**GROUP DENTAL SERVICE OF MD, INC.**
111 ROCKVILLE PIKE, SUITE 950
ROCKVILLE, MARYLAND 20850

**UNITED FOOD AND COMMERCIAL WORKERS UNION AND PARTICIPATING FOOD INDUSTRY EMPLOYERS TRI-STATE HEALTH AND WELFARE FUND**

# CERTIFICATE OF COVERAGE

## Local 27 - Plan X

**Group Dental Service of Maryland, Inc.**
111 Rockville Pike, Suite 950
Rockville, MD 20850

# CERTIFICATE OF COVERAGE

## I. Introduction

This Certificate of Coverage provides important information about the dental care services available to you as a member of the **UNITED FOOD AND COMMERCIAL WORKERS UNION AND PARTICIPATING FOOD INDUSTRY EMPLOYERS TRI-STATE HEALTH AND WELFARE FUND** ("the Fund"), which has enrolled in the Group Dental Service of Maryland, Inc. dental plan ("Dental Plan"). Because this Certificate of Coverage is only a summary of the Plan, you must consult the Group Dental Services Agreement between the Fund and the Dental Plan (the "Group Dental Services Agreement", or "Group Agreement") for exact terms and conditions.

Group Dental Service of Maryland, Inc. is a Maryland corporation that arranges the provision of dental care. All references to the "Dental Plan" refer to this system for obtaining dental care on a prepaid basis offered by Group Dental Service of Maryland, Inc.

## II. Eligibility

Participants and their Dependents are eligible to receive dental benefits under the Plan.

A "Participant" means a member of the Fund who meets the applicable eligibility requirements established by the Fund, which are set forth in Attachment C hereto, who is enrolled in the Dental Plan, and for whom prepayment has been received by the Dental Plan.

A "Dependent" means any member of a Participant's family who meets the Fund's dependent eligibility requirements set forth in Attachment C, who is enrolled in the Dental Plan, and for whom prepayment has been received by the Dental Plan. Notwithstanding any limiting age contained in the eligibility criteria, any unmarried child covered under the Group Agreement as a Dependent, who is chiefly dependent for support upon the Participant, and who, at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that commenced prior to the child's attaining the limiting age, shall continue to be covered under the Group Agreement while remaining so dependent, unmarried, and mentally or physically incapacitated, until the coverage of the Participant upon whom the child depends terminates.

An "Enrollee" means any Participant or Dependent as described above.

## III. Effective Date of Coverage

If you satisfy the eligibility requirements on or before the effective date of the Group Agreement you will be covered on the date the Group Agreement becomes effective.

Any person who satisfies the eligibility requirements after the effective date of the Group Agreement be covered on the first (1st) day of the calendar month which falls on or after the date said requirements are satisfied.

## IV. Benefits

A summary of the covered dental services is listed in the "Description of Dental Services and Fees", attached hereto as Attachment A. If a condition can be treated by more than one procedure, the Dental Plan will only cover the least costly professionally adequate procedure. If you, in consultation with the Participating Dentist, elect to have a more costly alternative procedure performed, you will be responsible for the difference.

To obtain benefits, first choose one of Dental Plan's Participating Dentists, who will become your and your Dependent's "Primary Care Dentist", by contacting the Dental Plan's Administrative Office at [1-800-242-0450]. A "Participating Dentist" means a Dentist licensed to practice dentistry in the state in which services are being provided, and with whom the Dental Plan has an agreement for rendering to Enrollees the dental services covered by

the Dental Plan. Your Primary Care Dentist will provide the care for you and your family. Once you have selected a Primary Care Dentist, you may call the Dentist to schedule an appointment.

If you wish to change your Primary Care Dentist, contact the Dental Plan's Administrative Office so that the necessary arrangements may be made for you.

Certain services require a patient co-payment, which the Participating Dentist may collect from you at the time the service is performed. The specific dental services and applicable copayments are set forth in Attachment A.

Within the Service Area, you are entitled to receive all the dental services specified in Attachment A from Participating Dentists. "Service Area" means the geographical area encompassing the Washington, D.C., Maryland, and Virginia areas.

If you seek treatment from a dentist who is not a participant in the Dental Plan (a "Non-Participating Dentist"), you will not be covered for services received, except in the following circumstances:

1. Your Participating Dentist refers you or your dependent to a Non-Participating specialist for covered services, or you have obtained prior approval directly from the Dental Plan to go to a Non-Participating Dentist. You may request a referral to a Non-Participating specialist if:
   a. You or your Dependent have a condition that requires specialized dental care; and
   b. The Dental Plan does not have a specialist in its network with the training and expertise to treat the condition; and
   c. The specialist agrees to accept the same reimbursement that the Dental Plan would pay a specialist who is a Participating Dentist.

   You may call the Dental Plan Administrative Office at [1-800-242-0450] to determine if a specialist is available in the network, and to request a referral to a Non-Participating specialist if one is not available.

   In this case, Dental Plan will pay for covered services to the extent the charges exceed the co-payment specified in Attachment A;

2. Your or your dependent have an Emergency that occurs further than 50 miles from your Primary Care Dentist while temporarily away from home. "Emergency" means an unforeseen situation requiring services necessary to treat a condition or illness that, without immediate dental attention, would result in unalleviated acute dental pain, dental infection, and/or dentally related bleeding. In the case of such an Emergency, you will be reimbursed for dental expenses relating to minor procedures for the palliative relief of pain up to $50.00 per occurrence; or

3. In the circumstances described in Article V below.

If you seek dental care from a Non-Participating Dentist for any other reason, you will not be covered for that dental care under the Dental Plan.

