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

INDIVIDUAL DENTAL BENEFITS PLAN

THIS DENTAL PLAN INCLUDES PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT.

THE COVERAGE EVIDENCED BY THIS PLAN PROVIDES DENTAL COVERAGE ONLY.

PLANOWNER Refer to Your ID Card
PLAN NUMBER Refer to Your ID Card
PLAN EFFECTIVE DATE The Effective Date Approved by Us.
PLAN ANNIVERSARY The Anniversary of the Effective Date, Each Year.

MANAGED DENTALGUARD, INC. (referred to in this Plan as "MDG," "us," "we," or "our"), in consideration of the application for this Plan and of the payment of premiums as stated herein, agrees to provide benefits in accordance with and subject to the terms of this Plan.

MDG AGREES to provide benefits in accordance with, and subject to, the terms of this Plan. This promise is based on the statements and agreements in the Application and payment of the required premiums. Please check the application form for errors. An incorrect or incomplete application may cause the Plan to be voided and claims to be reduced or denied.

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT DENTAL PLAN. THIS PLAN PROVIDES DENTAL BENEFITS ONLY. PLEASE READ THIS PLAN CAREFULLY.

TERM OF PLAN

This Plan is issued for a term of one year from the Plan Effective Date. All Plan years and Plan months will be calculated from the Plan Effective Date. All periods of coverage will begin and end at 12:01 AM Standard Time at the Planowner's place of residence, subject to the Grace In Payment Of Premiums. This Plan may then be renewed subject to the Renewal At The Option Of The Company provision.

RENEWAL AT THE OPTION OF THE COMPANY

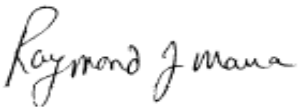
This Plan is conditionally renewable and will continue in effect as long as the premiums are paid when they are due or within the grace period in accordance with the terms and conditions of this Plan.

This Plan may be renewed for a further term by timely payment of renewal, unless We send prior notice of Our intention not to renew. If We do refuse to renew We must do so on all Policies of this form issued under the same class in the state. At least 90 days prior to the premium due date, We will send written notice of non-renewal to the last known address shown on record. Non-renewal will not affect any otherwise valid claim that starts while this Plan is in force.

We reserve the right to change rates on this Plan issued to an Insured Member of the same class in the state. If We do raise the premium due to a change in rates, than at least 60 days prior to the renewal date, We will send written notice to the last known address shown on record.

TEN-DAY RIGHT TO EXAMINE PLAN
There is a 10 day right to examine this Plan. If not satisfied for any reason this Plan may be returned to MDG within 10 days of receipt to have the premium refunded.

In Witness Whereof, MDG has caused this Plan to be executed as of the effective date approved by Us, which is its date of issue.



Raymond Marra
Vice President, Group Product
Managed Dental Guard

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:

1-866-569-9900

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.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-866-569-9900

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.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

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

Premium Rates

The monthly premium rates, in U.S. dollars, for the contract provided under this Plan are as follows:

Your monthly premium rates appear on Your Payment Notice.

We have the right to change any premium rate(s) set forth at the times and in the manner established by the provisions contained in this Plan entitled "Premiums" and "Adjustment of Premiums."

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GENERAL PROVISIONS

Effective Date

This Plan will: (a) be effective on the Plan effective date shown on the face page of this Plan; and (b) continue until the last day of the month in which the termination of this Plan occurs. All coverage under the Plan shall begin and end at 12:01 A.M. Standard Time at the Planowner's place of residence.

Premium Payments

The first premium payment for this Plan is due on the Plan effective date. Further payments shall be made on the first day of each month for each month this Plan is in effect. MDG may change such rates on the first day of any month. MDG must give You 60 days written notice of the rate change. Such change will apply to any premium due on or after the effective date of the change stated in such notice.

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 will be valid unless evidenced by: (a) an endorsement or rider to this Plan signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of MDG; or (b) an amendment to this Plan signed by the Planowner and by one of the aforesaid officers of MDG.

Entire Contract

This Plan, including any amendments to this Plan and application, constitutes the entire agreement of the parties. This Plan may only be modified by a writing executed by the parties. You 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 You or to Plan Members pursuant to 28 TAC Chapter 11.

