

**ACCESS DENTAL PLAN**

Benefits Provided by Access Dental Plan, Inc.  
8890 Cal Center Drive, Sacramento CA 95826  
Phone Number (866) 650-3660

**COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE STATEMENT  
Group Dental Plan Family Dental HMO**

Access Dental Plan ("Access Dental"), certifies that You are covered for the benefits described in this Evidence of Coverage and Disclosure statement, subject to the provisions of Schedule of Benefits and Exclusions and Limitations. This Evidence of Coverage is issued to You under the Group Contract and it includes the terms and provisions that describe Your benefits.

**PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY.**

This Evidence of Coverage is part of the Group Contract. The Group Contract is a contract between Access Dental and Your Organization and may be changed or ended without Your consent or notice to You.

**THIS EVIDENCE OF COVERAGE ONLY DESCRIBES DENTAL BENEFITS.**

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEARS ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE (SE) NOTICE(S) CAREFULLY.**

## Dental Plan Covered Benefits Matrix

### Information Concerning Benefits Under the Access Dental Program

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS. SEE ALSO, EXCLUDED BENEFITS AND THE SCHEDULE OF BENEFITS.**

Procedure Category	Child-ONLY* Copay Range	Adult-Only** Copay Range
<b><i>Diagnostic and Preventive</i></b> Exams, Cleanings, Fluoride, Sealants, X-rays and Consultations	\$0	\$0
<b><i>Basic Services</i></b> Amalgam Fillings, Composite Fillings (Anterior Only) and Emergency Palliative	\$0-\$25	\$0-\$25
<b><i>Major Services</i></b> Crowns & Casts, Prosthodontics, Endodontics, Periodontics, and Oral Surgery	\$0-\$300	\$0-\$300
<b><i>Orthodontia</i></b> (Only for pre-authorized Medically Necessary Orthodontia)	\$0-\$350	N/A
Individual Deductible (Waived for Diagnostic and Preventive)	\$0	N/A
Family Deductible (Waived for Diagnostic and Preventive)	\$0	N/A
Out of Pocket Maximum (OOP) (per person)	\$350	N/A
Out of Pocket Maximum (OOP) (2+ children)	\$700	N/A
Annual Maximum	N/A	N/A
Ortho Lifetime Maximum	N/A	N/A
Office Visit (Per Visit)	\$0	\$0
Waiting Period	N/A	N/A

\*Benefits are available for individuals up to age 19

\*\*Benefits are available for individuals ages 19 and over.

\*\*Please see Schedule of Benefits for a listing of all benefits and Exclusions and Limitations.

Each individual procedure listed within each category above that 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.

Table of Contents	
Confidentiality of Dental Records.....	1
Organ Donation.....	1
Language Assistance.....	1
Notice Regarding Your Rights and Responsibilities .....	2
Rights .....	2
Responsibilities .....	2
DENTAL BENEFITS.....	3
Dentist-Patient Relationship .....	3
Who May Enroll .....	4
SERVICE AREA.....	4
DEPENDENT COVERAGE.....	4
WHEN COVERAGE BEGINS.....	5
Choice of Dentists.....	5
Facilities .....	5
Changing Your Selected General Dental Office .....	5
Provider Reimbursement .....	5
Liability of Subscriber or Enrollee for Payment.....	6
Prepayment Fee.....	6
Dental Co-Payments .....	6
Orthodontic Covered Services.....	6
Yearly Maximums .....	7
Covered Services After Dental Coverage Ends .....	7
Non-Covered Services.....	7
Other Charges.....	7
Reimbursement Provisions.....	7
Specialty Care Referrals.....	7
Routine Care, Urgent and Emergency Referrals Timeframes .....	8
Authorization, Modification, or Denial of Services.....	8
Urgent Requests .....	8
Second Opinion .....	9
Emergency Dental Care .....	10
Urgent Care .....	10
TERMINATION OF BENEFITS.....	11
Cancellation of Benefits .....	11
Grace Period .....	11

Disenrollment.....	12
Renewal Provisions.....	12
Review of Cancellation or Non-Renewal.....	12
Reinstatement.....	12
CONTINUITY OF CARE.....	13
Current Members.....	13
New Members.....	13
INQUIRIES AND GRIEVANCE PROCEDURES.....	13
Routine Questions About Dental Benefits.....	13
Grievance Procedures.....	13
Arbitration.....	14
Coordination of Benefits.....	15
Third Party Liability.....	15
Assignment of Benefits.....	15
INDIVIDUAL CONTINUATION OF DENTAL BENEFITS WITH PAYMENT OF THE PREPAYMENT FEE.....	16
For Mentally or Physically Handicapped Children.....	16
For Family And Medical Leave.....	16
At Your Organization’s Option.....	16
Cal-Cobra Continuation of Dental Benefits.....	16
Events that Allow Continuation, and Length of Continuation.....	17
New Dependents.....	17
Termination of Coverage.....	17
Notice and Election of Coverage.....	18
Cost of Continued Coverage.....	18
Payment of the Prepayment Fees.....	19
Exceptions.....	19
Continuation under a New Plan.....	19
GENERAL PROVISIONS.....	20
Entire Contract.....	20
Incontestability: Statements Made by You.....	20
Misstatement of Age.....	20
Conformity with Law.....	20
Public Policy Committee.....	20
DEFINITIONS.....	21

## **NOTICE FOR RESIDENTS OF CALIFORNIA**

This Evidence of Coverage and Disclosure Statement provides a detailed summary of how Access Dental operates, Your entitlements, and the Contract's restrictions and limitations. **This combined Evidence of Coverage and Disclosure Statement constitutes only a summary of the contract. The contract must be consulted to determine the exact terms and conditions of coverage.** If You have special health care needs, You should read carefully those sections that apply to You. You may obtain a copy of the Contract by requesting it from Your Organization or requesting it in writing to Access Dental Plan P.O. Box 659032, Sacramento, Ca 95865-9032, or by calling (866) 650-3660.

This Evidence of Coverage and Disclosure Statement is subject to Chapter 2.2 of Division 2 of the California Health and Safety Code (commonly referred to as the Knox-Keene Act) and the regulations issued thereto by the Department of Managed Health Care. Should either the law or the regulations be amended, such amendments shall automatically be deemed to be a part of this document and shall take precedence over any inconsistent provision of this Contract. Any provision required to be in this Evidence of Coverage and Disclosure Statement by either law or the regulation shall automatically bind Access Dental.

