Managed DentalGuard
Group Benefit Plan

Prepared For:

IBEW LOCAL 18
CLASS 0002
DHMO DENTAL PLAN

Managed Dental Care of California
a wholly owned subsidiary of Guardian

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

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

GP-1-MDG1, et al.

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

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care of California
21255 Burbank Boulevard, Suite 120 or
P.O. Box 4391
Woodland Hills, California 91367
1-800-273-3330

We, MDC, certify that the *member* 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.

President

GENERAL PROVISIONS

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.

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures

Eligible Employees may enroll for dental coverage by filling out and signing the appropriate enrollment form and any additional material required by your Employer and returning the enrollment material to your Employer.

After your enrollment material has been received by MDC, you or your Dependents need only to contact the selected and assigned Primary Care Dentist's office to obtain services.

MDC will issue You and your Dependents, either directly or through your Employer's representative, an MDC identification (ID) card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

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:

(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.

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. You may request a copy of MDC's written policy, which includes information on how you may request a review under this Plan.

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) Dependent Child who has reached the upper age limit of a Dependent Child, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, and is chiefly dependent upon 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:

In order for a domestic partner to be treated as a spouse under this Plan, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- Share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the Employee's state of residence; and

- Be financially interdependent which must be demonstrated by at least four of the following:

  a. ownership of a joint bank account;

  b. ownership of a joint credit account;

  c. evidence of a joint mortgage or lease;

  d. evidence of joint obligation on a loan;

  e. joint ownership of a residence;

  f. evidence of common household expenses such as utilities or telephone

  g. execution of wills naming each other as executor and/or beneficiary;

  h. granting each other durable powers of attorney;

  i. granting each other health care powers of attorney;

  j. designation of each other as beneficiary under a retirement benefit account; or

  k. evidence of other joint financial responsibility.

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

Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the Employer. Once the Employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner will not be eligible for continuation of dental coverage as explained: (a) under the "Federal continuation Rights" section; and (b) under any other continuation rights section of this Plan, unless the Employee is also eligible for and elects continuation.

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. Coverage takes effect on the first day of the month of schedule effective date.

Any disputes or inquires regarding your eligibility, renewal, reinstatement and the like, should be directed to your Employer. 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 were received by MDC; or (b) the first day of the month after the end of any waiting period your Employer may require.

When Dependent Coverage Starts

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

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

Prepayment Fees (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 on the prepayment fee insert. Contact your Employer for questions regarding any sums to be withheld from your salary.

The first premium payment for this Plan is due on the Plan effective date by 5:00 p.m. Further payments shall be made on the first day of each month by 5:00 p.m. for each month this Plan is in effect. The Planholder shall pay MDC the total sum indicated for each eligible Member. MDC may change such rates on the first day of any month. MDC must give the Planholder 31 days written notice of the rate change. Such change will apply to any premium due on or after the effective date of the change stated in such notice. Payment should be sent to address listed in the Group Contract.

Other Charges

Member is responsible for applicable Patient Charges listed on the Plan Schedule included in this EOC. Patient Charges are incurred by Members and due to their PCD when services are rendered.

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 the usual Patient Charges plus an added charge equal to the actual laboratory cost of the high noble metal.

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 Provisions

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.

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Termination of Benefits

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.

(a) MDC will send a notice to the subscriber at least 90 days prior to the dependent child attaining the limiting age that the dependent child's coverage will terminate when the child reaches the limiting age unless proof the child's physical or mental disability, injury or condition is received by MDC within 60 days of receiving the notice requesting the proof.

(b) MDC will make a determination as to whether the dependent child is entitled to continue coverage before the child reaches the limiting age and if MDC fails to make the necessary determination by the time the child reaches the limiting age, coverage will continue pending the determination of continued eligibility due to physical or mental disability, injury, illness or condition.

(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.

(5) If the Member threatens the safety of Plan Members, 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.

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 non-payment 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.

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 Members 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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INDIVIDUAL CONTINUATION OF BENEFITS

Members may be eligible to retain coverage under this Plan during any Continuation of Coverage period or election period necessary for the 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 Members continue to be paid by or through the Employer pursuant to this Plan.

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to this Plan. The Member must contact the Employer to find out if:

(a) the Employer is subject to the "Federal Continuation Rights" section, and therefore;

(b) the section applies to the Member.

FEDERAL CONTINUATION RIGHTS

Important Notice

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

Under this section, a "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 *Member* of the Employer (b) the Dependent of an active, covered *Member.* 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 or any other qualified continuee; and (b) is subject to "When Continuation Ends."

