LOS ANGELES PREPAID HEALTH PLAN COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

FOR
Access Dental Plan, Inc.
P.O. Box 659005
Sacramento, CA 95865-9005
(888) 414-4110
www.premierlife.com.com

THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

This Evidence of Coverage ("EOC") states the terms and conditions of your coverage under the Los Angeles Prepaid Health Plan. This form is a summary of the dental services available to you as an Enrollee of Access Dental Plan, Inc. **Please keep these materials for your reference as they contain important information regarding the Plan and its operations.** Any questions you have regarding coverage on any of the following specific provisions may be directed to Member Services at (888) 414-4110.

You may also visit our website at www.premierlife.com to review your EOC, Benefit Schedule and a list of network providers.

Contents

INTRODUCTION

Using this Booklet

This booklet is the Combined Evidence of Coverage and Disclosure Form, or "EOC." It explains what is covered and not covered under your plan. It also has information you may need about special health care needs. Please read this booklet carefully. It will tell you how to use the plan. The "Benefit Schedule" Section includes a list of covered services.

Throughout this booklet, you will see the terms "**you**," "**your**," and "**member**". These terms refer to the child or children enrolled in the plan. "**We**," "**us**," "**our**," and "**Plan**" always refers to Access Dental Plan. "**Provider**" or "**dentist**" refers to a licensed dentist who is responsible for providing dental services to you.

Before enrolling under this plan, a person has a right to view this book. This can be done by contacting the Member Services Department. Member Services can send you a copy of this book.

Contact Member Services

Our Member Services Department is available to help you. Please contact us if you have a question or problem.

Phone: (888) 414-4110

By Mail: Access Dental Plan – Member Services
P.O. Box 659005
Sacramento, CA 95865-9005

You may also get information on our website. You can get a copy of this book, view your benefits and find a dentist. The website address is www.premierlife.com.

Language Assistance

The Plan offers language assistance services. There is no charge for the services. Call Member Services to request language services (TDD/TTY for the hearing impaired at 1-800-735-2929).

Please inform your provider if you have a preferred language other than English. Your provider will work with us to provide the language services you need.

- **Interpreter services:** You can speak to Member Services in your preferred language.
- **Find a provider who speaks your language:** We can help you find a provider who speaks your language. If a provider cannot be located, you can request an interpreter for your appointment.
- **Assistance filing a grievance:** The Grievances and Appeals Section describes the process for filing a complaint or grievance. You can ask for language assistance if you need help with the process.

Translated materials: Standard documents are available in certain languages under the LAPHP program. You can also request translation of a non-standard document. The Plan shall provide the translation within 21 days of the request.

DEFINITIONS

Adult: A Member age 21 and over who will continue to be enrolled in Medi-Cal Managed Care Plan with a limited scope of benefits effective July 1, 2009.

Benefits and Coverage: The dental health care services available under the Los Angeles Prepaid Health Plan and dental provisions of the California Medi-Cal program.

Denti-Cal: The dental program or dental services as a Medi-Cal benefit.

DHCS: Department of Health Care Services.

Disenrollment: When a Member is no longer able to receive Benefits and Coverage with Access Dental Plan.

DMHC: Department of Managed Health Care.

Elective Dentistry or **Exclusion:** Any dental procedure(s) or service(s) not available under the Los Angeles Prepaid Health Plan and the dental provisions of the California Medi-Cal program.

Eligible: A Member is allowed to use or qualifies for coverage.

Emergency Care: Services required for alleviation of severe pain or bleeding and / or immediate diagnosis and treatment of unforeseen conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction, or death.

EOC: Evidence of Coverage.

FRADS: The abbreviation for Federally Required Adult Dental Services. The services that are allowable as Federally Required Adult Dental Services under this definition are listed in Attachment B.

HCO: Health Care Options.

LAPHP: Los Angeles Prepaid Health Plan

Limitation: Any provision other than an Exclusion which restricts coverage for the providing of dental health care services under the Plan.

Medi-Cal Beneficiary: A California Medi-Cal recipient who is eligible to participate in the Plan pursuant to Plan eligibility requirements.

Member: means any presently enrolled Medi-Cal recipient who has completed a Plan membership application and receives Benefits and Coverage.

Plan: Access Dental Plan, Inc.

Primary Care Dentist (PCD): General or pediatric dentist that coordinates, supports, and provides the delivery of dental care.

Provider: Dentist providing general or specialty dental services under contract with the Plan.

Service Area: The geographic area where the Plan provides Benefits and Coverage for the LAPHP program.

You: The Member participating in the Plan.

MEMBER RIGHTS AND RESPONSIBILITIES

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

- Be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical and dental information.
- Be provided with information about the plan and its services, including covered services, as identified in the Medi-Cal Dental Manual of Criteria.
- Be able to choose a Primary Care Dentist within the Plan's network.
- Participate in decision making regarding your own dental care, including the right to refuse treatment.
- Voice grievances, either verbally or in writing, about the organization or the care received.
- Receive interpretation services for your language.
- Have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural Health Clinics or Indian Health Service Facilities, and access to emergency dental services outside the Plan's network pursuant to federal law.
- Request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
- Have access to, and where legally appropriate, receive copies of, amend or correct your dental record.
- Disenroll upon request.
- Receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, including informed consent.
- Have freedom to exercise these rights without adversely affecting how you are treated by the Plan, providers, or the State.
- Have access to the Plan's health education programs and outreach services in order to improve dental health.
- Request a second opinion, including from a specialist at no cost.

You have the responsibility 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.

ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

Eligibility and Enrollment

Any eligible Medi-cal Benificiary residing within Los Angeles Prepaid Health Plan County is eligible to receive Coverage for dental services. You may visit the Denti-Cal and Medi-Cal websites for updated information at www.denti-cal.ca.gov and www.medi-cal.ca.gov. To receive Coverage, a Medi-Cal Beneficiary should complete an Enrollment / Disenrollment form available through Health Care Options (HCO) who may be reached at 1-800-430-4263 or at the Plan Provider offices. Once completed, the form should be returned to:

Health Care Options (HCO)
P. O. Box: 989009
West Sacramento, California 95798-9850

The Health Care Options Program has also added language lines and has changed the process for answering those lines. The language lines now include:

Argentinean	(800) 840-5032
Cambodian	(800) 430-5005
Cantonese	(800) 430-6006
English	(800) 430-4263
Farsi	(800) 840-5034
Hmong	(800) 430-2022
Laotian	(800) 430-4091
Russian	(800) 430-7007
Spanish	(800) 430-3003
Vietnamese	(800) 430-8008
TDD	(800) 430-7077

Eligibility under the Plan will continue unless a Member becomes ineligible for coverage under the California Medi-Cal program, disenrolls from the Plan, moves out of the service area, or eligibility changes to a LAPHP ineligible aid category.

A Member may be entitled to continue to receive dental care by the Plan even if he or she is no longer eligible because of an increase in income. The California Health and Human Services offers dental coverage through the Transitional Medi-Cal Coverage Program. To receive additional information about the transitional coverage and whether you would qualify, please contact the California Department of Health and Human Services at 1-800-880-5305, or visit the Denti-Cal and Medi-Cal websites at www.denti-cal.ca.gov and www.medi-cal.ca.gov.

Coverage Effective Date

Coverage shall begin at 12:01 a.m. on the first day of the month for which the Member's name is added to the approved list of Members furnished by the Department of Health Care Services to the Plan.

The term of membership will continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described below.

Termination

Your coverage can end or be cancelled immediately, when:

- Access Premier Dental is notified that a Member is ineligible to participate in the Medi-Cal Program,
- Member's change of residence to a location outside Los Angeles County;
- A Member is covered by Medi-Cal in an ineligible aid category, and
- A Member ends (terminates) their own Plan Coverage.

Disenrollment (if appropriate) shall be effective within 15 to 45 days after receipt of a Member's complete and executed disenrollment form by HCO. A Plan disenrollment form is available at the Plan office headquarters, any Plan Provider office, or by calling 1-800-430-4263. A Member may voluntarily disenroll from the Plan at any time and can enroll in another plan either through Member's own choice or through default.

An individual whose Plan benefits have been previously terminated or canceled and who is now an eligible Medi-Cal Beneficiary may re-enroll in the Plan. Refer to the Eligibility Section of this booklet for information about enrollment..

A Member will be disenrolled from the Plan on the first day of the month following any of the following events:

1) Member seeks dental care on a fee-for-service basis from an Indian Health Service facility;
2) Member is receiving care under the Foster Care or Adoption Assistance Program or through the Child Protective Services;
3) Member has a complex medical condition, such as pregnancy, in need of an organ transplant, chronic renal condition, tested positive for HIV or AIDS, receiving treatment for cancer, requiring major surgery, receiving care for a complex neurological condition, or receiving sub-acute, acute, intermediate or skilled nursing care;
4) Member is enrolled in a Medi-Cal waiver program;
5) Member is participating in a Department of Health Care Services' Pilot Project;
6) Member was incorrectly assigned to the Plan;
7) Member has moved outside the Plan's approved service area; and
8) Member is already receiving dental care through another dental plan or Medicare.

Visit the Denti-Cal and Medi-Cal websites for updated information at www.denti-cal.ca.gov and www.medi-cal.ca.gov.

Plan-Initiated Disenrollment

The Plan may recommend to DHCS the disenrollment of any Member for cause. Except in cases of violent behavior or fraud, the Plan shall make significant effort to resolve the problem with the Member through avenues such as reassignment of Primary Care Dentist or education before requesting a Plan-initiated disenrollment. The Plan will submit to DHCS a written request for disenrollment with supporting documentation based on the breakdown of the Plan-Member relationship. The Plan may recommend to DHCS the disenrollment of a Member because of, but not limited to, one of the reasons below:

- Repeated and Unjustified Verbal Abuse:
  Member is repeatedly abusive to the Providers, ancillary or administrative staff, subcontractor staff or to other Plan Members;

- Unjustified Physical Abuse:
  Member physically assaults a Provider or staff person, subcontractor staff person, or other Member, or threatens another individual with a weapon on the Plan's premises. In this instance, the Plan or the Provider will file a police report and file charges against the Member;

- Unjustified Disruptive Behavior:
  Member is disruptive to Plan's operations in general;

- Habitual Use of Non-Network Providers:
  Member habitually uses providers not affiliated with the Plan for non-emergency services without required authorizations (causing Plan to be subjected to repeated Provider demands for payment for those services or other demonstrable degradation in Plan's relations with community Provider);

- Fraudulent Use of Medi-Cal Coverage:

Member has allowed the fraudulent use of Medi-Cal coverage under the Plan, which includes allowing others to use the Member's Plan Membership card to receive services from Provider; or

- Unjustified Noncompliance with Prescribed Treatment:
  A Member's failure to follow prescribed treatment (including failure to keep established dental appointments) will not, in and of itself, be good cause for the approval by the DHCS of a Plan-initiated disenrollment request unless the Plan can demonstrate to DHCS that, as a result of the failure, the Plan is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Plan and rate negotiations.

