MANAGED DENTALGUARD, INC.
4 Campus Drive
Parsippany, New Jersey 07054

INDIVIDUAL DENTAL BENEFITS PLAN

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

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

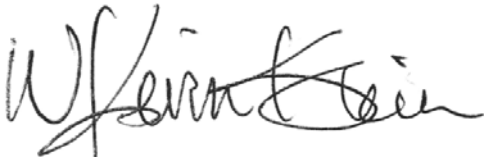
Premiums are payable by the Planowner as hereinafter provided. The first premium is due on the Plan Effective Date, and subsequent premiums are due, during the continuance of this Plan, the first day of each month.

The provisions set forth on the following pages are part of this Plan.

This Plan takes effect on the Plan Effective Date specified above, and terminates on the last day of the month one year later if not renewed.

In witness whereof, MDG has caused this Plan to be executed as of its date of issue.

Managed DentalGuard, Inc.



Kevin Klein, President,

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Premium Rates

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

Your monthly premium rates appear on Your Payment Notice.

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

GENERAL PROVISIONS

Effective Date This Plan will: (a) be effective on the Plan effective date shown on the face page of this Plan; and (b) will continue until the last day of the month in which the termination of this Plan occurs. All coverage under the Plan will begin and end at 12:01 A.M., Eastern Time.

Premiums The first premium payment for this Plan is due on the Plan effective date. Further payments will be made on the first day of each month for each month this Plan is in effect. You must pay premiums due under this Plan at an office of MDG or to a representative that We have authorized.

The initial premium is set forth on the application. The premium is paid by You, unless other provisions for payment are agreed to in advance by MDG.

We may change such rates on the first day of any month. We must give You 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.

Limitation Of Authority No agent is authorized: (a) to alter or amend this Plan; (b) to waive any conditions or restrictions contained in this Plan; (c) to extend the time for paying a premium; or (d) to bind MDG by making any promise or representation or by giving or receiving any information.

No change in this Plan will be valid unless evidenced by: (a) an endorsement or rider to this Plan signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of MDG; or (b) an amendment to this Plan signed by the Planowner and by one of the aforesaid officers of MDG.

Entire Contract This Plan, including any amendments thereto and application, constitutes the entire agreement of the parties. This Plan may only be modified by a writing executed by the parties.

Incontestability This Plan will be incontestable after two years from its effective date, except for non-payment of premiums.

No written statement in any application, except a materially fraudulent statement, made by a person covered under this Plan will be used in contesting the validity of his or her coverage or in denying a claim for a loss incurred, after such coverage has been in force for two years during his or her lifetime.

If this Plan replaces the plan of another company, We may rescind this Plan based on material misrepresentations made in a signed application for up to two years from the Plan effective date.

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

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

Statements No statement will void the coverage under this Plan, or be used in defense of any claim hereunder unless: (a) in the case of the Planowner, it is contained in the application signed by him or her; or (b) in the case of a Member, it is contained in a written instrument signed by him or her. All statements will be deemed representations and not warranties.

Claims Of Creditors Except when prohibited by the laws of the jurisdiction in which this Plan was issued, the coverage under this Plan will be exempt from execution, garnishment, attachment or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Examinations We have a right to have a doctor or Dentist of Our choice examine a person for whom a claim is being made under this Plan as often as may be reasonably necessary. We will pay for all such examinations.

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

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

Renewal Of Plan The Planowner may renew this Plan for a term of one (1) year, on the first and each subsequent Plan Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Plan's Adjustment Of Premiums section and to the provisions stated below.

We have the right to non-renew this Plan on the Plan Anniversary following written notice to the Planowner for the following reasons:

1. subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
2. subject to 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage;
3. subject to 90 days advance written notice the Board terminates a standard plan or a standard plan option; or
4. with respect to coverage issued through the marketplace, decertification of the plan.

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item 4. above will be subject to marketplace requirements, if any.

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures: You may enroll Yourself and Your Dependents for dental coverage by: (a) filling out and signing an enrollment form; and (b) returning the enrollment material to MDG. You will forward these materials to MDG.

The enrollment materials require the selection of a Primary Care Dentist (PCD) for each Member. After the enrollment material has been received by MDG, We will determine if a Member's selected PCD is available in this 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. A Member need only contact his or her assigned PCD's office to obtain services.

MDG will issue each Member, either directly or through Your representative, an MDG ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

Open Enrollment Procedures: The open enrollment period is the designated period of time each year during which:

1. individuals are permitted to enroll in the Individual Dental Benefits Plan; and
2. individuals who already have coverage may replace current coverage with a different Individual Dental Benefits Plan.