Changes to Benefits or Prepayment Fees

Plan may not decrease any benefits or increase Prepayment Fees as stated in the Group Contract except after a period of at least 30 days from and after the postage paid mailing to *Employer* at Employer's most current address of record with MDC.

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 the *Mmeber's* termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give his/her *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 his/her *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 continue; 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 the *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 Member's 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."

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Concurrent Continuations

If a *Dependent* elects to continue his or her group dental benefits due to: (a) The Member's termination of employment; or (b) reduction of the Member's work hours, the *Dependent* may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the *Dependent* becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (ii) the *Member* 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.

The Employer's Responsibilities

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

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group dental benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified 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* child.

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 your *Employer* would have paid. Except as explained in "Extra Continuation for Disabled Qualified Continuees," your *Employer* may 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 the Member's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental benefits would otherwise end;

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

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

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Cal-COBRA

Important Notice

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

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

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

Conversion

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

If Your Group Health Benefits End

If your group dental benefits end due to your termination of employment or reduction of work hours, *you* may elect to continue such benefits for up to 18 months, if *you* were not terminated due to gross misconduct.

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

Extra Continuation for Disabled Qualified Beneficiaries

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

To elect the extra 11 months of continuation, the qualified beneficiary must give your *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; or (b) 60 days after the date the qualified beneficiary is determined to be disabled. If, during this extra 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify *You* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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

If An Member Dies While Insured

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

If An Member's Marriage Ends

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

If A Dependent Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

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

Your Employer's Responsibilities

Your *employer* must notify the qualified beneficiary, 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.

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

The Employer's Liability

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

Election of Continuation

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

The subsequent premiums must be paid to your *Employer,* by the qualified beneficiary, 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 your *Employer* would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," your *Employer* may require an additional charge of 2% of the total premium charge.

If the qualified beneficiary fails to give your *Employer* notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

(d) with respect to a *Dependent* whose continuation is extended due to the *Member's* entitlement to Medicare, while the *Dependent* is on continuation, the end of the 36 month period which starts on the date of the qualifying event;

(e) the date your *Employer* ceases to provide any group dental plan to any *Member;*

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

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

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

Small Employer Group

Applies to Members who are covered under a Group Contract between MDC and a California small *Employer* group with two (2) through nineteen (19) eligible *Members.*

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

Permanent *Members* who work at least 20 hours but not more than 29 hours are deemed to be eligible *Members* if all four of the following apply: (1) they otherwise meet the definition of an eligible *Member* except for the number of hours worked; (2) the *Employer* offers the *Members* health coverage under a health benefit plan; (3) all similarly situated individuals are offered coverage under the health benefit plan; and (4) the *Member* must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter.

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

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

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

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

DENTAL EXPENSE COVERAGE

Managed Dental Care of California - This *Plan's* Dental Coverage Organization

Managed Dental Care of California

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 Dental Care of California network (*MDC* network).

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

When a *Member* enrolls in this *plan,* he or she will get information about *MDC's* current participating general dentists. Each *Member* must be assigned to a *primary care dentist (PCD)* from this list of *participating general dentists.* This *PCD* will coordinate all of the *Member's* dental care covered by this *plan.* After enrollment, a *Member* will receive an *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* is assigned to under this *plan.* What *we* cover is based on all the terms of this *plan.* Read this booklet carefully for specific benefit levels, payment rates, payment limits, conditions, exclusions and limitations and *patient charges.*

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

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Covered Dental Services and Patient Charges 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.

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

Choice of Dentists

A *Member* may request any available *participating general dentist* as his or her *PCD.* A request to change a *PCD* must be made to *MDC* at 1-800-273-3330. Any such change will be effective the first day of the month following approval; however, *MDC* may require up to 30 days to process and approve any such request. All fees and *patient charges* due to the *Member's* current *PCD* must be paid in full prior to such transfer.

MDC compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount each month based upon the number of *Members* that elect them as their PCD.

MDC may also make supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from *MDC.*

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

Changes In Dentist Participation

We may have to reassign a *Member* to a different *participating dentist* if: (a) the *Member's dentist* is no longer a *participating dentist* in the *MDC* network; or (b) *MDC* takes an administrative action which impacts the *dentist's* participation in the network. If this becomes necessary, the *Member* will have the opportunity to request another *participating dentist.* If a *Member* has a dental service in progress at the time of the reassignment, *we* will, at *our* option and subject to applicable law, either: (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.

