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State of California – Standard Plan

Schedule of Benefits

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I. DESCRIPTION OF BENEFITS AND COPAYMENTS

The benefits shown below are performed as deemed appropriate by the attending Primary Care Dentist (PCD) subject to the limitations and exclusions of the program. Enrollees should discuss all treatment options with their PCD prior to services being rendered.

The text that appears in italics below is specifically intended to clarify the delivery of benefits under Access Dental Plan. Please refer to the Benefit Plan Summary for frequency limitations and plan limitations.

If services for a listed procedure are performed by the assigned PCD, the member pays the specified co-payment.

Specialist Referrals

Listed procedures that require a dentist to provide specialized services and are referred by the assigned PCD must be preauthorized in writing by Access Dental Plan. The member pays the co-payment specified for such services, except for pedodontist services.

Pediatric Services

Children under six years of age who are unable to be treated by the assigned PCD may be referred to a pedodontist. The enrollee will be responsible for a co-payment equal to 50% of the pedodontist fee.

Code	Description	Standard Plan Enrollee Pays
D0100 – D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation — established patient	No Cost
D0140	Limited oral evaluation — problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation — new or established patient	No Cost
D0160	Detailed and extensive oral evaluation — problem focused, by report	No Cost
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation — new or established patient	No Cost
D0210	Intraoral radiographs — complete series (including bitewings) — limited to 1 series every 24 months	No Cost
D0220	Intraoral — periapical first film	No Cost
D0230	Intraoral — periapical each additional film (up to and including 13 films)	No Cost
D0240	Intraoral — occlusal film	No Cost
D0250	Extraoral — first film	No Cost
D0251	Extra-oral posterior dental radiographic image	No Cost
D0270	Bitewing radiograph — single film	No Cost
D0272	Bitewings radiographs — two films — limited to 1 series every 6 months	No Cost
D0273	Bitewings - three radiographic images	No Cost
D0274	Bitewings radiographs — four films — limited to 1 series every 6 months	No Cost
D0277	Vertical bitewings — 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0340	2D cephalometric radiographic image — acquisition, measurement and analysis	No Cost
D0350	Oral/facial photographic images	No Cost
D0415	Collection of microorganisms for culture and sensitivity	$45
D0425	Caries susceptibility tests	$20

Code	Description	Standard Plan Enrollee Pays
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities, including premalignant and malignant lesions, not to include cytology or biopsy procedures	$25
Code	Description	Standard Plan Enrollee Pays
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	$70
D0472	Accession of tissue, gross examination, preparation, and transmission of written report	$65
D0473	Accession of tissue, gross and microscopic examination, preparation, and transmission of written report	$130
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report	$150
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk	No Cost
D0999	Office visit, regular hours - per visit (Including all fees for sterilization/infection control), general dentist only	No Cost
D1000 – D1999	II. PREVENTIVE	
D1110	Prophylaxis — adult	No Cost
D1110	Additional prophylaxis — adult	$60
D1120	Prophylaxis — child	No Cost
D1120	Additional prophylaxis — child	$60
D1206	Topical application of fluoride varnish	No Cost
D1208	Topical application of fluoride — excluding varnish	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant — per tooth	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient — permanent tooth	No Cost
D1354	Interim caries arresting medicament application — per tooth	No Cost
D1510	Space maintainer — fixed — unilateral	No Cost
D1515	Space maintainer — fixed — bilateral	No Cost
D1516	Space maintainer – fixed – bilateral, maxillary	No Cost
D1517	Space maintainer – fixed – bilateral, mandibular	No Cost
D1520	Space maintainer — removable — unilateral	No Cost
D1525	Space maintainer — removable — bilateral	No Cost
D1526	Space maintainer – removable – bilateral, maxillary	No Cost
D1527	Space maintainer – removable – bilateral, mandibular	No Cost
D1550	Re-cement or re-bond space maintainer	$30
D1551	Re-cement or re-bond bilateral space maintainer — maxillary	$45
D1552	Re-cement or re-bond bilateral space maintainer — mandibular	$45
D1553	Re-cement or re-bond unilateral space maintainer — per quadrant	$45
D1555	Removal of fixed space maintainer	$35

Code	Description	Standard Plan Enrollee Pays
D1575	Distal shoe space maintainer — fixed — unilateral	No Cost
D2000 – D2999	III. RESTORATIVE Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners, and acid etch procedures. An additional charge will be applied for any procedure using noble, high noble metal, or titanium, and will be the member's responsibility. If porcelain, resin, or resin-based composite is used on molar crowns, the member is responsible for an additional $75 above the set crown copayment. Replacement of crowns requires the existing restoration to be three years old.	
D2140	Amalgam — one surface, primary or permanent	No Cost
D2150	Amalgam — two surfaces, primary or permanent	No Cost
D2160	Amalgam — three surfaces, primary or permanent	No Cost
D2161	Amalgam — four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite — one surface, anterior	No Cost
D2331	Resin-based composite — two surfaces, anterior	No Cost
D2332	Resin-based composite — three surfaces, anterior	No Cost
D2335	Resin-based composite — four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite — one surface, posterior	$45
D2392	Resin-based composite — two surfaces, posterior	$55
D2393	Resin-based composite — three surfaces, posterior	$65
D2394	Resin-based composite — four or more surfaces, posterior	$75
D2542	Onlay — metallic — two surfaces	$50
D2543	Onlay — metallic — three surfaces	$50
D2544	Onlay — metallic — four or more surfaces	$50
D2610	Inlay — porcelain/ceramic — one surface	$460
D2620	Inlay — porcelain/ceramic — two surfaces	$395
D2630	Inlay — porcelain/ceramic — three or more surfaces	$450
D2642	Onlay — porcelain/ceramic — two surfaces	$585
D2643	Onlay — porcelain/ceramic — three surfaces	$575
D2644	Onlay — porcelain/ceramic — four or more surfaces	$605
D2650	Inlay — resin-based composite — one surface	$390
D2651	Inlay — resin-based composite — two surfaces	$415
D2652	Inlay — resin-based composite — three or more surfaces	$415
D2662	Onlay — resin-based composite — two surfaces	$560
D2663	Onlay — resin-based composite — three surfaces	$530
D2664	Onlay — resin-based composite — four or more surfaces	$530
D2710	Crown — resin-based composite (indirect)	$50
D2712	Crown — ¾ resin-based composite (indirect)	$50
D2720	Crown — resin with high noble metal	$50
D2721	Crown — resin with predominantly base metal	$50
D2722	Crown — resin with noble metal	$50
D2740	Crown — porcelain/ceramic substrate	$50
D2750	Crown — porcelain fused to high noble metal	$50
D2751	Crown — porcelain fused to predominantly base metal	$50
D2752	Crown — porcelain fused to noble metal	$50
D2780	Crown — 3/4 cast high noble metal	$50
D2781	Crown — 3/4 cast predominantly base metal	$50

Code	Description	Standard Plan Enrollee Pays
D2782	Crown — 3/4 cast noble metal	$50
D2783	Crown — 3/4 porcelain/ceramic	$655
D2790	Crown — full cast high noble metal	$50
D2791	Crown — full cast predominantly base metal	$50
D2792	Crown — full cast noble metal	$50
D2794	Crown — titanium	$50
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	No Cost
D2915	Re-cement cast or prefabricated post and core	No Cost
D2920	Re-cement crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge, or cusp	No Cost
D2928	Prefabricated porcelain/ceramic crown — permanent tooth	$200
D2929	Prefabricated porcelain/ceramic crown — primary tooth	$200
D2930	Prefabricated stainless steel crown — primary tooth	No Cost
D2931	Prefabricated stainless steel crown — permanent tooth	No Cost
D2932	Prefabricated resin crown	$170
D2933	Prefabricated stainless steel crown with resin window	$205
D2934	Prefabricated aesthetic coated stainless steel crown — primary tooth	$50
D2940	Sedative filling	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$90
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention — per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated	No Cost
D2953	Each additional indirectly fabricated post — same tooth	$40
D2954	Prefabricated post and core in addition to crown	No Cost
D2955	Post Removal	$150
D2957	Each additional prefabricated post - same tooth	No Cost
D2960	Labial veneer (resin laminate) — direct	$250
D2962	Labial veneer (porcelain laminate) — indirect	$600
D2971	Additional procedure to construct new crown under existing partial denture framework	$80
D2980	Crown repair necessitated by restorative material failure	$145
D2981	Inlay repair necessitated by restorative material failure	$100
D2982	Onlay repair necessitated by restorative material failure	$100
D2990	Resin infiltration of incipient smooth surface lesions	No Cost
D3000 – D3999	IV. ENDODONTICS	
D3110	Pulp cap — direct (excluding final restoration)	No Cost
D3120	Pulp cap — indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$110
D3222	Partial pulpotomy for apexigenesis — permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) — anterior, primary tooth (excluding final restoration)	No Cost

Code	Description	Standard Plan Enrollee Pays
D3240	Pulpal therapy (resorbable filling) — posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal — endodontic therapy — anterior tooth (excluding final restoration)	$20
D3320	Root canal — endodontic therapy — bicuspid tooth (excluding final restoration)	$40
D3330	Root canal — endodontic therapy — molar (excluding final restoration)	$60
D3331	Treatment of root canal obstruction; non-surgical access	$215
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$20
D3333	Internal root repair of perforation defects	$190
D3346	Retreatment of previous root canal therapy — anterior	$20
D3347	Retreatment of previous root canal therapy — bicuspid	$40
D3348	Retreatment of previous root canal therapy — molar	$60
D3351	Apexifcation/recalcification — initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3352	Apexifcation/recalcification — interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3353	Apexifcation/recalcification — final visit (includes completed root canal therapy — apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3410	Apicoectomy/periradicular surgery — anterior	$50
D3421	Apicoectomy/periradicular surgery — bicuspid (first root)	$50
D3425	Apicoectomy/periradicular surgery — molar (first root)	$50
D3426	Apicoectomy/periradicular surgery (each additional root)	$50
D3430	Retrograde filling — per root	No Cost
D3450	Root amputation — per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	$215
D3950	Canal preparation and fitting of preformed dowel or post	$90
D4000 – D4999	V. PERIODONTICS Includes preoperative and postoperative evaluations and treatment under a local anesthetic	
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant	$5
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival fap procedure, including root planing — four or more contiguous teeth or tooth bounded spaces per quadrant	$350
D4241	Gingival fap procedure, including root planing — one to three contiguous teeth or tooth bounded spaces per quadrant	$325
D4245	Apically positioned fap	$315
D4249	Clinical crown lengthening - hard tissue	$405
D4260	Osseous surgery (including fap entry and closure) — four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4261	Osseous surgery (including fap entry and closure) — one to three contiguous teeth or tooth bounded spaces per quadrant	$150
D4263	Bone replacement graft — retained natural tooth — first site in quadrant	$295
D4264	Bone replacement graft — retained natural tooth — each additional site in quadrant	$235
D4268	Surgical revision procedure, per tooth	$125
D4270	Pedicle soft tissue graft procedure	$475
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	$500