Special Enrollment Period. A period of time that is no less than 60 days following the date of a triggering event during which:

1. individuals are permitted to enroll in an Individual Dental Benefits Plan; and
2. individuals who already have coverage are allowed to replace current coverage with a different Individual Dental Benefits Plan

A triggering event is an event that results in an individual becoming eligible for a Special Enrollment Period.
Triggering events are:

1. The date a Member loses eligibility for minimum essential coverage, or the Member's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
2. The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
3. The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
4. The effective date of a marketplace redetermination of a Member's subsidy, including a determination that a Member is newly eligible or no longer eligible for a subsidy.
5. The date a Member acquires a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
6. The date a Member who is covered under an individual dental benefits plan or group dental benefits plan moves out of that plan's service area.
7. The date of a marketplace finding that it erroneously permitted or denied a Member enrollment in a qualified health plan.
8. The date the Member demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

Note: The terms minimum essential coverage, marketplace, qualified health plan and subsidy have the meanings set forth in N.J.A.C. 11:20-1.2.

When Coverage Starts: Coverage starts on the date shown on the face page of this Plan for all Members enrolled on or before the Plan effective date. Coverage for a new Member starts on: (a) the first day of the month following the date enrollment materials were received by MDG; or (b) the first day of the month after the end of any waiting period You may require.

When Dependent Coverage Starts: Except as stated below, Dependents shall 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 the Dependent is a newborn child, his or her coverage begins on the date of birth. If the Dependent is: (a) a stepchild; or (b) a foster child, coverage begins on the date that child begins to reside in the home. If the Dependent is an adopted child, coverage begins on the date that the child is subject to a legal suit for adoption. If a newborn child, adopted child or foster child becomes covered under this Plan, You must complete enrollment materials for such Dependent within 30 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 30 days.

When Coverage Ends: Subject to any continuation of coverage privilege which may be available to a Member, a Member's coverage under this Plan ends when the Planowner's coverage terminates. A Member's coverage also ends on the first to occur of:

1. The end of the period for which the last premium payment is made for a Member;
2. The end of the month in which the Member is no longer eligible for coverage under this Plan;
3. The end of the month in which a Dependent is no longer a Dependent as defined in this Plan
4. The date on which the Member no longer resides or works in the Service Area;
5. The end of the month during which You receive written notice from the Member requesting termination of coverage, or on such later date as requested by the notice;
6. The date of entry of a Member into active military duty. But, coverage will not end if the Member's duty is temporary. Temporary duty is duty of 31 days or less;
7. 30 days after MDG sends written notice to a Member advising that his or her coverage will end because the Member has: (a) knowingly given false information in writing on his or her enrollment form; or (b) misused his or her ID card or other documents provided to obtain benefits under this Plan; or (c) otherwise acted in an unlawful or fraudulent manner regarding Plan services and benefits; or
8. 30 days after MDG sends written notice to a Member, where MDG has: (a) addressed the failure of the Member and his or her PCD to establish a satisfactory patient-dentist relationship; (b) offered the Member the opportunity to select another PCD; and (c) described the changes necessary to avoid termination.

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

Extended Dental Expense Benefits: If a Member's coverage ends, We extend dental expense benefits for him or her under this Plan as explained below.

Benefits for orthodontic services end at the termination of the Member's coverage under this Plan. We extend benefits for covered services other than orthodontic services only if the procedure(s) are: (a) started before the Member's coverage ends; and (b) are completed within 90 days after the date his or her coverage ends. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. Root canal is started when the pulp chamber is opened.

The extension of benefits ends on the first to occur of: (a) 90 days after the Member's coverage ends; or (b) the date he or she becomes covered under another Plan which provides coverage for similar dental procedures. But, if the Plan which succeeds this Plan excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the Member's coverage ends.

We do not grant an extension if the Member voluntarily terminates his or her coverage. And what We pay is based on all the terms of this Plan.

Extended Dental Expense Benefits During a Period of Total Disability: If a Member is totally disabled on the date this Plan ends, We extend dental expense benefits for him or her under this Plan as explained below.

We only extend benefits for covered charges for dental procedures, if the procedures are: (a) In connection with a specific accident or illness incurred while the Plan was in effect; and (b) are performed within 90 days after the date the Member's coverage ends.

We do not grant an extension if the Member's coverage ends because he or she failed to make required payments. And what We pay is based on all the terms of this Plan.

A Member is totally disabled if, due to sickness or injury, he or she cannot perform the main duties of his or her occupation. A Covered Dependent is totally disabled if, due to sickness or injury, the Covered Dependent cannot perform the normal activities of someone of the same age. You must submit evidence to Us that he or she or his or her Dependent is totally disabled, if We request it.

DENTAL BENEFITS PLAN

This Plan will cover many of a Member's dental expenses. MDG decides: (a) the requirements for benefits to be paid; and (b) what benefits are to be paid by this Plan. We also interpret how this Plan is to be administered. What We cover and the terms of coverage are explained below. But, decisions made by MDG may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Managed DentalGuard – This Plan's Dental Coverage Organization

Managed DentalGuard: This Plan is designed to provide quality dental care while controlling the cost of such care. To do this, this Plan requires Members to seek dental care from Participating Dentists that belong to the Managed DentalGuard network (MDG network). The MDG network is made up of Participating Dentists in the Plan's 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 current MDG Participating General Dentists. Each Member must be assigned to a Primary Care Dentist (PCD) from this list of Participating General Dentists. This PCD will coordinate all of the Member's dental care covered by this Plan. After enrollment, a Member will receive a MDG ID card. A Member must present this ID card when he or she goes to his or her PCD.