The Plan-initiated disenrollment must be prior approved by DHCS. The Plan will notify the Member in writing about the Plan's intent to disenroll the Member for cause. The Plan will allow a period of twenty (20) calendar days from the date of the receipt of the letter for the Member to respond to a proposed action prior to disenrollment.

****NOTE:** Except in cases of violent behavior or fraud, the Plan shall make significant effort to resolve the problem with the Member through avenues such as reassignment of Primary Care Dentist or education before requesting a Plan-initiated disenrollment.

The Plan shall not terminate or cancel Coverage to a Member based upon the Member's health status or requirements for health care services. Any Member who alleges that an enrollment has been canceled because of the Member's health status or requirements for health care services may request a review of cancellation by the Commissioner of the Department of Managed Health Care, at **1-866-452-8609**.

Disenrollment Process:

- The Plan will submit to DHCS a written request for disenrollment with supporting documentation based on the breakdown of the Plan-Member relationship.
- The Plan -initiated disenrollment must be prior approved by DHCS.
- The Plan will notify the Member in writing about the Plan's intent to disenroll the Member for cause.
- The Plan will allow a period of twenty (20) calendar days from the date of the receipt of the letter for the Member to respond to a proposed action prior to disenrollment

ACCESSING CARE

Physical Access

Access Dental Plan has made every effort to ensure that our offices and the offices and facilities of the Plan providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at (888) 414-4110 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 (888) 414-4110.

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 participating 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.

USING THE DENTAL PLAN

Member Identification Card

All members of the Plan are given a member identification card. This card contains important information for obtaining services. If you have not received or if you have lost your member identification card, please call us at (888) 414-4110. (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.

Facilities Locations

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

The Plan's Primary Care Dentists are located close to where you work and live. To find out the exact address of your Provider's dental office, you may look up his or her address in the Provider Directory or call the Plan at (888) 414-4110.

Choosing a Primary Care Dentist (PCD)

Members must select a Primary Care Dentist from the Plan's network of dentists. You can get a list of dentists online at www.premierlife.com. You can also call Member Services at (888) 414-4110 to get a list of dentists.

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 application. If a Member has an existing dentist who is in the Plan's network, the Member should select that dentist during enrollment. Once assigned, the Member can continue seeing that dentist with no disruption to his/her care. Members from the same family may select different Primary Care Dentists.

Should any Member fail to select a Primary Care Dentist at the time of enrollment, the Plan will assign the Member to an available Primary Care Dentist, who practices in close proximity to where the Member resides. You have 30 days, after enrollment to select a PCD. Each Member's Primary Care Dentist is responsible for the coordination of the Member's dental care (in coordination with the Plan). **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 and assistance, and the office hours of your Primary Care Dentist, Members should contact a Member Service Representative by calling 1-888-849-8440 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 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 Dental Condition exits.

You should not receive a bill for a Covered Service from a Plan Provider. However, if you do receive a bill, please contact the Plan's Member Services Department. The Plan will reimburse a Member for Emergency Dental Care services. 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 Dental Condition). If you choose to receive services, which are not Covered Services, you will be responsible for payment of those services.

Scheduling Appointments

It is very important to see a dentist and maintain good oral health! Make an appointment for your first visit today.

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. Provider offices are open during normal business hours. Some offices are open on

Saturdays. If you cannot go to your appointment, you must let the dental office know at least 24 hours in advance. A fee may be charged by your PCD for a missed appointment without 24 hours prior notification.

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.

If the Member requires specialty care, the Member's Primary Care Dentist will contact the Plan who will arrange for such care.

If you do not have transportation to a dental appointment, please contact Member Services at (888) 414-4110. The Plan will pay for your public transportation fare to and from your appointment. We can also help you arrange for taxi service. Taxi fare will not be paid for by the Plan.

Costs to You

There are no prepayment fees, periodic payments, co-payments, or other charges required from Members for Coverage under the Plan.

Changing Your Primary Care Dentist

A Member may transfer to another Primary Care Dentist by contacting the Plan at (888) 414-4110 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 more than four (4) business days prior to the end 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.

The Plan may be unable to assign Members to their choice of Primary Care Dentist for one of the following reasons:

- The Primary Care Dentist is not currently accepting new patients. (This is probably a temporary situation and the Members may transfer to this Primary Care Dentist at a later date.)
- If the Primary Care Dentist reaches a maximum ratio of assigned Members.

If your choice of Provider is unavailable:

- The Plan will assign one to you closest to your residence
- You may request a change of Provider by calling Member Services at (888) 414-4110.

MEMBERS MAY ALSO:

- Receive general dental care at a Native American Health Center or a Federal Qualified Health Center.
- If you would like information regarding receiving dental treatment at a Native American Health Center or a Federal Qualified Health Center, please contact the Plan's Member Representative.

**NOTE: No matter what the availability of Indian Health Service facilities, Members who are Native American may continue to receive treatment at his or her current dental provider. Native American members may disenroll from the Plan at any time, without cause.

Schedule of Benefits

For a complete listing of covered benefits for members under the age of 21, please see **Attachment A**.

For a complete listing of covered benefits for members age of 21 and over, please see **Attachment B**.