Pursuant to Section 1365(b) of the Knox-Keene Health Care Service Plan Act of 1975, as amended, an Enrollee or Subscriber who alleges that his or her enrollment has been canceled or not renewed because of his or her health status or requirements for health care services may request a review by the Director of California Department of Managed Health Care. If the Director determines that a proper complaint exists, the Director shall notify Access Dental. Within 15 days after receipt of such notice, Access Dental shall either request a hearing or reinstate the Enrollee or Subscriber. If, after hearing, the Director determines that the cancellation or failure to renew is improper, the Director shall order Access Dental to reinstate the Enrollee or Subscriber. A reinstatement pursuant to this provision shall be retroactive to the time of cancellation or failure to renew and Access Dental shall be liable for the expenses incurred by the Subscriber or Enrollee for covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement.

## **Confidentiality of Dental Records**

A STATEMENT DESCRIBING ACCESS DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF DENTAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

## **Organ Donation**

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If You are interested in organ donation, please speak with Your physician. Organ donation begins at the hospital when a person is pronounced brain dead and is identified as a potential organ donor. An organ procurement group will become involved to coordinate the activities.

## **Language Assistance**

As an Access Dental Member, You have a right to free language assistance services, including HBEX\_ADP\_CA\_GP\_EOC Family Plan

interpretation and translation services. Access Dental collects and maintains Your language preferences, race, and ethnicity so that we can communicate more effectively with our Members. If You require spoken or written language assistance or would like to inform Access Dental of Your preferred language, please contact us at (866)650-3660.

Como miembro de Access Dental usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretacion y traduccion. Access Dental recaba la informacion sobre sus preferencias de idioma, raza y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia verbal o escrita en su idioma o quiere informarle a Access Dental sobre su idioma de preferencia, comuniquese con nosotros al (866)650-3660.

## **Notice Regarding Your Rights and Responsibilities**

### **Rights**

- During the term of the group contract between Access Dental and Your Organization, Access Dental will not decrease any benefits, increase any Co-Payment or the Prepayment Fee, or change any exclusion or limitation, except after at least thirty (30) days written notice to Your Organization.
- We will provide written notice within a reasonable time to Your organization of any termination or breach of contract by, or inability to perform of, any contracting Provider if Your Organization may be materially and adversely affected.
- We will not cancel or fail to renew Your enrollment in this Group Contract because of Your health condition or Your requirements for dental care.
- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to dental treatment are the responsibility of You and Your Selected General Dentist. We neither require nor prohibit any specified treatment. However:
  - Only certain specified services are Covered Services. Please see the Schedule of Benefits. Please also review the DENTAL BENEFITS section of this Evidence of Coverage for more details.
  - Your Selected General Dentist must follow the rules and limitations set up by Access Dental and conduct his or her professional relationship with You within the guidelines established by Access Dental. If Access Dental's relationship with Your Selected General Dentist ends, Your Selected General Dentist must complete any and all treatment in progress. Access Dental will arrange a transfer for You to another Selected General Dentist to provide for continued coverage under this Group Contract. As indicated on Your enrollment form, Your signature authorizes Access Dental to obtain copies of Your dental records, if necessary.
- You may request a response from Access Dental to any written or oral concern or complaint.

### **Responsibilities**

- You should identify Yourself to Your Selected General Dentist as a covered person under the Group Contract. If You fail to do so, You may be charged the Selected General Dentist's usual and customary fees instead of the applicable Co-Payment, if any.
- You should treat the Selected General Dentist and his or her office staff with respect and courtesy and cooperate with the prescribed course of treatment. If You continually refuse a prescribed course of treatment, Your Selected General Dentist or Specialty Care Dentist has the right to refuse to treat You. Access Dental will facilitate second opinions and will permit You to change Your Selected General Dental Office; however, Access Dental will not interfere with the Dentist-Patient relationship and cannot require a particular Dentist to perform particular services.
- You should schedule appointments or contact the Selected General Dental Office twenty-four hours (24) in advance to cancel an appointment. If You do not, You may be charged a missed appointment fee.
- You are responsible for the prompt payment of any charges for services performed by the Selected General Dentist. If the Selected General Dentist agrees to accept part of the payment directly from Access Dental, You are responsible for prompt payment of the remaining part of the Selected General Dentist's charge.
- You should notify Access Dental of changes in family status. If You do not, Access Dental will be unable to authorize dental care for You and/or Your Dependents.
- You should consult with Your Selected General Dentist about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with Your Selected General Dentist the most current, complete and accurate information about Your medical and dental history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by Your Selected General Dentist.

## **DENTAL BENEFITS**

The Group Contract provides You with access to dental benefits through the use of Selected General Dentists. When You or a Dependent receive dental services, You, and not Access Dental or Your Organization, are solely responsible for payment of all Co-Payments and other charges listed in the Schedule of Benefits and for any excluded procedure, and must make payment directly to the Selected General Dentist rendering such services.

### **Dentist-Patient Relationship**

We do not provide dental services. Whether or not benefits are available for a particular service does not mean You should or should not receive the service. You, along with the Selected General Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed.

The relationship between You and the Selected General Dentist rendering services or treatment shall be subject to the rules, limitations and privileges incident to the professional relationship, and

Access Dental's Peer Review Committee. The Selected General Dentist shall be solely responsible to You without interference from Access Dental for all services or treatment within the professional relationship. The Selected General Dentist shall have the right to refuse treatment if You continually fail to follow a prescribed course of treatment, use the relationship for illegal purposes, or make the professional relationship onerous.

While Access Dental desires and will actively seek to contract with the most modern dental facilities available in the profession, it is understood and agreed that the operation and maintenance of the Selected General Dentist's facility, equipment and the rendition of all professional services shall be solely and exclusively under the control and supervision of the Selected General Dentist, including all authority and control over the selection of staff, supervision of personnel, and operation of the professional practice and/or the rendition of any particular professional service or treatment.

Access Dental will undertake to see that the services provided to You by Selected General Dentists shall be performed in accordance with professional standards of reasonable competence and skill of dental practitioners, as applicable, prevailing in the community in which each Selected General Dentist practices.

Upon termination of a Provider Contract with a Selected General Dentist, Access Dental is liable for Covered Services rendered by such Provider (other than for Co-Payments) to You who remain under the care of such Provider at the time of such termination until the services being rendered are completed, unless we make reasonable and medically appropriate provision for the assumption of such services by another Selected General Dentist.

In the event of termination of the Group Contract, each Selected General Dentist shall complete all dental procedures started prior to the date of termination, pursuant to the terms and conditions of this Evidence of Coverage.

## **Who May Enroll**

Your Organization is responsible for determining eligibility. Your Eligibility must meet Your Organization's eligibility requirements and/or the Service Area and Dependent Coverage requirements listed below.