When an appointment is made with a Participating Dentist, you are expected to honor such appointment. If you do not cancel the appointment at least 24 hours in advance, you will be charged a fee for each half-hour segment of the missed appointment, for which the Dental Plan shall not be liable. This missed appointment fee is listed in Attachment A. If an Enrollee arrives more than thirty (30) minutes late for a scheduled appointment, the Participating Dentist may treat the tardiness as a failure to keep a scheduled appointment and the missed appointment charge will apply.

## V. Visits to Non-Participating Dentists

If you do not reside or work within 20 miles or 30 minutes of a Participating Dentist you may choose to be treated by a Non-Participating Dentist within your vicinity, and Dental Plan's reimbursement, upon Dental Plan's receipt of written proof of the service, will be equal to the amount that Dental Plan would pay to a Participating Dentist to provide the same services. You may contact the Dental Plan's Administrative Office at [1-800-242-0450] prior to receiving dental services from a Non-Participating Dentist to determine the amount of Dental Plan's reimbursement for the services. You will be fully responsible for the Non-Participating Dentist's charges in excess of Dental Plan's reimbursement under this Article. Non-Participating Dentists are not obligated to abide by Dental Plan's fee schedule for dental procedures. Dental Plan will not review the qualifications or performance of any Non-Participating Dentist.

If, during the term of the Group Agreement, none of the Participating Dentists can render necessary care and treatment for you due to circumstances not reasonably within the control of Dental Plan, such as complete or partial destruction of facilities, war, riot civil insurrection, labor disputes, or the disability of a significant number of Participating Dentists, then you may seek treatment from an independent licensed dentist of your own choosing. Dental Plan will pay you for the expenses incurred for the dental services with the following limitation: Dental Plan will pay you for covered services to the extent that such fees are reasonable and customary for dentists in the same geographic area. Dental Plan will pay you for those covered services to the extent that the reasonable and customary fees for such services exceed the co-payment for such services as set forth in Attachment A, if any. You may be required to provide written proof of loss. Dental Plan agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by Participating Dentists.

## VI. Pre-Treatment Review

It is the responsibility of the Dentist to submit certain proposed services to the Dental Plan for pre-treatment review. The proposed services will be reviewed and a predetermination of benefits statement will be issued detailing the benefits that will be provided by the Dental Plan. If a Dentist performs a service that requires pre-treatment review without previously submitting the procedure to the Dental Plan, the Enrollee will not be responsible for payment for that procedure, except for the applicable co-payment, if any.

## VII. Exclusions and Limitations

A summary of the Exclusions is listed in the "Exclusions and Limitations to Coverage", attached hereto as Attachment B.

## VIII. Liability of the Dental Plan

Participating Dentists are solely responsible to you for all dental services, and the Dental Plan shall not be liable to you for the acts of Participating Dentists.

No Enrollee or the Fund shall be liable for any acts or omissions of the Dental Plan or its employees, agents, or Participating Dentists.

## IX. Discontinuance of Services By Participating Dentists

If for any reason a Participating Dentist fails to, or is unable to, render the services specified in Attachment A, the Dental Plan shall arrange and pay for the provision of those services by another Participating Dentist, up to the date for which payment has been made on your behalf, and until the Participating Dentist has completed the phase of any work in progress.

## X. Prohibited Referrals

Participating Dentists are prohibited from referring you or your Dependent to, or requesting reimbursement for, dental care services from a provider outside the Participating Dentist's office or group practice if:

1. The Participating Dentist, or the Participating Dentist in combination with his or her immediate family, owns a beneficial interest in that provider's business;

2. His or her immediate family owns a beneficial interest of three (3) percent or more in that provider's business; or

3. The Participating Dentist, his or her immediate family, or the Participating Dentist in combination with his or her immediate family has a compensation arrangement with that provider.

The Dental Plan will seek a refund for any payment it has made, or any co-payment you have paid, for a service that is later determined to have been provided as the result of a prohibited referral.

## XI. Continuation of Coverage

If your coverage terminates, Dental Plan will provide an extension of benefits for any treatment in progress at the time of termination, provided the treatment requires two (2) or more visits on separate days to the dentist's office. For all care other than orthodontics, such continuation of coverage will exist until completion of the procedure or ninety (90) days, whichever is earlier. For orthodontics, continued coverage will exist at least sixty (60) days if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis, to the end of the quarter in progress or sixty (60) days, whichever is longer. Thereafter, orthodontic treatment shall be available on a fee-for-service basis at prevailing rates.

## XII. Payment of Claims

If, as a result of prior special arrangements made by a Participating Dentist, an Out-of-Area Emergency or as otherwise provided under this Certificate of Coverage, you use a dentist other than a Participating Dentist, the Dental Plan shall reimburse you immediately upon receipt of written proof of such claim. Such written proof shall cover the occurrence, character and extent of the event for which a claim is made, and must be furnished to the Dental Plan within ninety (90) days after the commencement of the period for which the Dental Plan is liable.

Failure to furnish such proof within such time shall not invalidate nor reduce any claim if you demonstrate that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible, and, except in the absence of legal capacity of the claimant, not later than one (1) year from the time proof is otherwise required.

The Dental Plan, at its own expense, shall have the right and opportunity to conduct an oral examination of you when, and so often as, it may reasonably require during the pendancy of a claim under the Dental Plan.

You shall not bring a legal action to recover under the Dental Plan before sixty (60) days have elapsed after you have furnished written proof of a claim as described above. You shall not bring a legal action under the Dental Plan after three (3) years have elapsed from the time written proof of a claim was required to be submitted.