Code	Description	Standard Plan Enrollee Pays
D4274	Mesial/distal wedge procedure, single tooth when not performed in conjunction with surgical procedures in the same anatomical area)	$350
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$580
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$400
D4320	Provisional splinting — intracoronal	$200
D4321	Provisional splinting — extracoronal	$200
D4341	Periodontal scaling and root planing — four or more teeth per quadrant limited to 5 quadrants in any 12 consecutive months	No Cost
D4342	Periodontal scaling and root planing — one to three teeth per quadrant limited to 4 quadrants limited to 5 quadrants in any 12 consecutive months	No Cost
D4346	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without fap entry and closure	$20
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$40
D4910	Periodontal maintenance	$80
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$25
D4999	Periodontal maintenance, each additional service in same 12-month period	$60
D5000 – D5899	VI. PROSTHODONTICS (removable) Denture relines are limited to 1 during any 12 consecutive months. For all listed dentures and partial dentures, co-payment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The member must continue to be eligible, and the service must be provided at the Primary Care Dentist's facility where the denture was originally delivered. Replacement of a denture or a partial denture requires the existing denture to be 3 years old, unless due to loss of a natural functioning tooth. Replacement will be a benefit only if the existing denture is unsatisfactory and cannot be made satisfactory.	
D5110	Complete denture — maxillary	$65
D5110	Complete denture — maxillary - denture duplication	$65
D5120	Complete denture — mandibular	$65
D5120	Complete denture — mandibular - denture duplication	$65
D5130	Immediate denture — maxillary	$65
D5140	Immediate denture — mandibular	$65
D5211	Maxillary partial denture — resin base (including any conventional clasps, rests, and teeth)	$65
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests, and teeth)	$65
D5213	Maxillary partial denture — cast framework with resin denture bases (including any conventional clasps, rests and teeth)	$65
D5214	Mandibular partial denture — cast framework with resin denture bases (including any conventional clasps, rests and teeth)	$65
D5221	Immediate maxillary partial denture — resin base (including retentive/clasping materials, rests and teeth)	$65
D5222	Immediate mandibular partial denture — resin base (including retentive/clasping materials, rests, and teeth)	$65
D5223	Immediate maxillary partial denture — cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$65
D5224	Immediate mandibular partial denture — cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$65
D5225	Maxillary partial denture — flexible base (including retentive/clasping materials, rests, and teeth)	$750

Code	Description	Standard Plan Enrollee Pays
D5226	Mandibular partial denture — flexible base (including retentive/clasping materials, rests, and teeth)	$800
D5410	Adjust complete denture — maxillary	No Cost
D5411	Adjust complete denture — mandibular	No Cost
D5421	Adjust partial denture — maxillary	No Cost
D5422	Adjust partial denture — mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost
D5512	Repair broken complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth — complete denture (each tooth)	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken clasp	No Cost
D5640	Replace broken teeth — per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture — per tooth	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$365
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$365
D5710	Rebase complete maxillary denture	$20
D5711	Rebase complete mandibular denture	$20
D5720	Rebase maxillary partial denture	$20
D5721	Rebase mandibular partial denture	$20
D5730	Reline complete maxillary denture (direct)	No Cost
D5731	Reline complete mandibular denture (direct)	No Cost
D5740	Reline maxillary partial denture (direct)	No Cost
D5741	Reline mandibular partial denture (direct)	No Cost
D5750	Reline complete maxillary denture (indirect)	$15
D5751	Reline complete mandibular denture (indirect)	$15
D5760	Reline maxillary partial denture (indirect)	$15
D5761	Reline mandibular partial denture (indirect)	$15
D5810	Interim complete denture (maxillary)	$365
D5811	Interim complete denture (mandibular)	$365
D5820	Interim partial denture (including retentive/clasping materials and teeth) maxillary	$60
D5821	Interim partial denture (including retentive/clasping materials and teeth) mandibular	$60
D5850	Tissue conditioning (maxillary)	No Cost
D5851	Tissue conditioning (mandibular)	No Cost
D6000 – D6199	VII. IMPLANT SERVICES Implant Benefits are limited to a lifetime maximum benefit of $1,500. Member is responsible for specified co-payments and any charges exceeding the lifetime maximum benefit. Covered services are in lieu of covered benefits for fixed bridges or removable full or partial dentures. Services related to the surgical removal of an implant are not covered. An additional charge will be applied for any procedure using noble, high noble metal, or titanium, and will be the member's responsibility.	
D6010	Surgical placement of implant body	$1,550
D6058	Abutment supported porcelain/ceramic crown	$725
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$725

Code	Description	Standard Plan Enrollee Pays
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$645
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$685
D6062	Abutment supported cast metal crown (high noble metal)	$695
D6063	Abutment supported cast metal crown (predominantly base metal)	$645
D6064	Abutment supported cast metal crown (noble metal)	$685
D6065	Implant supported porcelain/ceramic crown	$725
D6066	Implant supported crown, porcelain fused to metal (titanium, titanium alloy, high noble metal)	$950
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$900
D6068	Abutment supported retainer for porcelain/ceramic FPD	$725
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$725
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$645
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$685
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$725
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$550
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$685
D6075	Implant supported retainer for ceramic FPD	$725
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$725
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$705
D6094	Abutment supported crown (titanium)	$650
D6200 – D6999	VIII. PROSTHODONTICS (fixed) (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge]) An additional charge will be applied for any procedure using noble, high noble metal, or titanium, and will be the member's responsibility. If porcelain, resin, or resin-based composite is used on molar crowns, the member is responsible for an additional $75 above the set crown copayment. Replacement of a crown or pontic requires the existing bridge to be 3 years old.	
D6205	Pontic — indirect resin based composite (excluding molars)	$50
D6210	Pontic — cast high noble metal	$50
D6211	Pontic — cast predominantly base metal	$50
D6212	Pontic — cast noble metal	$50
D6214	Pontic — titanium	$50
D6240	Pontic — porcelain fused to high noble metal	$50
D6241	Pontic — porcelain fused to predominantly base metal	$50
D6242	Pontic — porcelain fused to noble metal	$50
D6245	Pontic — porcelain/ceramic	$605
D6250	Pontic — resin with high noble metal	No Cost
D6251	Pontic — resin with predominantly base metal	No Cost
D6252	Pontic — resin with noble metal	No Cost
D6545	Retainer — cast metal for acid etch fixed prosthesis	$50
D6600	Retainer inlay — porcelain/ceramic, two surfaces	$505
D6601	Retainer inlay — porcelain/ceramic, three or more surfaces	$565
D6602	Retainer inlay — cast high noble metal, two surfaces	$450
D6603	Retainer inlay — cast high noble metal, three or more surfaces	$500
D6604	Retainer inlay — cast predominantly base metal, two surfaces	$435
D6605	Retainer inlay — cast predominantly base metal, three or more surfaces	$475

Code	Description	Standard Plan Enrollee Pays
D6606	Retainer inlay — cast noble metal, two surfaces	$310
D6607	Retainer inlay — cast noble metal, three or more surfaces	$490
D6608	Retainer onlay — porcelain/ceramic, two surfaces	$525
D6609	Retainer onlay — porcelain/ceramic, three or more surfaces	$575
D6610	Retainer onlay — cast high noble metal, two surfaces	$90
D6611	Retainer onlay — cast high noble metal, three or more surfaces	$90
D6612	Retainer onlay — cast predominantly base metal, two surfaces	$425
D6613	Retainer onlay — cast predominantly base metal, three or more surfaces	$545
D6614	Retainer onlay — cast noble metal, two surfaces	$595
D6615	Retainer onlay — cast noble metal, three or more surfaces	$555
D6624	Retainer inlay — titanium	$435
D6634	Retainer onlay — titanium	$460
D6710	Retainer crown — indirect resin based composite	$50
D6720	Retainer crown — resin with high noble metal	No Cost
D6721	Retainer crown — resin with predominantly base metal	No Cost
D6722	Retainer crown — resin with noble metal	No Cost
D6740	Retainer crown — porcelain/ceramic	$615
D6750	Retainer crown — porcelain fused to high noble metal	$50
D6751	Retainer crown — porcelain fused to predominantly base metal	$50
D6752	Retainer crown — porcelain fused to noble metal	$50
D6780	Retainer crown — 3/4 cast high noble metal	$50
D6781	Retainer crown — 3/4 cast predominantly base metal	$50
D6782	Retainer crown — 3/4 cast noble metal	$50
D6783	Retainer crown — 3/4 porcelain/ceramic	$635
D6790	Retainer crown — full cast high noble metal	$50
D6791	Retainer crown — full cast predominantly base metal	$50
D6792	Retainer crown — full cast noble metal	$50
D6794	Retainer crown — titanium	$50
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost
D7000 – D7999	IX. ORAL AND MAXILLOFACIAL SURGERY Includes preoperative and postoperative evaluations and treatment under a local anesthetic. Removal of asymptomatic third molars is not covered unless pathology exists. Biopsy of oral tissue does not include pathology laboratory services.	
D7111	Extraction, coronal remnants — deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal fap and removal of bone and/or section of tooth	No Cost
D7220	Removal of impacted tooth — soft tissue	No Cost
D7230	Removal of impacted tooth — partially bony	No Cost
D7240	Removal of impacted tooth — completely bony	No Cost
D7241	Removal of impacted tooth — completely bony, with unusual surgical complications	$15
D7250	Surgical removal of residual tooth roots (cutting procedure)	$15
D7251	Coronectomy – intentional partial tooth removal	$15

Code	Description	Standard Plan Enrollee Pays
D7260	Oroantral fistula closure	$700
D7261	Primary closure of a sinus perforation	$280
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$290
D7280	Exposure of an unerupted tooth	$305
D7283	Placement of device to facilitate eruption of impacted tooth	$155
D7285	Incisional biopsy of oral tissue — hard (bone, tooth)	No Cost
D7286	Incisional biopsy of oral tissue — soft	No Cost
D7287	Exfoliative cytological sample collection	$80
D7288	Brush biopsy — transepithelial sample collection	$75
D7310	Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions — one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions — one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor — lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor — lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess — intraoral soft tissue	$135
D7511	Incision and drainage of abscess — intraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	$225
D7520	Incision and drainage of abscess — extraoral soft tissue	$250
D7521	Incision and drainage of abscess — extraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	$750
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) — separate procedure	No Cost
D7963	Frenuloplasty	No Cost
D7970	Excision of hyperplastic tissue — per arch	$350
D7971	Excision of pericoronal gingiva	$170
D8000 – D8999	X. ORTHODONTICS	
D8010	Limited orthodontic treatment of the primary dentition	$800
D8020	Limited orthodontic treatment of the transitional dentition — child or adolescent to age 19	$950
D8030	Limited orthodontic treatment of the adolescent dentition — adolescent to age 19	$950
D8040	Limited orthodontic treatment of the adult dentition — adults, including covered dependent adult children	$1,000
D8050	Interceptive orthodontic treatment of the primary dentition	$1,000
D8060	Interceptive orthodontic treatment of the transitional dentition	$1,000
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,000
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,000