Limitations and Exclusions

LIMITATIONS (Members Under Age 21)

- Full upper and/or lower dentures are not to exceed one each in any five (5) year period
- Cleaning (prophylaxis) once every six (6) months
- Fluoride Varnish under (6) six years of age, up to three times in a 12-month period
- Relines limited to one per appliance per twelve (12) months

- Full mouth X-rays - once every three (3) years
- Posterior laboratory processed crown not a benefit for adults 21 years of age and older except when posterior tooth is used as an abutment for any fixed or removable prosthesis with cast clasps and rests and meets Denti-Cal Criteria.

EXCLUSIONS (Members Under Age 21)

- Braces, except in the treatment of malocclusion for persons under the age of 21 years, or cleft palate deformities under the case management of California Children Services Program
- Treatment of incipient or non-active cavities in adults
- Cosmetic procedures
- Removable partial dentures, except when necessary for balance of a complete artificial denture
- Extraction of healthy teeth, except for: serial extractions required to minimize problems with the bite; teeth that interfere with denture or bridge construction; conditions perceptible through x-rays but which fail to elicit symptoms
- Pulp caps
- Fixed bridges, except when necessary for obtaining employment; medical conditions which preclude use of removable dentures
- Pedodontist referrals are not available for children 11 years old and older

Exemptions to Eliminated Adult Benefits

The following are exemptions to the eliminated adult dental benefits. In the following circumstances, Medi-Cal Dental providers may continue to provide services after July 1, 2009 and be reimbursed by Medi-Cal for those services:

- Medical and surgical services provided by a doctor or dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state.

- Federal law requires the provision of these services. The services that are allowable as Federally Required Adult Dental Services (FRADS) under this definition are listed in **Attachment B**.

- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy.

- This includes 60 days of postpartum care. Services for pregnant beneficiaries who are 21 years of age or older are payable if the procedure is listed under Table 1 (Federally Required Adult Dental Services) or Table 2 (Allowable Procedure Codes for Pregnant Women), in **Attachment B**.

- Adult beneficiaries (age 21 and older) whose course of treatment began prior to July 1, 2009 and is scheduled to continue on or after July 1, 2009.

- In these cases, the beneficiary must have been seen by the provider and the necessary course of treatment was evident prior to July 1, 2009. Note, this relates to a specified course of treatment with a completion date (e.g., to prepare a patient for dentures, and fabricate and deliver the dentures). Treatment must be completed within 180 days of the date the treatment was determined necessary. **This provision only applies to the completion of treatment that was determined to be necessary before the benefits were eliminated.** This provision is not to be construed to continue "routine care" (i.e., exams, cleanings, fillings, etc.) beyond July 1, 2009.

- Beneficiaries who are under 21 years of age and whose course of treatment is scheduled to continue after he/she turns 21 years of age (continuing services for EPSDT recipients) [Note: With the exception of orthodontic services which must be completed by the beneficiary's 21st birthday.]

- In these cases, the beneficiary must have been seen by the provider and the necessary treatment was evident prior to his/her 21st birthday. Note, this relates to a specified course of treatment (e.g., to perform a root canal or complete a crown). Treatment must be completed within 180 days of the date the treatment was determined necessary. **This provision only applies to completion of treatment that was determined to be necessary**

before the person became ineligible for that service due to reaching age 21. This provision is not to be construed to continue "routine care" (i.e., exams, cleanings, fillings, etc.) after the person turns 21.

- Beneficiaries receiving long-term care in a Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF), as defined in the *Health and Safety Code* (H&S Code), Section 1250, subdivisions (c) and (d), and licensed pursuant to H&S Code Section 1250, subdivision (k) are exempt from the change in adult dental services on July 1, 2009.

Beneficiaries residing in ICF-Developmentally Disabled (DD), ICF-Developmentally Disable Habilitative (DDH) or ICF-Developmentally Disable Nursing (DDN) are also exempt from the change in adult dental services on July 1, 2009.

- The facility definitions are available on the California Department of Public Health Website at http://hfcis.cdph.ca.gov/servicesAndFacilities.aspx. Providers may confirm the licensing of a facility from this Web page.
- Dental Services do not have to be provided in the facility to be payable. Providers are reminded to follow the existing prior authorization and documentation requirements.
- If a provider receives a denial on a claim for a beneficiary who resides in a licensed SNF or ICF, the provider can submit a Claim Inquiry Form (CIF) including the facility name and address and have the claim reprocessed. If the services were denied on a prior authorization request, the provider can submit the prior authorization notice and request re-evaluation.

- Dental Service Precedent to a Covered Medical Service.

- Beneficiaries may receive dental services that are necessary (precedent) in order to undergo a covered medical service. The majority of these dental services are covered under FRADS listed in Table 1 of Attachment B. A precedent dental service that is not on the list of FRADS will be evaluated and adjudicated on a case by case basis.

An adult dental service may be reimbursable if any one of the above exceptions is met.

Continuity of Care

A Member may request to have treatment completed by a certain provider if:

- The treating provider is terminated while treatment is in progress, or
- A nonparticipating provider is treating a newly covered Member at the time coverage became effective. was providing the covered services to a newly covered Member at the time his or her coverage became effective.

A Member can continue services from such providers in the following cases:

Acute Conditions: The duration of an acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).

Newborn Children between Birth and Age 36 Months: Plan shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the provider's contract or 12 months from the effective date of coverage for a newly covered Member.

Surgery or Other Procedure: Performance of surgery or other procedure authorized by Plans part of a documented course of treatment that is to occur within 180 days of the contract termination date for current Members or 180 days from the effective date of coverage for newly covered Member.
PLAN is not required to provide benefits that are not otherwise covered under the terms and conditions of the subscriber contract. This policy does not apply to a newly covered Member covered under an individual subscriber agreement.