Refusal of Recommended Treatment

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

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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.

Specialist Referrals

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

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

Specialty referral is limited to the following specialties: Endodontic, Oral Surgeons; Orthodontists; Pediatric Dentists; and Periodontists. Additionally, specialist consultants that have not received prior authorization and are for non-covered services are excluded.

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

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

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

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

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

(4) If the *PCD's* request for specialty referral is denied, the *PCD* and the *member* will receive a written notice along with information on how to appeal the denial to an independent review organization.

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

(6) A specialty referral is not a guarantee of covered services. The *plan's* benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a *covered service* in the *plan,* the *member* will be responsible for the entire amount of the *specialist's* charge for that service.

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

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

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 *the Member.* He or she will be instructed to contact the *Participating Specialist* to schedule an appointment.

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

5. If a request for specialist referral is denied and the *Member* wishes to submit additional information or documentation to be considered in the evaluation of the request, he or she may submit an appeal of the determination. However, such material is not required to appeal 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 1-800-292-3330 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, the *Member* will only be responsible for the applicable *patient charge* that would apply if the services were rendered by a contracted specialist. If the *Member* receives a bill from a non-participating specialist for charges other than the applicable *patient charge,* the *Member* 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 21255 Burbank Boulevard, Suite 120, #100, 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 submit an appeal through the Grievance Process. This process is shown in the Grievance Process section of this Booklet.

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.

Facilities

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

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

Emergency Dental Services

The *MDC* network also provides for *emergency dental services* 24 hours a day, 7 days a week, to all *Members. You* should contact your selected *PCD,* who will arrange for such care.

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

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

Out-of-Area Emergency Dental Services

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

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
21255 Burbank Boulevard, Suite 120
Woodland Hills CA 91367

Continuity of Care - Terminated Dentist (Cont.)

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.

Continuity of Care - Non-Participating Dentist

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
21255 Burbank Boulevard, Suite 120
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.

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

Member grievances are to be submitted to MDC's Quality of Care Liaison (QCL) who processes the grievances. The QCL can be contacted at 800-273-3330 or by mail to P.O. Box 4391, Woodland Hills, CA 91367, or 21255 Burbank Boulevard, Suite 120, Woodland Hills, CA 91367. The Plan hours are from 8:00 a.m. to 5:00 p.m. Pacific Time.

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, appeals of Specialty Referral decisions, 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.

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 to complete, if requested. Grievances can also be submitted through the Plan's website www.manageddentalcare.net.

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 documentation.

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 is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL and 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.

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.

8. 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.

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

10. 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.

11. The plan shall keep all copies of grievances, and the responses to grievances, for a period of five years.

12. The Dental Director has primary responsibility for the Plan's grievance system.

13. 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.

14. 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. Grievances requiring expedited review also include, but are not limited to grievances related to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Plan.

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.

GCP-3-MDCGRV B850.1087-R

COVERED SERVICES

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

Covered Services include:

DIAGNOSTIC

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

* A complete list of covered diagnostic services is listed on the Plan Schedule.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed on the Plan Schedule.

RESTORATIVE

- Amalgam (silver fillings)
- Resin Based Composite (white fillings)
- Inlays
- Onlays
- Crowns
- Other Restorative Services

* A complete list of covered restorative services is listed on the Plan Schedule.

ENDODONTICS

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

* A complete list of covered endodontic services is listed on the Plan Schedule.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed on the Plan Schedule.

PROSTHODONTICS (Removable)

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

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

PROSTHODONTICS (Fixed)

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

* A complete list of covered prosthodontics (fixed) services is listed on the Plan Schedule.

Note: Treatment which requires the services of a Prosthodontist are not covered.

ORAL SURGERY

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

* A complete list of covered oral surgery services is listed on the Plan Schedule.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed on the Plan Schedule.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed on the Plan Schedule.

A list of the services covered by this Plan, including Patient Charges is provided in the section called Benefit Schedule.

Exclusions and Limitations will apply to some of the services that apply. Refer to the Principal Exclusions and Limitation of Benefits section of this document.

Covered Dental Services And Patient Charges - Plan U60 G

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

The Member must pay the listed Patient Charge. The benefits We provide are subject to all the terms of this Plan, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

The Patient Charges listed in this section are only valid for covered services that are: (1) started and completed under this Plan, and (2) rendered by Participating Dentists in the state of California.