Incontestability

All statements made by You 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 Your knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew your coverage or reduce benefits unless (a) it is in a written enrollment application signed You; and (b) a signed copy of the enrollment application is or has been furnished to You or Your personal representative.

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

Conformity With Law

If the provisions of this Plan do not conform to the requirements of Texas or federal law or regulation that applies, any such provision shall be construed and applied as if such provisions conform with the requirements of that law or regulation.

Disputes Between Parties

Any dispute, grievance, or controversy arising between a Member and MDG involving this Plan, any of its terms or conditions, its breach or non-performance may be settled, if both parties agree, by arbitration pursuant to the rules and regulations then in force and effect of the Texas Arbitration Act, Texas Civil Practice & Remedies Code - Section 171.001. The arbitration will take place in Texas and judgment on any award rendered by the arbitrator may be duly entered in any court in the State of Texas having jurisdiction thereof.

Members may also appeal the denial of an adverse determination to an independent review organization, as described in the Complaint and Appeals Process section. See page 14 of the Complaint and Appeals Process section.

Notice

Whenever it shall become necessary for either party to serve notice on the other with respect to this Plan, such notice shall be in writing and shall be served by certified mail, return receipt requested, addressed as follows:

If to a Planowner: At the Planowner's most current address on file with MDG (It is the Planowner's responsibility to timely notify MDG of address changes.)

If to MDG: Managed DentalGuard, Inc., 14643 Dallas Parkway, Suite 100, Dallas, TX 75254

Unenforceability, Invalidity Or Waiver Or Any Violation Of Any Provision Of The Plan

If any provision of this Plan is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Plan and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Plan.

Non-Assignability

This Plan is non-assignable by either party without consent of the other party. MDG may, in its sole discretion, delegate administration functions to other entities. Any attempt to make such an assignment shall be void and may result, at MDG's option, in the termination of a Member's coverage.

Clerical Error – Misstatements

Neither clerical error by You or MDG in keeping any records pertaining to coverage under this Plan, nor delays in making entries thereon, will: (a) invalidate coverage otherwise in force; or (b) continue coverage otherwise validly terminated. Upon discovery of such error or delay, an equitable adjustment of premiums will be made.

If the age of a Member, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of fees will be made. If such misstatement involves whether or not a risk would have been accepted by Us, or the amount of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amount.

Premiums

You must pay MDG the total sum indicated in the “Premium Rates” section of this Plan, commencing on the Plan effective date shown on the face page of this Plan. You must pay premiums due under this Plan at an office of MDG or to a representative that We have authorized.

Adjustment Of Premiums

The premiums due under this Plan on each due date will be the *sum* of each premium per Member covered by this Plan.

We may change such premiums: (a) on the first day of each Plan month; (b) on any date to the extent or terms of services provided to a Planowner are changed by amendment to this Plan; or (c) on any date Our obligation under this Plan with respect to You is changed because of statutory or other regulatory requirements.

We will provide You with 60 days advance written notice of any premium changes.

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.

Grace Period - Termination Of Plan

A grace period of 31 days, without interest charge, will be granted to You 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. You will still owe us premiums for the month this Plan was in effect during the grace period.

Renewal Of Plan

This Plan may be renewed on the Plan Anniversary date. You or MDG may modify, amend or alter this Plan at renewal. Any such modification, amendment or alteration shall be agreed to by both parties in writing and attached to this Plan.

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility Disclosure: You must reside, live or work in the service area and the legal residence of any enrolled dependents must be the same as Yours, or You must reside, live or work in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of such dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where You have legal responsibility for the health care of such dependents;

(ii) in the service area under other circumstances where You are legally responsible for the health care of such dependents;

(iii) in the service area with Your spouse; or

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

Enrollment Procedures: You may enroll Yourself and Your Dependents, if any for dental coverage by: filling out and signing MDG's enrollment form and any additional material required by MDG.

MDG will issue You and Your Dependents a MDG ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

When Coverage Starts: Your Coverage starts on the date shown on the face page of this Plan.

When Dependent Coverage Starts: Your Dependents coverage starts on the later of: (a) the date the You are eligible for coverage; or (b) the first day of the month following the date on which You acquire such Dependent.

If the Dependent is a newborn child, his or her coverage begins on the date of birth. If the Dependent is: (a) a stepchild; or (b) a foster child, coverage begins on the date that child begins to reside in the 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 Dependent within 31 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 31 days.

