

# **Managed DentalGuard Group Benefit Plan**

**Prepared For:**

**G&A PARTNERS  
CLASS 0014 0017 0020 0023  
DENTAL**

**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](http://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.

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**COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM**

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**Managed Dental Care of California**

21820 Burbank Boulevard, Suite 200 or  
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 Health *plan*. The dental care *plan* contract must be consulted to determine the exact terms and conditions of coverage." A specimen copy of the *plan* contract will be furnished upon request. The Health Plan Benefits and Coverage Matrix is attached. The applicant has a right to view the Evidence of Coverage prior to enrollment. The Evidence of Coverage discloses the terms and conditions of coverage. What we cover is based on all the terms of this *plan*. Read this booklet carefully and completely for specific benefit levels, payment rates, payment limits, and copayments. Individuals with special health care needs should read carefully those sections that apply to them. You may call the MDC Member Service Department at 1-800-273-3330 if you have any questions after reading this booklet, or contact the *plan* at the *plan's* principal address listed above.



Candee Bolyog  
**President, Managed Dental Care**

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## GENERAL PROVISIONS

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**Public Policy Committee** MDC maintains a Public Policy Committee composed 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. MDC communicates material changes affecting public policy to members in periodic newsletters.

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

You may contact our Member Services Department by telephone, 800-273-3330, or by mail to P.O. Box 4391, Woodland Hills, CA 91367 to request a copy of the plan's Confidentiality Statement. The Confidentiality Statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

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## MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

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**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 the selected and assigned Primary Care Dentist.

In the event dental coverage is provided for a dependent pursuant to a court or administrative order, a non-covered custodial parent (or guardian) will be provided a copy of the dependent's Evidence of Coverage and Disclosure Form and an ID card if requested by telephone or in writing. Upon receipt of appropriate notification, the Plan will notify the non-covered custodial parent or guardian if the dependent's coverage is altered or terminated.

In the event an eligible employee is required by a court or administrative order to provide dental coverage for a dependent, the dependent, who is otherwise eligible, will be permitted to enroll without regard to enrollment period restrictions.

If the enrolled employee fails to obtain coverage for the dependent, the dependent may be enrolled upon presentation of the court order, or request of the District Attorney, the other parent or guardian, or the Medi-Cal program.

The Plan shall not disenroll or eliminate coverage of the Dependent unless either of the following applies:

1. the Employer terminates coverage for all Employees.
2. the Plan is provided with satisfactory written evidence that either of the following apply:

## Member Eligibility and Termination Provisions (Cont.)

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- (a) court order or administrative order is no longer in effect or is terminated pursuant to Section 3770.
- (b) the dependent is or will be enrolled in comparable dental coverage that will take effect not later than the effective date of the dependent's disenrollment.

**Eligible Dependents** Eligible Dependents are (1) your spouse, (2) your or your spouse's Dependent Child who is less than 26 years of age. The term Dependent Child as us this Plan will include any stepchild, newborn child between birth and age 36 months, legally adopted child, child for whom you are court appointed legal guardian, or proposed adoptive child, during any waiting period prior to the formal adoption if the child is 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 has reached the upper age limit of a Dependent Child, is not capable of self-sustaining work, and depends primarily on you for support and maintenance; (4) an Employee's domestic partner, who may be treated as a spouse under this Plan, subject to the conditions below:

An employee's domestic partner will be eligible for dental coverage under this Plan. "Domestic Partner" means an adult who has chosen to share his or her life with the employee in an intimate and committed relationship of mutual caring. Coverage will be provided subject to all of the terms of this Plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, and not a member of another domestic partnership;
- have a common residence;
- agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
- not be related by blood in a way that would prevent them from being married to each other in the state of California;
- be capable of consenting to the domestic partnership;
- file a Declaration of Domestic Partnership with the Secretary of State of the state of California; and
- not have previously filed a Declaration of Domestic Partnership that has not been terminated; and
- be (a) members of the same sex, or (b) opposite sexes and one or both are eligible for Social Security benefits and over the age of 62.

Before coverage may become effective, the employee must submit to us, a copy of a valid Declaration of Domestic Partnership attesting to the relationship.

## Member Eligibility and Termination Provisions (Cont.)

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The domestic partner's dependent children will be eligible for coverage under this Plan on the same basis as if the children were the employee's dependent children.

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as described above. Upon termination of a domestic partnership, a "Notice of Termination of Domestic Partnership" must be completed and filed with the Secretary of State and the employer. A new Declaration of Domestic Partnership may not be filed with the Secretary of State until at least 6 months after the filing of a Notice of Termination of Domestic Partnership.

The domestic partner and his or her children will not be eligible for continuation of dental coverage as explained under the "Federal Continuation Rights" section of this Plan.

**Eligibility** The determination of who is eligible to participate and who is actually participating in the plan shall be determined by your Employer and the group contract.

Any disputes or inquiries regarding eligibility, renewal, reinstatement and the like should be directed to your Employer or MDC as appropriate. MDC will not discriminate against any member based upon age, race, religion, national origin, sex, or sexual orientation.

**Changes in Member Status** If a Member is terminated or is no longer employed: (a) he or she will continue to be eligible to receive services; and (b) MDC will be entitled to its monthly premium for the Member until such time that: (i) MDC is notified in writing of the Member's termination; and (ii) the Member is removed from the eligibility listing specified above.