CDT Code	Covered Services and Patient Charges - U60 G Current Dental Terminology (CDT) (c) American Dental Association (ADA)	Patient Charge
D0999	Office visit during regular hours, general dentist only	$0.00
	EVALUATIONS	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
	RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
	TESTS AND EXAMINATIONS	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00

D0470	Diagnostic casts	$0.00

DENTAL PROPHYLAXIS

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

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

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

OTHER PREVENTIVE SERVICES

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

SPACE MAINTENACE (PASSIVE APPLIANCES)

D1510	Space maintainer - fixed - unilateral	$0.00
D1515	Space maintainer - fixed - bilateral	$0.00
D1525	Space maintainer - removable - bilateral	$0.00
D1550	Re-cementation of fixed space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00

ALMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT

D2330	Resin-based composite - 1 surface, anterior	$0.00
D2331	Resin-based composite - 2 surfaces, anterior	$0.00
D2332	Resin-based composite - 3 surfaces, anterior	$0.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$0.00
D2390	Resin-based composite crown, anterior	$0.00
D2391	Resin-based composite - 1 surface, posterior	$0.00
D2392	Resin-based composite - 2 surfaces, posterior	$0.00

D2393	Resin-based composite - 3 or more surfaces, posterior	$0.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$0.00

INLAY/ONLAY RESTORATIONS [6]

D2510	Inlay - metallic - 1 surface [5]	$60.00
D2520	Inlay - metallic - 2 surfaces [5]	$75.00
D2530	Inlay - metallic - 3 or more surfaces [5]	$75.00
D2542	Onlay - metallic - 2 surfaces [5]	$80.00
D2543	Onlay - metallic - 3 surface [5]	$80.00
D2544	Onlay - metallic - 4 or more surfaces [5]	$80.00
D2610	Inlay - porcelain/ceramic - 1 surface	$60.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$75.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$75.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$80.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$80.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$80.00

CROWNS - SINGLE RESTORATIONS ONLY [6]

D2740	Crown - porcelain/ceramic substrate	$100.00
D2750	Crown - porcelain fused to high noble metal [5]	$95.00
D2751	Crown - porcelain fused to predominantly base metal	$95.00
D2752	Crown - porcelain fused to noble metal	$95.00
D2780	Crown - 3/4 cast high noble metal [5]	$85.00
D2781	Crown - 3/4 cast predominantly base metal	$85.00
D2782	Crown - 3/4 cast noble metal	$85.00
D2783	Crown - 3/4 porcelain/ceramic	$85.00
D2790	Crown - full cast high noble metal [5]	$95.00
D2791	Crown - full cast predominantly base metal	$95.00
D2792	Crown - full cast noble metal	$95.00
D2794	Crown - titanium	$95.00

OTHER RESTORATIVE SERVICES

D2910	Recement inlay, onlay, or partial coverage restoration	$0.00
D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2930	Prefabricated stainless steel crown - primary tooth	$10.00
D2931	Prefabricated stainless steel crown - permanent tooth	$10.00
D2932	Prefabricated resin crown	$20.00
D2933	Prefabricated stainless steel crown with resin window	$20.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$20.00
D2940	Sedative filling	$0.00
D2950	Core buildup, including any pins	$20.00
D2951	Pin retention - per tooth, in addition to restoration	$0.00
D2952	Post & core in addition to crown, indirectly fabricated	$30.00
D2953	Each additional indirectly fabricated post - same tooth	$10.00
D2954	Prefabricated post and core in addition to crown	$25.00
D2957	Each additional prefabricated post - same tooth	$8.00
D2960	Labial veneer (resin laminate) - chairside	$40.00
D2970	Temporary crown (fractured tooth)	$15.00

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

PULP CAPPING

D3110	Pulp cap - direct (excluding restoration)	$0.00
D3120	Pulp cap - indirect (excluding restoration)	$0.00

PULPOTOMY

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$10.00
D3221	Pulpal debridement, primary and permanent teeth	$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$10.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$15.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$15.00

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

D3310	Root canal, anterior (excluding final restoration)	$70.00
D3320	Root canal, bicuspid (excluding final restoration)	$80.00
D3330	Root canal, molar (excluding final restoration)	$140.00
D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair or perforation defects	$40.00

ENDODONTIC RETREATMENT

D3346	Retreatment of previous root canal therapy - anterior	$80.00
D3347	Retreatment of previous root canal therapy - bicuspid	$95.00
D3348	Retreatment of previous root canal therapy - molar	$150.00

