Group Essential Health Benefit Dental Program Combined Evidence of Coverage and Disclosure Form/Contract

Pediatric Dental Essential Health Benefit

Provided by:

DHMO Benefits Provided by Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95826
Phone: (877) 702-8800
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Website: www.PremierLife.com

11/2013

Welcome to Access Dental Plan

PEDIATRIC ESSENTIAL HEALTH BENEFIT PLAN – DENTAL BENEFITS

Dear New Member:

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

Enclosed are the following:

1. Information regarding Plan benefits;
2. Information on obtaining services during a dental emergency;
3. 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 (877) 702-8800.

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

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:

1. Información con respecto a los beneficios del Plan;
2. Información sobre cómo obtener servicios durante una emergencia dental; y
3. 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 (877) 702-8800. Nuevamente, gracias por seleccionar el Plan *Access Dental*. Esperamos poder servirle.

Dental Plan Covered Benefits Matrix

Benefits are provided if the plan determines the services to be medically necessary.

Each individual procedure within each category listed above, and which is covered under the Plan has a specific Copayment, which is shown in the *Schedule of Benefits* along with a benefit description and limitations. The Exclusions are also listed in the Schedule of Benefits.

California DHMO Child Only SHOP Plan

Smile for Kids Program

Child-ONLY*	LOW 70 DHMO	HIGH 85 DHMO
Diagnostic and Preventive Cleanings, Exams, Fluoride, Sealant, and X-Rays	$0	$0
Basic Services Basic Restorative	$0-$95	$0-$40
Major Services Crowns & Casts, Prosthodontics, Endodontics, Periodontics, and Oral Surgery	$0-$365	$0-$365
Orthodontia (Only for pre-authorized Medically Necessary Orthodontia)	$0-$1000	$0-$1000
Individual Deductible (Waived for Diagnostic and Preventive)	N/A	N/A
Family Deductible (Waived for Diagnostic and Preventive)	N/A	N/A
Out of Pocket Maximum (OOP) (per person)	$1,000	$1,000
Out of Pocket Maximum (OOP) (2+ children)	$2,000	$2,000
Annual Maximum	N/A	N/A
Ortho Lifetime Maximum	N/A	N/A
Office Visit	$20	$0
Waiting Period	N/A	N/A

** This plan is available for individuals up to age 19.*

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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.

Welcome! About the Dental Plan

Access Dental Plan (the "Plan") is a specialized health care service plan licensed in the state of California. The Plan provides comprehensive dental coverage for children under the age of 19 to satisfy the pediatric essential health benefit, which is required under the Affordable Care Act.. The Plan has a panel of dentists from whom you select to receive necessary dental care. Many dental procedures covered require no Copayment. 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 Copayments. If you have any questions regarding the material you are reading or the Plan, please contact Our Member Services toll-free number at 1-866-650-3660.

Language Assistance Services

Premier Access' 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 Premier Access' Member Service Line at (877) 702-8800 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 Premier Access or obtain assistance from the Department of Insurance. 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, Premier Access 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 (877) 702-8800 (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
- HIPPA related forms

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

Types of Coverage

The Plan offers to Groups a DMO only plan.

The DMO plan provides dental care coverage to you in accordance with the Description of Benefits and Copayments. You must pay the applicable Copayment to a Participating Provider at the time dental care is provided. The Exclusions and the Copayment amounts are set forth in the Description of Benefits and Copayment Schedule

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 (877) 702-8800 (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.

Children: The Employee's natural children, legally adopted children from the moment of placement in the Employee's home, the Employee's step children and other children for whom the Employee or Employee's spouse is a court appointed guardian, provided that they are solely supported by the Employee and are residing in the Employee's household and who is age 19 years old or younger.

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.

Copayment: 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.

Employee: means a person who is employed by and receiving pay from the Employer, in the form of wage or salary, on a Full-time basis. It is also the individual whose status is the basis of Child(ren) (age 19 or younger) eligibility under this dental plan.