Code	Description	Standard Plan Enrollee Pays
D8660	Pre-orthodontic treatment visit	$30
D8670	Periodic orthodontic treatment visit (as Part of Contract)	$235
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)	$240
D9000 – D9999	XII. ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain — minor procedure	No Cost
D9120	Fixed partial denture sectioning	$75
D9210	Local anesthesia not in conjunction with operative or surgical procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$120
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$120
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$35
D9239	Intravenous moderate (conscious) sedation/anesthesia — first 15 minutes	$120
D9243	Intravenous moderate (conscious) sedation/anesthesia — each subsequent 15 minute increment	$120
D9248	Non-intravenous conscious sedation	$120
D9310	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) — no other services performed	No Cost
D9440	Office visit — after regularly scheduled hours	No Cost
D9450	Case presentation, detailed and extensive treatment planning	$105
D9910	Application of desensitizing medicament	$20
D9940	Occlusal guard, by report	$255
D9942	Repair and/or reline occlusal guard	$60
D9943	Occlusal guard adjustment	$70
D9944	Occlusal guard — hard appliance, full arch	$275
D9945	Occlusal guard — soft appliance, full arch	$275
D9946	Occlusal guard — hard appliance, partial arch	$275
D9951	Occlusal adjustment — limited	$80
D9952	Occlusal adjustment — complete	$235
D9971	Odontoplasty — per tooth	$70
D9972	External bleaching — per arch — performed in office	$125
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$120
D9986	Missed appointment — without 24 hours notice	$5
D9987	Canceled appointment — without 24 hours notice	$5
D9991	Dental case management — addressing appointment compliance barriers	No Cost
D9992	Dental case management — care coordination	No Cost
D9993	Dental case management — motivational interviewing	No Cost
D9994	Dental case management — patient education to improve oral health literacy	No Cost

II. LIMITATION OF BENEFITS

a. Limitations on Diagnostic and Preventive Benefits:

   1. Prophylaxis (cleanings), are limited to two treatments in any 12 consecutive months.
   2. Sealants are covered to the age of 18 and are limited to permanent first and second molars only.
   3. Fluoride treatments are a covered benefit up to the age of 18, once every 12 months.
   4. Full mouth x-rays are limited to one set every 24 consecutive months.
   5. Bite-wing x-rays are limited to not m ore than one series of four films in any six-month period.

b. Limitation on Basic Benefits:

   1. Periodontal treatments (sub-gingival curettage and root planning) are limited to five (5) quadrants in any 12 consecutive months.

c. Limitation on Crowns, Jackets and Cast Restorations:

   1. Crowns, jackets and cast restorations on the same tooth are limited to once every three (3) years.

d. Limitation on Prosthodontic Benefits:

   1. Full upper and/lower dentures are not to exceed one each in any three-year period. Replacement will be provided for an existing denture or bridge if it is unsatisfactory and cannot be made satisfactory.
   2. Partial dentures are not to be replaced within any three-year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
   3. The carrier will not cover the surgical removal of implants. Implant Benefits are limited to covered services and limited to a Lifetime Maximum Benefit of $1,500.
   4. Denture relines are limited to one during any 12 consecutive months.

e. Limitations and Exclusions on Orthodontic Benefits: Access Dental Plan guarantees that a covered State employee will not lose benefits as a result of a change in dental plan carriers. In the event that a covered employee should change dental plans and the orthodontist with the previous carrier is unwilling to complete the orthodontic treatment that has been started for the co payment that was agreed upon between the orthodontist and the enrollee, Access Dental Plan will contact the orthodontist and at-tempt to make arrangements for no loss of coverage. Should the orthodontist not meet Access Dental Plan's standards, the covered employee may transfer to an Access Dental Plan orthodontist and the orthodontic treatment plan will be completed for an amount not to exceed the total co-payment that the patient is obligated to pay under the Access Dental plan, including credit for any payments that have already been paid as a part of that treatment plan. When a covered employee is changing from the indemnity plan to the Access Dental Plan pre-paid plan, Benefits will be limited to any remaining unused portion of the insurance benefit maximum.

   1. Orthodontic treatment must be provided by a member of the Access Dental Plan orthodontic panel.
   2. Benefits cover 24 months of usual and customary orthodontic treatment.
   3. Access Dental Plan will cover an orthodontic benefit for a member co-payment of $1,000.00 (excluding start-up fees). Start-up fees shall not exceed $250.00. The orthodontic program covers all eligible persons.
   4. Start-up fee shall consist of the initial examination, diagnosis and consultation, and the retention phase of treatment of up to two (2) years maximum. This includes initial construction, placement and adjustments to retainers for a maximum period of two (2) years.
   5. Surgical procedures (including extractions) are not included as a benefit.
   6. There are no benefits for stolen, lost, or broken appliances.
   7. Cephalometric x-rays, tracings, photographs, and study models are not included as a benefit.

III. EXCLUSION OF BENEFITS

The following services are not covered benefits:

a. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services, which are provided to the enrollee by State government, or agency thereof, are provided without cost to the enrollee by any municipality, county or other subdivisions.

b. Elective or cosmetic dental care.

c. Treatment for Temporomandibular Joint (T.M.J.) disorder.

d. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or extraction solely for orthodontic purposes.

e. Treatment of malignancies, cysts, neoplasms or congenital malformations, except as otherwise indicated in the Schedule of Benefits.

f. Hospital charges of any kind.

g. Loss or theft of dentures or bridgework.

h. Dispensing of drugs not normally supplied in dental office.

i. General anesthesia and the services of a special anesthesiologist.

j. Treatment required by reason of war.

k. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.

l. Any service that is not specifically listed as a covered expense.

m. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limits of the enrollee.

n. Fees incurred for missed appointments or failure to notify panel dentist of cancellation 24 hours prior to appointment.

Optional Treatment Plans

When an enrollee chooses a plan of treatment that is more expensive than is customarily provided and it is an upgraded alternative procedure presented by the provider to satisfy the same function of the covered procedure, it is optional treatment. The enrollee must pay the differences in the provider's contracted fees for the two procedures plus any applicable co-payment for the covered procedure.

Dear New Member:

Welcome to Access Dental Plan! We are pleased you selected us as your provider of dental services. Enclosed are the following:

- Information regarding Plan benefits;
- Information on obtaining services during a dental emergency;
- Your Combined Evidence of Coverage and Disclosure Form.

Access Dental Plan is proud to provide you with dental coverage. Good oral health is essential for overall well-being. We believe that a balanced diet, routine brushing and regular check-ups are necessary ingredients in achieving good oral health.

Please review the information included in this packet and contact your Primary Care Dentist to arrange an immediate initial assessment appointment. This appointment is necessary if you have not received a dental treatment from a Dentist within the last 12 months. If you have any questions regarding this appointment or the materials in this packet, please call us at (866) 650-3660.

Again, thank you for selecting Access Dental Plan. We look forward to serving you.

Sincerely,

Dr. Roshani Mehta,

Estimado(a) Nuevo(a) Afiliado(a):

¡Bienvenido(a) al Plan Access Dental! Nos complace que nos haya seleccionado como su proveedor de servicios dentales. Se le adjunta lo siguiente:

- Información con respecto a los beneficios del Plan;
- Información sobre cómo obtener servicios durante una emergencia dental; y
- Su Prueba de Cobertura Y Formulario de Revelación de Datos Conjuntos.

El Plan Access Dental se enorgullece de proporcionarle a usted con cobertura dental. Una buena higiene bucal es esencial para su bienestar en general. Creemos que una dieta balanceada, el cepillado rutinario y los exámenes regulares son ingredientes necesarios para lograr una buena higiene bucal.

Por favor, revise la información que se incluye en este paquete y comuníquese con su dentista de atención primaria a fin de hacer los arreglos para concertar una cita para recibir una evaluación dental inicial. Esta cita es necesaria si usted no ha recibido tratamiento dental de un Dentista durante los últimos 12 meses. Si usted tiene alguna pregunta con respecto a esta cita o a los materiales en este paquete, por favor l lámenos al teléfono (866) 650-3660.

Nuevamente, gracias por seleccionar el Plan Access Dental. Esperamos poder servirle.

Atentamente,

Dr. Roshani Mehta, D.

Table of Contents

I. Introduction – Combined Evidence of Coverage and Disclosure Form

Using this Booklet

This booklet, called the Combined Evidence of Coverage and Disclosure Form, or "EOC," contains detailed information about Benefits, how to obtain Benefits, and the rights and responsibilities of Access Dental Plan's Members. Please read this booklet carefully and keep it on hand for future reference. **Upon request, the health plan contract will be provided to you. This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.**

Throughout this booklet, "you," "your," and "Member" refers to the Eligible Person enrolled in Access Dental Plan. "We," "Us," and "Our" always refers to Access Dental Plan. "Primary Care Dentist" refers to a licensed dentist who is responsible for providing initial and primary care dental services to Members, maintains the continuity of patient care, initiates referrals for specialist care, and coordinates the provision of all Benefits to Members in accordance with the policy.

Supersession: This EOC is a general description of benefits and requirements of this plan. The contract between the State and carrier is the complete description of this plan and is the controlling document over this plan.

Welcome! About the Dental Plan

Access Dental Plan (the "Plan") is a prepaid dental plan. The Plan provides comprehensive dental coverage for individuals who participate in the Access Dental Plan. The Plan has a panel of dentists from whom you select to receive necessary dental care. Many dental procedures covered require no Co-payment. In addition, the Plan has made the process of dental treatment convenient by eliminating cumbersome claim forms when a Member receives routine care from his or her Primary Care Dentist. Please review the information included in this document and contact your Primary Care Dentist to arrange an immediate initial assessment appointment. If a Member moves, the Member must contact the Plan's Member Service Representative to assist the Member in selecting a new Primary Care Dentist if the Member desires a Primary Care Dentist closer to the Member's new residence. If a Member moves temporarily outside the Service Area such as to attend school, the Member may remain with the Plan and receive care from his or her Primary Care Dentist upon returning to the Plan's Service Area. If a Member moves temporarily, the Member may obtain Emergency Care or Urgent Care from any dentist and the Plan will reimburse the Member for the costs, less applicable Co payments. If you have any questions regarding the material you are reading or the Plan, please contact Our Member Services toll-free number at (888) 534-3466.

Language Assistance Services

Access Dental Plan's Language Assistance Program provides language assistance services for our members with a non-English preferred language at no charge.

