First Commonwealth, Inc., 550 West Jackson Blvd., Suite 800, Chicago, Illinois 60661

First Commonwealth is an Illinois domiciled Limited Health Services Organization licensed in accordance with the statutes and applicable provisions of the Illinois Administrative Code.

INDIVIDUAL DENTAL BENEFITS PLAN

THE INSURANCE EVIDENCED BY THIS PLAN PROVIDES DENTAL COVERAGE ONLY.

This dental plan includes pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

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

THIS PLAN is made and entered into this 1st day of January, 2021 by and between First Commonwealth Insurance Company (hereinafter referred to as "First Commonwealth"), and Subscriber (hereinafter referred to as "Planowner").

FIRST COMMONWEALTH INSURANCE COMPANY (referred to in this Plan as “First Commonwealth”, “FCW”, “us”, “we” or “our”) in consideration of the application for this Plan and of the payment of premiums as stated herein, agrees to provide the Plan Benefits described herein in accordance with and subject to the terms, conditions and provisions of this Plan. Please check Your application form for errors. An incorrect or incomplete application may cause Your Plan to be voided and claims to be reduced or denied.

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

RENEWAL PROVISION
This Plan is guaranteed renewable and will continue in effect as long as the Planowner pays the premiums when they are due or within the grace period in accordance with the terms and conditions of the Plan. The premium can be changed only if we change it on all policies of this kind in the state where the Plan is issued. If the premium is changed, the Planowner will be given 45 days written notice.

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties have executed this Plan.

Planowner

By:_____
(Type or print name below signature.)

_____
Planowner

First Commonwealth Insurance Company

Stuart Shaw
Vice President

Cherita L. Thomas
Secretary

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Premium Rates

Monthly Premium Rates

Planowner Only	Planowner and Dependent Spouse	Planowner and Dependent Child	Family
See Invoice	See Invoice	See Invoice	See Invoice

REFERENCE TO ATTACHMENTS

Various parts of this Plan refer to Schedules and the Application which are incorporated by reference herein as if fully set forth herein (the "Attachments"). Each such Attachment sets forth in detail the matters referenced herein which constitute additional provisions of this Plan.

DEFINITIONS

Application: shall mean the form completed by the Planowner which defines eligible Members, provides information, and is made a part of this Plan.

Condition: shall mean any limitation or restriction on a covered dental service.

Dependent: shall mean your (a) spouse (unless legally separated); (b) dependent children who are under age 26; and (c) unmarried dependent children who are age 26 but under age 30, if the children (i) are Illinois residents; (ii) served as members of the active or reserve components of any of the branches of the Armed Forces of the United States; and (iii) have received a release or discharge, other than a dishonorable discharge.

Eligible children include natural children, adopted children, children who are in the process of adoption pursuant to an Interim Court Order (whether or not a Final Adoption Order is ever issued), stepchildren, and foster children for whom you or your spouse are the legal guardian. Eligibility may also be extended to any child past the age of 26 who is handicapped and dependent on you for support.

Due Date: shall mean the 15th day of the month prior to the coverage period.

Emergency Dental Services: shall mean the provision of dental care for the sudden, acute dental condition or trauma to the mouth, teeth or cavity which would lead a prudent layperson, who possesses an average knowledge of dentistry, to believe that failure to receive immediate dental care would result in serious impairment to the dentition or would place the person's oral health in serious jeopardy. Services related to the initial emergency condition but not required specifically to relieve an acute dental condition or trauma to the mouth, teeth or cavity, including services performed at the emergency visit and services performed at subsequent visits, are not considered emergency dental services.

Exclusion: shall mean any dental service, treatment or procedure that is not a covered service.

First Commonwealth: shall mean First Commonwealth Insurance Company; an Illinois-domiciled Life, Accident and Health Insurance Company that is also licensed as a limited health services organization.

Limitation: shall mean any condition or restriction on a covered dental service.

Member: shall mean a Planowner or Dependent who is actually enrolled in this Plan.

Participating Dental HMO Dentist: shall mean a general dentist or dental specialist who is under contract to First Commonwealth of Illinois, Inc., a Preferred Provider Administrator registered with the Illinois Department of Insurance. First Commonwealth of Illinois, Inc., through its contracts with dentists, arranges for all covered dental services pursuant to its contract with First Commonwealth and on file with the Illinois Department of Insurance. The term Participating Dental HMO Dentist shall include any hygienist or technician recognized under Illinois law to act with and assist the dentist.