## XIII. Termination of Coverage

Your coverage shall be terminated if you cease to meet the eligibility requirements or if the Group Agreement is terminated. Termination of Coverage shall occur on the premium due date immediately following the date your eligibility ceased or this Agreement is terminated. Coverage shall never be terminated for any unfair, arbitrary, capricious or unfairly discriminatory reason; nor shall coverage be terminated if such termination would constitute abandonment of a patient.

## XIV. Claim Notice and Appeal Procedure

A dental provider or other authorized representative may file a claim or an Appeal on your behalf. All references in this section to "you or your Dependent" will include an authorized representative. The Dental Plan may require proof that a person is your or your Dependent's authorized representative.

### A. Definitions

**Adverse Decision** – A utilization review determination by the Dental Plan, a provider acting on behalf of the Dental Plan, or a private review agent acting on behalf of the Dental Plan, that a proposed or delivered dental service covered under the Claimant's contract is or was not Medically Necessary, appropriate or efficient; and may result in non-coverage of the dental service.

"Adverse Decision" includes the failure to cover services because they are determined to be experimental, investigative, or cosmetic when the determination is based in whole or in part on a medical judgment.

**Appeal** - A protest filed by a Claimant with the Dental Plan under its internal appeal process regarding a Coverage Decision or Adverse Decision concerning the Claimant.

**Appeal Decision** – A final determination by the Dental Plan that arises from an Appeal filed with the Dental Plan under its appeal process regarding a Coverage Decision or Adverse Decision concerning a Claimant.

**Authorized Representative** – An individual authorized by the Claimant or state law to act on the Claimant's behalf to submit Appeals and Grievances and file claims. A Provider may act on behalf of a Claimant with the Claimant's express consent, or without a Member's express consent in an emergency situation.

**Claimant** - The Enrollee or a dental provider filing on the Enrollee's behalf.

**Commissioner** – The Maryland Insurance Commissioner.

**Compelling Reason** – A showing that the potential delay in receipt of a dental service until after the Claimant exhausts the internal Grievance process and obtains a final decision under the Grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Claimant remaining seriously mentally ill with symptoms that cause the Claimant to be in danger to self or others.

**Complaint** - A protest filed with the Maryland Insurance Administration involving a Coverage Decision or Adverse Decision concerning a Claimant.

**Coverage Decision** – An initial determination by the Dental Plan or its representative that results in non-coverage of a dental service. A "Coverage Decision" includes non-payment of all or any part of a claim, but does not include an Adverse Decision regarding a utilization review determination.

**ERISA** – The Employee Retirement Income Security Act of 1974, as amended.

**Filing Date** - the earlier of:

1. 5 days after the date of mailing; or
2. the date of receipt.

**Notice of Benefit Determination** – A notice of approval, denial, reduction or termination of benefits or the failure to provide or pay for benefits.

**Post-Service Appeal** – An Appeal of an Adverse Decision or Coverage Decision for a service that has already been provided.

**Post-Service Claim** – A claim for dental services that the Claimant has already received or any claim that is not a Pre-Service Claim.

**Pre-Service Appeal** – An Appeal for which a requested service requires prior authorization and an Adverse Decision or Coverage Decision has been rendered.

**Pre-Service Claim** – A request for a dental service for which authorization is required in advance of the Claimant obtaining dental care for a service that has not already been provided.

**Urgent Care Appeal –** An Appeal that must be reviewed under the Urgent Care Appeal process because the application of non-urgent care Appeal time frames could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function. In determining whether an Appeal should be expedited, the Dental Plan will apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine. An Urgent Care Appeal is also an Appeal involving care that the provider deems urgent in nature, or the treating provider determines that a delay in care would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is being requested.

**Urgent Care Claim** - a claim for dental services that, in the opinion of the attending dentist, would either: a) result in acute dental pain, related infection and/or dental-related bleeding; or b) could seriously jeopardize the life or health of the Enrollee or the Enrollee's ability to regain maximum function, if non-urgent care time frames are applied. Once the dental services are provided, the claim is no longer an Urgent Care Claim.

## B. Initial Notice of Benefit Decisions

**Urgent Care Claims**

The Dental Plan will notify the Claimant whether a Pre-Service Claim for Urgent Care is approved or denied as soon as possible, but not later than 72 hours after it receives a claim, unless the claim is incomplete. If the claim is incomplete, the Dental Plan will notify the Claimant as soon as possible, but not more than 24 hours after receipt of the claim. Notice may be oral, unless written notice is requested. The Claimant will then have 48 hours to provide the required information. The Dental Plan will notify the Claimant of its decision as soon as possible, but not more than the earlier of: 48 hours after receiving the information; or the end of the period within which the Claimant had to provide the information.

If a Pre-Service Claim for Urgent Care is denied, in whole or in part, the Dental Plan will immediately call the Claimant, advise them of the reason for the denial and explain the Appeal process. The Dental Plan will document the Adverse Decision and send written notice to the Enrollee and the dental provider within 1 day after the oral notification.

**Pre-Service Claims**

When the Dental Plan receives a request for prior authorization of a dental service, the Dental Plan will notify the Claimant of the authorization within 2 business days after receipt of all necessary information, but not later than 15 days after the request is received. The Dental Plan may extend this time period for an additional 15 days if we do not have the necessary information to make a determination. The Dental Plan will notify the Claimant of the need for an extension within 3 calendar days of the initial request and explain in detail what information is required. The Dental Plan must receive the information within 45 days from receipt of the notice to provide the additional information.

