicuspid	$95.00
3348	Root canal - retreatment - molar	$150.00
3410	Apicoectomy/periradicular surgery - anterior	$90.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	$95.00

3425	Apicoectomy/periradicular surgery - molar - first root	$100.00
3426	Apicoectomy/periradicular surgery - each additional root	$40.00
3430	Retrograde filling - per root	$15.00

Periodontics

4210	Gingivectomy or gingivoplasty - per quadrant	$60.00
4211	Gingivectomy or gingivoplasty - per tooth	$20.00
4240	Gingival flap procedure - including root planing - per quadrant	$105.00
4249	Clinical crown lengthening - hard tissue	$85.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	$155.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	$95.00
4270	Pedicle soft tissue graft procedure	$100.00
4271	Free soft tissue graft procedure (including donor site surgery)	$110.00
4341	Periodontal scaling & root planing - per quadrant	$25.00
4355	Full mouth debridement to enable evaluation and diagnosis	$15.00
4910	Periodontal maintenance procedures (following active therapy)	$15.00
4920	Unscheduled dressing change (by other than treating dentist)	No Charge
9951	Occlusal adjustment - limited - per visit	No Charge

Prosthodontics (Removable)

5110, 5120	Complete denture (including routine post delivery care)	$110.00
5130, 5140	Immediate denture (including routine post delivery care)	$110.00

Partial dentures (including routine post delivery care):

5211, 5212	Resin base - including clasps, rests, teeth	$90.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth	$130.00

Repairs and adjustments:

5410, 5411, 5421, 5422	Denture adjustments	$5.00
5510, 5610	Repair denture base	No Charge
5520, 5640	Replace missing or broken teeth -per tooth	No Charge
5630	Repair or replace clasp	No Charge
5650	Add tooth to existing partial	No Charge
5660	Add clasp to existing partial	No Charge
5710, 5711, 5720, 5721	Rebase denture	No Charge
5730, 5731, 5740, 5741	Reline denture (chairside)	No Charge
5750, 5751, 5760, 5761	Reline denture (laboratory)	No Charge
5820, 5821	Interim partial denture (stayplate)	$45.00
5850, 5851	Tissue conditioning	No Charge

Oral Surgery

7110, 7120	Extraction - single tooth	$5.00
7130	Root removal - exposed roots	$15.00
7210	Surgical removal of erupted tooth	$35.00
7220	Removal of impacted tooth - soft tissue	$50.00
7230	Removal of impacted tooth - partially bony	$70.00
7240	Removal of impacted tooth - completely bony	$80.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$85.00
7250	Surgical removal of residual tooth roots (cutting procedure)	$40.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	$60.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	$90.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	$60.00
7285	Biopsy of oral tissue - hard	$45.00
7286	Biopsy of oral tissue - soft	$40.00
7310	Alveoplasty in conjunction with extractions - per quadrant	$35.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	$45.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm	$60.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm	$110.00
7470	Removal of exostosis - maxilla or mandible	$85.00
7510	Incision & drainage of intraoral abscess	$25.00
7960	Frenectomy (separate procedure)	$60.00

Miscellaneous Services

9110	Palliative (emergency) treatment	No Charge
9215	Local anesthesia	No Charge

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

* There will be an additional *patient charge* for the actual cost of gold/high noble metal for these procedures.

CGP-3-MDCL4 B850.0333

MDC CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
	Orthodontics	
8601	Orthodontic evaluation and consultation	$100.00
8602	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos	$150.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: dependent child to age 18 (as determined by the *member's* age on the date of banding)	$1975.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: employee, spouse and dependent child over age 18 (as determined by the *member's* age on the date of banding)	$2175.00
8670	Periodic comprehensive orthodontic treatment visit	No Charge
8680	Orthodontic retention	$300.00

+ Covered Services are subject to this *plan's* exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

* These Orthodontic *patient charges* are valid only for authorized services rendered by *participating orthodontists* in the State of California.

CGP-3-MDCL3A B850.0352

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 *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 *member* must also pay the additional cost of high noble metal, if high noble metal is selected.

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.

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.*

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

Multiple Crown/Bridge Unit Treatment Fee

A *member's* approved treatment plan may include 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the *member* must pay both: (a) the usual crown or bridge *patient charge* for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Covered Dental Services And Patient Charges section.