**SHOULD MDC BE NOTIFIED OF A MEMBER'S TERMINATION AFTER THE 20TH DAY OF THE MONTH FOLLOWING THE MONTH OF TERMINATION, MDC WILL RETAIN OR MUST BE PAID THE PREMIUM FOR THE MONTH IN WHICH THE MEMBER'S TERMINATION WAS REPORTED.**

**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.

## Member Eligibility and Termination Provisions (Cont.)

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**Premium** Your Employer is responsible for paying MDC the monthly premium for your coverage. This amount, along with any portion you must pay, is shown in your enrollment kit.

**Benefits, Limitations and Exclusions** A complete list of covered services, limitations and exclusions are included in the benefits section of this booklet. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a patient charge. Services specifically excluded from this coverage are listed in the section titled Exclusions and Limitations. Please read this section carefully. Dental services performed by a non-participating Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Care.

**Renewal** MDC has contracted with your employer to provide services for a specific time period as specified in the group contract. You are covered under the plan for that period. Upon renewal of the group contract, it is possible the plan may be amended. Your employer will notify you of any benefit changes made at renewal.

### Termination of Benefits

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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 ends on the first to occur of:

- Member Eligibility Reasons**
- (1) the end of the month in which a Member is no longer eligible for coverage under this Plan.
  - (2) the end of the month in which your Dependent is no longer a Dependent as defined in this Plan.
  - (3) the date on which you or your Dependent no longer reside or work in the Service Area.

A Member may be terminated at the end of the month following a period of at least fifteen (15) days from the date of notification of termination mailed by the Plan to the Member's address of record with the Plan. See Individual Continuation of Benefits, below.

- Member Cancellation Reasons**
- (4) Immediately, as of date of notification, if a Member has knowingly given false information in writing on an enrollment form or has misused his or her ID card or other documents provided to obtain benefits available under this Plan.

Member will be terminated immediately upon notification of termination mailed by the Plan to the Member's address of record with the Plan.

## Member Eligibility and Termination Provisions (Cont.)

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- (5) If the Member threatens the safety of Plan Employees, Dentists, Members, or other patients, or the Member's repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for the Member or other Members, or substantially impaired a dentist's ability to provide services to other patients. Member will be terminated immediately upon notification of termination mailed by the Plan to the Member's address of record with the Plan.

A Member may be terminated at the end of the month following a period of at least fifteen (15) days from the date of notification of termination mailed by the Plan to the Member's address of record with the Plan.

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

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 Managed Health Care.

### **Group Cancellation Reasons**

- (6) The end of the month during which your Employer receives written notice from you requesting termination of coverage for you or your Dependents, or on such later date as you may request by the notice.
- (7) A Member may also be terminated for Employer's nonpayment of premiums.

### **Nonpayment of Premiums**

Member's coverage will be terminated for nonpayment of premiums. This will not occur until at least 15 days have passed following Plan's mailing of a notice of cancellation to Employer. This is not applicable to a loss of eligibility for Medi-Cal Benefits. The effect of nonpayment of premium will result in the Member being financially responsible for the cost of services rendered after termination of benefits. However, ongoing services initiated prior to Member's termination of coverage, including inlays, onlays, crowns, fixed bridges, orthodontic or root canal treatment shall be completed by the member's PCD at the applicable Copayment.



## Member Eligibility and Termination Provisions (Cont.)

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**Notice of Cancellation** MDC will notify Employer in writing of the cancellation of the Group Contract. The group may be terminated at the end of the month following a period of at least (15) days from the date of notification of termination mailed to the Employer's address of record with the Plan. A notice of termination will be sent to the Employer following the (15) day notification period. Employer is required to mail Employees a legible, true copy of any notice of cancellation of the Group Contract which may be received from the Plan and must provide MDC with proof of the mailing and date of mailing, within 72 hours of receipt of Notice of Cancellation. The notice will include information regarding the conversion rights of Members covered under the Plan Contract. Plan will accept a copy of the notice as proof.

If the Group does not avoid cancellation of the Group Contract within the required 15 days, or if the Group Contract is cancelled for nonpayment during a contract year, the Group may need to reapply for coverage with a new application, for which the Plan may impose different premiums. The effect of nonpayment of premium will result in the Member being financially responsible for the cost of services rendered after termination of benefits. However, ongoing services initiated prior to Member's termination of coverage, including inlays, onlays, crowns, fixed bridges, dentures, orthodontic or root canal treatment shall be completed by the Member's PCD at the applicable Copayment.

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## YOUR CONTINUATION RIGHTS

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*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*.

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### An Important Notice About Continuation Rights

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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.

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### Federal Continuation Rights

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

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

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

**If Your Group Dental Benefits End** If your group dental benefits end due to termination of employment or reduction of 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.

## Federal Continuation Rights (Cont.)

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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.

## Federal Continuation Rights (Cont.)

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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*.

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### **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;

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## Federal Continuation Rights (Cont.)

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- (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

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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 this *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

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### MANAGED DENTAL CARE'S DENTAL COVERAGE PROGRAM

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**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).

## Managed Dental Care's Dental Coverage Program (Cont.)

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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 from this list of *participating general dentists* a *primary care dentist* (PCD) who will be responsible for coordinating all of the *member's* dental care. After enrollment, a *member* will receive a 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 *plan* carefully for specific benefit levels, exclusions and limitations 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 a *PCD* 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 a 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 procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from MDC. The *dentists* also receive 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 Charge 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 dentist* or the *dentist's* medical group or independent practice association regarding this information.

You may wish to consult another *dentist* for a second opinion regarding services recommended or performed by your *PCD* or 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. MDC will only cover a second opinion consultation when the recommended services are otherwise covered under the *plan*.

## Managed Dental Care's Dental Coverage Program (Cont.)

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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.