When Coverage Ends: Subject to any extension of coverage privilege which may be available to a Member, a Member's coverage under this Plan ends on the earliest of the following dates:

1. The end of the 31-day grace period following the period for which You last made the required premium payment.
2. The end of the month in which the Member is no longer eligible for coverage under this Plan.

3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. The date of a Member's misconduct, which is detrimental to safe Plan operations and the delivery of services.

Reinstatement: The Member may apply for reinstatement of this Plan if coverage ends at the the end of the 31-day grace period following the period for which You last made the required premium payment. If coverage is reinstated, the rights and coverages originally provided will not change.

Continuation Due to Change in Marital Status: If a person loses coverage due to a change in marital status, that person shall be issued a policy which most nearly approximates the coverage of this Plan which was in effect prior to the change in marital status. The new policy will be issued without evidence of insurability and will have the same effective date as the policy under which coverage was afforded prior to the change in marital status.

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.

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.

Emergency Dental Services: The MDG network provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. A Member should contact his or her PCD, who will arrange for such care.

A **Member may require Emergency Dental Services when he or she is unable to obtain services from his or her PCD**. The Member should contact his or her PCD for a referral to another dentist or contact MDG for 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 PCD, and without referral by the PCD or authorization by MDG, coverage is limited to the benefit for palliative treatment (code D9110 only).

COMPLAINT AND APPEALS PROCESS

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

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 or is experimental or investigational 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:

1-866-569-9900

or by mail at:

8890 Cal Center Drive, Sacramento CA 95826

The Plan hours are from 6:00 a.m. to 6:00 p.m. Pacific 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 Member because the Member has filed a Complaint against the Plan or appealed a decision of the Plan. The Plan is prohibited from retaliating against a dentist or network provider because the dentist or network provider has, on behalf of a Member, reasonably filed a Complaint against the Plan or appealed a decision of the Plan.

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

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

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

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

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

Complaint Appeal Process: If the Member is not satisfied with the resolution, the Member may make a telephone or written request within 30 days of the date of resolution 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 for appeal.

This Committee will meet within 30 days of the date the written request for 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.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

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.)

Appeal of Adverse Determination: Adverse Determination means a determination by MDG or a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary, are experimental or investigational, or are not appropriate.

If the Member is not satisfied with an initial denial of a claim, the Member may make a telephone or written request for appeal within 30 days of the date of denial that an additional review be conducted by a "Complaint Appeal Committee." A Member, an individual acting on behalf of the Member, of the Member's provider may initiate the appeal. 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 for appeal. Appeal decisions will be made by a provider who was not previously involved in the claim. In any instance in which the MDG or utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to issuance of an Adverse Determination, the MDG or utilization review agent will permit the provider of record a

reasonable opportunity to discuss the plan of treatment for the Member with a provider. The discussion will include the clinical basis for the MDG or utilization review agent's decision.

If an appeal is denied and, within 10 working days from the denial, the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial must be reviewed by a provider in the same or similar specialty that typically manages the dental condition, procedure, or treatment under discussion for review of the adverse determination. The specialty review must be completed within 15 working days of receipt of the request. Notification of the appeal under this paragraph shall be in writing.

The appeal shall be resolved as soon as practical, and in no case later than 30 calendar days after the date the MDG or utilization review agent receives the appeal from the appealing party.

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 the Member, the Member's designated representative or the Member's 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 the Member, the Member's designated representative or the Member's Dentist at the time of the denial of the appeal;

(3) We shall provide to the Member, the Member's designated representative or the Member's Dentist the prescribed form;

(4) The form must be completed by the Member, the Member's designated representative or the Member's
Dentist and returned to Us to begin the independent review process;

(5) In Life Threatening situations, the Member, the Member's designated representative or the Member's Dentist may contact Us by telephone to request the review and provide the required information.

The appeal process does not prohibit the Member 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 the Member's health in serious jeopardy.

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.

DENTAL BENEFITS

This Plan will cover many of a Member's dental expenses. What we cover and the terms of coverage are explained below.

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 Service Area. A "Participating Dentist" is a Dentist that has a participation agreement in force with Managed DentalGuard.

When a Member enrolls in this Plan, he or she will get information about current MDG 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 a MDG ID card. A Member must present this ID card when he or she goes to his or her PCD.