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

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

Choice Of Dentists: An adult Member may request any available Participating General Dentist as his or her PCD. You may request any available Participating General Dentist as your child member's PCD.. A request to change a PCD must be made to MDG. Any such change will be effective the first day of the month following approval; however, MDG may require up to 30 days to process and approve any such request. All fees and Copayments due to the Member's current PCD must be paid in full prior to such a transfer.

Right to Reassign Member: MDG reserves the right to reassign Members to a different Participating Dentist in the event that either: (a) the Member's Dentist is no longer a Participating Dentist in the MDG network; or (b) MDG takes an administrative action which impacts the Dentist's participation in the network. MDG will notify the Member of the Dentist's network status change in writing as soon as reasonably possible. If 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, MDG will, in its discretion and subject to applicable law, either: (a) arrange for completion of the service by the original Dentist; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service.

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.

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

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

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

MDG compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount each month. The amount a Participating General Dentist is paid is based upon the number of Members who have the Dentist assigned as their PCD. These are the only forms of compensation a Participating General Dentist receives from MDG. The Dentist also receives compensation from Members who may pay an office visit copayment for each office visit and a Copayment for specific dental services. The schedule of Copayments is shown in the Covered Dental Services and Copayment section of this Plan.

Specialty Care Referrals: A Member's PCD is responsible for providing all covered services covered by this Plan. But, certain services may be eligible for referral to a Participating Specialist. MDG will pay for covered services for specialty care, less any applicable Copayments, when such specialty referral services are provided in accordance with the specialty referral process described below.

MDG compensates a Participating Specialist the difference between the Specialist's contracted fee for a covered service and the Copayment for that service shown in the Covered Dental Services and Copayments section. This is the only form of compensation that a Participating Specialist receives from MDG.

ALL SPECIALTY CARE REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY MDG; 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 MDG IS RESPONSIBLE FOR ALL CHARGES INCURRED, EXCEPT: (A) WHEN THIS PLAN IS A SECONDARY PLAN OR (B) WHEN THE SPECIALTY DENTAL CARE IS IN THE CASE OF DENTAL EMERGENCY FOR A MEMBER WHO IS AGE 19 OR OLDER.

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 Specialist is required, the Member's PCD must contact MDG and request authorization.

3. If the PCD's request for specialty referral is approved, MDG 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 specialty referral is denied as not medically necessary (an adverse determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial. (See Grievance Procedure section.)

5. If the service in question: (a) is a service covered by this Plan; and (b) no limitations, conditions or exclusions 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, limitations, conditions and exclusions will determine coverage in all cases. If a referral is made for a service that is not a service covered by this 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 care services must pay all applicable Copayments for the services provided.

When specialty dental care is authorized by MDG, a Member will be referred to a Participating Specialist for treatment. The MDG network includes Participating Specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Plan's approved Service Area. If there is no Participating Specialist in the Plan's approved Service Area, MDG will refer the Member to a Non-Participating specialist of MDG's choice. In no event will MDG pay for dental care provided to a Member by a Specialist not pre-authorized by MDG to provide such services, except: (a) when this Plan is a secondary Plan or (b) when the specialty dental care is in the case of dental emergency for a Member who is age 19 or older. And, the Member must have the right to appeal any denial of specialty dental care.

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

A Member may require Emergency Dental Services when he or she is unable to obtain services from his or her PCD. The Member must submit to MDG: (a) the bill incurred as a result of the emergency; (b) evidence of payment; and (c) a brief explanation of the emergency. This should be done within 60 days or as soon as reasonably possible. MDG will reimburse the Member for the cost of covered Emergency Dental Services, less the applicable Copayment(s).

Cost Sharing Reduction Entitlement: There is no Coinsurance credit from previous coverage unless the Member is entitled to a cost sharing reduction under Federal law and as a result of an eligibility change replaces a prior plan issued by Us with this Plan where both Plans have the same classification of coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Procedures for Adverse Determination Appeals

Definitions: As used for these procedures:

"Adverse dental decision" means a dental decision made by MDG or a person acting on its behalf to deny, reduce or fail to provide payment, in whole or in part, for a covered service based upon that dental decision.

"Appeal" means a request to review and reconsider an adverse decision and is considered to be a grievance.

"Board" means the New Jersey State Board of Dentistry.

"MDG" means the health maintenance organization Managed DentalGuard, Inc. (MDG), an Authorized Dental Plan Organization in New Jersey, permitted to issue dental contracts or Policies in New Jersey.

"Complaint" means a telephone call or letter from a covered person, his or her representative or Dentist in regard to the Plan administration, availability, delivery and quality of care, but, does not include an adverse dental decision.

"Dental decision" means a decision based on a dental diagnosis or judgment related to dental services performed or to be performed in the State of New Jersey. This includes, but is not limited to, a decision that relates to: (a) the quality or appropriateness of dental services rendered or proposed to be rendered by a Dentist; (b) reasonable necessity for a dental service; (c) customary performance of a dental service; or (d) diagnosis and/or prognosis of a dental condition.