Interpreter and translation services at no charge to the member: Members can call our Member Service Line at (888) 534-3466 to access these free services (TDD/TTY for the hearing impaired at 1-800-735-2929).

Speak to a representative in your preferred language: Member Service representatives can answer your questions regarding benefits and eligibility and how to use your dental plan.

Find a provider who speaks your language: Member Service representatives can help you find a provider who speaks your language or who has a interpreter available. If you cannot locate a provider to meet your language needs, you can request to have an interpreter available for discussions of dental information at no charge.

Assistance filing a grievance: You have the right to file a grievance by mail or in person with the Plan or obtain assistance from the Department of Managed Health Care. You may request to speak with a representative in a specific language. The process for filing a grievance is described under the Grievances and Appeals section of this booklet.

Vital Documents: This notice of available language assistance services will be included with all vital documents sent to the member. Standardized vital documents will be translated into Spanish at no charge to enrollees. For vital documents that are not standardized, but which contain enrollee-specific information, the Plan shall provide the requested translation within 21 days of the receipt of the request for translation. It can be obtained by calling the Member Service Line at (888) 534-3466 (TDD/TTY for the hearing impaired at 1-800-735-2929).

Standardized vital documents:

- Welcome packet

- Benefit and Copay Schedule
- Exclusion and Limitation
- Grievance Form
- Member notification of change in Primary Care Dentist
- Privacy Notices
- HIPAA related forms

Provider Office: If you have a preferred language other than English, please inform your provider. Your provider will work with the Plan to provide language assistance services for you at no charge. You may request face-to-face interpreting service for an appointment by contacting Our Member Service Line. The Plan will provide timely access to Language assistance Services.

DHMO Coverage: The DHMO plan provides dental care coverage to you in accordance with the Schedule of Benefits. You must pay the applicable Co-payment to a Participating Provider at the time dental care is provided. The Exclusions and the Co-payment amounts are set forth in the Schedule of Benefits.

Member Identification Card: All Members of the Plan are given a Member Identification Card. This card contains important information for obtaining services. If you have not received or if you have lost your Member Identification Card, please call Us at (888) 534-3466 (TDD/TTY for the hearing impaired at 1-800-735-2929) and We will send you a new card. Please show your Plan Member Identification Card to your provider when you receive dental care.

Only the Member is authorized to obtain dental services using his or her Member Identification Card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your Member Identification Card, the Plan may not be able to keep you in Our plan.

II. Definitions

Acute Condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Benefits (Covered Services): Dental services and supplies that a Member is entitled to receive pursuant to the terms of this Agreement. A service is not a benefit (even if described as a covered service) or benefit in this booklet if it is not Dentally Necessary, or if it is not provided by an Access Dental Plan provider with authorization as required.

Complaint: A complaint is also called a grievance or an appeal. Examples of a complaint can be when:

- You can’t get a service, treatment, or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Coordination of Benefits (COB): The provision which applies when a covered person is covered by more then one plan at the same time. It is designed so that the payments of both plans do not exceed 100% of the covered charges. COB also designates the order in which the plans are to pay benefits.

Co-payment: A fee, which the Plan provider may collect directly from a Member for a particular covered benefit at the time the service is rendered.

Dental Plan or Plan: Access Dental Plan.

Dentally Necessary: Necessary and appropriate dental care for the diagnosis according to professional standards of practice generally accepted and provided in the community. The fact that a dentist may prescribe, order, recommend or approve a service or supply does not make it Dentally Necessary. We employ Dental Consultants who make the final determination on what is Dentally Necessary. You are bound by the determination of what is considered Dentally Necessary by Our Dental Consultants.

DHMO: Dental Health Maintenance Organization. 2

Eligible Dependent: Any of the dependents of an Eligible Employee who are eligible to enroll for Benefits and who meet the conditions of eligibility. Eligible children are defined as natural, adopted, step, or domestic partner's children, up to the age of 26. (Spouse or children of an Eligible Dependent are not eligible for benefits.)

Eligible Employee: Any employee who meets the conditions of eligibility.

Emergency Care: A dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's dental health in serious jeopardy, or
- Causing serious impairment to the Member's dental functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Exclusion: Any dental treatment or service for which the Program offers no coverage.

Experimental or Investigational Service: Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or if safety and efficacy have not been determined for use in the treatment of a particular dental condition for which the item or service in question is recommended or prescribed.

Evidence of Coverage and Disclosure Form (EOC): This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and Benefits.

Grievance: A written or oral expression of dissatisfaction regarding the Plan and/or a provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Group: The client (employer, or other organization) contracting to obtain dental Benefits for Eligible Employees.

Interpreting Service: The Plan's contracted vendor which provides phone and face-to-face language interpreting service.

Language Assistance Services: Translation of standardized and enrollee-specific vital documents into threshold languages and interpretation services at all points of contact.

Limited English Proficient or LEP Member: A member who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

Member: An Eligible Employee or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Member Identification Card: The identification card provided to Members by Access Dental Plan that includes the Member number, Primary Care Dentist information, and important telephone numbers.

Non-Participating Provider: A provider who has not contracted with Access Dental Plan to provide services to Members.

Open Enrollment Period: The period preceding the date of commencement of the Term or the period preceding the annual anniversary of the commencement of the Contract Term or a period as otherwise requested by the Applicant and agreed to by Access Dental Plan.

Optional Benefit: A dental benefit that you choose to have upgraded. For example, when a filling would correct the tooth but you choose to have a full crown instead.

Overage Dependent: An Employee's dependent child who is age 26 or over. 3

Participating Provider: A dentist or dental facility licensed to provide Covered Services who or which at the time care is rendered to a Member, has a contract in effect with Access Dental Plan to provide Covered Services to its Members.

Premium: Payments by an Eligible Person for coverage of a level of benefits for a specified time.

Primary: For the purpose of Coordination of Benefits, the dental plan determined to be the plan which must pay for Benefits first when the Eligible Person is covered by Us and another plan.

Primary Care Dentist: A duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed. A dentist, who is responsible for providing initial and primary care to Members, maintains the continuity of patient care, initiates referral for specialist care, and coordinates the provision of all

Benefits to Members in accordance with the policy.

Prior Authorization: The process by which Access Dental Plan determines if a procedure or treatment is a referable Benefit under the Eligible Enrollee's plan.

Program: DHMO Plan

Protected Health Information (PHI): Information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Provider Directory: The directory of all the providers contracted with Access Dental Plan to provide services to its Members.

Qualified Beneficiary: An Eligible Person covered by a group health plan, or Eligible Dependent of such an Eligible Person, as of the day before a COBRA Qualifying Event takes place and includes any of the following persons who are not entitled to Medicare on the day before a Qualifying Event:

1. You, the employee.
2. An employee's spouse.
3. An employee's former spouse (or legally separated spouse)
4. An employee's domestic partner.
5. A dependent child.

Qualifying Event: The actual day the even occurs e.g., the actual last day of work, or the date the divorce becomes legal and includes any of the following which results in loss of coverage for a Qualified Beneficiary:

1. Your employment ends, for a reason other than gross misconduct.
2. Your work hours are reduced.
3. Your marriage is dissolved.
4. You become legally separated from your spouse or domestic partner.
5. Your death.
6. You become entitled to Benefits under Medicare.
7. You are retired and your former employer files for bankruptcy. (This Qualifying Event applies only to Federal COBRA.)
8. Your child stops being an Eligible Dependent.

Second Opinion: The process of seeking an evaluation by another doctor or surgeon to confirm the diagnosis and treatment plan of a Primary Care Dentist or to offer an alternative diagnoses and/or treatment approach.

Service Area: The geographic area in the State of California where the Department of Managed Health Care has authorized Access Dental Plan to provide dental services.

Specialist (Specialty) Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry and which must be preauthorized in writing by Access Dental Plan.

Threshold language(s): The language(s) identified by the Plan. Generally, threshold languages are determined by the size of the dental plan.

Timely: In a manner appropriate for the situation in which language assistance is needed.

Treatment in Progress: Any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the Access Dental Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

Urgent Care: Dental care needed to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed, and includes Out-of-area dental services needed to prevent

serious deterioration of a Member's dental health resulting from unforeseen illness or injury for which treatment cannot be delayed until the member returns to the Service area.

Vital documents: The following documents, when produced by the Plan, including when the production or distribution is delegated by the plan to a dental provider or administrative services provider:

Letters containing important information regarding eligibility and participation criteria;

Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal;

Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees;

Explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee; and

The standard disclosure of benefits, limitations and exclusions, and co-payments document.

We, Us and Our: Access Dental Plan.

III. Member Rights and Responsibilities

As an Access Dental Plan Member, you have the right to:

- Be treated with respect and dignity.
- Choose your Primary Care Dentist from Our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your dental care needs, including appropriate or Dentally Necessary treatment options for your condition(s), regardless of cost or regardless of whether the treatment is covered by the Plan.
- Have your dental records kept confidential. This means that We will not share your dental care information without your written approval or unless it is required by law.
- Voice your concerns about the Plan, or about dental services you received, to Access Dental Plan.
- Receive information about Access Dental Plan, Our services, and Our providers.
- Make recommendations about your rights and responsibilities.
- See your dental records.
- Get services from providers outside of Our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family Members or friends.
- Receive Member materials translated into your language.
- File a complaint if your linguistic needs are not met.

Your responsibilities are to:

- Give your providers and Access Dental Plan correct information.
- Understand your dental problems(s) and participate in developing treatment goals, as much as possible, with your provider.
- Always present your Member Identification Card when getting services.
- Ask questions about any dental condition and make certain that the explanations and instructions are understandable.
- Make and keep dental appointments. You should inform your provider at least 24 hours in advance when an appointment must be canceled.
- Help Access Dental Plan maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health care coverage.

- Notify Access Dental Plan as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all Access Dental Plan personnel and providers respectfully and courteously.

IV. Accessing Care

Physical Access

Access Dental Plan has made every effort to ensure that Our offices and the offices and facilities of the Plan providers are accessible to the disabled. If you are not able to locate an accessible provider, please call Us toll free at (888) 534-3466 and We will help you find an alternate provider.

Access for the Hearing Impaired

The hearing impaired may contact Us through Our TDD number at 1-800-735-2929, Monday through Friday, from 8:00 AM to 6:00 PM. Between 6:00 PM and 8:00 AM and on weekends, please call the California Relay Service TTY at 1-800-735-2929 to get the help you need.

Access for the Vision Impaired

This Evidence of Coverage (EOC) and other important Plan materials will be made available in large print, enlarged computer disk formats, and audiotape for the vision impaired. For alternative formats, or for direct help in reading the EOC and other materials, please call Us at (888) 534-3466.

The Americans with Disabilities Act of 1990

Access Dental Plan complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects Members with disabilities from discrimination concerning Program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any Program or activity which receives or Benefits from federal financial assistance, nor be denied the Benefits of, or otherwise be subjected to discrimination under such a Program or activity.