*You* may appeal a denial for a second opinion to:

Managed Dental Care of California  
Grievance Committee  
21820 Burbank Boulevard, Suite 200  
Woodland Hills CA 91367

The appeal will be reviewed through the *plan's* grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available dental records and the input of the referring dentist or specialist. All appeals for the necessity of a second opinion are reviewed by a *dentist* having appropriate clinical background, as determined by MDC's Dental Director.

**Right to Reassign Member:** 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 a Dentist's participation in the network. If this becomes necessary, you will have the opportunity to choose another Participating Dentist. If a Member has a dental service in progress at the time of the reassignment, MDC will, at its 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.

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## Additional Information

In the event that MDC fails to pay your PCD, you shall not be liable to the participating general dentist for any sums owed by the *plan*. In the event MDC fails to pay a Non-Participating Dentist, you may be liable to the Non-Participating Dentist for the cost of services rendered.

**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 will be solely and exclusively under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment

MDC 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.

**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 shown 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.**

**EMERGENCY REFERRALS AUTHORIZED BY TELEPHONE MUST FOLLOW REFERRAL GUIDELINES TO BE COVERED UNDER THE PLAN OR RETROSPECTIVELY IT MAY BE DETERMINED THAT SERVICES RENDERED MAY BE THE RESPONSIBILITY OF THE REFERRING DENTIST AND/OR YOU. YOU ARE NOT HELD RESPONSIBLE IF THE REFERRING DENTIST DOES NOT FOLLOW PLAN GUIDELINES.**

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## Utilization Review

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 *you*. 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 of a denied request for authorization will follow the grievance process.
6. A *member* who receives authorized specialty services must pay for 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) pediatric dentistry; and (e) orthodontics, located in the Member's Service Area. If there is no *participating specialist* in the *member's service area*, or if the specialist is not readily available and accessible as defined by MDC's Access Standards (Member Services may be contacted at 1-800-273-3330 for Plan Access and Availability Standards), MDC will refer *you* to a non-participating specialist of our choice. For those services approved in writing with a non-participating specialist, *you* will only be responsible for the applicable *patient charge* that would apply if the services were rendered by a contracted specialist. If *you* receive a bill from a non-participating specialist for charges other than the applicable *patient charge*, *you* will forward the bill to the *plan* for appropriate follow up. The bill should be sent to the attention of the Specialty Referral Department, P.O. Box 4391, Woodland Hills CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills CA 91367. 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.

7. A *member*, member's designee and/or *dentist* whose *specialty referral* is denied as the service is not consistent with our clinical referral guidelines or is not necessary will receive written notification with a clear, concise explanation of the reasons for MDC's decision, a description of the screening criteria used, and the clinical reasons for the decision. The notification shall also include information as to how the *member* or member's designee may file an appeal or a grievance.
8. A *member*, member's designee and/or members of the public may request a copy of MDC's Specialty Referral Guidelines and/or Utilization Review and Utilization Review Appeals Processes. These are MDC's written policies and procedures that have established the processes by which the *plan* prospectively, retrospectively or concurrently reviews and approves, modifies, delays, denies, in whole or in part on medical necessity requests by dentists for plan enrollees. A copy may be obtained by contacting the Member Services Department by telephone at 800-273-3330 or by mail at P.O. Box 4391, Woodland Hills CA 91367.

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## Facilities

MDC's *PCD* offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if you cannot keep your scheduled appointment, you must notify your *PCD* at least 24 hours in advance or *you* will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet.

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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*. MDC will reimburse the *member* for the cost of the *emergency dental services*, less any *patient charge* which may apply.

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## 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.

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## Continuity of Care - Terminated Dentist

*Member* may request for the continuation of covered services to be rendered by a terminated *participating dentist* when *member* is undergoing treatment from a terminated dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current members or 180 days from the effective date for newly covered members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Participating Dentist's Agreement or 12 months from the effective date of coverage for newly covered members. This provision does not apply to *participating dentists* who voluntarily leave the *plan*. *Member* must make the request in writing and send to:

Managed Dental Care of California  
Quality Management Department  
21820 Burbank Boulevard, Suite 200  
Woodland Hills CA 91367

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## Continuity of Care - Terminated Dentist (Cont.)

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

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

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## Continuity of Care - Non-Participating Dentist

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

Managed Dental Care of California  
Quality Management Department  
21820 Burbank Boulevard, Suite 200  
Woodland Hills CA 91367

Or contact MDC's Member Services Department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the *member's* dental records from the *member's dentist* in order to evaluate the request. The Dental Director (or his/her designee) will determine if the *member* is eligible for continuation of care under this policy and the California Knox-Keene Act. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

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

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## Continuity of Care - Arrangements with Dentists

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MDC requires the terminated or non-participating dentist to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted dentists, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. MDC is not required to continue the services a *dentist* is providing to a *member* if the *dentist* does not agree to comply or does not comply with these contractual terms and conditions.

Unless MDC and *dentist* agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by MDC for currently contracted dentists providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the non-participating dentist. MDC is not required to continue the services a dentist is providing to a Member if the dentist does not accept the payment rates provided for in this paragraph.

The amount of, and the requirement for payment of copayments during the period of completion of covered services with a terminated dentist or a non-participating dentist are the same as would be paid by the *member* if receiving care from a dentist currently contracted with MDC.

