



SUMMIT CARE PLUS

GROUP DENTAL PLAN

Underwritten and managed by Total Dental Administrators Health Plan, Inc. (TDAHP),
domiciled in Arizona, using the DHMO Plan Network.



Dental · Life · Disability · Vision

Welcome to Summit Care Plus

Quality Dental Insurance, Redefined.

PLEASE RETAIN THIS BOOKLET FOR LIST OF COVERED SERVICES, ENROLLMENT INFORMATION AND HOW TO FIND A PROVIDER.

Summit Care Plus DHMO Plan is a comprehensive, total care group dental program with specialty care marketed, managed and administered by Total Dental Administrators Health Plan, Inc. (TDAHP). Its affiliated company, Total Dental Administrators, Inc. (TDA) has contracted with established private practicing dentists to provide you convenient, affordable and quality dental care.

HOW THE PLAN WORKS

SUMMIT CARE PLUS DHMO COVERAGE INCLUDES:		SUMMIT CARE PLUS ADVANTAGES:
Diagnostic	Refer to the enclosed Schedule of Benefits and Copayments for a detailed listing of covered procedures.	No Deductibles
Preventive		No Claim Forms
Restorative		No Annual or Lifetime Benefit Maximums
Endodontics		No Industry Exclusions
Periodontics		Covers Pre-existing Conditions
Prosthodontics		Covers Orthodontics (Braces)
Oral Surgery		Local Service
TMJ		
Orthodontics		
Cosmetic		

HOW TO ENROLL

1. Complete the enrollment form. Include information about your spouse and/or child(ren) if you are applying for dependent coverage.
2. Select the general dental office you and your dependents wish to use from the Participating Provider Directory located on our website. Each participating dental office listed in the directory has a dental office code number listed to the left of the dental office. Be sure to use the code number to identify your selection on the enrollment form. You may find a list of DHMO providers at TDAdental.com.
3. If employee contributions are required, premium payment is made by payroll deduction. Return your enrollment form in to your employer's personnel office or benefits department for processing.

UNDERSTANDING YOUR PLAN

Your general dentist and this booklet are the keys to your plan. You pay a pre-negotiated price for services provided by your general dentist. This is not a discount plan. There is no cost for preventative cleanings, x-rays and exams, and set copayments for other covered services. Some major services may require laboratory work which will be an additional variable cost to the fixed copayments. The plan does not cover services from out-of-network dentists, except for emergency care. Be sure to review your plan booklet for important plan information such as covered procedures.

DENTAL PLAN INFORMATION

This employee plan booklet explains the benefits, limitations, exclusions, provisions and conditions of your coverage through the Group Agreement your organization has with TDAHP. The Group Agreement is the document which specifies any rights to benefits you may have. If the explanations in this employee plan booklet can be interpreted differently from the provisions of the Group Agreement, the Group Agreement shall always prevail. You may examine the group agreement by contacting your organization or by contacting TDAHP at: 2800 N. 44th St., Suite #500, Phoenix, AZ 85008, toll-free 1 (888)422-1995.

Please read this document with care so that you will have a full understanding of the plan and what it could mean to you and your family. This document is void and of no effect if you are not entitled to or have ceased to be entitled to the dental coverage.

I. ELIGIBILITY

- A. You are eligible if you are an employee, working within an eligible class.
- B. Eligible dependents include your spouse and your child(ren), who are dependent on you for their support, through the last day of the month in which they turn age 26; Newborn and adopted children are covered from the first day of the month following birth or date of placement; Children for whom a court order of support applies.
- C. The date of eligibility is determined by your organization. Newborn children are covered the first day of the month following the date of birth and legally adopted children, foster children, and stepchildren are covered the first day of the month following placement, as long as TDAHP is notified within thirty (30) days and any prepayment fee is paid within that period. Check with your employer organization if you have any questions about when coverage begins.
- D. Dependents of an enrollee who are in active military service are not eligible for coverage under the plan.

The eligibility of all covered persons, for the purpose of receiving benefits under the plan, shall, at all times, be contingent upon the applicable monthly premium payment having been made for such covered persons by the group on a current basis.

For more information please contact us at:

Total Dental Administrators Health Plan, Inc.