## **SERVICE AREA**

Access Dental's Service Area is the geographic region in the state of California where Access Dental is authorized by the Department of Managed Health Care to provide Covered Services to Members and in which Access Dental has a panel of Selected General Dentists and Specialty Care Dentists who have agreed to provide dental care to Access Dental Members. To enroll in the Access Dental Plan, You must reside, live, or work in the Service Area.

## **DEPENDENT COVERAGE**

Dependent eligibility is determined by Your Organization. In the absence of a determination by your Organization, Access Dental defines eligible Dependents as:

- Your lawful Spouse or Domestic Partner
- Your unmarried children or grandchildren up to age 26 for whom You provide care, including adopted children, step-children, or other children for whom You are required to provide dental care pursuant to a court or administrative order.

- Your children who are incapable of self-sustaining employment because of a mental or physical handicap, illness, or condition and are chiefly dependent upon You for support and maintenance.
- Other dependents if Your Organization provides benefits for these dependents.

## **WHEN COVERAGE BEGINS**

Coverage will begin on the date determined by Your Organization.

Check with Your Organization if You have any questions about when Your coverage begins.

## **Choice of Dentists**

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

When enrolling for dental benefits, You must choose a Selected General Dental Office from Our Network. Every person eligible for coverage may select his or her own Selected General Dental Office. If You do not select a Selected General Dental Office or the one You chose is not available, Access Dental may do so for You. Please refer to the Directory of Participating Providers for a complete listing of Selected General Dental Offices. You may obtain a Directory of Participating Providers from our website at [www.premierlife.com](http://www.premierlife.com) or by calling 866-650-3660.

## **Facilities**

You may obtain a list of Access Dental's Selected General Dental Offices and their hours of availability by calling Access Dental at (866)650-3660. A list of Access Dental's participating General Dental offices can be found in the Directory of Participating Providers or online at [www.premierlife.com](http://www.premierlife.com).

## **Changing Your Selected General Dental Office**

You may change Selected General Dental Offices at any time. To do so, please contact us at 866-650-3660. We will help You locate a convenient Selected General Dental Office. The transfer will be effective on the first day of the month following the transfer request. There is no limit to how often You may change Selected General Dental Offices. You must pay all outstanding charges owed to Your Selected General Dental Office before transferring to a new Selected General Dental Office. You may also have to pay a fee for the cost of duplicating x-rays and dental records.

## **Provider Reimbursement**

By statute, every Contract between Access Dental and its Providers state that, in the event Access Dental fails to pay the Provider, the Member shall not be liable to the Provider for any sums owed by Access Dental. Selected General Dental Offices will collect all applicable Co-Payments from You directly at the time of service and then bill Access Dental for reimbursement according to the contracted plan provisions.

Selected General Dental Offices are paid on a per member, per month, or "Capitated" basis for

Members who have selected the Selected General Dental Office and/or may receive an additional or supplemental fees for certain procedures performed. Specialty Care Dentists are compensated according to a negotiated fee schedule. No bonuses or incentives are paid to Selected General Dental Offices or Specialty Care Dentists. For additional information, You may contact Access Dental at 866-650-3660 or speak directly with Your Provider.

#### **FOR EXCHANGE PLANS ONLY:**

The Children's Dental HMO/Family Dental HMO plan sold on Covered California is secondary to any medical plan including pediatric dental. In the event that you have duplicative coverage for children under 19, provider claims must first be processed through your medical carrier, at which time the claim may be sent to the dental plan for processing.

### **Liability of Subscriber or Enrollee for Payment**

Covered Services must be performed by Your Selected General Dental Office or a Specialty Care Dentist to whom You are referred in accordance with the terms of Your Evidence of Coverage and Schedule of Benefits. Services performed by any Out-of-Network Dentist are not Covered Services, without prior approval by Access Dental or Your Selected General Dentist, in accordance with the terms of Your Evidence of Coverage and Schedule of Benefits (except for out-of-area emergency services). If You self-refer to a Selected General Dentist (other than Your Selected General Dentist) or an Out-of-Network Dentist, You are responsible for the cost of those services.

### **Prepayment Fee**

Your Organization prepays Covered California for Your coverage. If You are responsible for any portion of this Prepayment Fee, Your Organization will advise You of the amount and how it is to be paid.

**Please refer to the Co-Payment section, below, for information relating to Your Co-Payments under this Group Contract. The Prepayment Fee is contained in the Group Contract between us and Your Organization. You may obtain a copy of the Group Contract from Your Organization, or by writing to Access Dental Plan, Inc. at P.O. Box 659005 Sacramento, Ca 95865-9032.**

### **Dental Co-Payments**

When You receive care from a Selected General Dentist, You must pay the Co-Payment. The Co-Payment is a fixed dollar amount as shown in the Schedule of Benefits enclosed with this Evidence of Coverage. When You are referred to a Specialty Care Dentist, the Co-Payment may be either a fixed dollar amount, or a percentage of the Dentist's usual fee. Please refer to the Schedule of Benefits for specific details. When You have paid the required Co-Payment, if any, You have paid in full. If we fail to pay the Selected General Dentist, You will not be liable to the Selected General Dentist for any sums owed by us. If You choose to receive services from an Out-of-Network Dentist, You will be liable to the Out-of-Network Dentist for the cost of services unless specifically authorized by us or in accordance with Emergency Dental Care provisions of this Evidence of Coverage. We do not require claim forms.

### **Orthodontic Covered Services**

Orthodontic treatment, if available, is governed by the Schedule of Benefits.

## **Yearly Maximums**

The Schedule of Benefits lists the Yearly maximums for Covered Services, if applicable.

## **Covered Services After Dental Coverage Ends**

Dental services received after Your coverage terminates are not covered. Your Selected General Dentist must complete any dental procedure started on or before Your termination, abiding by the terms and conditions of the Plan.

Orthodontic treatment is governed by the Orthodontic limitations listed in the Schedule of Benefits. If coverage from the Plan ends after the start of Orthodontic treatment, You will be responsible for any costs for Orthodontic treatment after coverage ends.

## **Non-Covered Services**

**IMPORTANT:** If You opt to receive dental services that are not Covered Services, a Selected General Dentist or Specialty Care Dentist 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 Service, 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 Access Dental at 866-650-3660. To fully understand Your coverage, You may wish to carefully review this Evidence of Coverage.

## **Other Charges**

All other charges You may be required to pay under this Evidence of Coverage are listed in the Schedule of Benefits. You must pay all Co-Payments that we are not responsible for under this Group Contract.

## **Reimbursement Provisions**

You are financially responsible for the cost of any services received from an Out-of-Network Dentist, except to treat an Emergency Dental Condition, pursuant to the Emergency Dental Care provision of this Evidence of Coverage.