V. Eligibility, Effective Dates, Termination

The following provisions set forth the general eligibility provisions under this Policy.

Eligibility for Coverage

You are eligible for coverage if:

1. You are an Eligible Employee as defined in the Definitions section of this Evidence of Coverage;
2. You are in an Eligible Employee class that is eligible for coverage under the policy; and
3. You have satisfied the Group's eligibility waiting period specified in your employer's group policy.

You are eligible for coverage for your Eligible Dependents if:

1. You have one or more Eligible Dependent, as defined in the Definitions section of this Evidence of Coverage; and
2. You enroll for dependent coverage.

You cannot be covered as both an Eligible Employee and an Eligible Dependent under the policy.

Effective Date of Coverage for You

Your coverage will become effective once you have satisfied the eligibility wait period specified in your employer's group policy. In order for your coverage to become effective, the State must provide eligibility information to Us and pay any required Premiums.

Effective Date of Coverage for Your Eligible Dependents

Coverage effective dates for Your Eligible Dependents will be determined by the State. In order for coverage to become effective for Your Dependents, the State must provide eligibility information to Us and pay any required Premiums.

Effective Date for Adding New Eligible Dependents (other than Newborn and Adopted Children)

Any Eligible Dependents who are eligible for coverage after your effective date of coverage (e.g., by marriage), will be

covered on the first of the month after the date they become eligible. In order for coverage to become effective for Your Dependent, the State must provide eligibility information to Us and pay any required Premiums.

Verification of Overage Dependent Status

An Overage Dependent is a dependent age 26 or over. The Overage Dependent is eligible to be enrolled under the Policy if the dependent is age 26 or over and incapable of self-sustaining employment by reason of a physical or mental injury, illness or condition and who is chiefly dependent upon the Eligible Employee or Eligible Employee's spouse for support and maintenance.

The State will determine eligibility for Overage Dependents. Please contact the Department of Personnel Administration or CalPERS for further information regarding overage dependents.

Effective Date of Coverage for Newborn Children

The effective date of coverage for a child born to you or your dependent spouse, while your coverage is in effect, will be determined by the State's eligibility policy. In order for coverage to become effective for Your Dependent, the State must provide eligibility information to Us and pay any required Premiums.

Effective Date of Coverage for Adopted Children

Coverage for a child adopted by you or your dependent spouse, while your coverage is in effect, will be determined by the State's eligibility policy. In order for coverage to become effective, the State must provide eligibility information to Us and pay any required Premiums.

Court Ordered Coverage for a Dependent

If a court has ordered you to provide coverage for a spouse or minor child, coverage will be effective the first of the month following the date of the court order. In order for coverage to become effective, the State must provide eligibility information to Us and pay any required Premiums.

Deferred Effective Date of Eligible Dependent Coverage

Initial coverage or a benefit increase will not become effective for an Eligible Dependent who is confined in an institution due to illness or injury on the date he or she would otherwise be eligible for coverage or benefit increase. Coverage or the increase in Benefits will not become effective until he or she is no longer confined. This provision does not apply to newborn children.

Termination of Coverage

Your coverage may terminate on the earliest of the following dates:

1. The date the policy, issued to your employer by Us, is canceled.
2. The date that you or the Group fails to make a required Premium. A Member could reinstate coverage for non-payment of Premium. See the section below entitled "Reinstatement of coverage for you and your Eligible Dependents."
3. The last day of the month in which your employment with the employer terminates.
4. The last day of the month in which you are no longer in an Eligible Employee.
5. The last day of the month in which you enter active duty with the armed forces of any country.
6. The date a Member becomes covered under another dental plan which is sponsored by the employer.
7. Upon written notice from Us if We determine that a Member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage. A Member could appeal the Plan's decision to terminate coverage. See the section below entitled "Reinstatement of coverage for you and your Eligible Dependents."
8. Upon written notice from Us if a Member permits any other person to use his or her Member Identification Card to obtain services under this dental plan. A Member could appeal the Plan's decision to terminate coverage. See the section below entitled "Reinstatement of coverage for you and your Eligible Dependents."
9. Upon written notice from Us if a Member assaults or threatens bodily injury to one of Our employees or an

affiliate or an employee of a provider. A Member could appeal the Plan's decision to terminate coverage. See the section below entitled "Reinstatement of coverage for you and your Eligible Dependents."

10. The Member fails to pay Co-payments. A Member could appeal the Plan's decision to terminate coverage. See the section below entitled "Reinstatement of coverage for you and your Eligible Dependents."

Your Eligible Dependents' coverage will terminate on the earliest of the following dates:

1. The date that your coverage terminates.
2. The date that you or the Group fails to make a required contribution or payment for Eligible Dependent Premiums.
3. The last day of the month in which an Eligible Dependent no longer meets the definition of Eligible Dependent.
4. For any Eligible Dependent, the last day of the month in which he or she enters active duty with the armed forces of any country.

Under certain conditions, when coverage terminates, you and your Eligible Dependents may be eligible to have dental coverage continued. Please refer to the "Continuation Options" section of this Evidence of Coverage for details.

Reinstatement of Coverage for you and your Eligible Dependents

Receipt by us of the proper monthly periodic Premium and Co-payment after cancellation for nonpayment of Premiums or Co-payments shall reinstate coverage as though it had never been cancelled, if such payment is received on or before the due date of the succeeding periodic Premium fee. However, we may avoid such reinstatement by one or more of the following methods:

1. Specifying in the notice of cancellation, that if payment is not received within fifteen (15) days of issuance of such notice, a new application will be required and a new contract issued or the original agreement reinstated or;
2. If such payment is received more than fifteen (15) days after issuance of the notice of cancellation, and the Plan refunds such payment within twenty (20) business days, or;
3. If such payment is received more than fifteen (15) days after issuance of the notice of cancellation, and the Plan issues to the Group within twenty (20) business days a receipt of such payment, along with a new contract accompanied by written notice stating clearly those aspects in which the new agreement differs from the canceled agreement in benefits, coverages and other aspects.
4. In the case of a Member who (1) performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage, (2) permitted any other person to use his or her Member Identification Card to obtain services under this dental plan, or (3) assaulted or threatens bodily injury to one of Our employees or an affiliate or an employee of a provider, the Plan will inform the Member and the Group in writing 90 days prior to the effective date of disenrollment. If the Member or Group desires to appeal the Plan's decision to terminate coverage of the Member, the Member, the Member's representative or the Group shall appeal in writing the Plan's decision. The appeal shall be provided to the Plan's Member Service Department within 30 days of receipt of the Plan's notice of disenrollment. Upon receipt by the Plan of the Member's appeal, the Plan shall meet with the Member and the Group to resolve the dispute. If the parties cannot resolve the dispute, the effective date of termination shall be 60 days from the date the parties met to resolve the dispute.

Reinstatement of coverage is subject to the State's policy on eligibility and enrollment, including continuity of enrollment.

Exceptions to Termination of Coverage

Your coverage will not terminate solely because you cease to be at work on a full-time basis. Your coverage could be continued through Direct Pay, SDI or as determined by your Employer.

Your Eligible Dependent child's dental coverage will not terminate when he or she reaches the limiting age, if he or she is incapable of self-support due to mental retardation or physical incapacity at that time.

Coverage for the Eligible Dependent child may be continued as long as the disability and dependency exist and you remain covered under the policy.

An enrollee who believes that enrollment has been canceled or not renewed because of the enrollee's health status or requirements for health care services, may request a review by the Director of the California Department of Managed Health Care in accordance with Section 1365(b) of the California Health and Safety Code.

VI. Continuation Options

A Member, who is a Qualified Beneficiary, and who loses coverage due to a Qualifying Event, may continue their coverage if they meet the requirements for timely election of COBRA coverage and make timely payments as specified below. In addition, continuation coverage may be available during a family leave as specified under "Continuation of Coverage During Family and Medical Leave" below.

Definitions Applicable to Cobra

COBRA means Federal COBRA rights applicable to employers with 20 or more Eligible Employees who are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Qualifying Event means any of the following which results in loss of coverage for a Qualified Beneficiary:

1. Your employment ends, for a reason other than gross misconduct.
2. Your work hours are reduced.
3. Your marriage is dissolved.
4. You become legally separated from your spouse.
5. Your death.
6. You become entitled to Benefits under Medicare.
7. You are retired and your former employer files for bankruptcy. (This Qualifying Event applies only to Federal COBRA.)
8. Your child stops being an Eligible Dependent.

Qualified Beneficiary means any of the following persons who are not entitled to Medicare on the day before a Qualifying Event:

1. You, the employee.
2. An employee's spouse.
3. An employee's former spouse (or legally separated spouse).
4. An employee's domestic partner.
5. A dependent child.

General Cobra Provisions

Employer's Responsibility Under Federal COBRA (Employers with 20 or more Employees)

If the employer is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, the employer is responsible for meeting all of the obligations under COBRA, including notifying all covered employees and dependents of their rights under COBRA. If the employer fails to meet its obligations under COBRA, We will not be liable for any claims incurred by you or any of your covered dependents after termination of coverage.

Continuing Coverage under COBRA

If you choose continuation coverage, your coverage will be identical to the coverage provided under the policy to similarly situated employees and dependents to which a Qualifying Event has not occurred. You do not have to show that you are insurable to choose continuation coverage. Coverage will continue until the earliest of the following dates:

18 months from the date that the Qualified Beneficiary's coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.

If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled at the time that the employee's employment stopped or work hours were reduced, that Qualified Beneficiary may elect an additional 11 months of coverage, subject to the following conditions:

- The Qualified Beneficiary must provide the employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18 months; and
- The Qualified Beneficiary must agree to pay any increase in the required Premium necessary to continue the

coverage for the additional 11 months.

- 36 months from the date coverage would have stopped due to a Qualifying Event other than those described above.
- The date that this policy stops being in force.
- The date that the Qualified Beneficiary fails to make the required payment for coverage.
- The date that the Qualified Beneficiary becomes entitled to Benefits under Medicare.
- The date that the Qualified Beneficiary, after electing this continuation, becomes covered under any other group dental plan. (This does not apply if the other group dental plan excludes or limits coverage for a Qualified Beneficiary's pre-existing condition.)

If a Qualified Beneficiary is already covered under any other group dental plan and elects continuation of dental coverage under this policy, the Qualified Beneficiary must stop coverage under the other group dental plan.

If after the Qualifying Event, another Qualifying Event occurs, coverage can be continued for an additional period, up to 36 months from the date coverage would have stopped due to the first Qualifying Event.