2800 N. 44th St., Suite #500

Phoenix, AZ 85008

www.TDAdental.com

Local: (602) 266-1995 Toll Free: 1 (888) 422-1995

SUMMIT CARE PLUS PLAN SAMPLE COST COMPERISON			
ADA Code	PROCEDURE	SUMMIT CARE PLUS PLAN COPAYMENT	PERCENT SAVINGS
	PREVENTIVE/DIAGNOSTIC		
D0210	Complex series x-rays	\$5.00	97%
D0150	Initial oral exam	\$0.00	100%
D1110	Adult - Prophylaxis (cleaning)	\$0.00	100%
D9430	Office Visit	\$0.00	100%
	RESTORATIVE		
D2140	Amalgam - One surface	\$13.00	94%
D2150	Amalgam - two surfaces	\$24.00	90%
D2330	Resin - one surface	\$29.00	83%
D2331	Resin - two surfaces	\$40.00	83%
	CROWN & BRIDGE		
D2750	Crown porcelain, hi noble metal	\$492.00*	61%
D2950	Crown buildup, including any pins	\$80.00	75%
	ENDODONTICS		
D3310	Root canal therapy - anterior	\$195.00	80%
D3330	Root canal therapy - molar	\$399.00	69%
	ORAL SURGERY		
D7140	Extraction, erupted tooth exposed roots	\$40.00	81%
D7220	Soft tissue impaction	\$90.00	75%
	PROSTHETICS		
D5110	Complete denture - maxillary	\$615.00*	71%
D5212	Partial denture - mandibular	\$550.00*	71%
	PERIODONTICS		
D4260	Osseous surgery/quad	\$390.00	75%
*Listed copayment includes lab fee. Lab fees may vary; please ask your provider for details			

SUMMIT CARE PLUS
III. SCHEDULE OF BENEFITS AND COPAYMENTS

ADA CODE	Procedure Description	Copayment
Diagnostic		
D0120	Periodic oral evaluation (2 every 12 months)	N/C
D0120	Periodic oral evaluation (additional)	\$15
D0140	Limited oral evaluation (problem focused)	\$15
D0145	Oral exam for patient under 3 years of age	N/C
D0150	Comprehensive oral exam (2 every 12 months)	N/C
D0150	Comprehensive oral exam (additional)	\$21
D0180	Comprehensive periodontal evaluation (2 every 12 months)	N/C
D0210	Intraoral - complete including bitewing x-ray (1 every 5 year period)	\$5
D0220	Single periapical x-ray	N/C
D0230	Periapical x-ray: each additional x-ray	N/C
D0270	Bitewing x-ray: single & 2 films (2 every 12 months)	N/C
D0272	Bitewing x-rays 2 films (additional)	\$12
D0273	Bitewing x-rays 3 films (2 every 12 months)	N/C
D0274	Bitewing x-rays 4 films (2 every 12 months)	N/C
D0274	Bitewing x-rays 4 films (additional)	\$21
D0277	Vertical bitewing x-rays (2 every 12 months)	N/C
D0330	Panoramic film incl. bitewing x-rays (1 every 5 years)	\$5
D0470	Diagnostic casts	N/C
D9310	Consultation	N/C
D9430	Office visit	N/C
Preventive		
D1110	Prophylaxis adult (2 every 12 months)	N/C
D1110	Prophylaxis adult (additional)	\$39
D1120	Prophylaxis child (2 every 12 months)	N/C
D1120	Prophylaxis child (additional)	\$27
D1206	Fluoride treatment (once in 12 month period to age 15)	N/C
D1310	Dietary planning	N/C
D1330	Preventative dental education, home care	N/C
D1351	Sealant per tooth	\$15
D1510	Space maintainer - fixed unilateral	\$175
D1515	Space maintainer- fixed bilateral	\$180
D1520	Space maintainer - removable unilateral	\$175
D1525	Space maintainer - removable bilateral	\$200
D1550	Recement space maintainer	\$20
Restorative		
D2140	Amalgam - 1 surface, permanent	\$13