When You receive a Covered Service from an Out-of-Network Dentist for an Emergency Dental Condition, You should request that the Out-of-Network Dentist bill us. If the Dentist refuses to bill us but agrees to bill You, You should immediately submit the bill to us in accordance with the sub-section titled Emergency Dental Care.

If You receive a bill or have paid for a Covered Service and seek reimbursement, please contact Access Dental at 866-650-3660. Once You have paid Your Co-Payments for Covered Services at Your Selected General Dentist Office, You are not responsible for any other payments for Covered Services.

## **Specialty Care Referrals**

During the course of treatment, Your Selected General Dentist may encounter situations that require the services of a Specialty Care Dentist. Your Selected General Dentist is responsible for determining when the services of a Specialty Care Dentist are necessary. All referrals to Specialty Care Dentists require a Specialty Care Referral.

## **Routine Care, Urgent and Emergency Referrals Timeframes**

Routine Care Referrals are processed within five (5) business days from the date the request is received in our office. Urgent care referrals are processed within seventy-two (72) hours or less of the receipt of the necessary documentation. Copies of authorizations for regular referrals are sent to You, the Specialty Care Dentist and Your Selected General Dentist. Emergency referrals are processed immediately.

You are encouraged to contact Your Selected General Dentist to schedule a follow-up appointment after the completion of the treatment by the Specialty Care Dentist. If You have any questions about Specialty Care Referrals, please call Access Dental by dialing (866) 650-3660.

## **Authorization, Modification, or Denial of Services**

Decisions to approve, modify, or deny, based on dental necessity, prior to or concurrent with the provision of dental care services to You shall be made by us in a timely fashion appropriate for the nature of Your condition, not to exceed five (5) business days from our receipt of the information reasonably necessary and requested by us to make the determination. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the Access Dental's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

## **Urgent Requests**

If Your condition is such that You face a imminent and serious threat to Your dental health including, but not limited to, the loss of major dental function, or if waiting in accordance with the timeframe noted in the above paragraph could jeopardize Your ability to regain maximum function, our decision to approve, modify, or deny referral requests by Your Selected General Dentist prior to, or concurrent with, the provision of dental care services to You shall be made in a timely fashion appropriate for the nature of Your condition, not to exceed seventy-two (72) hours after the Plan's receipt of the information reasonably necessary and requested by us to make the determination.

We shall initially notify by telephone or fax Your Selected General Dentist of our decision to approve, modify, or deny requests for referral authorization within twenty-four (24) hours of our decision. We will also immediately inform Your Selected General Dentist in writing of the decision to approve, modify or deny the referral. If the referral is approved, we will specify in the notice the specific dental care service approved and we will specify in the notice, the clear and concise explanation of the reasons for the decisions, the criteria or guideline used, and the clinical reasons for the decisions regarding dental necessity. Additionally, we will include the name and direct telephone number of who made the decision.

If we cannot approve, modify, or deny the request for authorization within the timeframes specified above because we are not in receipt of all the information reasonably necessary and requested, because we require consultation by an expert reviewer, or because we asked for an additional examination or test be performed upon You, then we will immediately upon the expiration of the timeframes noted above, or as soon as we become aware we will not meet those timeframes, whichever occurs first, notify Your Selected General Dentist and You, in writing, that we cannot make a decision within the required timeframe and specify the information requested but not received, or the expert reviewer to be consulted or the additional examinations or tests required.

Once we receive all the information reasonably necessary and requested, we will approve, modify, or deny the request for authorization in a timely fashion appropriate for the nature of Your condition, not to exceed seventy-two (72) hours or five (5) business days.

Information regarding the processes, criteria and procedures that we use to authorize, modify or deny dental services under the benefits provided by us are available to You, Your Selected General Dentist and the public upon request.

## **Second Opinion**

You may request a second opinion if there are unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental treatment. In addition, Access Dental, or You or Your Selected General Dentist may also request a second opinion. There is no second opinion consultation charge. You will be responsible for the office visit Co-Payment as listed in the Schedule of Benefits.

Reasons a second opinion may be provided or authorized shall include, but are not limited to, the following:

- If You question the reasonableness or necessity of recommended surgical procedures;
- If You question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Selected General Dentist is unable to diagnose the condition, and the Enrollee requests an additional diagnosis; or
- If the treatment plan in progress is not improving You dental condition within an appropriate period of time given the diagnosis and plan of care, and You request a second opinion regarding the diagnosis or continuance of the treatment.

Requests for second opinions are processed within five (5) business days of our receipt of such request except when an expedited second opinion is warranted; in which case a decision will be made and conveyed to You within twenty-four (24) hours. Upon approval, we will contact the consulting Selected General Dentist and make arrangements to enable You to schedule an appointment.

All second opinion consultations will be completed by a Selected General Dentist with qualifications in the same area of expertise as the referring Selected General Dentist or Selected General Dentist who provided the initial examination or dental care services.

You may request a second opinion or obtain a copy of the second dental opinion policy by contacting Access Dental either by calling 866-650-3660 or sending a written request to the following address:

Access Dental Plan  
Member Services  
PO Box 659032  
Sacramento, CA 95865-9032

## **Emergency Dental Care**

Emergency Dental Care means treatment to resolve an Emergency Dental Condition (see Definitions “Emergency Dental Condition”. Emergency Dental Care is treatment and procedures administered in a Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize an Emergency Dental Condition.

All Selected General Dental Offices provide treatment for Emergency Dental Conditions twenty-four (24) hours a day, seven (7) days a week and we encourage You to seek care from Your Selected General Dental Office. However, if treatment for an Emergency Dental Condition is required, You may go to any Dental Provider, go to the closest emergency room, or call 911 for assistance, as necessary. Prior authorization is not required.

Services for treatment of an Emergency Dental Condition will not be covered if treatment is provided by an Out-of-Network Dentist. If you seek Emergency Dental Care from an Out-of-Network Dentist, the Out-of-Network Dentist may require you to make immediate full payment for services or may allow you to pay any applicable Copayments. If you have to pay any portion of the bill, we will reimburse you for services that meet the definition of Emergency Dental Condition Care minus any applicable Copayments. If you pay a bill, please submit a copy of the bill to us for a benefits determination.

Your reimbursement from us for treatment for an Emergency Dental Condition, if any, is limited to the extent the treatment You received directly relates to the evaluation and stabilization of the Emergency Dental Condition. All reimbursements will be allocated in accordance with this Group Contract, subject to any exclusions and limitations. Hospital charges and/or other charges for care received at any hospital or outpatient care facility are not Covered Services.