Members may request continuation of care by calling Member Services at (888) 414-4110 during normal business hours.

The Plan will review the request for continuation of care. The Plan will provide the Member:

- with the Dental Director's decision in writing within 5 business days of the receipt of the request and
- the copy of the Member's dental record or in a sooner timely manner appropriate for the Member's clinical condition.

- The written notice shall inform the Member how to file a grievance in the event the Member is dissatisfied with the decision.

Plan requirements from the Provider:

- The terminated or nonparticipating provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers, including, but not limited to:
  - credentialing
  - hospital privileging
  - utilization review
  - peer review
  - quality assurance requirements.

Plan is not required to continue the services a Provider is providing to a Member if:

- The provider does not agree to comply or does not comply with these contractual terms and conditions.
- The provider does not accept the payment rates provided for in this paragraph.

Unless Plan and Provider agree otherwise:

- According to this policy, the services shall be compensated at rates and methods of payment similar to those used by Plan for currently contracting Providers providing similar services including those:
- Who are not capitated or
- Who is practicing in the same or a similar geographic area as the nonparticipating provider.

Members may request a copy the Plan's Continuation of Care Policy by calling the Plan's Customer Service Department at (888) 414-4110.

Referrals to Specialists

You must visit your PCD before going to a specialist. You must receive approval from the Plan before seeing the specialist. If you see the specialist without an approval, the cost of the services will be your responsibility.

How to get a referral:

A Member must first visit his or her PCD. If needed, the PCD will determine if a routine referral or emergency referral is needed.

- **Emergency Referrals:**
  Emergency referrals are processed by the Plan immediately. The Plan calls the specialist to schedule an appointment for the Member.
- **Routine referrals:**
  Routine referrals are processed within five (5) business days from the request date. If there is an imminent and serious threat to the Member's health, the referral is processed within 72 hours if the docmentation is complete.

- Copies of authorizations for regular referrals are sent to the MEMBER, the specialist and the Member's PCD.
- The Plan reserves the right to determine the facility and Plan provider from which covered services requiring specialty care are obtained.

The Member is encouraged to contact the PCD for follow-up care after treatment by a specialist.

Emergency services do not require a referral. The Plan will not cover non-emergency services provided by a dentist other than your PCD.

Prior Authorizations

Your primary care dentist may refer you to another dentist for consultation or specialized treatment. You 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.

Routine referrals are processed in a timely fashion appropriate for your condition, not to exceed five (5) business days of receipt.

Referrals affective care where you face an imminent and serious threat to our health or could jeopardize your ability to regain maximum function shall be made in a timely fashion appropriate for your condition not exceed seventy-two (72) hours after the Plan's receipt of the necessary documentation requested by the Plan to make the determination. Copies of authorization 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) business 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 provider for emergency dental care services. If the services are not authorized before they are provided, they will not be a covered benefit, even if the services are needed.

This is a summary of the Plan's referral policy. To obtain a copy of our policy please contact us at (888) 414-4110 (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 booklet.

Further information regarding the processes, criteria and procedures that the Plan uses to authorize, modify, or deny dental services under the benefits provided by the Plan are available to the Member, Primary Care Dentists, and the public upon request.

Emergency Care

Emergency Care is defined as services needed to ease or improve severe pain, swelling, or bleeding, associated with a sudden serious and unexpected illness or injury. During regular Provider office hours, Members may obtain care by contacting their Primary Care Dentist for Emergency treatment. Emergency Care is available to you twenty-four (24) hours a day.

- If it is an emergency, call 9-1-1 or go to the nearest hospital.
- During regular Provider office hours, Members may obtain care by contacting their PCD for Emergency treatment.
- After business hours, Members should contact their PCD or **Members may contact a twenty-four (24) hour answering service at (888) 414-4110.**
- The on-call operator will get information from the Member regarding the Emergency and relay the information to the on-call Provider.
- This Provider will then telephone the Member within one (1) hour from the time of the Member's call.
- The on-call Provider will assess the Emergency and in the event emergency dental services are required, a Plan Provider will meet the Member at the closest available Provider facility for treatment.
- If a Member requires Emergency Care when outside the Service Area, (the geographic area designated by the Plan within which the Plan shall provide Benefits and Coverage) a Member may seek treatment from the nearest available dentist or emergency room as the circumstances dictate.
- **Any Provider outside the Plan's Service Area may treat your emergency and will be reimbursed without prior authorization.**
- Care that the Plan determines not to meet the definition of Emergency Care will not be covered.
- Non-Plan Providers may require the Member to make immediate full payment for services.

- If the Member has to pay the full bill, the Plan will reimburse the Member for services that meet the definition of Emergency Care as defined above.
- If the Member pays a bill, a copy of the bill should be submitted to the following address within 90 days from the date of treatment:

  Access Dental Plan

  Attention: Claims Department

  P.O. BOX: 659005

  Sacramento, CA 95865-9005

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

Second Opinions

Getting a Second Opinion

You may ask for a second opinion for Covered Services from another Provider about a condition that your current Provider diagnoses or about a treatment plan that your Provider recommends.

Below are some reasons why you may want to ask for a second opinion.

- You have a question about a strategy, treatment, or procedure your Provider recommends.
- You have questions about a diagnosis that may threaten loss of life, substantial impairment, including a serious chronic medical condition.
- There is disagreement regarding your diagnosis or test results.
- Your health is not improving with your current treatment plan, after a reasonable period of time given.
- Your Provider is unable to diagnose your problem

How to request a second opinion:

Access Dental Plan shall provide or authorize a second opinion by an appropriately qualified dental provider. The second opinion will be rendered within 72-hours from the Plan's receipt of request where the Member's condition poses imminent and serious threat to the Member's life.