Patient Charges: shall mean the Member's portion of the cost of covered dental services that the Member is responsible for paying to the Participating Dental HMO Dentist directly at the time the service, treatment or procedure is rendered. The Covered Dental Services and Patient Charges section of this Plan lists the dental services, treatments and procedures that are covered dental services under this Plan and the applicable Patient Charges.

Plan: means the dental benefits Plan purchased by You and administered by First Commonwealth pursuant to this Plan.

Plan Benefits: shall mean the coverage for dental benefits that is provided under this Plan, is described in this Plan, and which is subject to all of the terms, limitations, conditions and exclusions of this Plan.

Plan Effective Date: shall mean the date that this Plan begins, as defined on the Face Page.

Planowner: shall mean the person who purchased this Plan.

Premium: shall mean the subscription rate for each Member enrolled in the Plan under the Plan during each month this Plan is in effect, as set forth on the Premium Rates schedule

Primary Care Dentist or PCD: shall mean a Participating Dental HMO general dentist that the Member selects from the list of participating dental HMO dentists to provide or arrange for all dental care needs.

Provider: shall mean any duly licensed dentist and shall include any hygienists and technicians recognized by the dental profession who act with and assist the dentist.

Service Area: shall mean the geographic area in which we provide Plan Benefits.

Specialist: shall mean a Participating Dental HMO Dentist who has satisfied the additional training requirements in a specific area of dentistry and obtained a separate license to practice in that specialty area. Examples of dental specialists include Oral Surgeons, Endodontists (root canals), Periodontists (gum surgery), Orthodontists (braces) and Pedodontists (special needs of children).

Spouse: shall mean an employee's lawful spouse including a partner to a civil union when that union is in accordance with Illinois law. Such unions include: (a) both same-sex and opposite-sex couples who enter into a civil union; or (b) such relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

Urgent Dental Services: shall mean only covered, bona fide urgent services which are reasonably necessary to relieve the sudden onset of considerable pain and discomfort. Services related to the initial urgent condition but not required specifically to relieve pain or discomfort are not considered urgent dental services.

We, Us and Our: shall mean First Commonwealth.

You or Your: shall mean the Planowner.

CONTRACT TERMS

Premium: As set forth in the Premium Rates schedule, You shall remit to First Commonwealth on or before the Due Date the applicable total Payment of Premium after receipt of this Plan constitutes acceptance of contract terms.

Plan Term: The initial Plan Term and each successive Plan Term shall be for one-year periods. This Plan shall become effective on the Plan Effective Date as specified on the Plan Face Page attached hereto.

Renewal: This Plan shall automatically renew for successive one-year Plan Terms unless either party provides 60 days written notice of non-renewal prior to the end of a one-year Plan Term.

ADMINISTRATION

Grievance Process: First Commonwealth agrees, subject to its Grievance Process, to duly investigate and endeavor to resolve any and all complaints and/or grievances received from Members. Any inquiries, complaints, grievances, or the like, shall be made to First Commonwealth in writing or by calling First Commonwealth at the address indicated in the General Provisions. The Grievance Process is set forth in this Plan.

Member Materials: First Commonwealth shall issue an identification card to the Planowner, identifying the Planowner and his or her enrolled Dependent(s) as eligible for Plan Benefits pursuant to this Plan. The Planowner will receive an identification card and a Plan within 30 days of the Plan Effective Date.

Member/Provider Relationship: It is expressly understood that the relationship between the Member and the Provider rendering services or treatment shall be subject to the rules, limitations, and privileges incident to the professional relationship. The Provider shall be solely responsible to the Member for all services or treatment within the professional relationship. It is understood and agreed that the operation and maintenance of the Provider's facilities, equipment, and the rendition of all professional services shall be solely and exclusively under the control and supervision of the Provider, including all authority and control over the selection of staff, supervision of personnel, and operation of the professional practice, and/or the rendition of any particular professional service or treatment.

BENEFITS TO BE PROVIDED

Plan Benefits: First Commonwealth and the Planowner agree that this Plan provides solely for the Plan Benefits to be provided to Members under this Plan as set forth in this Plan.