If the authorization procedures are not followed, the Dental Plan will notify the Claimant and/or the Authorized Representative of the failure to follow the procedures within 5 days of the request for authorization. The notice will include the proper procedures to be followed to request authorizations. If the request is not approved, the Claimant or Authorized Representative may appeal the decision as described below.

In select cases, the Dental Plan may request that the Enrollee be examined by a second Participating Dentist at the Dental Plan's expense.

**Post-Service Claims**

The Dental Plan will send a Notice of Benefit Determination (Explanation of Benefits) to the Claimant or Authorized Representative within 30 days after we receive the claim. The Notice of Benefit Determination will inform the Claimant or Authorized Representative that we have received the claim and the status of the claim as follows:

- The claim was paid; or
- The Dental Plan is refusing to reimburse all or part of the claim and the reason for the refusal; or
- The Dental Plan needs additional information to determine if all or part of the claim will be reimbursed and what the specific information is; or
- The claim was not submitted correctly and what information is necessary to complete the claim.

The Claimant or Authorized Representative has 45 days from the receipt of the notice to provide the additional information.

If the request is not approved, the Claimant or Authorized Representative may Appeal the decision as described below.

**Content of Adverse Decision and Coverage Decision Notice**

When a claim is denied, in whole or in part, the oral or written notice will include the following, as applicable:

a. The specific reason why the dental service was denied;
b. The specific plan provision on which the decision is based;
c. A description of any additional material or information necessary for the Claimant to perfect the claim, and an explanation of why such material or information is necessary;
d. If the service was not considered dentally necessary or appropriate, a reference to the specific criteria and standards, including interpretive guidelines, on which the Adverse Decision was based, and a statement that the Claimant can request an explanation of such criteria and standards free of charge. If an internal rule, guideline, protocol or other similar criterion was used to make the Adverse Decision, the notice will contain either the specific criterion, or a statement that the Claimant can request a copy of the criterion free of charge;
e. That the Claimant has a right to file an Appeal with the Dental Plan, a description of the Dental Plan 's internal appeal process, and the time limits applicable to such process;
f. The name, business address and business telephone number of the person responsible for the Dental Plan's internal appeal process for Adverse Decisions;
g. The address, telephone and facsimile number of the Maryland Insurance Administration;
h. That the Health Advocacy Unit is available to assist the member in both mediating and filing an appeal under the Dental Plan 's internal appeal process;
i. The address, telephone number, facsimile number, and email address of the Health Advocacy Unit; and.
j. A statement of the Claimant's right:
    a. To file a Complaint with the Maryland Insurance Administration within:
        1) 30 working days after receipt of the Dental Plan 's Appeal Decision for an Adverse Decision; or
        2) 60 working days after receipt of the Dental Plan 's Appeal Decision for a Coverage Decision;
    b. To file a Complaint with the Maryland Insurance Administration without first filing an Appeal, if the Claimant can demonstrate a Compelling Reason to do so; and/or
    c. [To file a voluntary appeal of the Dental Plan's Appeal Decision to the Fund's Board of Trustees as described in the Enrollee's Summary Plan Description (SPD); and/or]
    d. To bring a civil action under section 502(a) of ERISA following an Appeal Decision by the Dental Plan [or a decision by the Fund's Board of Trustees].

In addition, the notice will advise the Claimant that he or she is entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim decision.

**Help Available from the Health Advocacy Unit**

If a Claimant wants to dispute an Adverse Decision or Coverage Decision, there is help available from the Health Advocacy Unit. The Health Advocacy Unit can help a Claimant prepare an Appeal to file under the Dental Plan's internal appeal process. The Health Advocacy Unit can also attempt to mediate a resolution to the dispute, but at any time during a mediation attempt, the Claimant may file an Appeal with the Dental Plan. The Health Advocacy Unit is not available to represent the Claimant or accompany the Claimant during any proceeding of the Dental Plan's internal appeal process. A Claimant may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: http:/www.oag.state.md.us

## C. Internal Appeal Process

**Right to Appeal an Adverse Decision or Coverage Decision**

If a Claimant does not agree with an Adverse Decision, the Claimant may first contact the Dental Plan's Member Services Department at [(800) 242-0450] to discuss the specific reasons for the Adverse Decision. The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. At any time the Claimant may submit additional documentation to support the claim.

A Claimant may file a written Appeal within 180 days after the date of receipt of notice of the Adverse Decision or Coverage Decision. An expedited process is available for Urgent Care Claims as described below.

The Appeal should include written comments, documents, records and other information relating to the claim to support the Appeal, and must be sent to the following address:

Group Dental Service of Maryland, Inc.
Member Services Department
111 Rockville Pike, Suite 950
Rockville, MD 20850
Phone: [1-800-242-0450]

Review of an Appeal will be made by a licensed dentist. If the service under review is a specialty service, the review will be made in consultation with a dentist who is board certified or eligible in the same specialty as the service under review. The review will not afford deference to the initial Adverse Decision, and will be conducted by a person who is neither the person who made the initial Adverse Decision, nor the subordinate of such person. The review will take into account all documents and comments that support the Claimant's position, even if the information was not submitted or considered in making the initial Adverse Decision.

**Pre-Service Claim Appeals – Non-Urgent Care**

The Dental Plan will render an Appeal Decision for a Pre-Service Claim and notify the Claimant in writing within 30 days of the Filing Date of the Appeal.

If there is insufficient information to complete the review of the Appeal, the Dental Plan will notify the Claimant, within 5 working days of the date filed, of the specific additional information that is needed. The Dental Plan will assist the Claimant in gathering the necessary information without further delay.