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## MANAGED DENTAL CARE GRIEVANCE PROCESS

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Member grievances are to be submitted to MDC's Quality of Care Liaison or Designee ("QCL") who processes all grievances. The QCL may be contacted at 800-273-3330 between the hours of 8:00 a.m. and 5:00 p.m. Pacific Time or by mail to P.O. Box 4391, Woodland Hills, CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills, CA 91367. Grievances may also be submitted on the Plan's website at [www.manageddentalcare.net](http://www.manageddentalcare.net).

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

**Administrative Services** financial, accounting, procedural matters, coverage information such as effective dates, explanations of Contract and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.

**Health Services** quality of care, access, availability, standards of care, appeal of denied second opinion requests, Utilization Review Appeals, professional and ethical considerations.

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

## Managed Dental Care Grievance Process (Cont.)

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A grievance and a complaint are one and the same.

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

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

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the Member Services Representative documents the call and works with the Member to resolve the issue. If the issue is an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the Member Services Department. All other issues that are grievances will be documented on a Grievance Form by the Member Services Representative on behalf of the Member and the Grievance Form will be forwarded to the Quality of Care Liaison or Designee ("QCL"). The Member may be sent a Grievance Form (Exhibit 2) to complete, if requested.

A Member may visit MDC's website at [www.manageddentalcare.net](http://www.manageddentalcare.net) to submit a grievance. From the homepage, the Member must select the "Grievance Form" button. The Member will then be able to provide selected information and describe the grievance in detail. Following the completion of the Grievance Form, the Member is given the option to review the completed form prior to submission to MDC. The Member must then select the "Submit" button to send the grievance to MDC. All grievances submitted via MDC's website will be forwarded to the QCL or Designee.

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

2. Assistance in filing grievances shall be provided at each dental office as well as by the Plan. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.
3. Members may file a grievance up to 180 days following any incident or action that is the subject of the dissatisfaction.
4. No later than five(5) calendar days after receipt of the grievance, an acknowledgement letter (exhibit 3) is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL, that a review is taking place and the grievance will be responded to within 30 days from the date of the Plan's receipt of the grievance in a resolution letter.

## **Managed Dental Care Grievance Process (Cont.)**

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5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the dentist or office personnel. MDC may arrange a second opinion, if appropriate.
6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 days from the date of the Plan's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution. The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his or her review of available documentation by initialing a copy of the resolution letter.

The resolution letter to the Member will detail in a clear, concise manner the reasons for the Plan's response. For grievances involving the delay, denial or modification of health care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the Plan, or one of its clinical reviewers, issues a determination delaying, denying or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the Member, the letter shall clearly specify the provisions in the contract that exclude that coverage.

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

The use of voluntary mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care upon completion of mediation.

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

## Managed Dental Care Grievance Process (Cont.)

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8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.
9. Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function, or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.
10. The plan shall keep all copies of grievances, and the responses to grievances, for a period of five years.
11. The Vice President Operations and Finance who is an officer of the Plan, or designee, has primary responsibility for the Plan's grievance system.
12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by the Plan and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.
13. MDC asserts that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

### **Grievances Requiring Expedited Review**

The Plan will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but not be limited to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Plan.

## Managed Dental Care Grievance Process (Cont.)

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When the Plan has notice of a grievance requiring expedited review, the grievance process requires the Plan to immediately inform members in writing of their right to notify the Department of Managed Health Care of the grievance. The Plan also will provide members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

The following grievance disclosure will be on all member correspondence:

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

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## Covered Dental Services And Patient Charges - Plan 40 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
<b>Appointments and Diagnostic Services</b>		
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
<b>Radiographs</b>		
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
<b>Preventive Services &amp; Space Maintenance</b>		
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 . . . . .	\$5.00
1510	Space maintainer - fixed - unilateral . . . . .	\$35.00
1515	Space maintainer - fixed - bilateral . . . . .	\$65.00
1550	Recementation of space maintainer . . . . .	\$10.00
<b>Restorative</b>		
2110	Amalgam - one surface - primary . . . . .	\$5.00
2120	Amalgam - two surfaces - primary . . . . .	\$5.00
2130	Amalgam - three surfaces - primary . . . . .	\$10.00
2131	Amalgam - four or more surfaces - primary . . . . .	\$10.00
2140	Amalgam - one surface - permanent . . . . .	\$5.00
2150	Amalgam - two surfaces - permanent . . . . .	\$10.00
2160	Amalgam - three surfaces - permanent . . . . .	\$10.00
2161	Amalgam - four or more surfaces - permanent . . . . .	\$10.00

## Covered Dental Services And Patient Charges - Plan 40 M (Cont.)

<b>2210</b>	Silicate cement - per restoration . . . . .	\$10.00
<b>2330</b>	Resin/composite - one surface, anterior . . . . .	\$15.00
<b>2331</b>	Resin/composite - two surfaces, anterior . . . . .	\$20.00
<b>2332</b>	Resin/composite - three surfaces, anterior . . . . .	\$25.00
<b>2335</b>	Resin/composite - four or more surfaces or incisal angle, anterior . . .	\$25.00
<b>2336</b>	Composite resin crown, anterior - primary . . . . .	\$25.00
<b>2380</b>	Resin/composite - one surface, posterior - primary . . . . .	\$20.00
<b>2381</b>	Resin/composite - two surfaces, posterior - primary . . . . .	\$25.00
<b>2382</b>	Resin/composite - three or more surfaces, posterior - primary . . . . .	\$30.00
<b>2385</b>	Resin/composite - one surface, posterior - permanent . . . . .	\$20.00
<b>2386</b>	Resin/composite - two surfaces, posterior - permanent . . . . .	\$25.00
<b>2387</b>	Resin/composite - three or more surfaces, posterior - permanent . . .	\$35.00