If an employee becomes entitled to Medicare within an 18-month continuation period, a Qualified Beneficiary may continue coverage for an additional 36 months beginning on the date the employee becomes entitled to Medicare. Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Notification Requirements Under COBRA

- A Qualified Beneficiary must notify the employer or plan administrator within 60 days when any of the following Qualifying Events happen:
- The Qualified Beneficiary's marriage is dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse or domestic partner.
- A child stops being an Eligible Dependent.

The employer or plan administrator will send the appropriate election form to the Qualified Beneficiary within 14 days after receiving this notice.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date of the Qualifying Event.
- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the person receives notice of the right to continue coverage.

Unless otherwise specified, an employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Coverage Effective Date

Coverage will become effective on the day after coverage would otherwise be terminated. However, coverage will not be activated until the appropriate Premium has been received by Us.

Termination of Coverage Due to Non-Election

If you do not elect coverage and pay the Premium, your group dental insurance coverage will terminate in accordance with the provisions outlined in the policy.

Required Premium

The cost of continuation of coverage under COBRA will be 102% of the applicable group rate (including any portion previously paid by the employer). However, for Qualified Beneficiaries determined by the Social Security Administration to have been disabled at the time that the employee's employment stopped or work hours were reduced, the cost will be the applicable group rate (including any portion previously paid by the employer) for the additional 11 months.

Continuation of Coverage During Family and Medical Leave

If the employer is subject to the requirements of The Family and Medical Leave Act of 1993 (FMLA), you may be eligible

to continue coverage during a family leave. Consult your employer for details.

VII. Using the Dental Plan

Facilities / Locations

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

The Plan's Primary Care Dentists are located close to where you work or live. You may obtain a list of Access Dental Plan's participating providers and their hours of availability by calling the Plan at (888) 534-3466. A list of the Plan's participating providers can be found in the Provider Directory or online at **www.socdhmo.com.**

Choosing a Primary Care Dental Provider

Members must select a Primary Care Dentist from the list of providers listed in the Provider Directory. The Member should indicate his/her choice of Primary Care Dentist on the enrollment application. Members from the same family may select different Primary Care Dentists. Should any Member fail to select a Primary Care Dentist at the time of enrollment, the Plan will assign the Member to an available Primary Care Dentist, who practices in close proximity to where the Member resides. Each Member's Primary Care Dentist (in coordination with the Plan) is responsible for the coordination of the Member's dental care. **Except for Emergency Dental Care, any services and supplies obtained from any provider other than the Member's Primary Care Dentist without an approved referral by the Plan will not be paid by the Plan**. To receive information, assistance, and the office hours of your Primary Care Dentist, Members should contact a Member Service Representative by calling (888) 534-3466 during regular business hours.

As a Member of the Plan, you are eligible for Covered Services from a Plan provider. To find out which providers and facilities contract with the Plan, please refer to your Provider Directory. There is no charge for Covered Services (except Co-payments) provided by your Primary Care Dentist, or in the case of care provided by someone other than your Primary Care Dentist, approved by the Plan, or when an Emergency Care condition exits.

You should not receive a bill for a Covered Service from a Plan provider (except for Co-payments). However, if you do receive a bill, please contact the Plan's Member Services Department. The Plan will reimburse a Member for Emergency Care or Urgent Care services (less any applicable Co-payment). You will not be responsible for payments owed by the Plan to contracted Plan providers. However, you will be liable for the costs of services to providers who are not contracted with the Plan if you receive care without Prior Authorization (unless services are necessary as a result of an Emergency Care condition). If you choose to receive services, which are not Covered Services, you will be responsible for payment of those services.

Scheduling Appointments

Provider offices are open during normal business hours and some offices are open Saturday on a limited basis. If you cannot keep your scheduled appointment, you are required to notify the dental office at least 24 hours in advance. A fee of $5.00 will be charged by your Primary Care Dentist for failure to cancel an appointment without 24 hours prior notification. Members may call the provider directly to schedule an appointment or contact the Plan and the Plan will assist the Member in scheduling a dental appointment. If the Member requires specialty care, the Member's Primary Care Dentist will contact the Plan who will arrange for such care.

Primary Care Dentists are required to provide Covered Services to Members during normal working hours and during such other hours as may be necessary to keep Member's appointment schedules on a current basis.

Appointments for routine, preventive care and specialist consultation shall not exceed three weeks from the date of the request for an appointment. **Wait time in the Primary Care Dentist's office shall not exceed 30 minutes.**

Changing Your Provider

A Member may transfer to another Primary Care Dentist by contacting the Plan at (888) 534-3466 and requesting such a transfer. A Member may change to another Primary Care Dentist as often as once each month. If the Plan receives the request before the 25th of the month, the effective date of the change will be the first day of the following month. All requests for transfer are subject to the availability of the selected Primary Care Dentist. 11

Continuity of Care for New Members

Under some circumstances, the Plan will provide continuity of care for new Members who are receiving dental services

from a Non-Participating Provider when the Plan determines that continuing treatment with a Non-Participating Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving dental services from a Non-Participating Provider if you were receiving this care before enrolling in the Plan and if you have one of the following conditions:

- An Acute Condition. Completion of Covered Services shall be provided for the duration of the Acute Condition.
- A serious chronic condition. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Plan in consultation with you and the Non-Participating Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with the Plan.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the Non-Participating Provider to occur within 180 days of the time you enroll with the Plan.

Please contact Us at (888) 534-3466 to request continuing care or to obtain a copy of Our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable Co-payments under this plan.

We will request that the Non-Participating Provider agree to the same contractual terms and conditions that are imposed upon Participating Providers providing similar services, including payment terms. If the Non-Participating Provider does not accept the terms and conditions, the Plan is not required to continue that provider's services. The Plan is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Access Dental Plan coverage. Continuity of care does not provide coverage for Benefits not otherwise covered under this EOC.

All such notifications by a Member may be made to any Plan office. All such notifications shall be forwarded to the Plan's Dental Director for action. The Dental Director shall respond in writing to the Member within a dentally appropriate period of time given the dental condition involved, and in no event more than five (5) days after submission of such notification to the Plan.

Continuity of Care for Termination of Provider

If your Primary Care Dentist or other dental care provider stops working with Access Dental Plan, We will let you know by mail 60 days before the contract termination date.

The Plan will provide continuity of care for Covered Services rendered to you by a provider whose participation has terminated if you were receiving this care from this provider prior to the termination and if you have one of the following conditions:

- An Acute Condition. Completion of Covered Services shall be provided for the duration of the Acute Condition.
- A serious chronic condition. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Plan in consultation with you and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with the Plan.
- Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the terminated provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. You must be under the care of the Participating Provider at the time of Our termination of the provider's participation. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with the Plan prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, We are not required to continue the provider's services beyond the contract termination date.

Please contact Us at (888) 534-3466 to request continuing care or to obtain a copy of Our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Continuity of care does not provide coverage for Benefits not otherwise covered under this EOC. If your request is approved, you will be financially responsible only for applicable Co-payments under this plan.

If We determine that you do not meet the criteria for continuity of care and you disagree with Our determination, see the Plan's Grievance and Appeals Process in this EOC.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at **www.hmohelp.ca.gov.**

Prior Authorization for Services

Your Primary Care Dentist will coordinate your dental care needs and, when necessary, arrange Specialty Services for you. In some cases, the Plan must authorize certain services and/or Specialty Services before you receive them. Your Primary Care Dentist will obtain the necessary referrals and authorizations for you. Some services, such as Emergency Care, do not require Prior Authorization before you receive them.

If you see a specialist or receive Specialty Services before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If the Plan denies a request for Specialty Services, the Plan will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals to Specialists

Your Primary Care Dentist may refer you to another dentist for consultation or specialized treatment. Your Primary Care Dentist will submit a request to the Plan for authorization to see a specialist. Once your Primary Care Dentist determines that you require the care of a specialist, your Primary Care Dentist will determine if you need an emergency referral or a routine referral. The Plan processes emergency referrals immediately by calling a specialist to coordinate the scheduling of an appointment for you with the specialist. Routine referrals are processed in a timely fashion appropriate for your condition, not to exceed five (5) business days of receipt. Referrals affecting care where you face an imminent and serious threat to your health or could jeopardize your ability to regain maximum function shall be made in a timely fashion appropriate for your condition, not to exceed 72-hours after the Plan's receipt of the necessary documentation requested by the Plan to make the determination. Copies of authorizations for regular referrals are sent to you, the specialist and your Primary Care Dentist. Decisions resulting in denial, delay or modification of requested health care services shall be communicated to you in writing within two (2) days of the decision. The Plan reserves the right to determine the facility and Plan provider from which Covered Services requiring specialty care are obtained.

All services must be authorized before the date the services are provided, except for services provided by your Primary Care Dentist for Emergency Care services. If the services are not authorized before they are provided, they will not be a Covered Services, even if the services are needed.

The Plan covers Prior Authorized Specialty Services in all of its approved Service Areas. If you require Specialty Services, the Plan will refer you to a Participating Provider who is qualified and has agreed to provide the required specialty dental care. If a Participating Provider is unavailable to provide the necessary Specialty Service, the Plan will refer you to a non-Participating Provider, who is a specialist in the dental care you require. The Plan will make financial arrangements with a non-Participating Provider to treat you. In both instances, you are financially obligated to pay only the applicable Co-payment for the Covered Service. The Plan will pay the dentist any amounts that are in excess of the applicable Co-payment for the authorized Specialty Service.

This is a summary of the Plan's referral policy. To obtain a copy of Our policy please contact Us at (888) 534-3466 (TDD/TTY for the hearing impaired at 1-800-735-2929).

If your request for a referral is denied, you may appeal the decision by following the Plan's Grievance and Appeal Process found in this EOC.

Obtaining a Second Opinion

Sometimes you may have questions about your condition or your Primary Care Dentist's recommended treatment plan. You may want to get a Second Opinion. You may request a Second Opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment.
- Your provider's advice is not clear, or it is complex and confusing.
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.

- The treatment plan in progress has not improved your dental condition within an appropriate period of time.
- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

Members or providers may request a Second Opinion for Covered Services. After you or your Primary Care Dentist have requested permission to obtain a Second Opinion, the Plan will authorize or deny your request in an expeditious manner. If your dental condition poses an imminent and serious threat to your health, including but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function; your request for a Second Opinion will be processed within 72 hours after the Plan receives your request.

If your request to obtain a Second Opinion is authorized, you must receive services from a Plan provider within Our dental network. If there is no qualified provider in Our network, the Plan will authorize a Second Opinion from a Non-Participating Provider. You will be responsible for paying any applicable Co-payments for a Second Opinion.

If your request to obtain a Second Opinion is denied and you would like to appeal Our decision, please refer to the Plan's Grievance and Appeals Process in this EOC.

This is a summary of the Plan's policy regarding Second Opinions. To obtain a copy of Our policy, please contact Us at (888) 534-3466.