ADA CODE	Procedure Description	Copayment
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D2150	Amalgam - 2 surfaces, primary or permanent	\$24
D2160	Amalgam - 3 surfaces, primary or permanent	\$30
D2161	Amalgam - 4 or more surfaces, primary or permanent	\$35
D2330	Resin - 1 surface anterior	\$29
D2331	Resin - 2 surfaces anterior	\$40
D2332	Resin - 3 surfaces anterior	\$56
D2335	Resin - 4 or more surfaces anterior	\$72
D2391	Resin - 1 surface posterior	\$45
D2392	Resin - 2 surface posterior	\$65
D2393	Resin - 3 surface posterior	\$75
D2394	Resin - 4 or more surfaces posterior	\$80
D2510-30	Inlay metallic 1-4 surfaces	20% Discount
D2542-44	Onlay metallic 2-4 or more surfaces	20% Discount
D2710	Acrylic (plastic) crown - lab processed	\$195
D2720-22	Acrylic with metal crown	\$425
D2740	Porcelain crown	\$495
D2750-52	Porcelain with metal crown	\$495
D2780-82	3/4 metal crown	\$495
D2783	3/4 ceramic crown	\$495
D2790-92	Full crown	\$495
D2910-20	Recement crown, inlay, facing only	\$35
D2930	Stainless steel crown primary tooth	\$125
D2932	Prefabricated resin crown	\$175
D2933	Prefabricated stainless resin crown	\$120
D2940	Sedative filling	\$35
D2950	Crown buildup, including any pins	\$80
D2951	Pin retention per tooth	\$20
D2952	Cast post and core	\$135
D2954	Prefabricated post and core	\$135
D2960	Labial veneer laminate - chairside	\$295
D2980	Temporary crown (fractured tooth)	\$85
Endodontics**		
<i>Treatment from a plan specialist MUST be pre-approved by the plan PRIOR to any services rendered</i>		
D3110	Pulp capping/direct	\$20
D3120	Pulp capping/indirect	\$20
D3220	Therapeutic pulpotomy	\$60
D3310	Root canal therapy - anterior	\$195
D3320	Root canal therapy - bicuspid	\$275
D3330	Root canal therapy - molar	\$399
D3346-48	Retreat previous RCT (anterior, bicuspid, molar)	20% Discount
D3351-53	Apexification/Recalcification (Initial, interim, final)	20% Discount

ADA CODE Procedure Description
Copayment

D3410	Apicoectomy per tooth (anterior only)	\$290
D3421	Apicoectomy per tooth (bicuspid)	\$335
D3425	Apicoectomy per tooth (molar)	\$395
D3426	Apicoectomy per tooth (each additional)	\$190
D3430	Retro fill per tooth	\$50
D3450	Root amputation	\$95
D3920	Hemisection	\$90
Periodontics**		
<i>Treatment from a plan specialist MUST be pre-approved by the plan PRIOR to any services rendered</i>		
D4210	Gingivectomy or gingivoplasty/quad	\$225
D4211	Gingivectomy or gingivoplasty/tooth	\$96
D4240	Gingival flap procedure inc. rt. planning 4+ teeth	\$250
D4241	Gingival flap procedure inc. rt. planning 1-3 teeth	\$105
D4260	Osseous surg/quad (flap entry & closure) 4+ teeth	\$390
D4261	Osseous surg/tooth (flap entry & closure) 1-3 teeth	\$167
D4320	Provisional splinting - intracoronal	\$75
D4321	Provisional splinting - extracoronal	\$80
D4341	Periodontal scaling & root planing/quad 4+ teeth	\$90
D4342	Periodontal scaling & root planing/tooth 1-3 teeth	\$46
D4355	Full mouth debridement	\$50
D4381	Localized delivery of antimicrobial agents	\$75
D4910	Periodontal maintenance following active therapy	\$55
Removable Prosthodontics		
D5110	Complete upper dentures (3 adj w/in 60 days)	\$615
D5120	Complete lower denture (3 adj. w/in 60 days)	\$615
D5130	Immediate upper denture (4 adj. w/in 60 days)	\$640
D5140	Immediate lower denture (4 adj. w/in 60 days)	\$640
D5211/12	Upper or lower partial - resin base	\$550
D5213/14	Upper or lower partial - cast metal base with resin saddles (including any conventional clasps, rests & teeth)	\$600
D5281	Removable unilateral partial denture	\$355
D5410-22	Denture adjustment (upper, lower, complete or partial)	\$30
D5510	Repair broken complete denture base	\$30
D5520	Replace missing/broken teeth (complete denture base)	\$30
D5610	Repair resin saddle or base	\$30
D5620	Repair cast framework	\$30
D5630	Repair or replace broken clasp	\$30
D5640	Replace broken teeth (per tooth)	\$30
D5650	Add tooth to existing partial denture	\$30
D5660	Add clasp to existing partial denture	\$30
D5670/71	Replace all teeth and acrylic - cast metal	20% Discount