Dental Decisions Made by MDG: Dental decisions made by MDG for the processing and payment of dental claims or in the course of their dental benefit administrative activity shall be consistent with the following procedures.

Initial Adverse Determination: The initial adverse dental decision must be made by a Dentist duly licensed in this or another state. The initial adverse letter shall be sent when services are denied due to an adverse dental decision.

NOTE: A New Jersey appeal consent form must be completed by the covered person. If the treating Dentist or any party other than the covered person appeals the initial dental decision, the consent form should accompany that initial appeal. Only one consent form is needed for all appeal levels. If a consent form is asked for and a completed form is not received within 45 calendar days of the date of the request, notice will be sent that the appeal could not be performed.

Appeal Review: If the treating Dentist does not agree with the initial adverse dental decision, he or she shall specify in writing the details of the basis for his or her appeal of the decision. Within 30 days, the company shall designate a reviewing Dentist who is authorized to perform these appeals. The company will promptly notify the treating Dentist in writing of the name, address and telephone number where the reviewing Dentist can be contacted. If an agreement is not reached within a reasonable period of time, not to exceed 30 days from the date the notice of the

contact information is provided, the company will make its decision and advise the treating Dentist of the reviewing Dentist's decision.

Within 14 days of a written request by the treating Dentist, the patient or the patient's representative for the basis of an adverse dental decision by the reviewing Dentist that was provided to the treating Dentist as described above, the company shall send a written notice that contains the reviewing Dentist's name, address and telephone number and a narrative statement identifying the basis for the decision.

Complaint and Appeals Process

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

It is generally recognized that complaints may be classified into two categories:

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

Health Services: quality of care; access; availability; standards of care; benefits and coverage; professional and ethical considerations.

The Member or Dentist may contact the Member Services Department or the Quality of Care Liaison (QCL) to review a concern or file a complaint.

"Complaint" means any dissatisfaction expressed by a Member, the Member's designated representative or the Member's Dentist, by telephone or in writing, regarding the Plan's operation, including but not limited to Plan administration; denial of access to a referral; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; and disenrollment decisions. This term does not include: (a) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Member; or (b) a Dentist's or Members oral or written expression of dissatisfaction or disagreement with an adverse determination, (i.e., a complaint involving an adverse determination).

Member Services and the QCL can be contacted by telephone at:

1-866-569-9900

or by mail at:

8890 Cal Center Drive, Sacramento CA 95826

The plan hours are from 6:00 a.m. to 6:00 p.m. Pacific Time. A Member may leave a message when calling after business hours, weekends, or holidays.

If a Member has a complaint with respect to the resolution of an Appeal of an Adverse Determination, including denials based on the nature of the benefits that are described in the Plan, such as procedures that are covered or not covered, frequency limits, timely premium payments, and eligibility, the Member may contact the Department of Banking and Insurance (DOBI) at:

New Jersey Department of Banking and Insurance
Consumer Protection Services
P.O. Box 329
Trenton, New Jersey 08625-0329

OR

Office of Insurance Claims Ombudsman
20 West State Street
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
(outside of NJ call 609-292-5316 and ask for the Ombudsman's Office)
Fax: 609-292-2431
Email: ombudsman@dobi.state.nj.us

Complaint Process

Members make their concerns known by either calling the MDG Member Services Department by using the toll-free telephone number or by directly contacting MDG in writing.

Member Service Representatives document each telephone call and work with the Member to resolve their oral Complaint. If a Member's concern is regarding: Plan administration; denial of access to a referral; a determination that a benefit is not covered under the Plan; the denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions, the Member will be sent, within 5 days from the date of receipt of the telephone call, an acknowledgement letter and a Complaint Form to complete if the Member desires additional review.

The Complaint Form states that it must be returned within 30 days to the QCL and that the Member will receive a response to the Complaint within 15 days from receipt of the Complaint Form.

Upon receipt of a written Complaint or the Complaint Form, the QCL or QCL designee sends an acknowledgment letter to the Member within 5 business days.

MDG will review and resolve the written Complaint within 15 working days after the date of receipt. The QCL or QCL designee is responsible for obtaining the necessary documentation; building a case file; and researching remaining aspects of the Complaint and any additional information. MDG may arrange a second opinion, if appropriate. Upon receipt of complete documentation, a resolution is determined by the QCL or QCL designee. Any issue involving a matter of quality of care will be reviewed with the Dental Director or the Director's designee and, if needed, with the Vice President of Network Management, legal counsel, and/or the Complaint Committee and/or the Peer Review Committee.

The QCL or QCL designee is responsible for writing a resolution letter to the Member indicating the outcome of the review and the specialization of the Dentists consulted, if applicable. Treatment plans and procedures; general Dentist and/or specialty care Dentist clinical findings and recommendations; Plan guidelines, benefit information and contractual reasons for the resolution will be described, as appropriate. A copy of the Plan's appeal process will be enclosed with each resolution letter in the event the Member elects to have his or her Complaint re-evaluated.