What We cover is based on all the terms of this Plan. Read this Plan carefully for: (a) specific benefit levels; (b) conditions, exclusions and limitations; and (c) Patient Charges.

Members may call the MDG Member Services Department if they have any questions after reading this Plan.

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 a 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.

Right to Reassign Member: MDG reserves the right to reassign Members to a different Participating Dentist in the event that either: (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. MDG will notify the Member of the dentist's network status change in writing as soon as reasonably possible. 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, MDG will, in its discretion and subject to applicable law, either: (a) arrange for completion of the service 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.

If MDG Fails To Pay Participating Dentist: In the event MDG fails to pay a Participating Dentist, the Member shall not be liable to the Participating Dentist for any sums owed by MDG.

Relationship Between You And Participating Dentists And Institutions: You understand that: (a) the operation and maintenance of the participating dental offices, facilities and equipment; and (b) the rendition of all dental services are under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) the supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment.

MDG will undertake to see that the services provided to Members by Participating Dentists will be performed in accordance with professional standards prevailing in the county in which each Participating Dentist practices.

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 a 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 Charge section of this Plan.

ADDITIONAL CONDITIONS ON COVERED SERVICES

- General Guidelines For Alternative Procedures: 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 plan 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.

  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 placement 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.

- Multiple Crown and Bridge Unit Treatment Fee: When a Member's treatment plan includes six (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.

- 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 and 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: If during a Primary Care Dentist visit, a Member under age eight (8) is unmanageable, the Primary Care Dentist 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 Primary Care Dentist 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 eighth (8^{th}) birthday will not be covered, and the Member will be responsible for the Pediatric Specialty Care Dentist's usual fees.

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

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

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

  The Plan's benefit for a second opinion consultation is limited to $50.00. If a participating dentist is the consultant dentist, you are responsible for the applicable patient charge for code D9310. If the 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 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.

ORTHODONTIC TREATMENT

- The Plan covers orthodontic services as listed under Covered Dental Services and Patient Charges. 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 twenty-four (24) months of comprehensive orthodontic treatment. If treatment beyond twenty-four (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 the Treatment in Progress—Orthodontic Treatment section, 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 twelve (12) months and covers any and all necessary fixed and removable appliances and related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the Plan. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.
- The Plan does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the Member's responsibility.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialist Dentist's usual fee.

TREATMENT IN PROGRESS

- Treatment in progress: 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 listed as Covered Services 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).
- Treatment in progress: 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 listed on the Member's Plan Schedule that 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 or Specialty Care Dentist's usual fee.

- Treatment in progress: 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, have a Patient Charge equal to 85% of the Participating Specialty Care Dentist's usual fee.

LIMITATIONS AND EXCUSIONS

Limitations:

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) – a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D1208, D2999) – four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.
- Full mouth x-rays – one (1) set in any three (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, unless diagnostically necessary).
- Bitewing x-rays – two (2) sets in any twelve (12) month period.
- Panoramic x-rays – one (1) in any three (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, unless diagnostically necessary).
- Sealants – limited to permanent teeth, for Your dependent children – one (1) per tooth in any three (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, unless diagnostically necessary).
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) – a total of one (1) service per quadrant or area in any three (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, unless diagnostically necessary).
- Osseous surgery procedures (D4260, D4261) – one (1) 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, unless diagnostically necessary).

- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (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, unless diagnostically necessary).
- Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
- 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 (D9110) only.
- Reline of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Rebase of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Second Opinion Consultation – when approved by the Plan, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan.

Exclusions:

We will not cover:

- Any condition for which benefits of any nature are recovered whether by adjudication or settlement, under any Worker's 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 damaged due to the neglect of the Member.
- Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without a referral from the PCD and Plan approval.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; (c) splint or stabilize teeth for periodontal reasons; or (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- Dental services, other than covered Emergency Dental Services, which were performed by any dentist other than the Member's assigned PCD, unless we had provided written authorization.
- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a Prosthodontist.

- Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th (eighth) birthday.
- Consultations for non-covered services.
- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.
- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress-Restorative Treatment. (Inlays, onlays crowns or fixed bridges are 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.)
- 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.)
- Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist while the Member is covered under this Plan. (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 while the Member is covered under this Plan. (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 by a Non-Participating Dentist while the Member is covered under this Plan. (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.
- 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 of the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.

DEFINITIONS

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

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.