APICOECTOMY/PERIRADICULAR SERVICES

D3410	Apicoectomy/periradicular surgery - anterior	$90.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$95.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$40.00
D3430	Retrograde filling - per root	$15.00
D3950	Canal preparation and fitting of preformed dowel or post	$20.00

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$60.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$20.00

D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$105.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$35.00
D4249	Clinical crown lengthening - hard tissue	$85.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$155.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$95.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$100.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$110.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$120.00

NON-SURGICAL PERIODONTAL SERVICE

D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$25.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$15.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15.00

OTHER PERIODONTAL SERVICES

D4910	Periodontal maintenance, for the first two services in any 12-month period [1, 2]	$15.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$0.00
D4999	Periodontal maintenance, for each additional service in same 12-month period [1, 2]	$60.00

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5110	Complete denture - maxillary	$110.00
D5120	Complete denture - mandibular	$110.00
D5130	Immediate denture - maxillary	$110.00
D5140	Immediate denture - mandibular	$110.00

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$90.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$90.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$130.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$130.00

D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$140.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$140.00

ADJUSTMENTS TO DENTURES

D5410	Adjust complete denture - maxillary	$5.00
D5411	Adjust complete denture - mandibular	$5.00
D5421	Adjust partial denture - maxillary	$5.00
D5422	Adjust partial denture - mandibular	$5.00

REPAIRS TO COMPLETE DENTURES

D5510	Repair broken complete denture base	$0.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0.00

REPAIRS TO PARTIAL DENTURES

D5610	Repair resin denture base	$0.00
D5620	Repair cast framework	$0.00
D5630	Repair or replace broken clasp	$0.00
D5640	Replace broken teeth - per tooth	$0.00
D5650	Add tooth to existing partial denture	$0.00
D5660	Add clasp to existing partial denture	$0.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$0.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$0.00

DENTURE REBASE PROCEDURES

D5710	Rebase complete maxillary denture	$0.00
D5711	Rebase complete mandibular denture	$0.00
D5720	Rebase maxillary partial denture	$0.00
D5721	Rebase mandibular partial denture	$0.00

DENTURE RELINE PROCEDURES

D5730	Reline complete maxillary denture (chairside)	$0.00
D5731	Reline complete mandibular denture (chairside)	$0.00
D5740	Reline maxillary partial denture (chairside)	$0.00
D5741	Reline mandibular partial denture (chairside)	$0.00
D5750	Reline complete maxillary denture (laboratory)	$0.00
D5751	Reline complete mandibular denture (laboratory)	$0.00
D5760	Reline maxillary partial denture (laboratory)	$0.00
D5761	Reline mandibular partial denture (laboratory)	$0.00

INTERIM PROSTHESIS

D5820	Interim partial denture (maxillary)	$45.00
D5821	Interim partial denture (mandibular)	$45.00

OTHER REMOVABLE PROSTHETIC SERVICES

D5850	Tissue conditioning, maxillary	$0.00
D5851	Tissue conditioning, mandibular	$0.00

FIXED PARTIAL DENTURE PONTICS [6]

D6210	Pontic - cast high noble metal [5]	$90.00
D6211	Pontic - cast predomniantly base metal	$90.00
D6212	Pontic - cast noble metal	$90.00
D6214	Pontic - titanium	$90.00
D6240	Pontic - porcelain fused to high noble metal [5]	$90.00
D6241	Pontic - porcelain fused to predominantly base metal	$90.00
D6242	Pontic - porcelain fused to noble metal	$90.00
D6245	Pontic - porcelain/ceramic	$90.00

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS [6]

D6600	Inlay - porcelain/ceramic, - 2 surface	$75.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$75.00
D6602	Inlay - cast high noble metal, - 2 surfaces [5]	$75.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces [5]	$75.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$75.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$75.00
D6606	Inlay - cast noble metal, 2 surfaces	$75.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$75.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$80.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$80.00
D6610	Onlay - cast high noble metal, 2 surfaces [5]	$80.00
D6611	Onlay - cast high noble metal, 3 or more surfaces [5]	$80.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$80.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$80.00
D6614	Onlay - cast noble metal, 2 surfaces	$80.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$80.00
D6624	Inlay - titanium	$75.00
D6634	Onlay - titanium	$75.00

FIXED PARTIAL DENTURE RETAINERS - CROWNS [6]