If, due to special circumstances, a resolution is not possible within the initial 30 days, a letter will be sent to the Claimant explaining the reason for delay. Written consent will be obtained from the Claimant for an extension of not longer than an additional 30 days.

The review of a Pre-Service Claim Appeal will be conducted by a licensed dentist who is neither the individual who made the Adverse Decision, nor the subordinate of such individual. If the service under review is a specialty service, the Appeal Decision will be made by a licensed dentist in consultation with a dentist who is board certified or eligible in the same specialty as the service under review. Such consultant shall be an individual who is neither the individual who made the initial Adverse Decision, nor the subordinate of such individual.

In select cases, the Dental Plan may request that the Enrollee be examined by a second Participating Dentist at the Dental Plan's expense.

If the Appeal Decision has been given orally, the Dental Plan will document the decision in writing and, within 5 working days after the decision is made, send written notice of the Appeal Decision to the Enrollee and to the dental provider.

**Expedited Process for Urgent Care Claim Appeals**

If the Dental Plan has made an Adverse Decision for an Urgent Care Claim, a Claimant may request a review orally or in writing. All necessary information will be transmitted between The Dental Plan and the

Claimant by telephone, facsimile, or any other expedited method that is available. An Appeal may be sent by facsimile to the Dental Plan for an expedited review, at:

Group Dental Service of Maryland, Inc.
Member Services Department
Fax Number: 301-770-1488

The Appeal must include a telephone and/or facsimile number where the Dental Plan may reach the Claimant to communicate results immediately following review of the Appeal.

If there is insufficient information to complete the review of the Appeal, the Dental Plan will call the Claimant to request the specific information needed, and will assist the Claimant in gathering the necessary information by phone, facsimile or any other method to expedite the review.

The Dental Plan will render an Appeal Decision as soon as possible, but not more than 24 hours after the Appeal was filed. The Dental Plan will provide notice of the Appeal Decision to the Claimant by telephone, facsimile or other expedited method as soon as it has been made. Written notice of the Appeal Decision will be provided to the Claimant within 1 day after the Appeal Decision is made.

**Post-Service Claim Appeals**

The Dental Plan will notify a Claimant in writing of an Appeal Decision for a Post-Service Claim, within a reasonable time, but not more than 30 days after the Appeal Decision is made, and not more than 60 days after the date the Appeal was filed.

**Content of Notice of Adverse Decision and Coverage Decision on Appeal**

When a claim is denied on Appeal, in whole or in part, written notice will include the following as applicable, in clear understandable language:

1. The specific factual basis for the decision;
2. The specific plan provision on which the decision is based;
3. If the service was not considered dentally necessary or appropriate, a reference to the specific criteria and standards, including interpretive guidelines, on which the Appeal Decision was based, and a statement that the Claimant can request an explanation of such criteria and standards free of charge. If an internal rule, guideline, protocol or other similar criterion was used to make the Appeal Decision, the notice will contain either the specific criteria, or a statement that the Claimant can request a copy of the criteria free of charge;
4. The name, business address and business telephone number of the person responsible for the Dental Plan's internal appeal process for Adverse Decisions;
5. The identification of the expert whose advice was obtained for the review, if any, without regard to whether the advice was relied upon in making the Appeal Decision;
6. A statement of the Claimant's right:
    a. To file a Complaint with the Maryland Insurance Administration within:
        1) 30 working days after receipt of the Dental Plan's Appeal Decision for an Adverse Decision; or
        2) 60 working days after receipt of the Dental Plan's Appeal Decision for a Coverage Decision.
    b. [To file a voluntary appeal of the Dental Plan's Appeal Decision to the Fund's Board of Trustees as described in the Enrollee's Summary Plan Description (SPD), and to obtain further information from the Fund that will enable the Claimant to make an informed judgment about whether to submit a benefit dispute to this voluntary level of appeal; and/or]
    c. To bring a civil action under section 502(a) of ERISA following an Appeal Decision by the Dental Plan [or a decision by the Fund's Board of Trustees]; and

7. The address, telephone and facsimile number of the Maryland Insurance Administration.

In addition, the notice will advise the Claimant that he or she is entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

**Responsibility for Internal Review Process**

The representative of the Dental Plan who has responsibility for its internal appeal process for Adverse Decisions is:

Dental Director
Group Dental Service of Maryland, Inc.
111 Rockville Pike, Suite 950
Rockville, MD 20850
Phone: [1-800-242-0450]

**Voluntary Appeals Process and Right to File Under ERISA**

If an Enrollee does not agree with an Appeal Decision, the Enrollee may choose:

1. To file a Complaint with the Maryland Insurance Administration as described below; [or]
2. [To file a voluntary appeal with the Fund's Board of Trustees, as described in the Enrollee's SPD; and/or ]
3. To file a civil action under §502(a) of ERISA.

## D. Complaints – External Review

**Right to File Complaint**

A Claimant has the right to file a Complaint with the Maryland Insurance Administration within:

1. 30 working days after receipt of the Dental Plan's Appeal Decision for an Adverse Decision; or
2. 60 working days after receipt of the Dental Plan's Appeal Decision for a Coverage Decision.

The internal appeal process described above must be exhausted prior to filing a Complaint, unless the Claimant can demonstrate a compelling reason not to do so as provided below.

Unless written consent has been given for an extension of time for a Pre-Service Claim, a Complaint may be filed with the Maryland Insurance Administration if an Appeal Decision is not received:

1. Within 30 days after the Filing Date of an Appeal for an Adverse Decision;
2. Within 60 days after the Filing Date of an Appeal for a Coverage Decision; or
3. Within 24 hours after the filing of an Appeal for an Urgent Care Claim.