Members interested in obtaining the timeline for authorizing second dental opinions can contact the Plan at:

Access Dental Plan
Referrals Department
P.O. Box: 659005
Sacramento, CA 95865-9005
800-270-6743 ext. 6012

The cost of obtaining the second opinion will be paid by the PLAN.

GRIEVANCES AND APPEALS

Any information, dispute or complaint should be directed to the Plan at:

Access Dental Plan, Inc.
Complaint / Grievance Department
P.O. BOX: 659005
Sacramento, CA 95865-9005

Grievance Department: (916) 563-6013
Or (888) 414-4110

Members are encouraged to contact the Plan or their provider if they have a complaint or grievance. This could be related to the Plan or one of its providers.

Member complaints or grievances can be submitted at any time in the following ways:

- On the Plan's website at www.premierlife.com;
- In person at the Plan location: 8890 Cal Center Drive, Sacramento, CA 95826;.
- By phone to the Plan's Grievance Department at (916) 563-6013 or (888) 414-4110;or
- In writing to the Grievance Department at the address above.

A grievance form is at the back of this booklet. Staff will be available at the Plan office or any Plan Provider office to assist Members in completion of this form. Members will receive written notification of receipt of their complaint/grievance within five (5) days. This notice will include the Plan's contact person for their complaint. Additionally, the Member will receive a response within thirty (30) days as to resolution of their grievance. Members have the right to file a grievance if Members believe their linguistic needs have not been met. Members may also file a Request for Assistance to the Department of Managed Health Care after participating in the Plan's grievance procedure for 30 days.

The Plan will expedite the review of grievances for cases involving an imminent and serious threat to the health of the Member, including but not limited to, severe pain, potential loss of life, or major bodily function. In cases that require expedited review, the Member has the right to file a Request for Assistance with the Department of Managed Health Care immediately and without having to participate in the Plan's 30 days grievance procedures first. The Plan shall immediately inform the Member in writing of their right to notify the Department of Managed Health Care of the grievance. The Plan will also provide Members and the Department with a written statement of the disposition of pending status of the grievance no later than (3) days from the receipt of the grievance.

For grievances involving the delay, denial, or modification of dental care services, the Plan's response will describe the criteria used by the Planand the clinical reasons for its decision, including all criteria and reasons related to dental necessity. In the event that the Plan issues a decision delaying, denying, or modifying the dental services based on whole or part on a finding that the proposed services are not a covered benefit under the Member's contract, the Plan will then clearly specify the decision the provisions in the contract that exclude the coverage.

Appeals

If you are still unhappy with the decision of your complaint to Access Dental Plan:

- Members are encouraged to submit appeals to the Plan within 45 days from the date of the resolution of the grievance.
- Members will be informed in writing of the disposition of the appeal within 30 days of when the appeal request was received in writing.
- Members may also appeal grievance decisions by requesting a Fair Hearing from the Department of Social Services by contacting (800) 952-5253.
- The Plan can help Members request a State Fair Hearing.
- The Plan will provide annual notification to Members concerning its grievance procedures as well as periodic notification to MEMBERS of all changes in the Plan.

IF YOU STILL NEED HELP

Department of Health Care Services (DHCS)

The DHCS is responsible for monitoring contractual compliance of all managed care plans who serve Medi-Cal beneficiaries. DHCS has established an Ombudsman Unit to receive complaints regarding Medi-Cal managed care plans. To contact the DHCS Ombudsman Unit, call (866) 452-8609.

Fair Hearing

Member has the right to the Medi-Cal fair hearing process regardless of whether or not a complaint or grievance has been submitted or if the complaint or grievance has been resolved, when a health care service requested by the Member or Provider has not been provided. The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number is 1-800-952-5253. Or the Member may write to:

Office of the Chief Administrative Law Judge
State Department of Social Service
c/o The Department of Health Care Services
P.O. Box: 13189
Sacramento, California 95813-3189

Independent Medical Review (IMR)

IMR is a review of you case by one or more doctors who are not part of your health plan. You do not pay anything for an IMR. You should use Access Dental Plan's complaint and appeals processes, as described in the Grievances and Appeals Sectionabove, first.

You may qualify for an IMR if Access Dental Plan does one of the following:

- Denies, changes, or delays a service or treatment because Access Dental Plan determines it is not medically necessary.
- Denies an experimental or investigational treatment for a serious condition.
- Will not pay for emergency or urgent care that you already received.

If the IMR is decided in your favor, Access Dental Plan must give you the service or treatment you requested.

California law requires that we include the following statement:
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 **(1-800-707-6453)** 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.

Binding Arbitration

If you cannot solve your problem through the complaint processes listed above, you can ask for binding arbitration (see below for definition). Binding arbitration is the final step you can take to resolve your complaint with Access Dental Plan.

- Arbitration is usually less expensive and takes less time than a lawsuit.
- Arbitration can be requested by either the Access Dental Plan or the Member.

Definition of binding arbitration:

Arbitration is a way to solve disputes, disagreements, or problems without filing a formal lawsuit.

- One or more people, called arbitrators, who are not connected with you or with the Plan make the final decision on your case.