Getting Urgent Care

Urgent Care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan covers Urgent Care services any time you are outside Our Service Area or on nights and weekends when you are inside Our Service Area. To be covered by the Plan, the Urgent Care service must be needed because the illness or injury will become much more serious, if you wait for a regular doctor's appointment. On your first visit, talk to your Primary Care Dentist about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed.

To obtain Urgent Care when you are **inside** the Plan's Service Area on nights and weekends, the Member must notify his or her Primary Care Dentist, describe the Urgent Condition, and make an appointment to see his or her Primary Care Dentist within 24 hours. If the Primary Care Dentist is unable to see the Member within the 24-hour period, the Member must immediately contact the Plan at (888) 534-3466 and the Plan will arrange alternative dental care.

To obtain Urgent Care when you are **outside** the Plan's Service Area, the Member should seek care from any Non-Plan Provider. Services that do not meet the definition of Urgent Care will not be covered if treatment was provided by a Non-Plan Provider. Non-Plan Providers may require the Member to make immediate full payment for services or may allow the Member to pay any applicable Co-payments and bill the Plan for the unpaid balance. If the Member has to pay any portion of the bill, the Plan will reimburse the Member for services that meet the definition of Emergency Care or Urgent Care as defined above. If the Member pays a bill, a copy of the bill or invoice from the dentist who provided the care and a brief explanation of the circumstances that gave rise to the needed dental care should be submitted to the following address:

Access Dental Plan,
Attention: Claims Department,
P. O. Box 38313
Phoenix, AZ 85069

Benefits for Emergency Care not provided by the Primary Care Dentist are limited to a maximum of $100.00 per incident, less the applicable Co-payment. If the maximum is exceeded, or the above conditions are not met, the Eligible enrollee is responsible for any charges for services by a provider other than their Primary Care Dentist.

If you seek emergency dental services from a provider located more than 25 miles away from your participating provider, you will receive emergency benefits coverage up to a maximum of $100, less any applicable co-payments.

If you receive emergency dental services, you may be required to pay the provider who rendered such emergency dental service and submit a claim to the Plan for a reimbursement determination. Claims for Emergency Care should be sent to Access Dental Plan within 180 days of the end of treatment. Valid claims received after the 180-day period will be reviewed if the Eligible Enrollee can show that it was not reasonably possible to submit the claim within that time.

Decisions relating to payment or denial of the reimbursement request will be made within thirty (30) business days of the date of all information reasonably required to render such decision is received by the Plan.

Once the Member has received Urgent Care, the Member must contact his or her Primary Care Dentist (if the Member's own Primary Care Dentist did not perform the dental care) for follow-up care. The Member will receive all follow-up care from his or her own Primary Care Dentist.

Getting Emergency Services

Emergency Care is available to you 7 days per week, twenty-four (24) hours a day, both inside and outside Our Service Area.

If you need Emergency Care during regular Provider office hours, Members may obtain care by contacting a Primary Care Dentist or any available dentist for Emergency Care. After business hours, Members should first attempt to contact his or her Primary Care Dentist if the Member requires Emergency Care or Urgent Care services. If a Member's Primary Care Dentist is unavailable, the Member may contact the Plan's twenty-four (24) hour answering service at (888) 534-3466. The on-call operator will obtain information from the Member regarding the Emergency Care and relay the information to a dental provider. This provider will then telephone the Member as soon as possible but not to exceed one (1) hour from the time of the Members call to the answering service. The Plan provider will assess the Emergency and take the appropriate action.

Non-Covered Services

The Plan does not cover dental services that are not Emergency or Urgent Care if you reasonably should have known that an Emergency or Urgent Care situation did not exist. You will be responsible for all charges related to these services.

Follow-Up Care

After receiving any Emergency or Urgent Care services, you will need to call your Primary Care Dentist for follow-up care.

Co-payments

Members are required to pay any Co-payments listed in the Schedule of Benefits directly to the provider. Charges for broken appointments (unless notice is received by the provider at least 24 hours in advance or a Dental Emergency prevented such notice) and charges for Emergency Care visits after normal visiting hours are also shown on Schedule of Benefits.

Member Liabilities

Generally, the only amount a Subscriber pays for covered services is the required co-payment. However, you may be financially responsible for specialty services you receive without obtaining a referral or authorization. You may also be responsible for services you receive that are not covered services; non-emergency services received in the emergency room; non-emergency or non-urgent services received outside of the Plan's service area without prior authorization; and, unless authorized, services received that are greater than the limits specified in this Evidence of Coverage booklet. The Plan is responsible to pay for coverage of emergency services. You are not responsible to pay the provider for any sums owed by the health plan.

If the Plan does not pay a non-participating provider for covered services, you may be liable to the non-participating provider for the cost of the services. But, you may request reimbursement from the Plan for your payment to the non-participating provider for sums owed by the Plan for these covered services. You may also be liable for payment of non-covered services, whether received from a participating or non-participating provider.

In the event that the Plan fails to pay a participating provider, you will not be liable to the participating provider for any sums owed by the Plan for covered services you received while covered under your plan. This provision does not prohibit the collection of co-payments or fees for any non-covered services rendered by a participating provider. In addition, if you choose to receive services from a non-contracted provider, you may be liable to the non-contracted provider the cost of services unless you received prior approval from Access Dental Plan, or in accordance with emergency care provisions.

Prepayment of Fees

The Plan contracts with your employer and your employer has detailed information as to the Premium amount we charge to provide Covered Services to you and your Eligible Dependents. In addition, your employer will provide the amount of the Premium they cover and the amount that you must pay and deducted from your monthly salary, if any. Please contact

your employer's benefits administer with respect to Premium information, including the amount deducted from your salary.

Renewal

A Member's coverage will automatically renew unless terminated by the Group or by the Plan. At the time of renewal, the Plan has the right to increase the Premiums or change what is, or is not, a Covered Benefit. The Plan shall not increase premiums or Co-payments unless notice of such increase or reduction is provided in writing to the Member within 30 days prior to the contract renewal effective date, as required by Section 1374.21 of the Act.

VIII. Coordination of Benefits (COB)

Access Dental Plan does not coordinate benefits with any other carrier. If you have coverage with another carrier, please contact that carrier to determine whether coordination of benefits is available.

IX. Grievances and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Plan providers to the courtesy extended you by Our telephone representatives.

If you have questions about the services you receive from a Plan provider, We recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call the Plan's Member Service at (888) 534-3466 (TDD/TTY for the hearing impaired at 1-800-735-2929).

Grievances

You may file a Grievance with Access Dental Plan at any time. You can obtain a copy of the Plan's Grievance Policy and Procedure by calling Our Member Service number in the above paragraph. To begin the Grievance process, you can call, write, in person, or fax the Plan at:

Address:
Grievance Department
Access Dental Plan
P. O. Box: 38313,
Phoenix, AZ 85069

Telephone: (888) 534-3466
Fax: (602) 638-5956

E-mail: **GrievanceDept@premierlife.com**

Website: **www.socdhmo.com**

A Grievance form is attached to this EOC as **Attachment "B**" and is available at the Plan. Staff will be available at the Plan to assist Members in completion of this form.

You may also file a written grievance via our website at **www.socdhmo.com.**

There will be no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance

The Plan will acknowledge receipt of your Grievance within five (5) days. The Plan will resolve the complaint and will communicate the resolution in writing within thirty (30) calendar days. If your Grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function, you or your provider may request that the Plan expedite its Grievance review. The Plan will evaluate your request for an expedited review and, if your Grievance qualifies as an urgent Grievance, We will process your grievance within three (3) days from receipt of your request.

You are not required to file a Grievance with the Plan before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a Grievance with the Plan in which you ask for an expedited review, the Plan will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your Grievance involving an imminent

and serious threat to health, and

2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the Grievance no later than 72 hours from receipt of your request to expedite review of your Grievance.

Independent Medical Review

If dental care that is requested for you is denied, delayed or modified by the Plan or a Plan provider, you may be eligible for an Independent Medical Review (IMR). The IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an Experimental procedure.

If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, the Plan will provide coverage for the dental services.

Independent Medical Review for Denials of Experimental / Investigational Services

You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when We deny coverage for treatment We have determined to be Experimental / Investigational Service.

We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an Experimental / Investigational Service within five (5) business days of the decision to deny coverage.

- You are not required to participate in the Plan's Grievance process prior to seeking an Independent Medical Review of Our decision to deny coverage of an Experimental / Investigational Service.
- If a physician determines that the proposed service would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against the Plan, you should first telephone the Plan at **(888) 534-3466 (TDD/TTY for the hearing impaired at 1-800-735-2929)** and use the Plan's grievance process before contacting the department. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. The Department of Managed Health Care has a **toll-free telephone number, 1 (888) HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the department's **TDD line (1-877-688-9891)** number, to contact the department. The Department's **Internet website (http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

The Plan's Grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

X. Miscellaneous

Right of Recovery

Whenever We have made payments in excess of the Benefits payable under the policy, We have the right to recover the excess from any persons to, or for, or with respect to whom, such payments were made, or from any other insurers, health care service plans or other organizations.

Non-Duplication of Benefits with Workers' Compensation

Pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a

third party is responsible for all or part of the cost of dental services provided by the Plan will provide the Benefits of this agreement at the time of need. The Member will agree to provide the Plan with a lien to the extent of the reasonable value of the services provided by the Plan. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this agreement, Members agree to cooperate in protecting the interest of the Plan under this provision and to execute and to deliver to the Plan or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of the Plan or its nominee. Members also agree to fully cooperate with the Plan and not take any action that would prejudice the rights of the Plan under this provision.

Provider Payment

The Plan compensates its providers in a variety of ways. Generally, Primary Care Dentists are paid on what is called a "capitated basis." This means that the Plan pays a per-Member-per-month fee to the Primary Care Dentists who provide services regardless of the care required by the Member. Some providers are compensated based on a combination of monthly capitation and significant fee-for-service supplemental payments from the Plan. In addition to the Plan's provider's regular compensation, some providers are offered a supplemental capitation based on Member satisfaction and on the number of specialty referrals the provider makes. The Plan's providers are always required by the Plan to provide services in a quality manner in accordance with detailed regulatory and contractual requirements. These requirements help reduce overall costs by providing quality care which emphasizes preventive health care access and utilization of effective treatment methods.

A Member may obtain additional information regarding the providers' compensation by contacting the Plan, the Member's provider or the provider's dental Group.

Reimbursement Provisions – If You Receive a Bill

Except for applicable Co-payments, in the event a Member must pay a provider for Covered Services, including Emergency Care or Urgent Care, provided and is entitled to be reimbursed, the Member must submit a copy of the bill or invoice showing (1) the date of service, (2) a description of the services provided, (3) the provider's name, office location, and telephone number, and (4) amount paid. The bill or invoice shall be sent to Access Dental Plan to: Attention: Claims Department, P.O. Box: 38313, Phoenix, AZ 85069, or alternatively, a Member may access the Plan's e-mail account at **www.socdhmo.com** to obtain instructions regarding the procedures to invoice the Plan. Upon receipt of the required information, the Plan will pay the reimbursement amount, less any applicable Co-payments. If you have any questions regarding the reimbursement of Covered Services paid by a Member, please contact Member Services at (888) 534-3466 or access the Plan's Internet site at **www.socdhmo.com**.