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### Crown, Bridge & Other Cast Restorations

<b>2510</b>	Inlay - metallic - one surface* . . . . .	\$145.00
<b>2520, 6520</b>	Inlay - metallic - two surfaces* . . . . .	\$175.00
<b>2530, 6530</b>	Inlay - metallic - three or more surfaces* . . . . .	\$180.00
<b>2543, 6543</b>	Onlay - metallic - three surfaces* . . . . .	\$185.00
<b>2544, 6544</b>	Onlay - metallic - four or more surfaces* . . . . .	\$195.00
<b>2702</b>	Crown supporting existing partial denture - in addition to crown . . .	\$125.00
<b>2703</b>	Multiple crown and bridge unit treatment plan - per unit . . . . .	\$125.00
<b>2740</b>	Crown - porcelain/ceramic substrate . . . . .	\$240.00
<b>2750, 2751, 2752</b>	Crown - porcelain fused to metal* . . . . .	\$235.00
<b>2790, 2791, 2792</b>	Crown - full cast metal* . . . . .	\$215.00
<b>2810, 6780</b>	Crown - 3/4 cast metallic* . . . . .	\$225.00
<b>6210, 6211, 6212</b>	Pontic - cast metal* . . . . .	\$215.00
<b>6240, 6241, 6242</b>	Pontic - porcelain fused to metal* . . . . .	\$235.00
<b>6750, 6751, 6752</b>	Crown - abutment - porcelain fused to metal* . . . . .	\$235.00
<b>6790, 6791, 6792</b>	Crown - abutment - full cast metal* . . . . .	\$215.00

### Other Restorative Services

<b>2910, 2920, 6930</b>	Recementation inlay, crown, bridge . . . . .	\$5.00
<b>2930, 2931</b>	Prefabricated stainless steel crown . . . . .	\$20.00
<b>2932</b>	Prefabricated resin crown . . . . .	\$50.00
<b>2940</b>	Sedative filling . . . . .	\$5.00
<b>2950, 6973</b>	Core buildup, including any pins . . . . .	\$45.00
<b>2951</b>	Pin retention - per tooth, in addition to restoration . . . . .	No Charge
<b>2952, 6970</b>	Cast post & core . . . . .	\$70.00
<b>2954, 6972</b>	Prefabricated post & core . . . . .	\$55.00
<b>2960</b>	Labial veneer (laminare) - chairside . . . . .	\$95.00

### Endodontics

<b>3110, 3120</b>	Pulp cap . . . . .	\$5.00
<b>3220</b>	Therapeutic pulpotomy . . . . .	\$15.00
<b>3310</b>	Root canal - anterior . . . . .	\$95.00
<b>3320</b>	Root canal - bicuspid . . . . .	\$115.00
<b>3330</b>	Root canal - molar . . . . .	\$210.00
<b>3346</b>	Root canal - retreatment - anterior . . . . .	\$115.00
<b>3347</b>	Root canal - retreatment - bicuspid . . . . .	\$135.00
<b>3348</b>	Root canal - retreatment - molar . . . . .	\$225.00

## Covered Dental Services And Patient Charges - Plan 40 M (Cont.)

3410	Apicoectomy/periradicular surgery - anterior	\$135.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	\$140.00
3425	Apicoectomy/periradicular surgery - molar - first root	\$150.00
3426	Apicoectomy/periradicular surgery - each additional root	\$65.00
3430	Retrograde filling - per root	\$25.00

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### Periodontics

4210	Gingivectomy or gingivoplasty - per quadrant	\$90.00
4211	Gingivectomy or gingivoplasty - per tooth	\$30.00
4240	Gingival flap procedure - including root planing - per quadrant	\$155.00
4249	Clinical crown lengthening - hard tissue	\$125.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	\$235.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	\$140.00
4270	Pedicle soft tissue graft procedure	\$150.00
4271	Free soft tissue graft procedure (including donor site surgery)	\$165.00
4341	Periodontal scaling & root planing - per quadrant	\$40.00
4355	Full mouth debridement to enable evaluation and diagnosis	\$20.00
4910	Periodontal maintenance procedures (following active therapy)	\$20.00
4920	Unscheduled dressing change (by other than treating dentist)	No Charge
9951	Occlusal adjustment - limited - per visit	\$10.00

### Prosthodontics (Removable)

5110, 5120	Complete denture (including routine post delivery care)	\$265.00
5130, 5140	Immediate denture (including routine post delivery care)	\$265.00

#### Partial dentures (including routine post delivery care):

5211, 5212	Resin base - including clasps, rests, teeth	\$210.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth	\$310.00

#### Repairs and adjustments:

5410, 5411, 5421, 5422	Denture adjustments	\$15.00
5510, 5610	Repair denture base	\$15.00
5520, 5640	Replace missing or broken teeth -per tooth	\$15.00
5630	Repair or replace clasp	\$20.00
5650	Add tooth to existing partial	\$20.00
5660	Add clasp to existing partial	\$20.00
5710, 5711, 5720, 5721	Rebase denture	\$55.00
5730, 5731, 5740, 5741	Reline denture (chairside)	\$30.00
5750, 5751, 5760, 5761	Reline denture (laboratory)	\$45.00
5820, 5821	Interim partial denture (stayplate)	\$105.00
5850, 5851	Tissue conditioning	\$15.00

CGP-3-MDCL3

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## Covered Dental Services And Patient Charges - Plan 40 M (Cont.)