If You receive treatment for an Emergency Dental Condition from an Out-of-Network Dentist, the maximum reimbursement to you from Access Dental is limited to \$100.00, You will be required to pay all charges to the Out-of-Network Dentist and submit a claim to us for a benefits determination.

## **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. All Selected General Dental Offices provide treatment for Urgent Care services twenty-four (24) hours a day, seven (7) days a week. We encourage you to obtain Urgent Care from your Selected General Dentist/Office. If your Selected General Dentist is unable to see you within twenty-four (24) hours, you must immediately contact our Member Services Department at (866)650-3660 and we will arrange alternative dental care for you.

Services that do not meet the definition of Urgent Care will not be covered if treatment is provided by an Out-of-Network Dentist. If you seek Urgent Care from an Out-of-Network Dentist, the Out-of-Network Dentist may require you to make immediate full payment for services or may allow you to pay any applicable Copayments. If you have to pay any portion of the bill, we will reimburse you for services that meet the definition of Urgent Care minus any applicable Copayments. If you pay a bill, please submit a copy of the bill to us for a benefits determination.

If You receive treatment for Urgent Dental Care from an Out-of-Network Dentist, the maximum

reimbursement to you from Access Dental is limited to \$100.00, You will be required to pay all charges to the Out-of-Network Dentist and submit a claim to us for a benefits determination.

Once you have received Urgent Care, you must contact your Selected General Dentist (if your Selected General Dentist did not perform the service) for follow-up care. You will receive all follow-up care from your Selected General Dentist.

## **TERMINATION OF BENEFITS**

### **Cancellation of Benefits**

If the required Premium is not paid, your coverage may be cancelled prior to the end of the Contract Term. If any applicable Premium payment due from you is not paid timely, your benefits may be cancelled not less than 30 days after the last day of paid coverage.

Coverage for an Enrollee will terminate as of the date enrollment is cancelled under the terms of this Evidence of Coverage. However, we will continue to provide Benefits for completion of any treatment in progress (less any applicable Copayment).

In the event Your enrollment is cancelled, Access Dental and/or Covered California] will send notification to Your Organization, which will in turn, notify You. Your Organization will also send You notice of when coverage is terminated.

For all terminations not based on non-payment of premiums, enrollment will be cancelled as of the last day for which Prepayment Fees have been received, subject to compliance with notice requirements.

Orthodontic treatment is governed by the Orthodontic Limitations listed on Your Schedule of Benefits. If You terminate coverage from the Plan after the start of orthodontic treatment, You will be responsible for any additional incurred charges for any remaining orthodontic treatment.

### **Grace Period**

If You or your Organization fail to make a premium payment, you will be notified that Your coverage will be cancelled if payments are not made within 30 days after the last date of paid coverage. This Grace Period of 30 days will be granted for the payment of premiums accruing after the first premium. During the Grace Period, the Evidence of Coverage shall continue in force, but the Organization shall be liable for the Prepayment fees.

If Your Organization fails to pay the Prepayment Fees through and including the final month of the group contract, all coverage may be terminated at the end of the Grace Period, and You may be responsible for the usual and customary fees for any services received from Your Selected General Dentist or Specialty Care Dentist during the period the Prepayment Fees went unpaid, including the Grace Period.

If you fail to make your Premium payment and are receiving advance payments of the premium tax credit (APTC), and have previously paid at least one full month's premium to Access during the benefit year, You will be given a Grace Period of three months to make your payment(s). Premier Access will pay all appropriate claims for services during the first month of the Grace Period and may pend claims for services rendered to you during the second and third months of the Grace

Period. You are responsible for making all unpaid Premium payments during the Grace Period.

### **Rescission**

Enrollment may be cancelled for reasons other than nonpayment of premium, upon 30 days' written notice if we can demonstrate that you committed fraud or an intentional misrepresentation of material fact under the terms of this contract. If We intend to rescind the contract because We can demonstrate that you committed fraud or an intentional misrepresentation of material fact under this contract, you will receive a thirty (30) day notice prior to the effective date of rescission. In addition, you will be notified of your right to appeal our decision.

### **Disenrollment**

You may dis-enroll from the Plan at the end of the term of the Group Contract. Please contact Your Organization for more information.

### **Renewal Provisions**

Your Organization has contracted with Access Dental to provide services for the time period specified in the Group Contract. Your coverage under this Plan is guaranteed for that time period so long as You meet the eligibility requirements under the plan. When the Group Contract expires, it may be renewed. If renewed, it is possible that the terms of the plan may have been changed. If changes to Covered Services, Copayments, or Your contribution to the Prepayment Fees have been made to a renewed contract, Your Organization and/or Covered California will notify You not less than sixty (60) days before the effective date.

### **Review of Cancellation or Non-Renewal**

A Member who alleges that his or her enrollment has been improperly cancelled, not renewed, or rescinded, or that his or her enrollment was terminated because of his or her health status or requirements for health care services, may request a review by the Director of the California Department of Managed Health Care. If the Director determines that the cancellation, nonrenewal, or rescission is improper, the Director shall notify Access Dental. Within fifteen (15) days after receipt of such notice, Access Dental will either request a hearing or reinstate the person as a member. If after the hearing the director determines that the cancellation or failure to renew is improper, the Director shall order Access Dental to reinstate the person as a Member. A reinstatement pursuant to this provision shall be retroactive to the time of cancellation or failure to renew and Access Dental shall be liable for the expenses incurred by the subscriber or Member for the covered health care services from the date of cancellation or non-renewal to and including the date of reinstatement.

### **Reinstatement**

Access Dental will reinstate your enrollment under the Group Contract upon the occurrence of the following:

1. Payment of Premium within the Grace Period;
2. Determination by the Department of Managed Health Care that the cancellation,

- nonrenewal or rescission was improper;
3. At the discretion of Access Dental for clerical or other errors.

Receipt by Access Dental of the proper Prepayment Fees after cancellation of the Contract for nonpayment or any other reason shall reinstate the Contract as though it had never been cancelled. You will remain responsible for any pre-payment fees, copayments or coinsurance that you may have incurred prior to the reinstatement.

## **CONTINUITY OF CARE**

### **Current Members**

If You are a current Member of Access Dental, You may be eligible to temporarily continue receiving Covered Services from a former Selected General Dentist Office or Specialty Care Dentist whose Contract with Access Dental is terminated (a "Terminated Provider") for treatment of certain specified dental conditions. Please call Access Dental at (866)650-3660 to see if You are eligible for this benefit. You may request a copy of Access Dental's Continuity of Care Policy from Access Dental. You must make a specific request to continue under the care of Your Terminated Provider. Access Dental is not required to continue Your care with Your Terminated Provider if You are not eligible under Access Dental's Continuity of Care Policy or if Access Dental cannot reach an agreement with Your Terminated Provider on the terms regarding Your care in accordance with California law.