Complaints regarding an Adverse Determination will be handled according to the established process outlined in the Procedures for Adverse Determination Appeals, above.

MDG asserts it is prohibited from retaliating against a group Planowner or a Member because the group Planowner or Member has filed a Complaint against the Plan or appealed a decision of the Plan. The Plan is prohibited from retaliating against a Dentist or network provider because the Dentist or network provider has, on behalf of a Member, reasonably filed a Complaint against the Plan or appealed a decision of the Plan.

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

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

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

The Complaint Committee and the Peer Review Committee will meet quarterly and as needed. Minutes will be compiled for each Committee Meeting and will be maintained in the office of MDG. Minutes of the meetings will be forwarded to the Quality Improvement Committee and the Board of Directors.

Complaint Appeal Process: If the Member is not satisfied with the resolution, the Member may make a telephone or written request within 30 days from the date of the resolution letter that an additional review be conducted by a "Complaint Appeal Committee." The telephone appeal request will be logged in the Member's file and the Member will be asked to send the request in writing. An acknowledgement letter will be forwarded to the Member within 5 business days from receipt of the written request.

This Committee will meet within 30 days of the date the written appeal is received. The Committee is composed of an equal number of:

a. Representative(s) from MDG;
b. Representative(s) selected from Participating General Dentists;
c. Representative(s) selected from Participating Specialists (if the Complaint concerns specialty care); and
d. Representative(s) selected from Plan Members who are not MDG employees.

Members of the Complaint Appeal Committee will not have been previously involved in the Complaint resolution. A representative from the Complaint Appeal Committee panel will be selected by the panel to preside over the Committee.

Within 5 working days from the date of receipt of the written request for an appeal, the Member will be sent written notice acknowledging the date the appeal was received, and the date and location of the Committee meeting. The Member will also be advised that(s)he may either appear in person (or through a representative if the Member is a minor or disabled) before the Committee, or address a written appeal to the Committee. The Member may also bring any person to the Committee meeting (participation of said person subject to MDG's Complaint Appeal Committee guidelines). The Member has the right to present written or oral information and alternative expert testimony, and to question the persons responsible for making the prior determination that resulted in the appeal.

The Committee will meet within the Member's county of residence or the county where the Member normally receives dental care, unless another site is agreeable to the Member.

MDG will make a good faith effort to meet the Member's needs in selecting the site and shall complete the appeals process under this section within 30 calendar days after the date of the receipt of the request for appeal.

Not less than 5 working days prior to the Committee meeting unless the complainant agrees otherwise, the Plan will submit to the Member any and all documentation to be presented to the Committee, and the specialization of any Dentist consulted during the investigation.

The Member will receive a written notice of resolution within 5 working days after the date of the Committee resolution. The resolution notice will include a written statement of the specific medical determination, clinical basis and contractual criteria used to reach the final decision.

The Member will provide for his/her own expenses relating to the Committee process. MDG will pay for its expenses relating to the Committee process. MDG will pay for the expenses of the representative(s) from MDG and representative(s) selected from Participating General Dentists and/or Participating Specialists and the expenses of representative(s) selected from Plan Members. Following the decision of the Committee, the Member and MDG each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Participating Dentist.

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

Emergency Complaints: Complaints involving an emergency will be concluded in accordance with the dental immediacy of the case and shall not exceed 24 hours from the receipt of the Complaint.

If the appeal of the emergency Complaint involves a life-threatening condition, the Member or Member's Designee and Dentist may request the immediate assignment of an IRO without filing an appeal.

Documentation/Database: With MDG's QMP database, it will be possible to track a Member's concern from the initial call through the final resolution of the issue. All steps in the resolution process may be documented in the database. Information will be accessible on groups, Members, and Dentists. The database will be accessed for information for the Quality Improvement Committee, the Complaint Committee and the Credentialing Committee. The database will provide aging reports and the reasons that Complaints are not resolved within 30 days, if applicable.

"Reason Codes" will be used in the database for tracking purposes. Reason Code categories are Access, Benefits and Coverage, Claims, and Quality of Care.

The objectives of the logging system in the database are:

1. Accurate tracking of status of Complaints;
2. Accountability of the different departments/personnel involved in the resolution process; and
3. Trending of the dental providers, Members and groups for appropriate follow-up.

Documentation/Files: Each written Complaint will be logged into the database by the QCL or QCL designee on the date it was received. The Member's data management system is documented that a Complaint has been received and is being reviewed by the QCL or QCL designee. A paper file is created and labeled with the Member's name and social security number. Any subsequent follow-up information is recorded in the file by the QCL or QCL designee. The file is to be kept in the Complaint File for 3 years. The file will include all correspondence regarding the issue, copies of records, radiographs and resolution. Only when a resolution is completed can the Complaint be closed and noted as closed in the Member's file and the database. Complaint files are available for regulatory review.

The Complaint Log will be reviewed quarterly by the Quality Improvement Committee.

Additional Conditions on Covered Services

Crowns, Bridges and Dentures applicable to Members who are age 19 or older: 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.

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 Copayment for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Copayments section.