Member Out-of-Pocket Expenses: The Member and not First Commonwealth shall be solely responsible for payment of all non-covered dental services and for the Member's portion of the charges for covered dental services (Patient Charges) as specified in this Plan.

GENERAL PROVISIONS

Indemnity. First Commonwealth shall defend, indemnify, and hold the Planowner harmless from and against any and all injuries, claims, demands, liabilities, suits at law or in equity, or judgments of any nature whatsoever, which the Planowner, representatives, agents, or third parties may sustain or incur by reason of any act, neglect, default, alleged malpractice, or inadequate care or services rendered to the Member by any Provider. Planowner agrees to defend, indemnify, and hold First Commonwealth harmless for and against any and all injuries, claims, demands, liabilities, suits at law or in equity, or judgments of any nature whatsoever, which the Planowner's representatives, agents, administrators, or third parties may sustain or incur by reason of any act, neglect, default, or lack of due care caused or alleged to have been caused by the Planowner any of its agents in the performance of the services, duties and obligations of the Planowner under this Plan.

Waiver. The waiver by either party of one or more defaults, if any, under this Plan shall not be construed to operate as a waiver of any other of future default, either in the same condition or covenant or any other condition or covenant contained within this Plan. No agent or other person, except an officer of First Commonwealth, has authority to waive any conditions or restrictions of this Plan, to extend the time for making payment, or to bind by making any promise to representation or by giving or receiving any information. No change in this Plan shall be valid unless evidenced by an endorsement on it signed by one of the aforesaid officers.

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

A. If directed to First Commonwealth, it shall be addressed as follows: First Commonwealth, Inc., 550 West Jackson Blvd., Suite 800, Chicago, Illinois 60661, ATTN: President, 312-644-1800.

B. If directed to Planowner, it shall be addressed as indicated in the Plan Face Page.

Terms. Throughout this Plan, the singular shall include the plural and the plural the singular; the masculine shall include the neuter and feminine; and the neuter shall include the masculine and feminine.

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

Assignment. No provision of the Illinois Insurance Code, or any other law, prohibits a Member from making an assignment of all or any part of his/her rights and privileges under the Plan.

Workers' Compensation. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation.

Amendment. Except as provided herein, modifications or alterations must be mutually agreed to in writing, signed by the parties, and attached hereto.

Acknowledgement. Each of the parties acknowledges that it has read this Plan, understands its contents, and executes this Plan voluntarily.

Entire Contract; Changes. This Plan and a completed Application, constitutes the entire Plan. No change in this Plan shall be valid until approved in writing by an executive officer of First Commonwealth and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Plan or to waive any of its provisions. All statements made by the Members, shall, in the absence of fraud, be deemed representations and not warranties, and shall not be used in defense of a claim under this Plan, unless they are contained in a written application.

Time Limit on Certain Defenses: This Plan is incontestable two years from the date of issue, except for fraudulent misstatements made by the applicant or Subscriber on the application.

Governing Law. This Plan shall be governed by the laws of the State of Illinois.

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

Premium Rate Adjustments. First Commonwealth shall adjust Premium rate(s) by providing the Planowner written notice of the change at least 60 days prior to the last day of the period for which the Premium rate(s) are guaranteed.

CLAIM PROVISIONS

Claim: shall mean a first-party claim made by a Member under this Plan that First Commonwealth must pay directly to the Member.

Notice of Claim: shall mean any written notification provided to First Commonwealth by a Member that reasonably informs First Commonwealth of the facts relating to a claim. You must send written proof to Our designated office within 20 days of the occurrence or commencement of any loss.

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

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

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

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

If First Commonwealth notifies a Member that the claim is rejected, the notice will state the reasons for rejection.

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

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

Time of Payment of Claims: Indemnities payable under this Plan for any loss other than loss for which this Plan provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

All claims and indemnities payable under the terms of a this Plan shall be paid within 30 days following receipt by Us of due proof of loss. Failure to pay within such period shall entitle the Member to interest at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

DENTAL BENEFITS

Welcome to First Commonwealth

We at First Commonwealth are pleased that You have become a Member of the Plan. We encourage You to maintain Your oral health by visiting Your Dentist on a regular basis.

To assist You in using Your Plan Benefits, we have made this Plan available to You. Please review it carefully and keep it with Your other important documents. For information You may contact First Commonwealth.