### **New Members**

If You are a new member of Access Dental, You may be eligible to temporarily continue receiving Covered Services from an Out-of-Network Dentist for treatment of certain specified conditions if the services were being provided by an Out-of-Network Dentist at the time the Your coverage becomes effective. Please call Access Dental at (866)650-3660 to see if You may be eligible for this benefit. You may request a copy of Access Dental's Continuity of Care Policy from Access Dental. You must make a specific request to continue under the care of Your Out-of-Network Dentist. Access Dental is not required to continue Your care with Your Out-of-Network Dentist if You are not eligible under Access Dental's Continuity of Care Policy or if Access Dental cannot reach agreement with Your Out-of-Network Dentist on the terms regarding Your care in accordance with California law.

## **INQUIRIES AND GRIEVANCE PROCEDURES**

### **Routine Questions About Dental Benefits**

If You have any questions about dental benefits provided by the Group Contract, please call Access Dental by dialing (866) 650-3660.

### **Grievance Procedures**

If You have a Grievance with Access Dental or Your Selected General Dentist, You may submit such Grievance by calling our Member Service Department at (866)650-3660. When You call, You may:

- Submit the Grievance orally, or
- Request a Grievance form to submit the Grievance in writing.

To submit the Grievance in writing, complete the Grievance Form, or provide a detailed summary of

Your grievance to:

Access Dental Plan  
Grievance Department  
P.O. Box: 255039  
Sacramento, CA 95865-5039

You may also file a Written Grievance via our website at [www.premierlife.com](http://www.premierlife.com). Please click on Grievance Form, Online Grievance and sign in using Your User Name and Password.

In all written correspondence, please be sure to include at least the following information:

- Your Name (or name of the patient if different);
- Name of the Group Contract You are under
- Identification Number of the person You are Writing about; and
- Facility (or selected General Dental office) name and number.

We agree to investigate and try to resolve Grievances received. We will confirm receipt of Your Grievance in writing within five (5) calendar days of receipt. We will resolve the Grievance and communicate the resolution in writing within thirty (30) calendar days. A grievance must be filed within one hundred eighty (180) days of the occurrence or incident that is the subject of the grievance.

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 an expedited review, and if Your grievance qualifies as an urgent Grievance, we will process Your Grievance within three (3) calendar days from receipt of Your request. You are not required to file a grievance with Access Dental before asking the California Department of Managed Health Care ("Department") to review Your case on an expedited basis. The Department may be contacted at **(1-888-HMO-2219)**, TDD line **(1-877-688-9891)** for the hearing and speech impaired, or <http://www.hmohelp.ca.gov>.

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.

## Arbitration

Each and every disagreement, dispute or controversy which remains unresolved concerning the construction, interpretation, performance or breach of this Contract, or the provision of Dental Services under this Contract after exhausting Access Dental's complaint procedures, arising between You, a Member or the heir-at-law or personal representative of such person, as the case may be, and Access Dental, its employees, officers or directors, or participating Dentist or their Dental Groups, Partners, Agents, or Employees, may be voluntarily submitted to arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability or malpractice that is as to whether any dental services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this Contract but which gives rise to a claim after the termination of this Contract. Arbitration shall be initiated by written notice to:

Access Dental Plan at  
P.O. Box 00000, Sacramento, CA 95826.

### **Coordination of Benefits**

If this policy is purchased as duplicative coverage for pediatric services (under 19), Access Dental will act as a secondary payor after claims are submitted to the medical carrier for coverage.

### **Third Party Liability**

If benefits covered by the Group Contract or Evidence of Coverage are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that You are made whole for all other damages resulting from the wrongful act or omission before Access Dental is entitled to reimbursement. You shall:

- Reimburse Access Dental for the reasonable cost of services paid by Access Dental to the extent permitted under California law immediately upon collection of damages by You, whether by action or law, settlement or otherwise; and
- Fully cooperate with Access Dental's effectuation of its lien rights for the reasonable value of services provided by Access Dental to the extent permitted under California Civil Code section 3040. Access Dental's lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

Access Dental shall be entitled to payment, reimbursement, and subrogation in third party recoveries and You shall cooperate to fully and completely effectuate and protect the rights of Access Dental, including prompt notification of a case involving possible recovery from a third party.

### **Assignment of Benefits**

By accepting coverage under this Group Contract, You agree to cooperate in protecting the interest of Access Dental under this provision and to execute and deliver to Access Dental 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 Access Dental or its nominee. You also agree to fully cooperate with Access Dental and not take any action that would prejudice the rights of Access Dental under this provision.

## **INDIVIDUAL CONTINUATION OF DENTAL BENEFITS WITH PAYMENT OF THE PREPAYMENT FEE**

### **For Mentally or Physically Handicapped Children**

Benefits for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to us within thirty- one (31) days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the Termination of Benefits section, benefits will continue while such Child:

- Remains incapable of self-sustaining employment because of a mental or physical handicap, illness, or condition; and
- Continues to qualify as a child, except of the age limit.

### **For Family And Medical Leave**

Certain leaves of absence may qualify under the Family Medical Leave Act of 1993 (FMLA) for continuation of benefits. Please contact Your Organization for information regarding the FMLA.

### **At Your Organization's Option**

Your Organization may elect to continue benefits by paying the Prepayment Fee for any of the reasons specified below. Please check with Your Organization if You have questions regarding continuation. If Your benefits are continued, benefits for Your dependents may also be continued. You will be notified by Your Organization how much You will be required to contribute.

- For the period You are laid off, up to two (2) months;
- For the period You are not at work due to injury or sickness, up to (9) months;
- For the period You are not at work due to any other Organization approved leave of absence; up to two (2) months.

At the end of any of the continuation periods listed above, Your benefits will be affected as follows:

- If You return to work within these time periods, Your coverage will continue under the Group Contract;
- If You do not return to work within these time periods, Your employment will be considered to end and Your benefits will end.

If Your benefits end, Your dependents' benefits will also end.

### **Cal-Cobra Continuation of Dental Benefits**

If dental benefits for You or Your dependents' end, You and Your dependent may qualify for

continuation of such benefits under Cal-Cobra, section 1366.20 of the California Health and Safety Code. Cal-Cobra is available for groups with no more than 19 employees.

### **Events that Allow Continuation, and Length of Continuation**

You and Your dependent may continue dental benefits under this plan for a period of up to thirty-six (36) months, if Your dental benefits would otherwise end because:

- Your employment ends for any reason other than Your gross misconduct; or
- Your hours worked are reduced.