Crown Supporting Existing Partial Denture

A crown may be: (a) placed under an existing partial denture; and (b) be customized to physically support the metal framework of the partial denture. In such case, the *member* must pay the *patient charge* for a crown supporting an existing partial denture. This charge is shown in the Covered Dental Services And Patient Charges section. This charge is in addition to the *patient charge* for the crown or bridge unit itself. The *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* must pay the *patient charge* for a multiple crown/bridge unit treatment plan.

Pediatric Specialty Services

During a *PCD* visit, a *member* under age 6 may be unmanageable. In such case, the *member* may be referred to a *participating pediatric specialist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *PCD* for further services. Later referrals to the *participating pediatric specialist,* if any, must first be authorized by MDC. Any services performed by a *pediatric specialist* after the *member's* 6th birthday will not be covered. And the *member* must pay the *pediatric specialist's* usual charges for such services.

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 specialist* through an authorized referral. To have a second opinion consultation covered by MDC, *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 *specialist 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 *plan's* benefit for a second opinion consultation is limited to $50.00. If a *participating dentist* is the consultant, there is no cost to *you.* If a *non-participating dentist* is the consultant, *you* must pay any portion of his or her fee over $50.00.

MDC has a written policy describing how *we* administer the second opinion program. *You* may request a complete copy of MDC's written policy by contacting the Member Services Department.

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, *you* must pay: (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; plus (b) an added charge equal to the actual laboratory cost of the high noble metal.

Orthodontic Treatment

This *plan* covers orthodontic services as shown in Covered Dental Services And Patient Charges. Coverage is limited to one course of treatment per *member* per lifetime. Treatment must be: (a) preauthorized by MDC; and (b) performed by a *participating orthodontist.*

The *plan* covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, *you* must pay an added charge for each added month of treatment. Such charge is based on the *participating orthodontist's* contracted fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under this *plan.* If a *member's* coverage terminates after the fixed banding appliances are inserted, the *participating orthodontist* will continue to honor the contracted fee arrangement in effect when the *member's* fixed banding appliances were inserted.

After the termination date, *you* must pay only the usual *patient charge* for comprehensive orthodontic treatment. If a *member* transfers to another *participating orthodontist* after comprehensive orthodontic treatment has been started, *you* must pay any added costs associated with: (a) the change in *orthodontist;* and (b) subsequent treatment.

The covered service 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. *You* must pay for additional fixed or removable appliances. The benefit for orthodontic retention covers: (a) any and all necessary fixed and removable appliances; and (b) 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 orthodontic appliances made with: (a) clear; (b) ceramic; (c) white or other optional material; or (d) lingual brackets. *You* must pay any added costs for the use of optional materials.

If a *member* has orthodontic treatment associated with orthognathic surgery, the *plan* provides its standard orthodontic benefit. Orthognathic surgery is a non-covered procedure involving the surgical moving of teeth. *You* must pay any added charges related to: (a) the orthognathic surgery; and (b) the complexity of the orthodontic treatment. The added charges will be based on the *participating orthodontist's* usual and customary charge.

CGP-3-MDCGG2-A B850.0197

Limitations on Benefits for Specific Covered Services

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

- Routine cleaning (prophylaxis) or periodontal maintenance procedure - 2 services in any 12 month period. One periodontal maintenance procedure may be performed by a *participating periodontist* if done within 3 to 6 months following completion of approved, active periodontal therapy by the *participating periodontist.* Such therapy includes periodontal scaling and root planing or periodontal surgery.
- Fluoride treatment - up to the 18th birthday - 2 in any 12 month period.
- Full mouth x-rays - one set in any 3 year period unless diagnostically necessary.
- Bitewing x-rays - 2 sets in any 12 month period unless diagnostically necessary.

- Panoramic x-rays - one in any 3 year period unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one per tooth in any 3 year period.
- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one service per quadrant or area in any 3 year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one service per area in any 3 year period.
- Periodontal scaling and root planing - one service per quadrant in any 12 month period.
- *Emergency dental services* when more than 50 miles from the *PCD's* office - up to $50.00 per incident.
- Reline of a complete or partial denture - one per denture in any 12 month period.
- Rebase of a complete or partial denture - one per denture in any 12 month period.
- Second opinion consultation - when approved by MDC, up to $50.00.