Employer means the Employer shown on your identification card.

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.

Full-Time Student: A student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

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 Children.

Interpreting Service: Access'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.

Late Enrollee: A late enrollee is an individual who enrolls in a plan other than on either the earliest date on which coverage can become effective under the terms of the plan or on a special enrollment date.

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 30-day period immediately 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.

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.

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

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 Premier***.*** 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 Access Dental, 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 copayments document.

We, Us and Our: Access Dental Plan.

You, Yours: The member, enrollee or Employee's Children.

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 cancelled.
- 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 1-866-650-3660 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 8:30 AM to 6:00 PM. Between 6:00 PM and 8:30 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 1-866-650-3660.

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

Who is eligible for coverage?

- You, if you are under the age of 19 and live or work in the Access Dental HMO service area.
- Children up to age 19, who live or work in the Access Dental HMO service area, regardless of any, or a combination of any, of the following factors: financial dependency, residency with parent, student status, employment or marital status.

Effective Date

Coverage begins on the first of the month following timely receipt of the Premium and complete enrollment information. If the Premium must be received by the 15th of the month preceding the desired month of coverage. If Premium is not received by the 15th of the month prior to the month of desired coverage, coverage will begin in the second month after receipt of Premium.

Termination of Coverage

If the required Premium is not paid, coverage may be terminated prior to the end of the Contract Term. If any applicable Premium payment is not paid timely, benefits may be cancelled not less than 31 days after such Premium was due.

Reinstatement of Coverage

Receipt by us of the proper monthly periodic Premium and Copayment after cancellation for nonpayment of Premiums or Copayments 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 cancelled 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.

An enrollee who believes that enrollment has been cancelled 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.

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 (877) 702-8800. A list of the Plan's participating providers can be found in the Provider Directory or online at **www.premierlife.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 may 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 (877) 702-8800 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 Copayments) 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 Copayments). 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 Copayment). 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 may 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 four 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 (877) 702-8800 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.

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 1-866-650-3660 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 Copayments 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 (877) 702-8800 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 Copayments 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 Copayment for the Covered Service. The Plan will pay the dentist any amounts that are in excess of the applicable Copayment 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 (877) 702-8800 (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 Copayments 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 (877) 702-8800.

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 (877) 702-8800 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 Copayments 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: 659005, Sacramento, CA 95865-9005.**

Benefits for Emergency Care not provided by the Primary Care Dentist are limited to a maximum of $100.00 per incident, less the applicable Copayment. 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 copayments.

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 (877) 702-8800. 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 listed in the Schedule of Benefits and 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.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options you may call the Plan's Member Service at (877) 702-8800.

Follow-Up Care

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

Copayments

Members are required to pay any Copayments listed in *Schedule A* 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 A*.

Member Liabilities

Generally, the only amount a Subscriber pays for covered services is the required copayment. 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 Premier's service area without prior authorization; and, unless authorized, services received that are greater than the limits specified in this Evidence of Coverage

booklet. Premier 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 Premier 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 Premier for your payment to the non-participating provider for sums owed by Premier 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 copayments or fees for any noncovered services rendered by a participating provider. In addition, if you choose to receive services from a noncontracted provider, you may be liable to the noncontracted 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 Copayments 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)

We will coordinate your dental Benefits with Benefits payable under another plan. The other plan is one that provides services in connection with dental care or treatment through:

1. Group, blanket or franchise insurance (other than school accident policies).
2. Group hospital, dental service organizations, Group practice, or other prepayment coverage on a Group basis.
3. A labor management trustee plan, union welfare plan, employer or employee benefit plan, or any other arrangement of Benefits for individuals or a Group.
4. Medicare Parts A and B when you are eligible for Medicare coverage. For purposes of determining your Medicare Benefits, you will be deemed to have enrolled for all coverage for which you are eligible under Medicare Parts A and B, whether or not you actually enroll.
5. Any coverage under government programs or coverage required or provided by law, but not Medicaid.