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. Any services performed by a Pediatric Specialist after the Member's eighth (8^{th}) birthday will not be covered, and the Member will be responsible for the Pediatric Specialist's usual fees.

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 Copayment for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

Orthodontic Treatment: The Plan covers orthodontic services as listed under Covered Dental Services and Copayments. 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 the Treatment in Progress 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 Copayment 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 for Members 19 and above.

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

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

Treatment In Progress:

Treatment in progress: Restorative Treatment – Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are listed as Covered Services and were started but not completed prior

to the Member's eligibility to receive benefits under this plan, have a Copayment equal to 85% of the Participating General Dentist's usual fee (there is no additional charge for high noble metal).

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

Treatment in progress: Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are listed on the Covered Dental Services and Copayments 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 Copayment equal to 85% of the Participating Orthodontic Specialist's usual fee.

General Anesthesia / IV Sedation:: General anesthesia or IV 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 Copayment is shown in the Covered Dental Services and Copayments section.

Limitations On Benefits For Specific Covered Services

Limitations on Benefits for Specific Covered Services applicable to Members who are age 19 or older:

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 shown in the Covered Dental Services and Copayments section.

We do not 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 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.

- Fluoride treatment (D1203, D1204, D1206, D1208, D2999) – four (4) in any twelve (12) month period.

- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.

- Full mouth x-rays – one (1) set in any three (3) year period.

- Bitewing x-rays – two (2) sets in any twelve (12) month period.

- Panoramic x-rays – one (1) 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 fifty (50) miles from the Primary Care Dentist's office – limited to a $50.00 reimbursement per incident.

- Reline of a complete or partial denture – one (1) per denture in any twelve (12) month period.

- Rebase of a complete or partial denture – one (1) per denture in any twelve (12) month period.

- Treatment of jaw joint problems (TMJ) – covered only with prior authorization. Clinical documentation of condition treatment plan and diagnosis to substantiate request required.

- Emergency room services provided by a dentist – evidence of need required to treat lacerations, trauma, and fractures.

- Inpatient hospital services – medical necessary diagnosis required.

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

Exclusions

Exclusions applicable to Members who are age 19 or older:

We will not pay for:

- 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.

- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.

- Any treatment or appliances: (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.

- The use of: (a) intramuscular sedation or (b) oral sedation.

- 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.

- Any Member request for: (a) specialist services or treatment which can be routinely provided by the Primary Care Dentist, or (b) treatment by a specialist without a referral from the Primary Care Dentist and Plan approval, except for Emergency Dental Services.

- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

- Dental services, other than covered Emergency Dental Services, which were performed by any dentist other than the Member's selected and assigned Primary Care Dentist, unless we had provided written authorization.

- Treatment which requires the services of a Prosthodontist.

- Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's (eighth) birthday.

- Consultations for non-covered services.

- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Copayment section.

- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken, and (b) completed when the denture is delivered to the member.)

- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)

- Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Inlays, onlays, crowns, or 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 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 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.

- 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.

Plan Provisions, Exclusions and Limitations

Plan Provisions, Exclusions and Limitations applicable to Members who are under age 19:

Subject to the applicable Copayments shown in the Covered Dental Services and Copayments section, coverage is provided for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision.

- Dental services are available from birth with an age one dental visit encouraged.

- A second opinion is allowed.

- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for; pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures or facial bones or dislocation of the mandible.

- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available, radiographs needed to diagnose and treat will be allowed.

- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.

- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on state of completion.

- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.

- Services that are considered experimental in nature will not be considered.

- This Plan will not cover any charges for broken appointments.

Definitions

Copayment means the amount, if any, specified in the Covered Dental Services And Copayments section of this Plan. Such amount is the patient's portion of the cost of covered dental services.

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

Dependent means a person listed on the Planowner's enrollment form who is any of the following:

(1) Your spouse. Spouse also means a partner to a domestic or civil union when such union is in accordance with New Jersey law. We treat the domestic or civil union partner as a spouse in a marriage, and the

domestic or civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage; or

(2) an unmarried and unpartnered Dependent child of either You or Your spouse who is:

(a) less than 23 years of age, or less than 25 if a full-time student; and

(b) primarily dependent upon You or Your spouse for support and maintenance.

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

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

Emergency Dental Services, for Members who are age 19 or older, means procedures to evaluate and stabilize dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infections that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

Member means You and any of Your Dependents: (a) as defined under the eligibility requirements of this Plan; and (b) as determined by the Planowner, who are actually enrolled in and eligible to receive benefits under this Plan. To be eligible, You and Your Dependents must be United States citizen(s), nationa(s or lawfully present in the United States. Depdendents do not need to be residents of the State of New Jersey.

Non-Participating Dentist means any Dentist that does not have an MDG participation agreement in force with Us to provide services to Members.

Participating Dentist means a Dentist who has an MDG participation agreement in force with Us. This term includes any hygienist and technician recognized by the dental profession who assists and acts under the supervision of such Dentist.

Participating General Dentist means a Dentist who has an MDG participation agreement in force with Us: (a) who is listed in MDG'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 MDG to provide or arrange for a Member's dental services.