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 who is dependent on You for most of the child's support and maintenance; (b) newborn child; (c) legally adopted child; (d) 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 is the court-appointed legal guardian, if the child; (i) is a part of Your household, and (ii) is primarily dependent on You for support and maintenance. The term also includes any child for whom a court-ordered decree requires You to provide dependent coverage, and any child who is the subject of a legal suit for adoption by You.
3. a mentally retarded or physically handicapped child who: (a) has reached the upper age limit of a dependent child; (b) is not capable of self-sustaining work; and (c) depends primarily on You for support and maintenance. You must furnish proof of such lack of capacity and dependence to MDG within 31 days after the child reaches the limiting age, and each year after that, if requested by MDG.

Your domestic partner may be treated as a spouse under this Plan. In order for a domestic partner to be treated as a spouse under this Plan, both You and Your domestic partner must:

a. be 18 years of age or older;
b. be unmarried; constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
c. share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
d. share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
e. not be related by blood to a degree that would prohibit marriage in the Planowner's state of residence; and
f. be financially interdependent which must be demonstrated by at least four of the following:

   - ownership of a joint bank account;
   - ownership of a joint credit account;
   - evidence of a joint mortgage or lease;
   - evidence of joint obligation on a loan;
   - joint ownership of a residence;

- evidence of common household expenses such as utilities or telephone;
- execution of wills naming each other as executor and/or beneficiary;
- granting each other durable powers of attorney;
- granting each other health care powers of attorney;
- designation of each other as beneficiary under a retirement benefit account; or
- evidence of other joint financial responsibility.

You must complete a "Declaration of Domestic Partnership" attesting to the relationship.

Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with MDG. Once You submit a "Statement of Termination", You may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

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 a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

Member means You and any of Your eligible Dependents, as defined under the eligibility requirements of this Plan, who are actually enrolled in and eligible to receive benefits under this Plan.

Non-Participating Dentist means any Dentist that is not under contract with MDG to provide services to Members.

Participating Dentist means a Dentist under contract with MDG and shall include any hygienists and technicians recognized by the dental profession who assists and act under the supervision of a Participating Dentist.

Participating General Dentist means a licensed Dentist under contract with MDG who is listed in The MDG's directory of Participating Dentists as a general practice Dentist, and who may be selected as a Primary Care Dentist by a Member to provide or arrange for a Member's dental services.

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) Orthodontic Specialty Care Dentist.

Patient Charge means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this Plan, which represents the patient's portion of the cost of covered dental procedures.

Plan means the MDG Individual Plan for Dental Services described herein.

Primary Care Dentist means a Participating General Dentist, selected by a Member, who is responsible for providing and arranging for a Member's dental services.

Service Area means the geographic area in which MDG is licensed to provide dental services for Members, and includes Austin, Bains, Bastrop, Bell, Blanco, Bosque, Brazoria, Burleson, Burnet, Caldwell, Chambers, Collin, Colorado, Comal, Cooke, Dallas, Denton, El Paso, Ellis, Erath, Fannin, Fayette, Fort Bend, Galveston, Gonzales, Grayson, Grimes, Guadalupe, Harris, Hays, Henderson, Hill, Hood, Hunt, Jack, Johnson, Kaufman, Kendall, Lampasas, Lee, Liberty, Llano, Madison, Matagorda, Milam, Montague, Montgomery, Navarro, Palo Pinto, Parker, Polk, Rockwall, San Jacinto, Somervell, Tarrant, Travis, Trinity, Van Zandt, Walker, Waller, Washington, Wharton, Williamson, and Wise counties.