Your Organization must notify us of Your termination or reduction of hours within thirty-one (31) days after Your termination or reduction of hours.

Your dependent may continue coverage under this plan for up to thirty-six (36) months if Your Dependent's dental benefits would otherwise end because of:

- Your divorce,
- Your legal separation,
- Your death, or
- Your becoming eligible for Medicare.

Also, Your dependent may continue coverage under this plan for up to thirty-six (36) months if such child's benefits would otherwise end because that child no longer qualifies as a dependent under the terms of this plan.

### **New Dependents**

During the continuation period, a child of Yours that is:

1. Born;
2. Adopted by You; or
3. Placed with You for adoption;

Will be treated as if the child were a dependent at the time benefits were lost due to an event described above. To obtain benefits for the child, You must enroll the child for coverage within thirty (30) days of birth, adoption or placement for adoption.

### **Termination of Coverage**

With respect to each person who continues benefits, the continued benefits of coverage will end on the earliest of:

- The end of thirty six (36) month continuation period;
- The date of expiration of the last period for which the required payment was made;
- The date this plan or coverage for Your class is cancelled;
- The date the person becomes entitled to Medicare;
- The date the person becomes covered by another group benefit plan that does not have an exclusion or limitation for pre-existing conditions that applies to that person;

- The date the person becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);
- The date the person becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;
- The first day of the first month that begins more than thirty-one (31) days after the date of final determination under Title I or Title XVI of the Social Security Act that the person is no longer disabled.

### **Notice and Election of Coverage**

When You or Your dependents become entitled to continue benefits under the plan because of:

1. Your termination or
2. Your reduction of hours worked,

We will send You, at Your last known address, the necessary Prepayment Fee Information and enrollment forms and disclosures within fourteen (14) days. You will then have sixty (60) days to elect to continue benefits from the latest of:

- The date of the event that gives a right to continue coverage;
- The date You are given notice of a right to continue coverage; and
- The date coverage under this plan ends.

When You become entitled to continue benefits under the Plan because of:

- You or Your dependent's receipt of determination of disability under the terms of the Social Security Act;
- Your dependent child ceasing to qualify as a dependent under this plan;
- Your divorce;
- Your legal separation;
- Your death; or
- Your becoming eligible for Medicare;

You must notify us within sixty (60) days. If we do not receive notice within sixty (60) days, the person or persons who would otherwise have been entitled to continued benefits will be disqualified from having dental benefits continued. You or Your dependent's notice and request for continued benefits must be in writing and delivered to us by first class mail or other reliable means of delivery including personal delivery, express mail, or private courier company.

### **Cost of Continued Coverage**

Any person who elects to continue coverage under the plan must pay not more than one-hundred and ten percent (110%) of the full cost of that benefit (including both the share You now pay and the share Your Organization now pays).

## **Payment of the Prepayment Fees**

The first Prepayment Fee must be paid within forty-five (45) days of Your election to continue benefits. Your first payment of the Prepayment Fee must be sufficient to pay all required Prepayment Fees and all Prepayment Fees due. The Prepayment Fee payment must be sent to us by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company. After the first Prepayment Fee payment, Your payments for continued coverage must be made on the first day of each month in advance. Failure to submit the correct Prepayment Fee amount within the forty-five (45) day period will disqualify the person to whom the Prepayment Fee relates from receiving continuation coverage.

## **Exceptions**

The right to continue coverage under this plan does not apply:

- To a person who is not a resident of California;
- To a person who is covered by or eligible to be covered by Medicare;
- To a person who is covered or who becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;
- To a person who is covered, becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);
- To a person who is covered, becomes covered, or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain group Health Plans for Certain State and Local Employees;
- To a person who fails to meet any one or more of the time limits set forth above for notice and election of coverage;
- To a person who fails to submit the correct Prepayment Fee when or before it is due;
- If at the time coverage under this plan ends Your Organization has twenty (20) or more employees; or
- If Your Organization fails to notify Us of Your termination or reduction in hours within thirty-one (31) days.

## **Continuation under a New Plan**

Your Organization must notify each person who has continued benefits under this plan if this plan ends for any reason and is replaced by Your Organization with a new group plan. The notice must be given thirty (30) days before this Plan ends. The notice will be sent to the last known address of the person who has continued coverage under this Plan. If this Plan ends, continued benefits under this Plan will end. A person who has continued benefits under this Plan may then elect similar

coverage under Your Organization's new Group Plan, if any for the balance of the period that the person would have remained covered under this plan. Continued benefits will end for that person if the person does not, within thirty (30) days of receiving notice that this plan has ended, enroll in the new plan and pay any required contribution to the cost of the new plan. Your Organization will provide benefit and contribution information, enrollment forms and instructions for enrolling in the new plan. This information will be sent to the last known address of the person who has a right to continue benefits. If Your Organization or any successor Organization or purchaser of Your Organization ceases to provide a similar group benefit plan to active employees, the right to continue benefits ends.

## **GENERAL PROVISIONS**

### **Entire Contract**

Your dental benefits are provided under a Group Contract with Your Organization. The entire contract with Your Organization is made up of the following:

1. The Group Contract and its Exhibits or Attachments, which include the Evidence of Coverage and Disclosure Statement and Schedule of Benefits;
2. Your Organization's application; and
3. Any amendments and/endorsements to the Group Contract.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid or reduce benefits or defend a claim unless the following requirements are met:

- The statement is in a written Application or Enrollment Form;
- You have signed the Application or Enrollment Form; and
- A copy of the Application or Enrollment Form has been given to You or Your Beneficiary.

### **Misstatement of Age**

If Your (or Your Dependent's age is misstated), the correct age will be used to determine eligibility for dental benefits and, as appropriate, we will adjust the benefits and/or premiums.

### **Conformity with Law**

If the terms and provisions of this Evidence of Coverage do not conform to any applicable law, this Evidence of Coverage shall be interpreted to so conform.

### **Public Policy Committee**

The Public Policy Committee ("Committee") provides our clients with the opportunity to participate in the review of quality improvement activities. Representatives of group contract holders, Selected General Dentists and Specialty Care Dentists, and our employees, meet quarterly to discuss quality improvement activities and policies. If You are interested in being a representative to the Committee meeting, please contact us (866)650-3660 at and ask for the Director of Quality Management.