D6740	Crown - porcelain/ceramic	$100.00
D6750	Crown - porcelain fused to high noble metal [5]	$95.00
D6751	Crown - porcelain fused to predominantly base metal	$95.00
D6752	Crown - porcelain fused to noble metal	$95.00
D6780	Crown - 3/4 cast high noble metal [5]	$85.00
D6781	Crown - 3/4 cast predominantly base metal	$85.00
D6782	Crown - 3/4 cast noble metal	$85.00
D6783	Crown - 3/4 porcelain/ceramic	$85.00
D6790	Crown - full cast high noble metal [5]	$95.00
D6791	Crown - full cast predominantly base metal	$95.00
D6792	Crown - full cast noble metal	$95.00
D6794	Crown - titanium	$95.00

OTHER FIXED PARTIAL DENTURE SERVICES

D6930	Recement fixed partial denture	$0.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$30.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$25.00
D6973	Core buildup for retainer, including any pins	$20.00
D6976	Each additional cast post - same tooth	$10.00
D6977	Each additional prefabricated post - same tooth	$8.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment [6]	$125.00

EXTRACTIONS

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

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

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$35.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$70.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$85.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40.00
D7261	Primary closure of a sinus perforation	$250.00

OTHER SURGICAL PROCEDURES

D7280	Surgical access of an unerupted tooth	$90.00
D7283	Placement of device to facilitate eruption of impacted tooth	$35.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$45.00
D7286	Biopsy of oral tissue - soft	$40.00
D7288	Brush biopsy - transepithelial sample collection	$65.00

ALEVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$35.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$16.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$45.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	$30.00

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$60.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$110.00

EXCISION OF BONE TISSUE

D7471	Removal of lateral exostosis (maxilla or mandible)	$75.00
D7472	Removal of torus palatinus	$75.00
D7473	Removal of torus mandibularis	$75.00

SURGICAL INCISION

D7510	Incision and drainage of abscess - intraoral soft tissue	$25.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30.00

OTHER REPAIR PROCEDURES

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$60.00
D7963	Frenuloplasty	$100.00

UNCLASSIFIED TREATMENT

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

PROFESSIONAL CONSULTATION

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

PROFESSIONAL VISITS

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

MISCELLANEOUS SERVICES

D9951	Occlusal adjustment - limited	$0.00
D9971	Odontoplasty, 1-2 teeth	$10.00
D9972	External bleaching - per arch	$165.00
	Broken Appointment	$25.00

[1] The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first 2 services in any 12-month period. For each additional services in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.

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

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

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

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

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

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

Covered Dental Services And Patient Charges - Plan U60 G

CDT Code	Covered Services and Patient Charges - U60 G Current Dental Terminology (CDT) (c) American Dental Association (ADA)	Patient Charge
	ORTHODONTICS [8, 10]	
D8070	Comprehensive orthodontic treatment of the transitional dentition [9, 11]	Child: $1500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition [9, 11]	Child: $1500.00
D8090	Comprehensive orthodontic treatment of the adult dentition [9, 11]	Adult: $2800.00
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention	$400.00
	Broken Appointment	$25.00

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

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

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

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

Additional Conditions On Covered Services

General Guidelines For Alternative Procedures

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

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

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

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

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

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

General Guidelines For Alternative Treatment By The PCD

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

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

Crowns, Bridges And Dentures

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

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

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

Multiple Crown/Bridge Unit Treatment Fee

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

Pediatric Specialty Services

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

Second Opinion

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.*

Plan will review and approve second opinions if there are questions regarding the following:

- The reasonableness or necessity of a recommended surgical procedure.
- Diagnosis or plan of care, including once care has been initiated.
- Treatment in progress.
- Authorization or denial will be provided in an expeditious manner. *Member* will be notified in writing if the second opinion is denied and reason for denial will be included. *Member* will have the right to file a grievance with the Plan. The grievance process is located in this booklet.
- The second opinion consultation will be provided by an MDC Participating Dentist of the *Member's* choice. *Member* is responsible for office visit Patient Charge.

A Member Services Representative will help *you* identify a *Participating Dentist* to perform the second opinion consultation. *The member* 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.* Authorizations for second opinions are valid for sixty (60) days from the date of approval. 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.

You may appeal a denial for a second opinion to:

Managed Dental Care of California
Grievance Committee
21255 Burbank Boulevard, Suite 120
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. Second opinions that have not received prior authorization and are for non-covered services are excluded.