First Commonwealth
550 West Jackson Blvd., Suite 800
Chicago, IL 60661
Member Services (844) 561-5600

For Your Information

By acceptance of coverage under the terms of this Plan, You as the Planowner, authorize every provider rendering services under this Plan to disclose to us, upon request, all treatment facts pertaining to You and Your enrolled Dependents.

Furthermore, You as the Planowner, represent to the best of Your knowledge or information, that information contained in any applications, forms or statements submitted to First Commonwealth shall be true, correct and complete. All rights to Plan Benefits are subject to the condition that all such information shall be true, correct and complete.

Please be aware that all rights of You and Your enrolled Dependents to Plan Benefits are personal and may not be assigned to anyone else.

For Assistance Call 844-561-5600

Our specially trained Member Services Representatives are available Monday through Friday, from 9:00 am to 9:00 pm EST to assist You. They can answer any questions You may have regarding how Your dental Plan works, assist in selecting or changing a Primary Care Dentist (PCD), assist in status changes and handle any inquiries or complaints You may have.

Your Effective Date of Coverage and Eligibility

The Effective Date of Your coverage is specified in the Application and in the Plan Face Page.

As the Planowner, You may enroll Yourself alone, or together with Your spouse and/or eligible dependent children (subject to age limits in the Plan). If You do not enroll Your Dependent(s) on the date You enroll, You must wait to add them until the next open enrollment period.

Dependents may be added, deleted, or you may change your coverage status on the date of the qualifying event, provided that First Commonwealth is notified in writing at least 31 days after the date of the qualifying event.

Children that are newly acquired Dependents through adoption or children placed for adoption may be enrolled on the date of the qualifying event, if First Commonwealth is given written notice within 60 days of the qualifying event.

Qualifying Events

1. Marriage
2. Birth
3. Adoption

4. Children Placed for Adoption
5. Becoming a legal guardian of a child
6. Divorce
7. Death
8. Children who are in the process of adoption pursuant to an Interim Court Order (whether or not a Final Adoption Order is ever issued);"

Enrollment Procedures

You and Your dependents may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and (b) returning the enrollment material to Us.

The enrollment materials require You to select a Primary Care Dentist (PCD) for each Member from the list of Participating Dental HMO Dentists. After we receive Your enrollment material, we will determine if a Member's selected PCD is available in Your Plan. If so, the selected dentist will be assigned to the Member as his or her PCD. If a Member's selection is not available, an alternate dentist will be assigned as the PCD.

All dental services covered by this Plan must be coordinated by the PCD to whom the Member is assigned to under this Plan. **Care rendered by a non-participating dentist, or care rendered by a Specialist without obtaining prior written authorization for such care, is not a covered dental service, except for Emergency dental Services.**

First Commonwealth will issue You and Your dependents, either directly or through Your representative, a First Commonwealth ID card. The ID card will show the Member's name. A Member need only contact his or her assigned PCD's office to obtain services.

Choice of Dentist/Changing A Member's Selection

A Member may request any available participating general dentist from the list of Participating Dental HMO Dentists as his or her PCD.

A Member may change his or her PCD selection at any time during the benefit year. A change can be made by calling our Member Services Department 844-561-5600 with the change information. If First Commonwealth is notified by the 15th of the month, the change will be effective the first of the following month. If First Commonwealth is notified after the 15th of the month, the change will be effective the first day of the second month following the request. The Member may call his or her new PCD's office to schedule an appointment after the request for a change has become effective. All fees and Patient Charges due to the Member's current PCD must be paid in full prior to such transfer.

Changes In Dentist Participation

We may have to reassign a Member to a different Participating Dental HMO Dentist if: (a) the Member's PCD is no longer a participating dentist in our network; or (b) First Commonwealth takes an administrative action which impacts the PCD's participation in the network. If this becomes necessary, the Member will have the opportunity to request another Participating Dental HMO 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 Dental HMO Dentist to complete the service, for the sole benefit of the member.

Refusal of Recommended Treatment

A Member may decide to refuse a course of treatment recommended by his or her PCD or Specialist. The Member can request and receive a second opinion by contacting First Commonwealth's Member Services Department. Second opinion consultations must be approved by First Commonwealth. If the Member still refuses the recommended course of treatment, the PCD or Specialist may have no further responsibility to provide services for the condition involved and the Member may be required to select another PCD or Specialist.