CGP-3-MDCLMT B850.0199

Exclusions

We won't pay for:

- any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law. This will apply even if the *member* fails to claim his or her rights to such benefit.
- dental services performed in a hospital or related hospital fees.
- any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.
- any treatment of congenital and/or developmental malformations. This will not apply to an otherwise covered service involving: (a) congenitally missing teeth; or (b) supernumerary teeth.
- any oral surgery requiring the setting of a fracture or dislocation.
- dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- any treatment or appliance: (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) general anesthesia; (b) intramuscular sedation; (c) intravenous sedation; or (d) 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 a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD;* or (b) treatment by a specialist without referral from the *PCD* and MDC approval.
- treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons.
- any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- dental services received from any *dentist* other than the selected and assigned *PCD,* unless expressly authorized in writing by the *plan.* This will not apply to covered *emergency dental services.*
- 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 specialist,* after the *member's* 6th birthday.
- consultations for non-covered services.
- any procedure not listed as a covered service.
- 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 started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* (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.)
- root canal treatment started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* (Root canal treatment is: (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.)
- inlays, onlays, crowns or fixed bridges started (as defined above) by a *non-participating dentist.* This will not apply to covered *emergency dental services.*

- dentures or orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan.* (Dentures are started when the impressions are taken. Orthodontic treatment is started when the teeth are banded.)
- root canal treatment started (as defined above) by a *non- participating dentist.* This will not apply to covered *emergency dental services.*
- extractions performed solely to facilitate orthodontic treatment.
- extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- orthognathic surgery and associated incremental charges. Orthognathic surgery is a procedure which involves the surgical moving of teeth.
- procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- procedures, appliances or devices: (a) to 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.*

CGP-3-MDCEXC-B B850.0202

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-MDCD1 B850.0205

Combined Evidence of Coverage and Disclosure Form means this booklet issued to *you,* which summarizes the essential terms of this *plan.*

CGP-3-MDCD2 B850.0207

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-MDCD3 B850.0208

Dependent means a person listed on your enrollment form who is:

(1) your spouse; or

(2) your or your spouse's unmarried dependent child who is: (a) less than 20 years of age, or less than 26 if a full-time student; (b) whose principal residence is with *you;* and (c) is primarily dependent upon you or your spouse for support and maintenance.

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

(3) A mentally retarded or physically handicapped *dependent child* who: (1) has reached the upper age limit of a *dependent child;* (2) is not capable of self-sustaining work; and (3) depends primarily on *you* for support and maintenance. *You* must furnish proof of such lack of capacity and dependence to MDC within 31 days after the child reaches the limiting age, and each year after that, if requested by MDC.

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-MDCD4-C B850.0209

Emergency Dental Services mean only covered, bona fide emergency services which are reasonably necessary to: (a) relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort; or (b) prevent the imminent loss of teeth.

Services related to the initial emergency condition that are not bona fide emergency services, as described above, are not considered *emergency dental services.* This includes: (a) services performed at the emergency visit; and (b) services performed at later visits.

CGP-3-MDCD5 B850.0212

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-MDCD6 B850.0213

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-MDCD7 B850.0214

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-MDCD8 B850.0215

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

CGP-3-MDG-DEF9 B850.0217

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

CGP-3-MDCD10 B850.0218

Participating General Dentist means a *dentist* under contract with MDC: (a) who is listed in MDC'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 MDC to provide or arrange for a *member's* dental services.

CGP-3-MDCD11 B850.0219

Participating Specialist means a *dentist* under contract with MDC as an: (a) *endodontist;* (b) *pediatric specialist;* (c) *periodontist;* (d) *oral surgeon* or (e) *orthodontist.*

CGP-3-MDC12-B B850.0220

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-MDCD13 B850.0222

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

CGP-3-MDCD14 B850.0223

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 MDC to provide and arrange for his or her dental services.

CGP-3-MDCD15 B850.0224

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

CGP-3-MDCD16 B850.0225

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

CGP-3-MDCD17 B850.0226

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. 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.

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 MDC *patient charge.*

For *participating specialists'* services and *emergency dental services* within the *service area,* when this *plan* is primary, *our* benefits are paid without regard to the other coverage. When this *plan* is 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 up to $50.00 for such services not paid by the primary plan.

Coordination With An Indemnity or PPO Dental Plan

When a me 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.

Managed Dental Care of California
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