Complaints may be sent to:

Maryland Insurance Administration
Life and Health Complaints Unit
525 St. Paul Place
Baltimore, MD 21202
Telephone: 800-492-6116 or 410-468-2000
Fax: 410-468-2270

**Demonstration of a Compelling Reason to File a Complaint**

A Claimant may file a Complaint with the Maryland Insurance Administration without first exhausting the internal appeal process above, if:

1. The Dental Plan has denied authorization for a health care service not yet provided; and
2. The Claimant can give sufficient information and supporting documentation in the Complaint to demonstrate to the satisfaction of the Maryland Insurance Administration a Compelling Reason to do so.

Supporting documentation includes showing that, in the opinion of the attending dentist, the Adverse Decision involves an urgent dental condition, and the delay of dental attention until after exhaustion of the internal appeal process and receipt of an Appeal Decision, could result in either:

1. The Enrollee is experiencing acute dental pain, dentally related infection and/or dentally related bleeding; or
2. Placing the Enrollee's life or health in jeopardy; the inability of the Enrollee to regain maximum function; serious impairment to a bodily function; or serious dysfunction of any bodily organ or part.

If a claim involves a denial for a service already provided, there can be no compelling reason to allow a Claimant to file a Complaint without first exhausting the internal appeal process.

**E. Other Complaints**

If an Enrollee has a complaint for any reason other than denial of a claim as stated above, such as a complaint about the Enrollee's dentist/dental office or a non-quality of care issue, the Enrollee should first contact Member Services at [800-242-0450].

If the complaint is not resolved, the Enrollee does not have to exhaust the Grievance and Appeal Process before contacting the Maryland Insurance Administration about filing a complaint. The Enrollee may contact:

Maryland Insurance Administration
Life and Health Complaints Unit
525 St. Paul Place
Baltimore, MD 21202
Telephone: 800-492-6116 or 410-468-2000
Fax: 410-468-2260

**ATTACHMENT A**

**DESCRIPTION OF DENTAL SERVICES AND FEES**
**UNITED FOOD AND COMMERCIAL WORKERS UNION AND PARTICIPATING FOOD INDUSTRY EMPLOYERS TRI-STATE HEALTH & WELFARE FUND – PLAN X**

| Procedure Code | Description | Member Co-Pay |
|---|---|---|
| ***Diagnostic & Preventive*** | | |
| 00120 | Periodic Oral Exam | N/C |
| 00140 | Limited Oral Evaluation - Problem Focused | N/C |
| 00150 | Comprehensive Oral Evaluation | N/C |
| 00170 | Re-evaluation - Limited, Problem Focused | N/C |
| 00210 | Intraoral - Complete Series, Including Bitewings (once per 3 years) | N/C |
| 00220 | Intraoral - Periapical - First Film | N/C |
| 00230 | Intraoral - Periapical - Each Additional Film | N/C |
| 00240 | Intraoral - Occlusal Film | N/C |
| 00270 | Bitewings - Single Film | N/C |
| 00272 | Bitewings - Two Films | N/C |
| 00274 | Bitewings - Four Films | N/C |
| 00277 | Vertical Bitewings - 7 to 8 Films | N/C |
| 00330 | Panoramic Film (once per 3 years) | N/C |
| 00340 | Cephalometric Film | N/C |
| 00460 | Pulp Vitality Tests | N/C |
| 01110 | Prophylaxis - Adult (once per 6 months) | N/C |
| 01120 | Prophylaxis - Child (once per 6 months) | N/C |
| 01201 | Top Application of Fluoride. (Including Prophy) - Child | N/C |
| 01510 | Space Maintainer - Fixed - Unilateral | $10 |
| 01515 | Space Maintainer - Fixed - Bilateral | $20 |
| 01550 | Recementation of Space Maintainer | N/C |
| ***Basic Restorative*** | | |
| D2140 | Amalgam - One Surface, Primary or Permanent | N/C |
| D2150 | Amalgam - Two Surfaces, Primary or Permanent | N/C |
| D2160 | Amalgam - Three Surfaces, Primary or Permanent | N/C |
| D2161 | Amalgam - Four or More Surfaces, Primary or Permanent | N/C |
| D2330 | Resin - One Surface, Anterior | N/C |
| D2331 | Resin - Two Surfaces, Anterior | N/C |
| D2332 | Resin - Three Surfaces, Anterior | N/C |
| D2335 | Resin - Four or More Surfaces or Incisal Angle | N/C |
| D2390 | Resin - Crown, Anterior | N/C |
| D2391 | Resin - One Surface, Posterior | N/C* |
| D2392 | Resin - Two Surfaces, Posterior | N/C* |
| D2393 | Resin - Three Surfaces, Posterior | N/C* |
| D2394 | Resin - Four or More Surfaces, Posterior | N/C* |