### Oral Surgery

<b>7110, 7120</b>	Extraction - single tooth . . . . .	\$5.00
<b>7130</b>	Root removal - exposed roots . . . . .	\$15.00
<b>7210</b>	Surgical removal of erupted tooth . . . . .	\$45.00
<b>7220</b>	Removal of impacted tooth - soft tissue . . . . .	\$60.00
<b>7230</b>	Removal of impacted tooth - partially bony . . . . .	\$80.00
<b>7240</b>	Removal of impacted tooth - completely bony . . . . .	\$100.00
<b>7241</b>	Removal of impacted tooth - completely bony, with unusual surgical complications . . . . .	\$100.00
<b>7250</b>	Surgical removal of residual tooth roots (cutting procedure) . . . . .	\$45.00
<b>7270</b>	Tooth reimplantation and/or stabilization of accidentally evulsed tooth . . . . .	\$70.00
<b>7280</b>	Surgical exposure of impacted or unerupted tooth for orthodontic reasons . . . . .	\$110.00
<b>7281</b>	Surgical exposure of impacted or unerupted tooth to aid eruption . . . . .	\$75.00
<b>7285</b>	Biopsy of oral tissue - hard . . . . .	\$55.00
<b>7286</b>	Biopsy of oral tissue - soft . . . . .	\$50.00
<b>7310</b>	Alveoplasty in conjunction with extractions - per quadrant . . . . .	\$40.00
<b>7320</b>	Alveoplasty not in conjunction with extractions - per quadrant . . . . .	\$55.00
<b>7450</b>	Removal of odontogenic cyst/tumor - up to 1.25 cm . . . . .	\$70.00
<b>7451</b>	Removal of odontogenic cyst/tumor - over 1.25 cm . . . . .	\$135.00
<b>7470</b>	Removal of exostosis - maxilla or mandible . . . . .	\$100.00
<b>7510</b>	Incision & drainage of intraoral abscess . . . . .	\$30.00
<b>7960</b>	Frenectomy (separate procedure) . . . . .	\$75.00

### Miscellaneous Services

<b>9110</b>	Palliative (emergency) treatment . . . . .	No Charge
<b>9215</b>	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.

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MDC CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
<b>Orthodontics</b>		
<b>8601</b>	Orthodontic evaluation and consultation . . . . .	\$100.00
<b>8602</b>	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos . . . . .	\$150.00
<b>8070, 8080, 8090</b>	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 <i>member's</i> age on the date of banding) . . . . .	\$1975.00
<b>8070, 8080, 8090</b>	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 <i>member's</i> age on the date of banding) . . . . .	\$2175.00
<b>8670</b>	Periodic comprehensive orthodontic treatment visit . . . . .	No Charge
<b>8680</b>	Orthodontic retention . . . . .	\$300.00

## Covered Dental Services And Patient Charges (Cont.)

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+ 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.

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### Additional Conditions on Covered Services

<b>General Guidelines for Alternative Procedures</b>	<p>There may be a number of accepted methods of treating a specific dental condition. When a <i>member</i> selects an <i>alternative procedure</i> over the service recommended by the <i>PCD</i>, the <i>member</i> must pay the difference between the <i>PCD's</i> usual charges for the recommended service and the <i>alternative procedure</i>. He or she will also have to pay the applicable <i>patient charge</i> for the recommended service.</p> <p>When the <i>PCD</i> recommends a crown, the <i>alternative procedure</i> 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 <i>member</i> must pay the applicable <i>patient charge</i> for the crown actually placed. The <i>member</i> must also pay the additional cost of high noble metal, if high noble metal is selected.</p>
<b>Crowns, Bridges and Dentures</b>	<p>A crown is a covered service when it is recommended by the <i>PCD</i>. The replacement of a crown or bridge is not covered within 5 years of the original placement under the <i>plan</i>.</p> <p>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 <i>plan</i>.</p> <p>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.</p>
<b>Multiple Crown/Bridge Unit Treatment Fee</b>	<p>A <i>member's</i> 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 <i>member</i> must pay both: (a) the usual crown or bridge <i>patient charge</i> 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.</p>

## Additional Conditions on Covered Services (Cont.)

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**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 or the Member's *PCD* may request the Member 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. Authorizations for second opinions are valid for sixty (60) days from the date of approval.

The request for a second opinion may be approved at the time of the request, or within 72 hours if an emergency exists.

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. Once the second opinion consultation is completed and the Second Opinion Form is returned to the Member Services Representative, you and your dentist will receive a copy of the findings and recommendations.

The Plan's benefit for a second opinion consultation is \$50.00. If a participating dentist is the consultant, there is no cost to you. If a non-participating dentist is the consultant, you may pay any portion of his or her fee over \$50.

We will not deny a request for a second opinion until it has been reviewed by the Dental Director or Designee. All appeals of denials will be reviewed by the Grievance and/or Peer Review Committee. If the request for a second opinion is denied, the Member and/or *PCD* will receive a written notice of the reasons for the denial. The notice will also state the Member and/or *PCD* has the right to contact the Member Services Department to file a grievance.

## Additional Conditions on Covered Services (Cont.)

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MDC has a written policy describing the timeline for second opinions and how we administer the second opinion program. You may request a complete copy of MDC's written policy by contacting the Member Services Department at 800-273-3330, or by mail at P.O. Box 4391, Woodland Hills, CA 91367.

### **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.

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### **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*.

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.

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.

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## Additional Conditions on Covered Services (Cont.)

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### 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.

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## Exclusions

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- 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.
  - hospitalization costs (and any associated charges, including but not limited to, physician charges, prescriptions or medications), for any dental services performed on an inpatient or outpatient basis in a hospital.



## Exclusions (Cont.)

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- 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.