ADA CODE	Procedure Description	Copayment
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D5710-21	Rebase (upper, lower, complete or partial)	\$150
D5730-41	Reline chairside (upper, lower, complete or partial)	\$125
D5750-61	Reline lab (upper, lower, complete or partial)	\$195
D5850	Tissue reconditioning per denture	\$15
Fixed Prosthodontics		
D6010-95	Implant procedures	20% Discount
D6100-99	Implant procedures continued	20% Discount
D6210-12	Cast pontic	\$455
D6240-42	Porcelain w/ metal pontic	\$495
D6245	Porcelain ceramic pontic	\$495
D6250-52	Acrylic pontic	\$495
D6720-22	Acrylic w/ metal crown retainer	\$280
D6740	Porcelain ceramic crown retainer	\$495
D6750-52	Porcelain w/ metal crown retainer	\$495
D6780-83	3/4 metal crown retainer	\$495
D6790-92	Full metal crown retainer	\$495
D6920	Connector bar	\$90
D6930	Recement bridge - per cemented unit	\$10
D6940	Stress breaker, simple	\$35
D6950	Precision attachment	\$260
D6980	Bridge repair	\$100
Oral Surgery**		
<i>Treatment from a plan specialist MUST be pre-approved by the plan PRIOR to any services rendered</i>		
D7111	Extraction, coronal remnants - deciduous tooth	\$35
D7140	Extraction, erupted tooth or exposed roots	\$40
D7210	Surgical extraction	\$70
D7220	Soft tissue impaction	\$90
D7230	Partial bony impaction	\$110
D7240	Complete bony impaction	\$150
D7250	Surgical root recovery	\$75
D7270	Tooth reimplantation & stabilization	\$140
D7280	Surgical exposure of impacted tooth	\$135
D7286	Biopsy of oral tissue - soft	\$50
D7310	Alveoloplasty/quad with extraction 1 to 3 teeth	\$85
D7311	Alveoloplasty/quad with extraction 4 or more teeth	\$85
D7320	Alveoloplasty/quad without extraction 1 to 3 teeth	\$190
D7321	Alveoloplasty/quad without extraction 4 or more teeth	\$135
D7471	Removal of exostosis - maxilla or mandible	\$320
D7510	Intra - oral I & D or abscess	\$65
D7960	Frenectomy	\$135

ADA CODE Procedure Description
Copayment

Orthodontics		
D8030	Limited ortho treatment (adolescent dentition)	\$2,900
D8040	Limited ortho treatment (adult dentition)	\$3,300
D8080	Comprehensive ortho treatment (adolescent dentition)	\$4,100
D8090	Comprehensive ortho treatment (adult dentition)	\$4,300
D8210	Removable appliance therapy	\$750
D8220	Fixed appliance therapy	\$750
D8660	Pre-ortho treatment visit	\$75
D8670	Periodic orthodontic TX visit	\$125
D8680	Orthodontic retention - removal of appliance, construct and place retainer(s)	\$225
D8690	Orthodontic TX (alter bill contract)	\$125
D8691	Repair of orthodontic appliance	\$75
D8692	Replacement of lost or broken retainer	\$175
D8693	Rebonding/recementing; and/or repair as required of fixed retainers	\$75
D8999	Unspecified orthodontic procedure	15-25% Discount
Temporomandibular Joint Dysfunction (TMJ)		
	TMJ Treatment	15-25% Discount
Other Services		
D9110	Emergency palliative treatment	\$20
D9210	Local anesthetic	N/C
D9223	Deep sedation/general anesthesia (each 15 minute increments)	\$105
D9230	Analgesia/Nitrous oxide	\$35
D9310	Consultation	N/C
D9440	Office visit (after regular scheduled hours)	\$40
D9940	Nightguard - occlusal guard (limited to 1 in a 24 month period)	\$200
D9951	Occlusal adjustment - limited per visit	\$40
D9952	Occlusal adjustment - complete	\$250
D9972	Cosmetic bleaching, per arch	15-25% Discount
D9973	Cosmetic bleaching, per tooth	15-25% Discount
D9986	Missed/canceled appointment (without 24 hours notice)	\$25
D9999	Unspecified adjunctive procedure, by report	\$25

Special Limitations

This Schedule of Benefits and Copayments is for non-precious metals only. If gold is used, there will be an additional charge according to the current market value of gold. Procedures or services not listed will be provided at usual & customary fees.