Dental HMO Quality Assessment

Participating Dental HMO Dentists must meet certain standards prior to acceptance in our network. Availability, access to care, license standing, professional liability insurance coverage, emergency care provisions, National Practitioner Data Bank ("NPDB") reports and State Board ("BODEX") histories are some of the factors considered in reviewing an application.

First Commonwealth periodically reviews the care provided through a peer review process. If a Member has any questions or concerns about the care he or she is receiving, the Member is encouraged to review them first with his or her PCD or Specialist. Our Member Services Department is also available to answer any questions or to discuss any concern the Member may have.

Specialty Care Referrals

A Member's PCD is responsible for providing all dental services covered by this Plan. But, certain services may be eligible for referral to a participating Specialist. First Commonwealth 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.

First Commonwealth compensates a participating Specialist the difference between the Specialist's contracted fee for a covered service and the Patient Charge for that service shown in the Covered Dental Services and Patient Charges section. This is the only form of compensation that a participating Specialist receives from First Commonwealth.

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

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a *S*pecialist is required, the PCD must complete the specialty referral request form. At this point, the following options are available:

  (a) The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to First Commonwealth. First Commonwealth will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Specialist to schedule an appointment.

  (b) The PCD may determine that the direct referral to the Specialist fits the referral plan guidelines. If so, the PCD will complete the specialty referral request form and provide this form to the Member and the Specialist. We will retrospectively review the direct referral upon receipt of the Specialist's claim, once the Specialist's procedures or services have been completed.

If the PCD's request for specialty referral is denied (an Adverse Determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. Refer to the Complaint and Appeal Procedures section for additional information.

If the service in question is a covered service and no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

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 under the Plan, the Member will be responsible for the entire amount of the specialist's charge for that service.

A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

When specialty dental care is referred by the PCD, a Member will be referred to a Specialist for treatment. The network includes Specialists 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 Specialist in the Plan's approved Service Area, We will refer the Member to a Non-Participating Dentist of Our choice.

How To Make An Appointment

A Member may schedule appointments with his or her PCD by calling the dentist's office **after the effective date of the Member's coverage.** When You call to schedule an appointment for Yourself or a covered dependent, notify the office that You [4]or Your covered dependent is a Member of First Commonwealth's dental Plan. Be aware that You, like all other patients at your dentist's office, may need to wait longer for appointments at peak times (e.g. evenings, weekends). If You are flexible about time and days, You should generally expect to receive a routine appointment within several weeks of calling.

Canceled Appointments

The time set aside for a Member's appointment is very valuable to Your dentist. **Therefore, if a Member cannot keep an appointment, notify the dentist's office at least 24 hours in advance.** A charge may be assessed for broken appointments with less than 24-hours notice. Frequent broken appointments can result in the Member's inability to establish and maintain a satisfactory dentist-patient relationship and thereby jeopardize our ability to provide the Member with ongoing coverage.

Emergency Dental Services

Emergency Dental Services mean the provision of dental care for the sudden, acute dental condition or trauma to the mouth, teeth or cavity which would lead a prudent layperson, who possesses an average knowledge of dentistry, to believe that failure to receive immediate dental care to result in serious impairment to the dentition or would place the person's oral health in serious jeopardy. Services related to the initial emergency condition but not required specifically to relieve an acute dental condition or trauma to the mouth, teeth or cavity, including services performed at the emergency visit and services performed at subsequent visits, are not considered emergency dental services.

A Member should contact his or her PCD who will arrange for Emergency Dental Services, but if the Member's PCD is unavailable he or she can seek treatment from any Dentist that can provide care. The Member must submit to First Commonwealth: (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 30 days or as soon as reasonably possible. First Commonwealth will reimburse the Member for the cost of covered Emergency Dental Services, less the applicable Patient Charge(s).

Follow-up care, if needed, should be provided by the Member's PCD.

Urgent Dental Services

Urgent Dental Services mean only covered, bona fide urgent services which are reasonably necessary to relieve the sudden onset of considerable pain and discomfort. Services related to the initial urgent condition but not required specifically to relieve pain or discomfort are not considered urgent dental services.

A Member should contact his or her PCD who will arrange for Urgent Dental Services. All general dentists are required to have arrangements for Urgent Dental Services 24 hours a day, 7 days a week.