- Together, you and the Plan choose and approve the arbitrator(s).
- If the parties are unable to agree on the selection of a neutral arbitrator, the Plan shall use the method provided in section 1281.6 of the Code of Civil Procedure to select the arbitrator.
- If the parties agree to waive the requirement to use a single neutral arbitrator:
  - The enrollee or subscriber shall have three business days to cancel the agreement.
- If the agreement is also signed by counsel of the enrollee or subscriber:
  - The agreement shall be binding and may not be cancelled
- The arbitrator(s) review the case and then write a decision, called an *opinion.*
- Both you and Plan must accept (be bound by) the decision of the arbitrators.

How to request arbitration:

Send a written request (also called a *demand)* for arbitration to Access Dental Plan, Attn: Arbitration Requests, 8890 Cal Center Drive, Sacramento, CA 95826:

Your written request must include:

- A statement describing the nature of the dispute
- The specific issue
- Amount involved
- Remedies sought
- A description of the steps leading up to arbitration
- Attempts to resolve the dispute with Access Dental Plan.

For further assistance, the MEMBER may also write the AAA at 3055 Wilshire Blvd., 7th Floor, Los Angeles, CA 90010-1108, or telephone (213) 383-6515.

Paying for arbitration:

Attorney(s) fees: You must pay your own attorney's fees, if you choose to have an attorney. The Plan pays its own attorney's fees.

Arbitrator fees: You and the Plan share equally the fees and expenses of the arbitrator(s). If you cannot pay your part of the arbitrator's fees and expenses, you may ask the Plan to pay. Write to Access Dental Plan Member Services and ask for a hardship application. The Plan will send your application to an independent organization or person to decide if the Plan should pay for some or all of your part of the arbitrator's fees and expenses.

MEMBER agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association ("AAA").
The arbitrator(s) shall make the necessary arrangements for the services of an interpreter upon the request of any party, which party shall assume the cost of such services.

The arbitration shall take place in Sacramento, California, unless some other location is mutually agreed upon by the parties, and shall be governed by the rules of the American Arbitration Association.

The agreement shall clearly indicate, in boldface type, that "A case or dispute subject to binding arbitration has arisen between the parties and we mutually agree to waive the requirement that cases or disputes for which the total amount of damages claimed is two hundred thousand dollars ($200,000) or less be adjudicated by a single neutral arbitrator."

MEMBER PRIVACY

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.

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.
- We may collect, use, and share medical information when medically 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.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Call your Provder's office or Access Dental Plan Member Services at (888) 414-4110.

PUBLIC POLICY PARTICIPATION

Access Dental Plan has a public policy committee. This committee includes providers, members, and a member of the Board of Directors. If you would like to be considered for this committee, please write to Access Dental Plan – Public Policy Committee, 8890 Cal Center Drive, Sacramento, CA 95826.

- This committee advises the Board of Directors about how to assure the comfort, convenience, and dignity of our members.
- The committee may also review the Plan's financial information and information about the complaints we receive.
- The Plan will reimburse Members $100.00 per meeting for their participation.
- 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.
- 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 the Member applicants.
- A Public Policy Committee membership application is attached to this Combined Evidence of Coverage and Disclosure Form as **Attachment "D".**
- The Plan will also annually mail applications to all Members for membership on the Public Policy Committee as positions on the committee become available.

Members are also encouraged to visit the Plan's website at www.premierlife.com to obtain educational information related to oral health or contact the Plan at (888) 414-4110 to receive a copy.

PROMOTION OF A HEALTHY LIFESTYLE

The Plan will ensure that the network of Primary Care Dentists perform preventive services, encouraging providers to conduct Member education, and providing health education materials at each Primary Care Dentist's office.

CALIFORNIA CHILDREN SERVICES

California Children Services (CCS) is a state program operating in local county offices. The program is paid for by California taxpayers and offers medical care to children whose families cannot afford all or part of the needed care.

- The program treats children under 21 years of age with certain physical limitations and diseases.
- If a Member has a CCS eligible condition, Member needs to apply to CCS for services under the CCS program.
- If you suspect that you have a CCS condition, it is recommended that you also contact your primary care physician.
- For any further information concerning the CCS program, please contact your local CCS Chapter at (916) 875-9900

Members who may be eligible for dental services through the CCS program include

- Those who have been accepted for and are authorized to receive orthodontic services for medically handicapping malocclusion by a CCS-paneled orthodontist.
- Clients with CCS-eligible conditions such as
- Cleft lip and/or palate
- Congenital and/or acquired oral and craniofacial anomalies
- Complex congenital heart disease
- Seizure disorder
- Immune deficiencies
- Cerebral palsy
- Hemophilia
- Other blood dyscrasia
- Malignant neoplasms, including leukemia, rheumatoid arthritis, nephrosis, cystic fibrosis, and organ transplants.

The Plan shall continue to provide all dentally necessary covered services and case management services for Members referred to CCS until eligibility for the CCS program is established.

Once eligibility for the CCS program is established for a Member the Plan shall continue to provide:

- Primary Dental Care
- Other dentally covered services unrelated to the CCS-eligible condition and
- The coordination of services between its Primary Care Dentists, the CCS-specialty providers, and the local CCS Program.

WORKERS' COMENSATION

The Plan agrees to advance the services and benefits covered. If a Member receives services which are recoverable by:

- Arbitration or settlement
- Under any worker's compensation law
- Employer liability law
- Occupational disease law

The Plan will:

- NOT make a claim against or otherwise obtain reimbursement for such recovery.
- Notify the Department of Health Care Services within 10 days of discovery an action by a Member involving the tort or worker's compensation liability of a third party that may result in recovery of funds to which the Department has lien rights.