*Endodontic, periodontic and oral surgery treatments from a plan specialist must be pre-approved by the plan administrator, TDAHP, prior to any services rendered. Specialty care services not listed are discounted by the rate filed with TDAHP. Pedodontist coverage is the discount filed with TDAHP (20-25% off the participating periodontists regular fee).

**Orthodontic coverage is the discount filed with TDAHP Please see provider listing for details.

III. COPAYMENTS

The copayment amount in the Schedule Of Benefits and Copayments, contained herein are payable by you directly to the dental office as treatment is received. You should discuss all future payments and costs before new appointments are made. The dental office staff will help you plan your dental treatment and payments.

IV. SPECIALTY CARE

Sometimes your selected dentist will identify a problem that is best treated by a specialist. In this case, your dentist will refer you, where available, to a fully qualified specialist in the DHMO network who specializes in the care you need. Depending on your plan of coverage (refer to your Schedule of Benefits and Copayments), treatment provided by a specialist may require plan authorization. Your selected general dentist will initiate this authorization. Eligible dental care services from a specialist are those services specifically listed under the specialist category of the Schedule of Benefits and Copayments.

V. EXTENDED CARE

Upon termination of eligibility or termination of the Group Agreement, the plan will complete any procedures started, but only the procedures in progress.

VI. EFFECTIVE DATE OF COVERAGE

- A. Initial enrollment must be made within thirty (30) days following the date of hire or the employer's period of probation. If enrollment is received prior to the fifteenth (15th) day of the month, coverage will begin on the first day of the following month. If TDAHP does not receive the completed application as required above, the employee must wait until the next open enrollment period.
- B. A spouse and child(ren), newly acquired through marriage, must make an application within thirty (30) days of marriage. If said application is received prior to the fifteenth (15th) day of the month, coverage will begin on the first day of the following month. Except for newborn natural children and adopted children, who are enrolled within thirty (30) days from the date of the birth of the natural child or thirty (30) days after placement of the adopted child, family members, who do not enroll during the initial enrollment period, cannot enroll until the next annual open enrollment period.

VII. PARTICIPATING DENTAL OFFICES

- A. Benefits Obtained From General Dentists: Except for out of area emergency care, benefits are available only from your selected general dentist.
- B. List of General Dentists: You may obtain a current list of general dentists from the plan's administrative office located at 2800 N. 44th St., Suite #500, AZ 85008, by calling (602) 266-1995 or 1 (888) 422-1995, or on our website at TDA dental.com and the "Find a Provider" link.
- C. Choosing a General Dentist: You may choose any general dentist from the list of general dentists listed on our website. Upon request, the plan administrator will assist you in selecting a plan dentist, but may not recommend any particular dentist. All covered family members must go to the same general dentist. You must choose a general dentist at the time you enroll. You must have a general dentist to receive benefits.
- D. Changing General Dentists: You may change general dentists. If you notify the plan, in writing, by the fifteenth (15th) day of the month, the change will be effective on the first of the following month. Should your general dentist stop participation, the plan reserves the right to transfer you to another general dentist of your choosing.

All dentists furnishing services to a member do so as independent contractors. TDAHP shall not be liable for any claim or demand for damages arising out of or in any manner connected with any injuries suffered by a member while receiving dental services.

VIII. EMERGENCY CARE

- A. If you are less than fifty (50) miles from your general dentist, you should always attempt to obtain emergency care from your general dentist FIRST.
- B. If you are seeking emergency care during normal business hours and your selected general dentist is not accessible, you should contact the plan for assistance at (602) 266-1995 or 1 (888) 422-1995.
- C. If your general dentist is not accessible and you have made a reasonable attempt to contact the plan for assistance or you are more than fifty (50) miles from your general dentist, then you should seek emergency dental care for the relief of pain, bleeding or swelling from any licensed dentist. Under such circumstances, the plan will pay up to a maximum of \$50.00 per contract year per person. A written itemized statement for these services must be presented to TDAHP for reimbursement. If it is necessary to have additional treatment, it must be done by your general dentist.

IX. SCHEDULING AN APPOINTMENT

After your plan becomes effective, you can schedule an appointment by contacting your selected general dentist. Your dentist will offer you an appointment generally within thirty (30) days of your call or within 24 hours for emergency care. Most dental appointments are

scheduled Monday through Friday during regular working hours. Each dentist is an independent practitioner who establishes his or her own hours. Call your general dentist to ask about office hours and the availability of emergency dental services.