Participating Specialist means a Dentist who has an MDG participation agreement in force to provide services to Members as an: (a) Endodontist; (b) Pediatric Specialist; (c) Periodontist; (d) Oral Surgeon; or (e) Orthodontist.

Plan means MDG's Plan of group dental benefits described in this Plan.

Primary Care Dentist (PCD) means a dental office location: (a) at which one or more Participating General Dentists provide covered services to Members; and (b) which has been selected by a Member and assigned by MDG to provide and arrange for his or her dental services.

Service Area means the geographic area in which MDG is licensed to provide for dental services for Members.

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

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

TECHNICAL DENTAL TERMS

ABSCESS
acute or chronic, localized inflammation, with a collection of pus, associated with tissue destruction and, frequently, swelling.

ABUTMENT
a tooth used to support a prosthesis.

ALVEOLAR
referring to the bone to which a tooth is attached.

ALVEOLOPLASTY
surgical procedure for recontouring alveolar structures, usually in preparation for a prosthesis.

AMALGAM
an alloy used in direct dental restorations.

ANALGESIA
loss of pain sensations without loss of consciousness.

ANESTHESIA
partial or total absence of sensation to stimuli.

ANTERIOR
refers to the teeth and tissues located towards the front of the mouth - maxillary and mandibular incisors and canines.

APEX
the tip or end of the root end of the tooth.

APICOECTOMY
amputation of the apex of a tooth.

BICUSPID
a premolar tooth; a tooth with two cusps.

BILATERAL
occurring on, or pertaining to, both sides.

BIOPSY
process of removing tissue for histologic evaluation.

BITEWING RADIOGRAPH
interproximal view radiograph of the coronal portion of the tooth.

BRIDGE
a fixed partial denture(fixed bridge) is a prosthetic replacement of one or more missing teeth cemented or attached to the abutment teeth.

CANAL
space inside the root portion of a tooth containing pulp tissue

CARIES
commonly used term for tooth decay.

CAVITY
decay in tooth caused by caries; also referred to as carious lesion.

CEPHALOMETRIC RADIOGRAPH
a radiographic head film utilized in the scientific study of the measurements of the head with relation to specific reference points.

COMPOSITE
a tooth-colored dental restorative material

CROWN
restoration covering or replacing the major part, or the whole of the clinical crown -(i.e., that portion of a tooth not covered by supporting tissues.)

CROWN LENGTHENING
a surgical procedure exposing more tooth for restorative purposes by apically positioning the gingival margin and removing supporting bone.

CYST
pathological cavity, containing fluid or soft matter.

DEBRIDEMENT
removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an evaluation.

DECAY
the lay term for carious lesions in a tooth; decomposition of tooth structure.

DENTURE
an artificial substitute for natural teeth and adjacent tissues.

DENTURE BASE
that part of a denture that makes contact with soft tissue and retains the artificial teeth.

DIAGNOSTIC CAST
plaster or stone model of teeth and adjoining tissues; also referred to as study model.

DISTAL
toward the back of the dental arch(or away from the midline).

ENDODONTIST
a dental specialist who limits his/her practice to treating disease and injuries of the pulp(root canal therapy) and associated periradicular conditions.

EVULSION
separation of the tooth from its socket due to trauma.

EXCISION
surgical removal of bone or tissue.

EXOSTOSIS
overgrowth of bone.

EXTRAORAL
outside the oral cavity.

FRENULECTOMY
excision of muscle fibers covered by a mucous membrane that attaches the cheek, lips and or tongue to associated dental mucosa.

GINGIVA
soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted, serving as the supporting structure for sub-adjacent tissues.

GINGIVAL CURETTAGE
the surgical procedure of scraping or cleaning the walls of a gingival pocket.

GINGIVECTOMY
the excision or removal of gingiva.

GINGIVOPLASTY
surgical procedure to reshape gingiva to create a normal, functional form.

HEMISECTION
surgical separation of a multirooted tooth so that one root and/or the overlaying portion of the crown can be surgically removed.

HISTOPATHOLOGY
the study of composition and function of tissues under pathological conditions.

IMMEDIATE DENTURE
removable prosthesis constructed for placement immediately after removal of remaining natural teeth.

IMPACTED TOOTH
an unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

IMPLANT
material inserted or grafted into tissue; dental implant - device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement

INCISAL ANGLE
one of the angles formed by the junction of the incisal and the mesial or distal surfaces of an anterior tooth.

INLAY
an intracoronal restoration; a dental restoration made outside of the oral cavity to correspond to the form of the prepared cavity, which is then cemented into the tooth.

INTERCEPTIVE ORTHODONTIC TREATMENT
an extension of preventive orthodontics that may include localized tooth movement in otherwise normal dentition.

INTERIM PARTIAL DENTURE
a provisional removable prosthesis designed for use over a limited period of time, after which it is to be replaced by a more definitive restoration.

INTRAORAL
inside the mouth.

LABIAL
pertaining to or around the lip.