Public Policy Participation

The Plan seeks Members who would be interested in participating in the Public Policy Committee for the purposes of establishing the public policy of the Plan. This committee consists of three (3) Plan Members, the Plan's Dental Director, a Plan Provider and the Plan's Administrator. Plan Members shall each serve a one (1) year term while the Plan's Administrator and Dental Director will be permanent committee Members. The Plan will reimburse Members $100.00 per meeting for their participation.

The Public Policy Committee meets quarterly to review the Plan's performance and future direction of Plan operations. Information regarding Plan operations, grievance log reports, financial operations and the like will be made available to Plan Members for review and comment. Recommendations and reports from the Public Policy Committee will be made to the Plan's Board of Directors at the next regularly scheduled Board meeting. Receipt of the recommendations and any reports from the Public Policy Committee shall be considered by the Board of Directors and duly noted in the Board's meeting minutes.

Membership in the Public Policy Committee is voluntary, and will be determined by the entire Public Policy Committee with special consideration being made to the ethnicity, geographic location and economic status of Member. A Public Policy Committee Membership application is attached to this Evidence of Coverage as **Attachment "C".**

Notifying You of Changes in the Plan

Throughout the year We may send you updates about changes in the Plan. This can include updates for the Provider

Directory, handbook, and Evidence of Coverage. We will keep you informed and are available to answer any questions you may have. Call Us toll-free (888) 534-3466 if you have any questions about changes in the Plan.

XI. Benefits Plan Summary

The Schedule of Benefits enclosed with this EOC describes the covered services and exclusions and limitations under the Plan. The Schedule of Benefits also includes the co-payment schedule for your cost associated with each procedure.

XII. Privacy Practices

Except as permitted by law, Member information is not released without your or your authorized representative's consent. Member-identifiable information is shared only with Our consent or as otherwise permitted by law. The Plan maintains policies regarding the confidentiality of Member-identifiable information, including policies related to access to dental records, protection of personal health information in all settings, and the use of data for quality measurement. We may collect, use, and share medical information when Dentally Necessary or for other purposes as permitted by law (such as for quality review and measurement and research.)

All of the Plan's employees and providers are required to maintain the confidentiality of Member information. This obligation is addressed in policies, procedures, and confidentiality agreements. All providers with whom We contract are subject to Our confidentiality requirements.

In accordance with applicable law, you have the right to review your own medical information and you have the right to authorize the release of this information to others.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE BELOW.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways Access Dental Plan, Inc. ("Access Dental Plan") may collect, store, use and disclose your Protected Health Information and your rights concerning your Protected Health Information.

Federal and state laws require Us to provide you with this Notice about your rights and Our legal duties and privacy practices with respect to your Protected Health Information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information

We may use and disclose your Protected Health Information for different purposes. The examples below are illustrations of the different types of uses and disclosures that We may make without obtaining your authorization.

Payment: We may use and disclose your Protected Health Information in order to pay for your covered health expenses. For example, We may use your Protected Health Information to process claims or be reimbursed by another insurer that may be responsible for payment.

- Treatment: We may use and disclose your Protected Health Information to assist your health care providers (dentists) in your diagnosis and treatment.
- Health Care Operations: We may use and disclose your Protected Health Information in order to perform Our plan activities, such as quality assessment activities, or administrative activities, including data management or customer service. In some cases, We may use or disclose the information for underwriting or determining Premiums.
- Enrolled Eligible Dependents and Family Members: We will mail explanation of Benefits forms and other mailings containing Protected Health Information to the address We have on record for the subscriber of the dental plan.
- Other Permitted or Required Disclosures
- As Required by Law: We must disclose Protected Health Information about you when required to do so by law.
- Public Health Activities: We may disclose your Protected Health Information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

- Victims of Abuse, Neglect or Domestic Violence: We may disclose your Protected Health Information to government agencies about abuse, neglect or domestic violence.
- Health Oversight Activities: We may disclose Protected Health Information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.
- Judicial and Administrative Proceedings: We may disclose Protected Health Information in response to a court or administrative order. We may also disclose Protected Health Information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- Law Enforcement: We may disclose Protected Health Information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- Coroners or Funeral Directors: We may release Protected Health Information to coroners or funeral directors as necessary to allow them to carry out their duties.
- Research: Under certain circumstances, We may disclose Protected Health Information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Avert a Serious Threat to Health or Safety: We may disclose Protected Health Information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions: We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- Workers' Compensation: We may disclose Protected Health Information to the extent necessary to comply with state law for workers' compensation programs.
- Other Uses or Disclosures With an Authorization
- Other uses or disclosures of your Protected Health Information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding your Protected Health Information

You may have certain rights regarding Protected Health Information that the Plan maintains about you.

- Right To Access Your Protected Health Information. You have the right to review or obtain copies of your Protected Health Information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your Protected Health Information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but We will tell you the cost in advance.
- Right to Amend Your Protected Health Information. If you feel that your Protected Health Information maintained by Access Dental Plan is incorrect or incomplete, you may request that We amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask Us to amend information that was not created by Access Dental Plan or you ask Us to amend a record that is already accurate and complete. If We deny your request to amend, We will notify you in writing. You then have the right to submit to Us a written statement of disagreement with Our decision and We have the right to rebut that statement.
- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures We have made of your Protected Health Information. The list will not include Our disclosures related to your treatment, Our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, We may charge for providing the accounting, but We will tell you the cost in advance.
- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to

request that We restrict or limit how We use or disclose your Protected Health Information for treatment, payment or health care operations. We may not agree to your request. If We do agree, We will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell Us (1) what information you want to limit; (2) whether you want to limit how We use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- Right to Receive Confidential Communications. You have the right to request that We use a certain method to communicate with you or that We send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from Us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting Our Privacy Officer. See the end of this Notice for the contact information.

Health Information Security

Access Dental Plan requires its employees to follow its security policies and procedures that limit access to health information about Members to those employees who need it to perform their job responsibilities. In addition, Access Dental Plan maintains physical, administrative and technical security measures to safeguard your Protected Health Information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for Protected Health Information that We already have about you as well as any other information that We receive in the future. We will provide you with a copy of the new notice whenever We make a material change to the privacy practices described in this Notice. Any time We make a material change to this Notice, We will promptly revise and issue the new Notice with the new effective date.

Complaints

If you are concerned that We have violated your privacy rights, or you disagree with a decision We made about access to your records, you may file a complaint with Us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

We support your right to protect the privacy of your Protected Health Information. **We will not retaliate against you or penalize you for filing a complaint.**

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about Our information practices, and follow the information practices that are described in this notice.

Disclaimer

If you are a Medi-Cal beneficiary, the law may not allow some of the disclosures listed above. Medi-Cal limits the use of information about you to purposes directly connected to the operation of the Medi-Cal program.

Privacy Officer

If you have any questions or complaints, please contract the Plan's Privacy Officer at:

Privacy Officer
Access Dental Plan
P. O. Box 38312
Phoenix, AZ 85069

Phone: (888) 534-3466
Fax: (855) 691-2927
Email: **PrivacyOffice@avesis.com**

For Medi-Cal beneficiary, you may also contact the California Department of Health Care Services at:

Privacy Officer
c/o Office of Legal Service California Department of Health Care Services
P.O. Box 997413, MS0010
Sacramento, CA 95899-7413.

Phone: (916) 440-7840,
Email: **privacyofficer@dhs.ca.gov**

Authorization to Use and Disclose Health Information

Attachment A

Name of Member: _____ I.D. Number: _____

Address of Member: _____

I authorize Access Dental Plan to use and disclose a copy of the specific health and dental information described below regarding:

Consisting of: (Describe information to be used/disclosed:_____

_____

Name of the Person(s) or Organization(s) to whom you authorize us to use or disclose your information:_____

_____

For the purpose of: (Describe intended use or purpose of this disclosure) _____

_____

Expiration Date of Authorization: (For how long do you wish this Authorization to last) _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____

Member's Signature

By: _____ Date: _____

Member's Representative's Signature (such as a parent of a minor, guardian, foster parent)

Description of Representative's Authority : _____

Please mail this form to the above-mentioned address to the attention of Member Services. You may also FAX this form to (855) 691-2927 to the attention of Member Services.

For Internal Use Only

Authorization received on:_____ Entered into Member's Record by:_____

Original given to Privacy Officer on:_____

Grievance Form

Attachment B

Access Dental Plan, Inc. (the "Plan") takes very seriously problems raised by its Members and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact any Plan Member Services Representative at (888) 534-3466 or any Plan provider representative.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Nature of Complaint (be as specific as possible and use additional sheets if more space is needed):

_____

_____

_____

_____

_____

Date of Incident Giving Rise to This Complaint: _____

Names of Plan Personnel Involved in Incident:

_____

_____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **888-534-3466** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a **toll-free telephone number (888-HMO-2219)** and a **TDD line (877-688-9891)** for the hearing and speech impaired. The department's **Internet Web site http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Please Mail This Form To:
Grievance Department
Access Dental Plan
P.O. Box: 38313
Phoenix, AZ 85069

Please Do Not Write Below This Line - For Plan Use Only

Name of Person Taking Complaint: _____

Date Received: _____ Time Received: _____ Date/Time Logged: _____

Public Policy Committee Application

Attachment C

Thank you for your interest in the Public Policy Committee for Access Dental Plan. Please complete this form and return by mail. If you are asked to join the Public Policy Committee, you will receive a check for $100.00 f or each meeting that you attend. **Please refer to Section IX of this booklet for a description of the Public Policy Committee.**

Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip: _____ Phone: _____

Work Experience (List Most Recent Employer):

Employer: _____

Employment Dates: _____ to _____ Job Title: _____

Responsibilities: _____

_____

Educational Background (Highest Level Completed):

☐ 8th Grade ☐ High School Graduate ☐ Associate of Arts ☐ College Graduate ☐ Graduate School

Provide a brief description as to why you would like to serve on Access Dental Plan's Policy Committee:

_____

_____

_____

_____

Signature: _____ Date: _____

— — — — — — — — — FOLD HERE — — — — — — — — —

Access Dental Plan
P.O. Box 38312
Phoenix, AZ 85069

Place Stamp Here

Access Dental Plan
P.O. Box 38312
Phoenix, AZ 85069

Corporate Office
8890 Cal Center Drive,
Sacramento, CA 95826
888-534-3466
888-534-DHMO
email: socdental@premierlife.com

SOCDHMO.com

Premier Access | Access Dental Plan
1295 W. Washington Street; Suite 212
Tempe AZ 85288