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, the member will be responsible for the patient charge for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

General Anesthesia / IV Sedation

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

CGP-3-MDC-CA-COND-08 B850.1021-R

Orthodontic Treatment

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

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

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

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

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

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

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

CGP-3-MDG-NY-ORTHO-R-08 B850.1019-R

Treatment In Progress

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

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

- Endodontic Treatment - Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are listed on the Member's Plan Schedule that were started but not completed prior to the *member's* eligibility to receive benefits under this *plan* may be covered if the *member* identifies a *Participating General or Specialty Care Dentist* who is willing to complete the procedure at a patient charge equal to 85% of *Participating Dentist's* usual fee.

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

Takeover Benefit for Orthodontic Treatment

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

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

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

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

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

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

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

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Limitations on Benefits For Specific Covered Services

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

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

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

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) - a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a *Participating Periodontal Specialty Care Dentist* if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a *Participating Periodontal Specialty Care Dentist.* Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride Treatment (D1203, D1204, D1206, D2999) - Four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to one (1) in any two (2) year period on or after the 40th birthday.
- Full mouth x-rays - one (1) set in any three (3) year period.
- Bitewing x-rays - two (2) sets in any twelve (12) month period.
- Panoramic x-rays - one (1) set in any three (3) year period.
- Sealants - limited to permanent teeth, up to the 16th birthday - one (1) per tooth in any three (3) year period.

- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) - a total of one (1) service per quadrant or area in any three (3) year period.
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) - a total of one (1) service per area in any three (3) year period.
- Periodontal scaling and root planing (D4341, D4342) - one (1) service per quadrant or area in any twelve (12) month period.
- Emergency dental services when more than 50 miles from the *PCD's* office - limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the *member's* assigned *PCD,* and without referral by the *PCD* or authorization by *MDC* - limited to the benefit for palliative treatment (code D9110) only.
- Reline of a complete or partial denture - one (1) per denture in twelve (12) month period.
- Rebase of a complete or partial denture - one (1) per denture in any twelve (12) month period.
- Second Opinion Consultation - when approved by us, a second opinion consultation will be reimbursed up to $50.00 per treatment plan. The office visit patient charge will apply.

CGP-3-MDC-CA-LMTS-08 B850.1022-R

Exclusions

We won't cover:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise Covered Service involving (a) congenitally missing or (b) supernumerary teeth.
- Any *histopathological* examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.

- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the *participating dentist* is not necessary for maintaining or improving the *member's* dental health, or (b) which is solely for cosmetic purposes.
- Precision attachments, stress breakers, magnetic retention or *overdenture* attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to *nitrous oxide.*
- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the negligence of the member.
- Any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD,* or (b) treatment by a specialist without a referral from the *PCD* and approval from *us.*
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for *periodontal* reasons (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the *temporomandibular joint (TMJ).*
- Dental services, other than covered *Emergency Dental Services,* which were performed by any *dentist* other than the *member's* assigned *PCD,* unless *we* had provided written authorization.
- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a *Prosthodontist.*
- Treatment which requires the services of a *Pediatric Specialty Care Dentist,* after the *member's* 8th birthday.
- Consultations for non-covered services.
- Any procedure not specifically listed in the Covered Dental Services and Patient Charges Section.

- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Restorative Treatment. (Inlays, onlays crowns or fixed bridges are (a) considered to be started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are (a) considered to be started when the impressions are taken, and (b) completed when the denture is delivered to the *member.)*
- Root canal treatment started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Endodontic Treatment. (Root canal treatment is: considered to be (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)
- Orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)
- Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the *plan* as *Emergency Dental Services.*
- *Root canal* treatment started by a *non-participating dentist. (Root canal* treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the *plan* as *Emergency Dental Services.*
- Orthodontic treatment started by a non-participating dentist while the Member is covered under This Plan. (Orthodontic treatment is considered to be started when the teeth are banded.)
- Extractions performed solely to facilitate *orthodontic* treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- *Orthognathic* surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening (D4249) performed in the presence of *periodontal* disease on the same tooth.
- Procedures performed to facilitate non-covered services, including but not limited to: (a) *root canal* therapy to facilitate *overdentures, hemisection* or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Any endodontic, *periodontal,* crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the *member.*

CGP-3-MDC-CA-EXCL-08 B850.1024-R

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

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

CGP-3-MDCD B850.0826-R

Advertisement means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of Plan Contracts.

CGP-3-MDC-CA-GLS-08 B850.1088-R

Code means the California Health and Safety Code.