A Member may require Urgent 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 First Commonwealth's Member Services Department for an authorization to obtain services from another dentist. The Member must submit to First Commonwealth: (a) the bill incurred as a result of the urgency; (b) evidence of payment; and (c) a brief explanation of the urgency. This should be done within 30 days

or as soon as reasonably possible. First Commonwealth will reimburse the Member for the cost of covered Urgent Dental Services, less the applicable Patient Charge(s).

When Urgent Dental Services are provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by First Commonwealth, coverage is limited to the benefit for palliative treatment (code D9110) only.

Follow-up care, if needed, should be provided by the Member's PCD.

Identification Cards

Each Member will receive an identification (ID) card. The ID card will show the Member's name. A Member need only contact his or her assigned PCD's office to obtain services. The ID card will show the First Commonwealth Member Services Department phone number and the address to send any Emergency Dental Services claim forms or other correspondence to First Commonwealth.

The ID card serves as a reminder of the Plan under which the Member is enrolled and of the PCD assigned to the Member. The ID card is not needed to schedule an appointment. The ID card is only issued for the Member's convenience, and is not a guarantee of coverage.

Patient Charges (Your Payment Responsibilities)

Patient Charges are the Member's portion of the cost of covered dental services that the Member is responsible for paying to the Participating Dental HMO Dentist directly at the time the service, treatment or procedure is rendered. The Covered Dental Services and Patient Charges section lists the dental services, treatments and procedures that are covered dental services under this Plan and the applicable Patient Charges.

Compensation of Participating Dentist

First Commonwealth compensates its participating general dentists through a capitation agreement by which they are paid a fixed amount each month. The amount a participating general dentist is paid is based upon the number of Members who have the dentist assigned as their PCD. First Commonwealth may also make minimum monthly payments, supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation a participating general dentist receives from First Commonwealth. The dentist also receives compensation from Members who may pay an office visit charge for each office visit and a Patient Charge for specific dental services. The schedule of Patient Charges is shown in the Covered Dental Services and Patient Charges section of this Plan.

Automatic Renewal of Coverage

Your coverage will automatically be renewed each year unless You notify Us of Your intent to terminate coverage no later than thirty-one days prior to the renewal date.

Termination of Coverage

Plan Benefits may be terminated for any of the following reasons:

1. Upon the Member's failure to meet the eligibility requirements.
2. A Member's failure to pay applicable Patient Charges wihin 30 days of the due date on the bill.
3. Upon discovering intentional misrepresentation of material facts (fraud) in obtaining coverage.
4. Upon permitting the use of a Member's identification card by another person, or using another person's identification card to obtain care to which one is not entitled.
5. Failure to pay a Premium in accordance with this Plan's Grace Period.
6. Upon the Member's threatening behavior toward a provider or his or her staff.

Coverage for a Planowner [4]and his/her Dependents will terminate according to the terms of this Plan, except for any of the reasons (1-6) above when termination is immediate. In the event coverage is terminated, the Member shall become liable for charges resulting from treatment received after termination.

GRIEVANCE PROCESS

Overview: Members are entitled to have any grievance reviewed by First Commonwealth and to be provided with a resolution in a timely manner. 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 Plan, 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, adverse determinations, utilization review appeals, and professional and ethical considerations.

Definitions: As used with respect to the Grievance Process:

"**Grievance"** means any complaint or 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 because services are covered at the PCD's office; a determination that a procedure is not a covered dental service; an adverse determination; a utilization review appeal; 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.

First Commonwealth will not treat inquiries as grievances. However, if First Commonwealth cannot determine if a Member's issue is an inquiry or a grievance, the issue will be treated as a Grievance.

"Adverse Determination" means a determination by First Commonwealth or a Utilization Review Agent that a proposed or delivered dental service, by specialty care referral, which would otherwise be a covered dental service, is or was not a medically necessary service and may result in non-coverage of the dental procedure.

"Medically Necessary Service" means a covered dental service, requested by specialty care referral, which is: (1) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (2) consistent with nationally accepted standards of practice.

"Utilization Review Agent" means an entity that conducts utilization review for First Commonwealth.

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

"**QCL"** means First Commonwealth's Quality of Care Liaison or a person designated to act on behalf of the Quality of Care Liaison.

"Member" means the Member or a person designated to act on behalf of the Member.

"Dental Director" means First Commonwealth's Dental Director or a person designated to act on behalf of the Dental Director.