*** GDS-MD pays up to the cost of Amalgam, patient pays the difference**

- **N/C – No Charge**
- **Procedures not shown are not covered by Dental Plan.**
- **When gold is used, a gold surcharge will be charged. Patient will be advised of the surcharge prior to performance of procedure.**
- **If a condition can be treated by more than one procedure, GDS will only cover the least costly professionally adequate service.**

| Procedure Code | Description | Member Co-Pay |
|---|---|---|
| ***Crowns (Single Restorations)*** | | |
| 02740 | Crown - Porcelain/Ceramic Substrate | $125 |
| 02750 | Crown - Porcelain fused to High Noble Metal | $125 |
| 02751 | Crown - Porcelain Fused to Predominately Base Metal | $125 |
| 02752 | Crown - Porcelain Fused to Noble Metal | $125 |
| 02790 | Crown - Full Cast High Noble Metal | $125 |
| 02791 | Crown - Full Cast Predominately Base Metal | $125 |
| 02792 | Crown - Full Cast Noble Metal | $125 |
| 02920 | Recement Crown | N/C |
| 02930 | Prefabricated Stainless Steel. Crown-Primary Tooth | $30 |
| 02931 | Prefabricated Stainless Steel. Crown-Permanent Tooth | $30 |
| 02932 | Prefabricated Resin Crown | $30 |
| 02940 | Sedative Filling | N/C |
| 02950 | Core Buildup, Including Any Pins | N/C |
| 02951 | Pin Retention - Per Tooth, In Addition to Restoration | N/C |
| 02952 | Cast Post & Core in Addition to Crown | N/C |
| 02954 | Prefabricated Post & Core in Addition to Crown | N/C |
| 02980 | Crown Repair, by Report | N/C |
| ***Endodontics*** | | |
| 03110 | Pulp Cap Direct (excluding final restoration) | N/C |
| 03120 | Pulp Cap Indirect (excluding final restoration) | N/C |
| ***Removable Prosthetics*** | | |
| D5110 | Complete Upper Denture (Includes adjustments) | $30 |
| D5120 | Complete Lower Denture (Includes adjustments) | $30 |
| D5130 | Immediate Upper Denture (Includes adjustments) | $30 |
| D5140 | Immediate Lower Denture (Includes adjustments) | $30 |
| D5211 | Upper Partial Resin Base (Includes adjustments) | $30 |
| D5213 | Upper Partial - Cast Metal Frame w/Resin Base | $30 |
| D5214 | Lower Partial - Cast Metal Frame w/Resin Base | $30 |
| D5410 | Adjust Complete Denture - Upper | N/C |
| D5411 | Adjust Complete Denture - Lower | N/C |
| D5421 | Adjust Partial Denture - Upper | N/C |
| D5422 | Adjust Partial Denture - Lower | N/C |
| D5510 | Repair Broken Complete Denture Base | N/C |
| D5520 | Replace Missing/Broken Tooth - Complete Denture -Ea. Tooth | N/C |
| D5610 | Partial Denture - Repair Resin Sole/Base | N/C |
| D5620 | Partial Denture - Repair Cast Framework | N/C |
| D5630 | Repair or Replace Broken Clasp | N/C |
| D5640 | Partial Denture - Replace Broken Tooth - Per Tooth | N/C |
| D5650 | Add Tooth to Existing Partial Denture | N/C |
| D5660 | Add Clasp to Existing Partial Denture | N/C |
| D5670 | Replace All Teeth & Acrylic on Cast Metal Frame (Upper) 4 or More | N/C |
| D5671 | Replace All Teeth & Acrylic on Cast Metal Frame (Lower) 4 or More | N/C |
| D5730 | Reline Complete Upper Denture (Chairside) | N/C |
| D5731 | Reline Complete Lower Denture (Chairside) | N/C |
| D5740 | Reline Upper Partial (Chairside) | N/C |
| D5741 | Reline Lower Partial (Chairside) | N/C |
| D5750 | Reline Complete Upper Denture (Lab) | N/C |

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- **If a condition can be treated by more than one procedure, GDS will only cover the least costly professionally adequate service.**

| Procedure Code | Description | Member Co-Pay |
|---|---|---|
| ***Removable Prosthetics (continued)*** | | |
| D5751 | Reline Complete Lower Denture (Lab) | N/C |
| D5760 | Reline Upper Partial (Lab) | N/C |
| D5761 | Reline Lower Partial (Lab) | N/C |
| ***Fixed Prosthetics, per Unit (each retainer and each pontic constitutes a unit in a fixed partial denture)*** | | |
| 06210 | Pontic - Cast High Noble Metal | $125 |
| 06211 | Pontic - Cast Predominately Base Metal | $125 |
| 06212 | Pontic - Cast Noble Metal | $125 |
| 06240 | Pontic - Porcelain to High Noble Metal | $125 |
| 06241 | Pontic - Porcelain to Predominately Base Metal | $125 |
| 06242 | Pontic - Porcelain Fused to Noble Metal | $125 |
| 06245 | Pontic - Porcelain/Ceramic | $125 |
| 06545 | Retainer - Cast Metal Resin Bonded Bridge | $50 |
| 06740 | Crown - Porcelain/Ceramic | $125 |
| 06750 | Bridge Crown - Porcelain to High Noble Metal | $125 |
| 06751 | Bridge Crown - Porcelain to Predominately Base Metal | $125 |
| 06752 | Bridge Crown - Porcelain Fused to Noble Metal | $125 |
| 06783 | Bridge Crown - Porcelain/Ceramic | $125 |
| 06790 | Bridge Crown - Full Cast High Noble Metal | $125 |
| 06791 | Bridge Crown - Full Cast Predominately Base Metal | $125 |
| 06792 | Bridge Crown - Full Cast Noble Metal | $125 |
| 06930 | Recement Bridge | N/C |
| ***Oral Surgery*** | | |
| D7111 | Coronal Remants – Deciduous Tooth | N/C |
| D7140 | Extraction, Erupted Tooth or Exposed Root | N/C |
| D7210 | Surgical Removal of Erupted Tooth (including removal of bone and/or section of tooth) | N/C |
| D7220 | Remove Impacted Tooth - Soft Tissue | N/C |
| D7230 | Remove Impacted Tooth - Partially Bony | N/C |
| D7240 | Remove Impacted Tooth - Completely Bony | N/C |
| D7241 | Remove Impacted Tooth - Completely Bony, Unusual | N/C |
| D7250 | Surgical Removal of Residual Roots | N/C |
| D7310 | Alveoplasty in Conjunction w/Extractions, per Quad | N/C |
| D7510 | Incision & Drainage of Abscess - Intraoral Soft Tissue | N/C |
| ***Miscellaneous*** | | |
| 09110 | Palliative (Emergency) Treatment of Dental Pain - Minor Procedure | N/C |
| 09215 | Local Anesthesia | N/C |
| 09220 | General Anesthesia - 1st 30 Min (Extractions Only) | N/C* |
| 09221 | General Anesthesia - Each Addl. 15 Min (Extractions Only) | N/C* |
| 09230 | Analgesia, Anxiolysis, Inhalation of Nitrous Oxide (Extractions Only) | N/C* |
| 09241 | I.V. Sedation/Analgesia - 1st 30 Min (Extractions Only) | N/C* |
| 09242 | I.V. Sedation/Analgesia - Each Addl 15 Min (Extractions Only) | N/C* |
| 09248 | Non-Intravenous Conscious Sedation | N/C |
| 09310 | Consultation (by dentist other than attending dentist) - per Session | N/C |
| 09999 | Broken Appointment Charge (per 1/2 hour) | $10 |