X. PLAN IDENTIFICATION CARD

Although an ID card will be issued to you, it is not necessary in order to receive dental care from your general dentist. Your name will appear on an eligibility list, which is sent to your selected dentist each month.

XI. WORKERS' COMPENSATION EXCLUSION

Expenses for which payment is required under applicable Workers' Compensation statutes are not eligible for payment under this dental plan.

XII. COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies to this plan when a member and/or subscriber has other dental care coverages. In the event benefits apply under two or more dental care coverages, each plan determines its order of benefits using the first of the following rules that apply:

- A. Non-Dependent or Dependent: The plan that covers the person other than as a dependent, such as an employee, member, policyholder, retiree or subscriber, is the primary plan and the plan that covers the person as a dependent is the secondary plan.
- B. Child Covered Under More Than One Plan: Unless there is a court decree stating otherwise, plans covering a child shall determine the order of benefits as follows:
 1. For a child whose parents are married or living together if they have never been married:
 - a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - b. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
 2. For a child whose parents are divorced or separated or are not living together if they have never been married:
 - a. If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage, the responsible parent's plan is primary.
 - b. If the parent with responsibility has no healthcare coverage for the child's healthcare expenses, but the spouse of the responsible parent does have healthcare coverage for the child's healthcare expenses, the responsible parent's spouse's plan is the primary plan. If a court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, the provisions of R590-131-6.B.1. shall determine the order of benefits.
 - c. If a court decree states that the parents have joint custody without stating that one parent has responsibility for the healthcare expenses or healthcare coverage of the child the provisions of R590-131-6.B.1. shall determine the order of benefits, or
 - d. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - i. the plan covering the custodial parent;
 - ii. the plan covering the custodial parent's spouse;
 - iii. the plan covering the non-custodial parent; and then
 - iv. the plan covering the non-custodial parent's spouse.
 - e. For a child covered under more than one plan, and one or more of the plans provides coverage for individuals who are not the parents of the child, such as a guardian, the order of benefits shall be determined under R590-131-6.B.1. or 2. as if those individuals were parents of the child.
- C. Longer or Shorter Length of Coverage
 1. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
 2. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the claimant was eligible under the second within 24 hours after coverage under the first plan ended.
 - a. The start of a new plan does not include:

- i. a change in the amount or scope of a plan's benefits;
 - ii. a change in the entity that pays, provides or administers the plan's benefits; or
 - iii. a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
- b. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
- c. If none of the above rules determine the primary plan, the allowable expenses shall be shared equally between the plans.
- d. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

XIII. THIRD PARTY RESPONSIBILITY

In the event a member and/or subscriber sustains any illness or injury for which a third party may be responsible, the plan, up to the amount of benefits paid or provided, shall be entitled to the proceeds of any settlement or judgment which results in a recovery from the third party; but only under the conditions that the covered member and/or subscriber is made whole first.

XIV. CONTINUATION OF COVERAGE

You and your dependents are entitled to continue coverage, should you and/or your dependents' eligibility lapse under the plan. You must provide written notification of request for continuation of coverage with appropriate membership dues (premium) within sixty (60) days of the date your eligibility ceases. For continuation under the COBRA Act, if applicable, contact your employer for details.

XV. TERMINATION

Benefits under this plan shall cease upon any of the following events:

- A. On the date of the expiration of the period for which the last payment was made.
- B. Upon the date of entry into full-time military service.
- C. On the last day of the month during which termination notice occurs, or thirty (30) days from the date that the termination notice is received by the member and/or subscriber, whichever date is later, in the event that a member and/or subscriber fails to maintain a satisfactory dentist-patient relationship, i.e. the general dentist no longer desires to treat the member and/or subscriber.
- D. In the event premiums are delinquent, services and benefits under the plan shall be suspended effective on the last day of the month during which the delinquency occurred.
- E. On the date the plan contract terminates, if not renewed.

XVI. DENTAL RECORDS

The dental records of the member and/or subscriber concerning services performed herein shall remain the property of the plan dentist.

XVII. CUSTOMER SERVICE INQUIRES

Plan member and/or subscriber customer service is available by calling TDAH at (602) 266-1995 or toll-free 1 (888) 422-1995 during normal business hours. All group dental plan inquiries, including grievance procedures are handled by TDAH.