Grievance Process:

1. Questions or concerns may be directed by the Member to First Commonwealth either by telephone or by mail. The Member Services Department may be reached at 1-866-494-4542 between 8:00 a.m. and 7:00 p.m., CST, or by mail sent to:

   First Commonwealth
   Complaints & Grievances
   P.O. Box 2474
   Spokane, WA 99210-2474

   When a Member's issue or concern is received by telephone, a Member Services Representative documents the call in the Call Log and works with the Member to resolve the issue. If the Member's concern is beyond the scope of the issues routinely handled by the Member Services Department, the concern will be forwarded to the QCL. All Member issues handled by the QCL are recorded in the Patient Inquiry Resolution Team database.

2. The Member will be sent a Grievance Form or a Member Request Form to complete, with instructions on how to collect and submit proper documentation, including Authorization for Records from dentists who are not Participating Dental HMO Dentists. The Member may ask his or her assigned PCD for help in completing a Grievance Form.
3. No later than 5 business days after receipt of the Grievance Form, an acknowledgment letter is sent to the Member indicating that a review is taking place and the Grievance will be responded to within 30 days in a resolution letter. With the acknowledgement, the Member will receive a request for any additional information that may be needed by the QCL to complete the investigation.
4. Under the supervision of the QCL, supporting documentation is collected with respect to the Grievance. The Member's PCD 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. First Commonwealth may arrange a second opinion, if appropriate. If resolution of the Grievance takes longer than 30 days, First Commonwealth will inform the Member, in writing, of the reason for the delay and the anticipated time for completion of the resolution.
5. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. Quality of care issues or potential quality of care issues are resolved under the supervision of the 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.
6. 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 before they are sent to Members. The Dental Director will indicate his/her review of available documentation by initialing a copy of the resolution letter.
7. The resolution letter to the Member will detail in a clear, concise manner the reasons for First Commonwealth's decision. For Grievances involving the delay, denial or modification of dental services, the response letter will describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If First Commonwealth, or one of our clinical reviewers, makes a determination delaying, denying or modifying dental services based on a finding that the proposed dental services are not covered dental services; the letter will clearly specify the contract provisions that exclude coverage of such services.
8. Within 30 days following receipt of a resolution letter, a Member may appeal the decision with First Commonwealth. Additional time may be requested due to a Member's extraordinary circumstance.
9. Members may file a Grievance with the Illinois Department of Insurance before or after completing the Grievance Process or submitting an appeal. The State of Illinois Department of Insurance may be contacted at:

Consumer Service Department
Illinois Department of Insurance
320 West Washington
Springfield, IL 62767

or

Illinois Department of Insurance
122 S. Michigan Avenue, Suite 1900
Chicago, IL 60603

10. First Commonwealth will record all Grievances, call logs, Member correspondence, and resolutions in a suitable relational database, and will keep all copies of Grievances and the responses to Grievances for a period of 5 years.

Grievances Requiring Expedited Review: First Commonwealth will review Grievances on an expedited basis when the Grievances involve Emergency Dental Services.

In such situations, the Member must notify First Commonwealth immediately so that First Commonwealth staff can make the required expedited determination.

- 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.

LIMITATIONS, CONDITIONS, EXCLUSIONS

- 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 t*he Covered Dental Services and Patient Charges section.
- Medical necessity services must be preauthorized.

Limitations:

1. 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 Specialist 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 Specialist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
2. Fluoride treatment (D1203, D1204, D1206, D1208) – four (4) in any twelve (12) month period.
3. 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.
4. Routine examinations/evaluations (D0120, D0140. D0145, D0150, D0170, D0180) – one (1) every six (6) months per dentist in an office setting; every twelve (12) months in a school setting.
5. Full mouth x-rays – one (1) set in any three (3) year period.
6. Bitewing x-rays – two (2) sets in any twelve (12) month period.
7. Panoramic x-rays – one (1) in any three (3) year period.
8. Sealants – limited to permanent teeth, up to the 19th birthday – one (1) per tooth in any three (3) year period.
9. 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.
10. Periodontal soft tissue graft procedures (D4270, D4271, D4277, D4278) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
11. Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
12. Urgent dental services when more than fifty (50) miles from the Primary Care Dentist's office – limited to a $50.00 reimbursement per incident.
13. Urgent dental services when provided by a dentist other than the member's assigned PCD, and without referral by the PCD or authorization by First Commonwealth – limited to the benefit for palliative treatment (D9110) only.
14. Reline of a complete or partial denture – one (1) per denture (upper and lower) in any twelve (12) month period.
15. Rebase of a complete or partial denture – one (1) per denture (upper and lower) in any twelve (12) month period.