***Anesthesia and/or general anesthesia is covered only when administered in an oral surgeon's office for extractions and related services.**

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- **If a condition can be treated by more than one procedure, GDS will only cover the least costly professionally adequate service.**

**ATTACHMENT B**

## EXCLUSIONS AND LIMITATIONS TO COVERAGE

Any service that is not specifically listed as a covered dental service in Attachment A is excluded. In addition, the covered dental services are subject to the following exclusions and limitations:

1. Prophylaxis, including scaling and polishing, is limited to once every six months.

2. Dentures are limited to one partial or complete denture per arch within a five-year period.

3. Orthodontia coverage, when provided, is limited to:

   a. Diagnosis, including models, photographs, x-rays, and tracings.

   b. Active fully banded treatment, including necessary appliances and progress x-rays.

   c. Retention treatment following active treatment (not to exceed ten visits in any 18 month period).

   d. Phase I (interceptive orthodontic treatment) is excluded.

   e. Benefits will not be provided beyond a period of 24 consecutive months of active treatment; nor beyond a period of 18 consecutive months of retention treatment.

   f. Dental Plan will not be liable for the replacement and/or repair of any appliance that was not initially furnished by Dental Plan.

   g. Benefits will be provided to an Enrollee not more than once within a five-year period.

   h. Patients must be age 11 or older.

4. Covered services are limited to services provided by a Participating Dentist except in the following circumstances:

   a. When referred by your Participating Dentist to a Non-Participating specialist.

   b. When authorized in advance by Dental Plan.

   c. In the case of an Emergency, as defined in Article IV, and subject to the conditions contained therein.

   d. In the circumstances described in Article V. and subject to the limitations contained therein.

5. Cosmetic services are excluded. Cosmetic services are those services that are elective and that are not necessary for good dental health. Cosmetic services include, but are not limited to:

   a. Alteration or extraction and replacement of sound teeth.

   b. Any treatment of the teeth to remove or lessen discoloration.

6. Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction is excluded.

7. Replacement of dentures, bridgework or any other dental appliances previously supplied by Dental Plan, due to loss or theft is excluded, unless the Enrollee received such appliance prior to the immediately preceding five-year period.
8. Dental expenses incurred in connection with any dental procedure started prior to an Enrollee's effective date of coverage under this Agreement are excluded. Examples: orthodontic work in progress, teeth prepared for crowns, root canal therapy in progress.
9. Hospitalization for any dental procedure is excluded.
10. Drugs obtainable with or without a prescription are excluded.
11. Dental implants, and any prosthesis, crown, bridge, or denture associated with a dental implant are excluded.
12. Services rendered by prosthodontic specialists are excluded.
13. Procedures requiring fixed prosthodontic restorations that are necessary for complete oral rehabilitation or reconstruction are excluded.
14. Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion are excluded.
15. General anesthesia is covered only when administered in an oral surgeon's office for extractions.
16. Treatment of malignancies, cysts, neoplasms or congenital malformations is excluded.
17. Services for injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws are excluded; services that are provided without cost to the Enrollee by any municipality, county, or other political subdivision are excluded.
18. New services performed after the last day of the month during which an Enrollee ceases to be eligible under the Group Agreement are excluded, except as provided in the Continuation of Coverage provision.
19. Any service that the appropriate regulatory board determines was provided as a result of a prohibited referral as set forth in Article X.

**ATTACHMENT C**

## CATEGORIES AND CRITERIA FOR ELIGIBILITY

### WHO IS ELIGIBLE?

The eligibility of Participants and their dependents will be determined in accordance with the Fund's eligibility rules under the terms of the plan of benefits applicable to such Participant.

The GDS-MD Dental Plan covers unmarried dependent children who are at least four (4) years of age, to age 26.

All eligibility and termination of eligibility is determined by the Fund Administrator. An employee may be required to submit proof of dependency, as required by the Fund Administrator or GDS-MD.

### COBRA CONTINUATION RIGHTS

Eligible Enrollees who will lose eligibility under the Agreement may be entitled to elect to continue coverage under the provisions of COBRA. Refer to the Fund Administrator for details