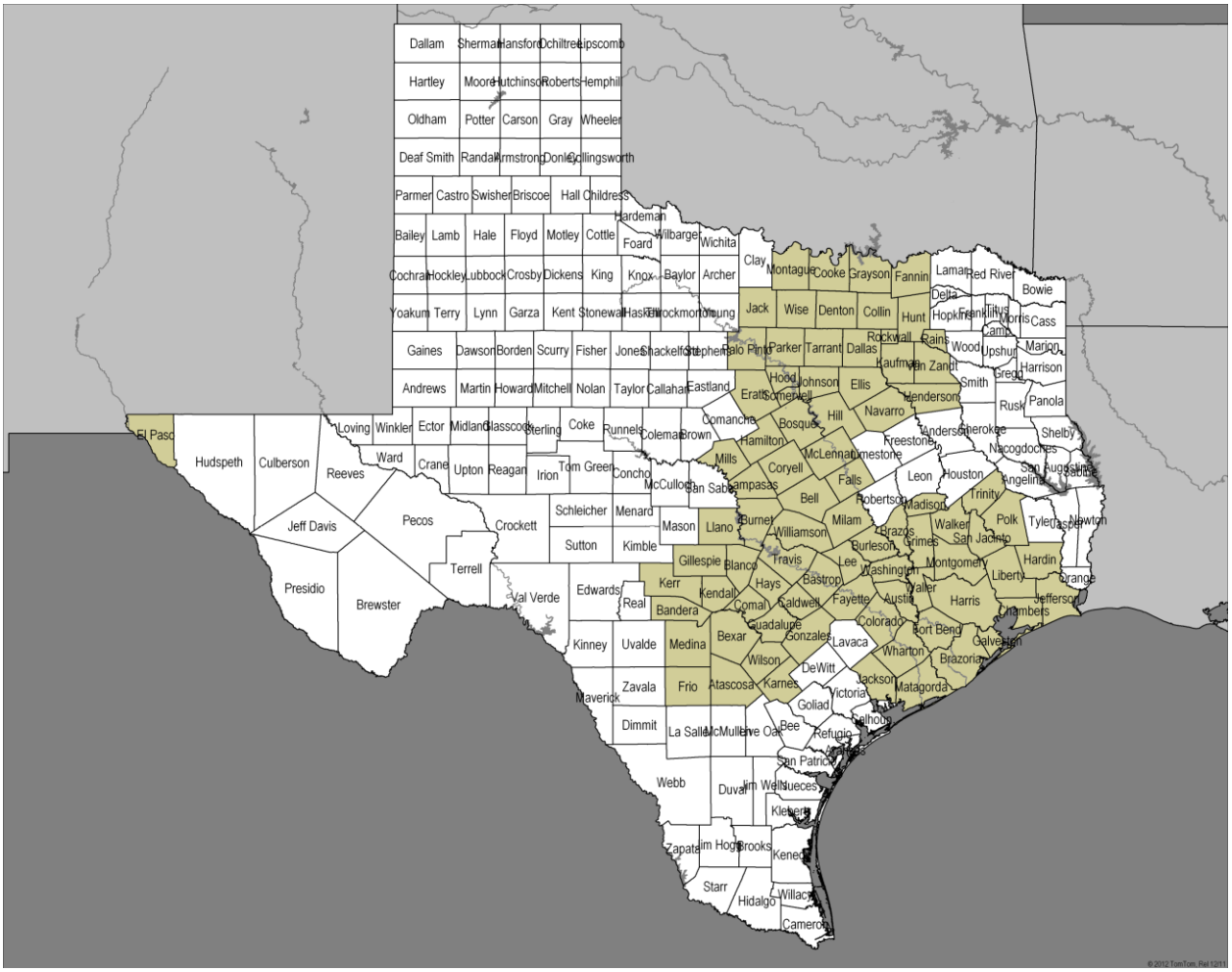
We, Us, Our and MDG mean Managed DentalGuard, Inc.

You, Your or Planowner means the Planowner who purchased this Plan.

Dental Network Adequacy Analysis 1
Provider Map
TEXAS - DHMO
July 16, 2013

Service Areas
TEXAS - DHMO

1 in. = 117.94 miles



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.

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.

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Armenian **Հայերեն**	Եթե դուք կամ այն անձը, դուք օգնում ունի հարցեր ձեր ապահովագրական հատուցումներից, պահանջների, կամ լուսաբանման, դուք իրավունք ունեք ստանալու օգնություն եւ տեղեկատվություն Ձեր լեզվով ոչ մի գնով: Խոսել է թարգմանչի: Եթե ունեք ապահովագրություն Ձեր գործատուի, զանգահարեք հեռախոսահամարը Ձեր նույնականացման քարտ. բոլոր մյուս անդամների համար, խնդրում ենք զանգահարել 866-569-9900. The Guardian եւ իր դուստր ձեռնարկություններն * համապատասխանեն կիրառելի դաշնային քաղաքացիական իրավունքների օրենքների եւ չի խտրականություն հիման վրա ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի, հաշմանդամության, կամ սեռից:
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