16. Second Opinion Consultation – when approved by Us, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan.

Conditions:

1. 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 the Member must pay.

2. 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 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 written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the Member must pay, and to fully document informed consent.

   - If any of the recommended alternate services is selected by the Member and is 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.
   - The Member can request and receive a second opinion by contacting Member Services in the event he or she has questions regarding the recommendations of the PCD or Specialist.

3. 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 (upper and lower) 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.

4. Pediatric Specialty Services -

   If during a Primary Care Dentist visit, a Member under age eight (8) is unmanageable, the Primary Care Dentist may refer the Member to a Participating Pediatric Specialist for the current treatment plan only. Following completion of the approved pediatric treatment plan, the Member must return to the Primary Care Dentist for further services. If necessary, we must first authorize subsequent referrals to the Participating Specialist.

5. Orthodontic Treatment -

   The Plan covers orthodontic services listed under Covered Dental Services and Patient Charges. Limited to one course of treatment per Member. We must preauthorize treatment, and treatment must be performed by a Participating Orthodontic Specialist.

   The Plan covers up to twenty-four (24) months of comprehensive orthodontic treatment. If treatment beyond twenty-four (24) months is necessary, the Member will be responsible for each additional month of treatment, based upon the Participating Orthodontic Specialist's contracted fee.

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

   If a Member transfers to another Orthodontic Specialist 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 Specialist 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 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.

6. Treatment In Progress -

   1. Treatment in progress: Restorative Treatment – Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed

when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are listed as Covered Services and were started but not completed prior to the Member's eligibility to receive benefits under this Plan, have a Patient Charge equal to 85% of the Participating General Dentist's usual fee (there is no additional charge for high noble metal).

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

3. Treatment in progress: Orthodontic Treatment - Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are listed on the Covered Dental Services and Patient Charges Section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a Participating Orthodontic Specialist who is willing to complete the treatment, including retention, at a patient charge equal to 85% of the Participating Orthodontic Specialist's usual fee.

7. General anesthesia / IV sedation / Nitrous oxide / Non-intravenous conscious sedation – General anesthesia, IV sedation, nitrous oxide or non-intravenous conscious sedation is limited to services provided by a Participating Oral Surgery Specialist. Not all Participating Oral Surgery Specialists offer these services. The Member is responsible to identify and receive services from a Participating Oral Surgery Specialist willing to provide general anesthesia or IV sedation. The Member's Patient Charge is shown in the Covered Dental Services and Patient Charges section.

8. Multiple Crown and Bridge Unit Treatment Plan – 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.

9. 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.

Exclusions:

This Plan does not pay benefits for the following:

1. 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.
2. Dental services performed in a hospital, surgical center, or related hospital fees, unless actual emergency treatment is rendered at a hospital or trauma center, where the Member has sustained trauma to the teeth, mouth or oral cavity area, which qualify such serious injuries for emergency treatment.
3. 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.
4. Any histopathological examination or other laboratory charges.
5. Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
6. Any oral surgery requiring the setting of a fracture or dislocation.
7. Placement of osseous (bone) grafts.
8. Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
9. 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.
10. Precision attachments, stress breakers, magnetic retention or overdenture attachments.
11. The use of: (a) intramuscular sedation or (b) oral sedation.
12. 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.
13. Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
14. Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
15. 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.
16. Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
17. 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.
18. Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
19. 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.
20. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
21. Treatment which requires the services of a Prosthodontist.
22. Treatment which requires the services of a Pediatric Specialist, after the Member's 19th birthday.
23. Consultations for non-covered services.

24. Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.
25. 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.
26. Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress - Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be: (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be: (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.)
27. 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.)
28. 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.)
29. Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which are covered under the Plan as Emergency Dental Services.
30. 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 are covered under the Plan as Emergency Dental Services.
31. 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.)
32. Extractions performed solely to facilitate orthodontic treatment.
33. Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
34. Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
35. Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
36. 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.
37. Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
38. 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.
39. Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
40. Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.