LIMITED ORTHODONTIC TREATMENT

orthodontic treatment with a limited objective, not involving the entire dentition

LINGUAL
pertaining to or around the tongue.

MESIAL
toward the midline of the dental arch.

METALS, CLASSIFICATION OF
The noble metal classification system is defined on the basis of the percentage of noble metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) greater than 60% (with at least 40% Au); noble – Gold (Au), Palladium (Pd), and/or Platinum (Pt) greater than 25%; and predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) less than 25%.

MOLAR
teeth posterior to the premolars (bicuspids) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.

OCCLUSAL ADJUSTMENT, LIMITED
reshaping of the occlusal surfaces of teeth to create harmonious contact relationships between the upper and lower teeth; typically on a "per visit" basis.

OCCLUSAL RADIOGRAPH
an intraoral radiograph made with the film being held between the occluded teeth.

OCCLUSION
any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

ONLAY
a restoration made outside the oral cavity that replaces a cusp or cusps of the tooth, which is then cemented to the tooth.

ORAL SURGEON
a dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases of the oral regions.

ORTHODONTIST
a dental specialist whose practice is limited to the treatment of malocclusion of the teeth

ORTHOGNATHIC
functional relationship of maxilla and mandible.

OVERDENTURE
prosthetic device that is supported by retained teeth roots.

PALLIATIVE
action that relieves pain but is not curative.

PANORAMIC RADIOGRAPH
an extraoral radiograph on which the maxilla and mandible are depicted on a single film.

PARTIAL DENTURE, REMOVABLE
a prosthetic replacement of one or more missing teeth on a framework that can be removed by the patient.

PEDIATRIC DENTIST
a dental specialist whose practice is limited to treatment of children

PERIAPICAL
the area surrounding the end of the tooth root.

PERIODONTAL
pertaining to the supporting and surrounding tissues of the teeth.

PERIODONTAL DISEASE
inflammatory process of the gingival tissues and/or periodontal membrane of the teeth, resulting in an abnormally deep gingival sulcus, possibly producing periodontal pockets and loss of supporting alveolar bone.

PERIODONTIST
a dental specialist whose practice is limited to the treatment of periodontal diseases.

PERIRADICULAR
surrounding a portion of the root of the tooth.

PONTIC
the term used for the artificial tooth on a fixed bridge.

POST
an elongated metallic projection fitted and cemented within the prepared root canal, serving to strengthen and retain restorative material and/or a crown restoration.

POSTERIOR
refers to teeth and tissues towards the back of the mouth(distal to the canines) - maxillary and mandibular premolars and molars.

PRECISION ATTACHMENT
interlocking device, one component of which is fixed to an abutment or abutments and the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it.

PREMOLAR
see bicuspid.

PRIMARY DENTITION
the first set of teeth.

PROPHYLAXIS
scaling and polishing procedure performed to remove coronal plaque, calculus and stains.

PROSTHESIS, DENTAL
any device or appliance replacing one or more missing teeth and/or, if required, certain associated structures.

PROSTHODONTIST
a dental specialist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

PULP
the blood vessels and nerve tissue that occupies the pulp chamber of a tooth.

PULP CAP
procedure in which the exposed or nearly exposed pulp is covered with a protective dressing or cement to maintain pulp vitality and/or protect the pulp from additional injury

PULP CHAMBER

the space within a tooth which contains the pulp.

PULPOTOMY
surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

QUADRANT
one of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth.

RADIOGRAPH
x-ray.

REBASE
process of refitting a denture by replacing the base material.

REIMPLANTATION, TOOTH
the return of a tooth to its alveolus.

RELINE
process of resurfacing the tissue side of a denture with new base material.

RETENTION
the phase of orthodontics used to stabilize teeth following comprehensive orthodontic treatment.

RETROGRADE FILLING
a method of sealing the root canal by preparing and filling it from the root apex.

ROOT
the anatomic portion of the tooth that is located in the alveolus (socket) where it is attached by the periodontal apparatus.

ROOT CANAL
the portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

ROOT CANAL THERAPY
the treatment of disease and injuries of the pulp and associated periradicular conditions.

ROOT PLANING
a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased tooth structure on the root surfaces and in the pocket.

SCALING
removal of plaque, calculus, and stain from teeth.

SPLINT
a device used to support, protect, or immobilize oral structures that have been loosened, replanted, fractured or traumatized.

STRESS BREAKER
that part of a tooth-borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.

STUDY MODEL
plaster or stone model of teeth and adjoining tissues; also referred to as diagnostic cast.

TEMPOROMANDIBULAR JOINT (TMJ)
the connecting hinge mechanism between the mandible (lower jaw) and base of the skull (temporal bone).

TISSUE CONDITIONING
material intended to be placed in contact with tissues, for a limited period, with the aim of assisting their return to healthy condition.

UNERUPTED
tooth/teeth that have not penetrated into the oral cavity.

UNILATERAL
one-sided; pertaining to or affecting but one side.

VENEER

in the construction of crowns or pontics, a layer of tooth-colored material, usually, but not limited to, composite, porcelain, ceramic or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention; also refers to a restoration that is cemented to the tooth.

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