## Exclusions (Cont.)

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- 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.

## Exclusions (Cont.)

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- 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*.

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## GLOSSARY

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This Glossary defines the italicized terms appearing in your booklet.

<b>Act</b>	means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).	
	CGP-3-MDCD	B850.0826
<b>Combined Evidence of Coverage and Disclosure Form</b>	means this booklet issued to <i>you</i> , which summarizes the essential terms of this <i>plan</i> .	
	CGP-3-MDCD2	B850.0207
<b>Dentist</b>	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 <i>plan</i> .	
	CGP-3-MDCD3	B850.0208
<b>Dependent</b>	means the spouse and dependent children of the employee as defined herein under the section entitled Eligible Dependents.	
	CGP-3-MDCDMST-C	B850.1472
<b>Emergency Dental Services</b>	are defined as dental services limited to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under this plan.	
	CGP-3-MDCD5	B850.0828
<b>Employee or You</b>	means a person: (a) who meets your <i>employer's</i> eligibility requirements; and (b) for whom your <i>employer</i> makes monthly payments under this <i>plan</i> .	
	CGP-3-MDCD6	B850.0213
<b>Employer or Planholder</b>	means your <i>employer</i> or other entity: (a) with whom or to whom this <i>plan</i> is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its <i>members</i> .	
	CGP-3-MDCD7	B850.0214
<b>Member</b>	means <i>you</i> and any of your eligible <i>dependents</i> : (a) as defined under the eligibility requirements of this <i>plan</i> ; and (b) as determined by your <i>employer</i> , who are actually enrolled in and eligible to receive benefits under this <i>plan</i> .	
	CGP-3-MDCD8	B850.0215
<b>Non-Participating Dentist</b>	means any <i>dentist</i> who is not under contract with MDC to provide dental services to <i>members</i> .	
	CGP-3-MDG-DEF9	B850.0217
<b>Participating Dentist</b>	means a <i>dentist</i> under contract with MDC.	
	CGP-3-MDCD10	B850.0829

## Glossary (Cont.)

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<b>Participating General Dentist</b>	means a <i>dentist</i> under contract with MDC: (a) who is listed in MDC's directory of <i>participating dentists</i> as a general practice <i>dentist</i> ; and (b) who may be selected as a <i>PCD</i> by a <i>member</i> and assigned by MDC to provide or arrange for a <i>member's</i> dental services.	CGP-3-MDCD11	B850.0219
<b>Participating Specialist</b>	means a <i>dentist</i> under contract with MDC as an: (a) <i>endodontist</i> ; (b) <i>pediatric specialist</i> ; (c) <i>periodontist</i> ; (d) <i>oral surgeon</i> or (e) <i>orthodontist</i> .	CGP-3-MDC12-B	B850.0220
<b>Patient Charge</b>	means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this <i>plan</i> . Such amount is the patient's portion of the cost of covered dental services.	CGP-3-MDCD13	B850.0222
<b>Plan</b>	means the MDC group <i>plan</i> for dental services described in this booklet.	CGP-3-MDCD14	B850.0223
<b>Primary Care Dentist (PCD)</b>	means a dental office location: (a) at which one or more <i>participating general dentists</i> provide <i>covered services</i> to <i>members</i> ; and (b) which has been selected by a <i>member</i> and assigned by MDC to provide and arrange for his or her dental services.	CGP-3-MDCD15	B850.0224
<b>Service Area</b>	means the geographic area in which MDC is licensed to provide dental services for <i>members</i> .	CGP-3-MDCD16	B850.0225
<b>We, Us, Our and MDC</b>	mean Managed Dental Care of California.	CGP-3-MDCD17	B850.0226

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## COORDINATION OF BENEFITS

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Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a Member has coverage under more than one plan. The primary carrier pays up to its maximum liability and the secondary carrier considers the remaining balance for covered services up to, but not exceeding, the benefits that are available and the Dentist's actual charge.

Determination of primary coverage is as follows:

**For Adults** A plan covering an adult as an Employee is primary, and determines its benefits first. A plan covering an adult as a Dependent (through a plan from a spouse's Employer) is secondary, and determines its benefits only after the primary plan's benefits have been paid.

## Coordination of Benefits (Cont.)

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If a person is covered as an Employee or a former Employee under more than one plan, a plan which covers him or her as an active Employee determines benefits before any Plan covering the person as a laid-off or retired Employee. Otherwise, the plan covering that person longer determines its benefits before the other plan does.

**For Dependent Children** The determination of primary and secondary coverage for Dependent Children covered by two parents' plans follows the birthday rule. The plan of the parent with the earlier birthday (month and day, not year) is the primary coverage. Different rules apply for the children of divorced or legally separated parents; contact the Member Services Department if you have any questions.

Coverage under MDC and another prepaid dental plan: When an MDC Member has coverage under another prepaid plan, whether MDC is the primary or the secondary coverage, PCD may not collect more than the applicable copayment from the Member.

Coverage under MDC and a traditional or PPO fee for service plan: When a Member is covered by MDC and a fee for service plan, the following rules will apply:

When MDC is the primary plan (e.g., when an MDC Member also has fee for service coverage under a spouse's plan), you may only bill the secondary carrier for the Patient Charge amount. Any payment made by the secondary carrier must be credited against the Member's payment.

When MDC is the secondary plan (e.g., when an MDC Member's eligible Dependent spouse has fee for service coverage through his or her Employer), PCD should bill the primary plan first. The primary payment is then credited against the Patient Charge. The Member will be responsible for a payment only if the primary carrier's payment is less than the applicable MDC Copayment.