CGP-3-MDC-CA-GLS-08 B850.1089-R

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

CGP-3-MDCD2 B850.0207-R

Coordination of Benefits means the method by which a health care service plan contract, covering dental services of a specialized health care service plan contract, covering dental services, and one or more other health care service plans, specialized health care service plans, or disability insurers, covering dental services, pay their respective reimbursements for dental benefits when an enrollee is covered by multiple health care service plans or specialized health care service plan contracts, or a combination thereof, or a combination of health care service plans or specialized health care service plan contracts and disability insurers.

CGP-3-MDC-CA-GLS-08 B850.1090-R

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

CGP-3-MDCD3 B850.0208-R

Dependent means the spouse and dependent children of the employee as defined herein under the section entitled Eligible Dependents.

CGP-3-MDCDMST-C B850.1472

Emergency Dental Services 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-R

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

CGP-3-MDCD6 B850.0213-R

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

CGP-3-MDCD7 B850.0214-R

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Subscriber or Member setting forth the coverage to which they are entitled.

CGP-3-MDC-CA-GLS-08 B850.1110-R

Exclusions means those services or conditions that are not intended to be covered by the Plan. Services not specifically listed on the Benefit Schedule are not covered.

CGP-3-MDC-CA-GLS-08 B850.1091-R

Facility means (1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of a Plan or any affiliate thereof, and (2) any premises maintained by a provider to provide services on behalf of a Plan.

CGP-3-MDC-CA-GLS-08 B850.1092-R

Group Contract and Plan Contract means a contract, which by its terms limits the eligibility of subscribers and enrollees to a specified group.

CGP-3-MDC-CA-GLS-08 B850.1093-R

Limitations means restrictive conditions stated in a dental benefit contract, such as age, length of time covered and waiting periods that affect an individual's or group's coverage. Limitations may be based on frequency, age, time periods for replacement of a service (i.e. life expectancy of a service), time periods for treatment (e.g., comprehensive orthodontic treatment), waiting periods, and annual or lifetime payment amounts.

CGP-3-MDC-CA-GLS-08 B850.1094-R

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

CGP-3-MDCD8 B850.0215-R

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

CGP-3-MDG-DEF9 B850.0217-R

Other Party means the group representative designated in the Plan Contract.

CGP-3-MDC-CA-GLS-08 B850.1095-R

Participating Dentist means a *dentist* under contract with MDC.

CGP-3-MDCD10 B850.0829-R

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

CGP-3-MDCD11 B850.0219-R

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

CGP-3-MDC12-B B850.0220-R

Patient Charge means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this *plan.* Such amount is the patient's portion of the cost of covered dental services and is paid to the treating dentist at the time services are rendered.

CGP-3-MDC-CA-GLS-08 B850.1100-R

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

CGP-3-MDCD14 B850.0223-R

Primary Care Dentist (PCD) means a Participating General Dentist who provides *covered services* to *members;* and (b) which has been selected by a *member* and assigned by MDC to provide and arrange for his or her dental services.

CGP-3-MDC-CA-GLS-08 B850.1101-R

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

CGP-3-MDCD16 B850.0225-R

Solicitation means any presentation or advertising conducted by, or on behalf of, a Plan, where information regarding the Plan, or Services offered and charges therefore, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the Plan.

CGP-3-MDC-CA-GLS-08 B850.1096-R

Specialized Health Care Service Plan means any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribes or enrollees.

CGP-3-MDC-CA-GLS-08 B850.1097-R

Specialized Health Care Service Plan Contract means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

CGP-3-MDC-CA-GLS-08 B850.1098-R

Utilization Review means the process that includes prospective, retrospective and/or concurrent review of dental care and which approves, modifies, or denies benefits for care, based on whole or in part on medical necessity.

CGP-3-MDC-CA-GLS-08 B850.1099-R

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

CGP-3-MDCD17 B850.0226-R

COORDINATION OF BENEFITS

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.

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 primary, MDC will pay the maximum amount required by its contract or policy with the Member when coordinating benefits with a secondary dental benefit plan.

When MDC is secondary, MDC will pay the lesser of either the amount that we would have paid in the absence of any other dental benefit coverage or the Member's total out-of-pocket cost under the primary dental benefit plan for benefits covered under the secondary dental benefit plan.

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 Medicad, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

CGP-3-MDC-COB-08 B850.1111

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

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

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

U60 (Cont.)	**Deductibles**	**Lifetime Maximums**	**Professional Services (Continued)**			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, Up To 16th Birthday, One Per Tooth In Any 3-Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

MDC U60 0308

B850.1076-R

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

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

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

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

B850.1080-R

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.

MDC U60 0308

B850.1078-R

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

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

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

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

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

MDC U60 0308

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