## **DEFINITIONS**

As used in this Evidence of Coverage, the terms listed below will have the meanings set forth below. When defined terms are used in this Evidence of Coverage, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Child** means the following:

For dental benefits, Your natural or Adopted Child; Your Step-child who resides with You; or a Child who resides with and is fully supported by You (including the Child of a Domestic Partner), and who, in each case, is under age 19, and:

- Unmarried;
- Supported by You;
- Not employed on a full-time basis; and
- A full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

The term does not include any person who:

- Is in the military of any country or subdivision of any country;
- Lives outside of the United States or Canada; or

An adopted child from the earlier of:

- The moment the Child is placed in Your residence, and
- The Child's birth, if You have entered into a Written Agreement to adopt the Child prior to its birth.

**Co-Payment or Co-Pay** means a fixed dollar amount or a fixed percentage of the Maximum Allowed Charge of the Covered Services performed by Your Selected General Dentist, for which We are not responsible, as shown in the Schedule of Benefits. You must pay Your Co-Payment at the time of delivery of supplies or services.

**Covered Service** means a dental service used to treat You dental condition which is:

- Prescribed or performed by a Dentist while such person is covered for dental benefits;
- Dentally necessary to treat the condition; and
- Described in the Schedule of Benefits, or

**Covered Service** means a dental service used to treat Your dental condition which is:

- Prescribed or performed by a Dentist while such person is covered for dental benefits;
- Dentally Necessary to treat the condition; and
- Described in the Schedule of Benefits; or
- Dental Benefits sections of this evidence of coverage.

**Dental Hygienist** means a person trained to:

- Remove calcareous deposits and stains from the surfaces of teeth; and

- Provide information on the prevention of oral disease.

The term does not include:

- You;
- Your Spouse; or
- Any member of Your immediate family including Your and/or Your Spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

**Dentally Necessary** means that a dental service or treatment is performed in accordance with generally accepted dental standards and is:

- Necessary to treat decay, disease or injury of the teeth; or
- Essential for the care of the teeth and supporting tissues of the teeth.

**Dentist** means:

- A person licensed to practice dentistry in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of the group contract. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.
- For purposes of dental benefits, the term will include a physician who performs a Covered Service.

The term does not include:

- You;
- Your spouse; or
- Any member of Your immediate family including Your and/or Your spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

**Dependent(s)** means Your Spouse, Domestic Partner, and/or Child.

**Directory of Participating Providers** means the list of Selected General Dentists from whom You must select to receive Covered Services.

**Domestic Partner** means a couple who is registered pursuant to California Family Code section 297.

**Emergency Dental Condition** means a dental condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, bleeding, swelling or severe pain, that a prudent layperson, possessing an average knowledge of dentistry and health, could reasonably expect the absence of immediate dental attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious impairment or dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

**Experimental** means services that do not have endorsement from professional organizations whose role is to evaluate such items. Services that are either unproven for the diagnosis or treatment of a condition or not generally recognized by the professional community as effective or appropriate for the diagnosis or treatment of a condition.

**Experimental** means services that do not have endorsement from professional organizations

whose role is to evaluate such items. Services that are either unproven for the diagnosis or treatment of a condition or not generally recognized by the professional community as effective or appropriate for the diagnosis or treatment of a condition.

**Grievance** means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where Access Dental is unable to distinguish between a grievance and an inquiry, it shall be considered a Grievance. A "complaint" is the same as a Grievance.

**Group Contract** means the contract with Access Dental and Your Organization that sets forth the terms and conditions of coverage for dental benefits.

**Maximum Allowed Charge** means the lesser of:

- The amount charged by the Selected General Dentist; or
- The maximum amount which the Selected General Dentist has agreed with Premier Access to accept as payment in full for the dental service.

**Member** means an individual enrolled in the Access Dental plan.

**Orthodontics** means braces and other procedures or appliances to help align the upper and lower teeth.

**Out-of-Network Dentist** means a Dentist who does not have a contractual agreement with us to provide Covered Services to You.

**Periodontics** means procedures related to treatment of the supporting structures of the teeth (e.g., gums and underlying bone).

**Organization** means an employer or other entity that has contracted with Us to arrange for the provision of dental care benefits.

**Orthodontics** means braces and other procedures or appliances to help align the upper and lower teeth.

**Out-of-Network Dentist** means a Dentist who does not have a contractual agreement with Us to provide Covered Services to You or a dependent.

**Pediatric** means infants, children and adolescents, up to the age of 19.

**Periodontics** means procedures related to treatment of the supporting structures of the teeth, such as gums and underlying bone.

**Prepayment Fee** means the monthly fee paid to Us by Your Organization. The prepayment fee is not the same as a Co-Payment.

**Proof** means written evidence satisfactory to us that a person has satisfied the conditions and requirements for any benefit described in this Evidence of Coverage. When a claim is made for any benefit described in this Evidence of Coverage, Proof must establish:

- The nature and extent of the loss or condition;
- Our obligation to pay the claim; and

- The Claimant's right to receive payment.

**Reasonable and Customary Charge** means the least of:

- The amount charged by the Selected General Dentist for a Covered Service;
- The usual amount charged by the Selected General Dentist for dental services which are the same as, or similar to, the Covered Service; or
- The usual amount charged by other Selected General Dentist in the same geographic area for dental services which are the same as, or similar to, the Covered Service.

**Selected General Dentist** means Access Dental contracted Dentist who agrees in Writing to provide dental services under special terms, conditions and financial reimbursement arrangements with Access Dental.

**Selected General Dental Office** means a dental office contracted with Access Dental consisting of Dentists who agree in Writing to provide dental services under special terms, conditions and financial reimbursement arrangements with Access Dental.

**Specialty Care** means services provided by an endodontist, periodontist, pediatric Dentist, oral surgeon, or orthodontist.

**Specialty Care Dentist** means Access Dental contracted Dentist who agrees in Writing to provide Specialty Care services under special terms, conditions and financial reimbursement arrangements with Access Dental.

**Service Area** means the geographical area in which Access Dental has a panel of Selected General Dentists and Specialty Care Dentists who have agreed to provide care to Access Dental customers. To enroll in the Access Dental plan, You and Your dependents (except dependent children, if applicable) must, reside, live, or work in the Service Area.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to us and consistent with applicable law.

**Spouse** means Your lawful spouse. The term also includes Your Domestic Partner. The term does not include any person who:

- Is in the military of any country or subdivision of any country;
- lives outside of the United States or Canada; or
- is covered under the Individual Contract.

**Urgent Care** means services needed to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed.

**We, Us and Our** mean Access Dental Plan, Inc.

**Written or Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to us and consistent with applicable law.

**Year or Yearly** means the 12 month period that begins January 1.

**You and Your** mean a person who is eligible to receive services under this Evidence of Coverage and/or a dependent, if applicable, who is covered under the Group Contract for the dental benefits

described in this Evidence of Coverage.