When an MDC Member with other coverage receives authorized services from a Participating Specialist Dentist, and MDC is primary, the MDC benefits are paid without regard to the other coverage. When MDC is the secondary plan, any payment made by the primary carrier is credited against the copayment. MDC will then issue payment of the Specialist up to the unpaid remainder of the fee schedule amount. In many cases the Member will have no out-of-pocket expenses.

MDC will not coordinate or pay for the following:

Any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease law.

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.

CGP-3-MDC-COB

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## STATEMENT OF ERISA RIGHTS

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As a participant, an employee is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

### **Receive Information about the Plan and Benefits:**

- a. Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Dental Health Plan Coverage**

Continue dental health care coverage for the employee, his or her spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. The employee and his or her dependents may have to pay for such coverage. The employee should review the summary plan description and the documents governing the plan on the rules governing his or her COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

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

## Statement of Erisa Rights (Cont.)

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**Enforcement of An Employee's Rights** If an employee's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an employee can take to enforce the above rights. For instance, if an employee requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the employee up to \$110 a day until he or she receives the material, unless the materials were not sent because of reasons beyond the control of the administrator. If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if an employee is discriminated against for asserting his or her right, the employee may seek assistance from the U.S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person he or she sued to pay these costs and fees. If the employee loses, the court may order him or her to pay these costs and fees, for example, if it finds that the employee's claim is frivolous.

**Assistance with Questions** If an employee has questions about the plan, he or she should contact the plan administrator. If an employee has questions about this statement or about his or her rights under ERISA, or if the employee needs assistance in obtaining documents from the plan administrator, he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210. An employee may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CGP-3-MDCER

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

PLAN 40	Deductibles	Lifetime Maximums	Professional Services			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			No Charge	Prophylaxis - \$0; Flouride - \$0; Sealants - \$5; Space Maintainers - \$35 - \$65	Amalgam - \$5 - \$10; Resin - \$15 - \$35; Crowns - \$215 - \$240; Inlays & Onlays - \$145 - \$195; Miscellaneous: Restorative Services - \$0 - \$95	Pulp Cap - \$5; Pulpotomy - \$15; Root Canals - \$95 - \$210; Retreatments - \$115 - \$225; Apicoectomy: - First Root - \$135 - \$150; Each Additional Root - \$65; Retrograde Filling - Per Root - \$25
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member Per Lifetime	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period	Prophylaxis - 2 In Any 12 Month Period; Flouride Treatment Up To 18th Birthday - 2 In Any 12 Month Period; Sealants - Limited To Molars, Up To 16th Birthday, One Per Tooth In Any 3 Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

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<b>Plan 40 (Continued)</b>	<b>Professional Services (Continued)</b>				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Services (Continued)	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Crown Lengthening; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor	Comprehensive Treatment; Retention; Evaluation And Consultation; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - \$30 - \$90*; Gingival Flap Procedure - \$155; Osseous Surgery - \$140 - \$235*; Scaling & Root Planing - \$40; Soft Tissue Graft - \$150 - \$165; Crown Lengthening - \$125; Miscellaneous Periodontal Services - \$0 - \$20  *Limited - Quadrant	Complete Dentures - \$265; Partial Dentures - \$105 - \$310; Reline - \$30 - \$45; Repair - \$15 - \$55; Denture Adjustment - \$15	Simple Extractions - Removal Of Complete Bony Impactions - \$5 - \$110; Biopsy, Oral Tissue - \$50 - \$55; Alveoplasty - \$40 - \$55 Incision And Drainage - \$30 Frenectomy/ Frenulectomy - \$75; Removal Of Cyst/Tumor - \$70 - \$135	To Age 18 - \$1975 Over Age 18 - \$2175; Retention - \$300; Evaluation and Consultation - \$100; Treatment Plan And Records - \$150	Office Visit - \$0 - \$5; After Hours Office Visit - \$50; Palliative Treatment - \$0 Local Anesthesia - \$0

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<b>Plan 40 (Continued)</b>	<b>Professional Services (Continued)</b>				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations (Continued)	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/ Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member Per Lifetime; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

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

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

MDG 40 0899

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

<b>PLAN 40</b>	<b>Outpatient Services</b>	<b>Hospitalization Service</b>	<b>Emergency Health Coverage</b>		<b>Ambulance Services</b>	<b>Prescription Drug Services</b>
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to \$50 Reimbursement Per Incident	Not Covered*	Not Covered*
<b>PLAN 40 (CONT.)</b>	<b>Durable Medical Equipment</b>	<b>Mental Health Services</b>	<b>Chemical Dependency Services</b>	<b>Home Health Services</b>	<b>Other</b>	
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	

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

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

MDG 40 0899

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## **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED  
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Effective: 5/01/2016

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

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

### **What is Protected Health Information (PHI):**

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

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

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

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

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

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

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

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

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

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

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

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Guardian is required to use or disclose your PHI :

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

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

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

Other Uses and Disclosures .

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

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

**Your Rights with Regard to Your Protected Health Information (PHI):**

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

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

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

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

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

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

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

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

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

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

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

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

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**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

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

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

**How to Contact Us:**

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

**Attention:**

Guardian Corporate Privacy Officer  
National Operations

**Address:**

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

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## **YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE**

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**[www.GuardianAnytime.com](http://www.GuardianAnytime.com)**

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

[GuardianAnytime.com](http://GuardianAnytime.com) - 24 hours a day, 7 days a week.

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

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

To register, go to [www.GuardianAnytime.com](http://www.GuardianAnytime.com)

***Managed Dental Care of California***

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