XVIII. EARLY TERMINATION PENALTY

While employed with the group, the subscriber agrees to remain enrolled as a member of the group dental plan for a minimum of one year. Less than one year membership may result in the subscriber being billed usual service fees minus premium and copayments paid.

XIV. PROOF OF LOSS

Written proof of loss must be given to plan within ninety (90) days after the date of the loss for which encounter is made. If it was not reasonably possible to give written proof within the 90 day period, plan will not reduce or deny an encounter for this reason if the proof is filed as soon as is reasonably possible.

PRINCIPLE EXCLUSIONS AND LIMITATIONS

1. Sealants are covered to the age of fifteen (15) and are limited to once per permanent molars only.
2. Periodontal treatment (sub-gingival curettage and root planing) is limited to four quadrants in any thirty-six (36) consecutive months.
3. Replacement of a restoration is covered only when it is dentally necessary.
4. Fixed bridgework shall be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
5. Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
6. Partial dentures are not to be replaced within any five (5) year period from the date of last placement, regardless if last placement occurred while covered under this plan, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
7. Full upper and/or lower dentures are not to exceed one each in any five (5) year period from the date of last placement, regardless if last placement occurred while covered under this plan. Replacement shall be provided by the plan for an existing full or partial denture only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
8. Denture relines are limited to two (2) in any year.
9. Services for injuries or conditions, which are covered under Workers' Compensation or Employers' Liability Laws. Services, which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
10. Services of a Pedodontist (children's dentist) are not covered except as provided herein.
11. Services, which, in the opinion of the attending dentist are not necessary for patient's dental health, are not covered.
12. Temporomandibular Joint Treatment (TMJ), except as provided herein.
13. Elective or cosmetic dentistry, except as provided herein.
14. Oral surgery requiring the setting of fractures or dislocations.
15. Orthognathic surgery or extractions solely for orthodontic purposes are not covered.
16. Treatment of malignancies, cysts, neoplasms or congenital malformations, except congenital anomaly of a tooth or teeth covered from birth, adoption or placement for adoption.
17. Dispensing of drugs is not covered.
18. Hospital charges of any kind are not covered.
19. Loss or theft of dentures or bridgework are not covered
20. Any procedure of implantation or of an experimental nature, (i.e., a service, procedure, drug or treatment for a specific diagnosis from the appropriate governmental regulatory body) are not covered.
21. General anesthesia or IV/conscious sedation, except as provided herein.
22. Fees incurred for broken or missed appointments (without 24 hours notice) are the member's responsibility.
23. Dental expenses incurred in connection with any dental procedure started prior to the effective date of coverage are the member's responsibility and are not covered.
24. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage are the member's responsibility are not covered.
25. Any procedure performed for the purpose of correcting contour, contact or occlusion, except as provided herein, is not covered.
26. Any procedure to correct tooth structure lost due to attrition, erosion or abrasion.
27. Any procedure that is not specifically listed as a covered benefit is not covered.
28. Provider may refuse treatment to any patient who continually fails to follow a prescribed course of treatment.
29. Any dental treatment, which, in the opinion of the plan's dental consultant, has a poor prognosis is not covered.
30. Night guard (occlusal guard) limited to one each twenty-four (24) months.
31. Services performed by a dentist who is not a participating dentist are not covered, except for emergency care provided herein.

ORTHODONTIC PLAN EXCLUSIONS AND LIMITATIONS

1. No benefits will apply for a treatment program which began before the member/subscriber enrolled in the orthodontic plan.
2. No benefits will apply for lost or broken appliances.
3. Extractions are not included as a benefit.
4. Additional fees, for which you are responsible, may be charged by the dentist for:
 - a. Care required in excess of twenty-four (24) months from the time of banding.
 - b. Cross non-cooperation.
 - c. Accidents occurring during the period of treatment.
 - d. Cases involving surgical orthodontics.
 - e. Cases involving myofunctional therapy of TMJ.
5. If the member and/or subscriber relocates to an area and is unable to receive treatment from a member orthodontist, coverage under the plan ceases and it becomes the obligation of the member and/or subscriber to pay the usual and customary fee of the orthodontist where the treatment is completed.
6. Choice of an orthodontist is limited to orthodontists participating in the plan or to orthodontists who will accept the fees outlined in the plan.
7. If the member and/or subscriber becomes ineligible for benefits under the plan for treatment, coverage under the plan ceases and it becomes the obligation of the member and/or subscriber to pay the remaining balance to the orthodontist.