How COB Works

One of the plans involved will pay the Benefits first. That plan is Primary. The other Plan will pay Benefits next. That plan is secondary.

If We are Primary, We will pay the maximum required Benefits first. Benefits under Our plan will not be reduced due to Benefits payable under another plan.

If We are secondary, Benefits under Our plan may be reduced due to Benefits paid under the Primary plan. The amount of Our payment will be determined first. Then the amount of Benefits paid by plans Primary to Our plan will be subtracted from the submitted amount. We will pay the difference between the submitted amount and the amount paid by the Primary plan, but no more than the amount We would have paid without this provision.

Determining Which Plan is Primary

In order to pay Benefits, We must determine which plan is Primary and which plan is secondary. The following rules are used until one is found that applies to the situation. They are always used in the following order:

1. A plan that has no Coordination of Benefits provision will be Primary to a plan that does have a Coordination of Benefits provision.
2. A plan that covers the person as an employee will be Primary to the plan that covers the same person as an Eligible Dependent.
3. The plan that covers the person as an Eligible Dependent of the person whose birthday is earlier in the calendar year will be Primary to a plan which covers that person as a Eligible Dependent of a person whose birthday is later in the calendar year. The Eligible Person's year of birth is ignored.

For an Eligible Dependent child, if both parents have the same birthday, the plan which has covered the parent longer will be Primary to the plan that has covered the other parent for the shorter period of time.

If the other plan does not have a rule based on birthdays, then this rule will not apply, and the rule of the other plan will determine which plan is Primary.

However, the person may be covered as an Eligible Dependent under two or more plans of divorced or separated parents. In that case, the plan of the parent with custody will be Primary to the plan of the parent without custody. Further the parent with custody may have remarried. In that case, the order of payment will be as follows:

1. The plan of the parent with custody will pay Benefits first.
2. The plan of the spouse of the parent with custody will pay Benefits next.
3. The plan of the parent without custody will pay Benefits next.

There may be a court decree that has specific terms giving one person financial responsibility for the dental or other health expenses of the Eligible Dependent child. If We have been provided with notice of those terms, Benefits of that plan will be determined first.

A plan may cover a person as an Eligible Employee who is not laid off or retired, or as an Eligible Dependent of that Eligible Employee. This plan will be Primary to any plan that covers the person as a laid off or retired Eligible Employee, or as an Eligible Dependent of that Eligible Employee. The other plan may not have a rule for laid off or retired Eligible Employees similar to this rule. In this case, this rule will not apply.

If none of the above rules apply, the plan that covered the person for the longest time will be Primary to all other plans.

We may obtain or release any information needed to carry out the intent of the Coordination of Benefits provision. You must inform Us of your coverage under an other plan when you make a claim. We have the right to recover from you, or any other organization or person, any amounts that are overpaid.

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 (877) 702-8800 (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: Access Dental Plan	**Telephone:**	**(800) 270-6743 ext. 6013**
Complaint/Grievance Dept.	**Fax:**	**(916) 646-9000**
P. O. Box: 659005	**E-mail:**	**GrievanceDept@accessdental.com**

Sacramento, CA 95865-9005 Website: www.accessdental.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.accessdental.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 (877) 702-8800 (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 Copayments, 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: 659005, Sacramento, CA 95865-9005, or alternatively, a Member may access the Plan's e-mail account at www.AccessDental.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 Copayments. If you have any questions regarding the reimbursement of Covered Services paid by a Member, please contact Member Services at 1-866-650-3660 or access the Plan's internet site at www.AccessDental.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 (877) 702-8800 if you have any questions about changes in the Plan.

XI. Benefits Plan Summary

This section lists the dental benefits and services you are allowed to obtain through the Plan when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exceptions and limitations listed here and in the Exclusions section of this EOC. Please refer to your Co-Payment schedule for your cost associated with each procedure.

Diagnostic and Preventive Benefits

Description

Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (x-rays)
- Prophylaxis services (cleanings) (once every six months)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type.

Limitations

Roentgenology (x-rays) is limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis
- Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months
- Panoramic film x-rays are limited to once every 24 consecutive months
- Prophylaxis services (cleanings) are limited to two in a 12-month period (once every six months).
- Dental sealant treatments are limited to permanent first and second molars only.

Restorative Dentistry

Description

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic.
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration

- Sedative base and sedative fillings

Limitations
Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are optional.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary

Oral Surgery

Description
Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation
The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontic

Description
Endodonitcs benefits include:

- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations
Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics

Description

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitation

Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Crown and Fixed Bridge

Description

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitation

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Description

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 36 consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  2. The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture
- Implants are considered an optional benefit
- Stayplates are a benefit only when used as anterior space maintainers for children

Other Benefits

Description

Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

Orthodontic Benefits

Orthodontic treatment includes medically-necessary orthodontia only.

XII. Exclusions and Limitations

Exclusions

The following dental Benefits are excluded:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
5. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficacy have not been determined for use in the treatment for which the item or service in question is recommended or prescribed.
6. Services which were provided without cost to the member by State government or an agency thereof, or any municipality, county or other subdivisions.
7. Hospital charges of any kind.
8. Major surgery for fractures and dislocations.
9. Loss or theft of dentures or bridgework.
10. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member became eligible for such services.
11. Any service that is not specifically listed as a covered benefit.
12. Malignancies.
13. Dispensing of drugs not normally supplied in a dental office.
14. 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 limitations of the member.
15. The cost of precious metals used in any form of dental benefits.
16. The surgical removal of implants.
17. Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel provider is a pedodontist/pediatric dentist. 18. Dental Services that are

received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.

XIII. 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.

- **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:

Ms. Terri Abbaszadeh, Privacy Officer
Access Dental Plan,
P. O. BOX: 659005
Sacramento, CA 95865-9005
Phone: (916) 922-5000
Fax: (916) 646-9000
Email: Terri@Premierlife.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, or
Email: privacyofficer@dhs.ca.gov.

ATTACHMENT A

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

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.

Information consisting of: *(Check all that apply.)*

□ Eligibility □Benefits □Claims □Prior Authorizations/Specialty Referrals

□Other (*Please specify*) _____

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

Please check all that apply, and list the name or organization:

□ Spouse _____ □ Mother_____

□ Employer _____ □ Father _____

□ Child _____ □ Other _____

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

_____

_____

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

□1 year □3 years □5 years □No expiration □Other _____

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: _____
Signature of Member (*or authorized representative, if Member is a minor*)

Printed Name of Authorized Representative _____

Relationship to Member _____

Please mail this form to the above-mentioned address to the attention of Customer Service. You may also FAX the form to (916) 646-9000 to the Attention of Customer Service.

FOR INTERNAL USE ONLY		
Date Received	Entered into Member's Record By	Date original given to Privacy Officer

ATTACHMENT B

GRIEVANCE FORM

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 (877) 702-8800 or any Plan provider representative.

Name: _____

Address: _____

City: _____State: _____ Zip Code:_____ Telephone: (_____) _____-_____

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & 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 **(1-866-707-6453)**, 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 **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** 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: 255039
Sacramento, CA 95865-9005

Please do not write below this line – for Plan use only.

Name of Person Taking Complaint:_____ **Date Received:**_____ **Time Received:**_____ **Date/Time Logged:**_____

ATTACHMENT C

PUBLIC POLICY COMMITTEE APPLICATION

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 for 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 Code: _____ Telephone: (____) ____-____

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 Public Policy Committee:

_____

_____

_____

_____

Signature: _____ **Date:** _____

… . . FOLD HERE
… . . …

Access Dental Plan
P.O. Box 659005
Sacramento, CA 95865-9005

Place stamp here

Access Dental Plan
P. O. Box 659005
SACRAMENTO, CA 95865-9005