ORGAN DONATION

The donation of 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 patient is pronounced brain dead and identified as a potential organ donor. Any individual who is at least 18 years of age, or an individual who is between 15 and 18 years of age (only upon the written consent of a parent or guardian), has the choice of making an organ donation.

An organ donation may be made only by the following:

- A document of donation signed by donor.
- A document of donation signed by another individual and by two witnesses, all of whom signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.
- A document of donation orally made by a donor by means of tape recording in his or her own voice.

- If a document of donation is attached to or imprinted on a donor's motor vehicle driver's license, the document of donation shall comply with the above-mentioned criteria. Revocation, suspension, expiration, or cancellation of the license does not invalidate the organ donation.
- A document of donation may designate a particular physician or surgeon to carry out the appropriate procedures.

BENEFITS SCHEDULE FOR MEMBERS UNDER THE AGE OF 2

9010 Complete examination, initial episode of treatment only
9015 Examination periodic (annual)
9020 Office visit during regular office hours for treatment and/or observation of teeth or support structures
9030 Professional visit after regular office hours, or to bedside
9035 Hospital care
9040 Specialist consultation
9045 Pit and Fissure Dental Sealants for Permanent First Molars, to age eight (8)
9046 Pit and Fissure Dental Sealants for Permanent Second Molars, to age fourteen (14)
9047 Pit and Fissure Dental Sealants for beneficiaries to age twenty-one (21)
9049 Prophylaxis-beneficiaries through age 12
9050 Prophylaxis-beneficiaries age 13 years and older
9061 Prophylaxis, including topical application of fluoride-beneficiaries ages 6 through 17 years of age
Topical Fluoride Varnish: Therapeutic application for moderate to high caries risk patients-is a Medi-Cal benefit for children younger than (6) six years of age-D1206
9080 Emergency treatment, palliative
9110 Intraoral periapical, single, first film
9111 Intraoral periapical, each additional film
9112 Intraoral, complete series consisting of at least 14 periapical films plus bite-wings
9113 Intraoral, occlusal, each film
9114 Extraoral single, head or lateral jaw
9115 Extraoral each additional head or lateral jaw
9116 Bite-wing, two films
9117 Bite-wing, four films
9118 Bite-wings, anterior, one film
9119 Photograph or slide, first
9120 Photograph or slide, each additional (maximum five)
9125 Panographic-type film, single film
9150 Biopsy of oral tissue
9160 Gross and microscopic histopathological report

ORAL SURGERY
(9200-9299)

9200 Removal of erupted tooth, uncomplicated, first tooth
9201 Removal of erupted tooth, uncomplicated, each additional tooth
9202 Removal of erupted tooth, surgical
9203 Removal of root or root tip, completely covered by bone
9204 Removal of root or root tip not completely covered by bone
9220 Postoperative visit, complications (e.g. osteitis)
9230 Removal o f impacted tooth-soft tissue
9231 Removal of impacted tooth-partial bony
9232 Removal of impacted tooth-complete bony
9250 Alveoplasty per quadrant, edentulous
9252 Alveoplasty per quadrant, in conjunction with extractions
9255 Vestibuloplasty, submucosal resection (not to include grafts)
9256 Alveoplasty with ridge extension secondary epithelialization (per arch)
9257 Removal of palatal exostosis (torus)
9258 Removal of mandibular exostosis (torus)-per quadrant
9259 Excision of hyperplastic tissue-(per arch)
9260 Incision and drainage of abscess, intraoral
9261 Incision and drainage of abscess, extraoral
9262 Excision pericoronal gingiva, operculectomy
9263 Sialolithotomy-intraoral
9264 Sialolithotomy-extraoral
9265 Closure of salivary fistula
9266 Dilation of salivary duct
9267 Reduction of tuberosity, unilateral
9269 Excision of benign tumor, up to 1.25 cm
9270 Excision of benign tumor, larger than 1.25 cm
9271 Excision of malignant tumor
9273 Reimplantation and/or stabilization of accidentally avulsed or displaced permanent teeth and/or alveolus
9275 Transplantation of tooth or tooth bud
9276 Removal of foreign body from bone-independent procedure
9277 Radical resection of bone for tumor with bone graft
9278 Maxillary sinusotomy for removal of tooth fragment or foreign body
9279 Oralantral fistula closure
9280 Excision of cyst, up to 1.25 cm
9281 Excision of cyst over 1.25 cm
9282 Sequestrectomy
9285 Condylectomy of mandible, unilateral
9289 Menisectomy of temporomandibular join, unilateral
9290 Excision of foreign body, soft tissue
9291 Frenectomy, or frenotomy, separate procedure
9292 Suture of soft tissue wound or injury
9294 Injection of sclerosing agent into temporomandibular joint
9295 Injection of Trigeminal nerve branches for destruction
9296 Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissue

9297 Surgical exposure of impacted or unerupted tooth to aid eruption, partial bony
9298 Surgical exposure of impacted or unerupted tooth to aid eruption, complete bony
9299 Unlisted surgical service or procedure

DRUGS AND ANESTHESIA
(9300-9449)

9300 Therapeutic drug injection
9301 Conscious sedation relative analgesia, Nitrous oxide (N2O), per visit
9400 General anesthesia

PERIODONTICS
(9450-9499)

9451 Emergency treatment: (periodontal abscess, acute periodonitis, etc.)
9452 Subgingival curettage and root planning per full mouth treatment
9453 Occlusal adjustment (limited) per quadrant (minor spot grinding)
9472 Gingivectomy or gingivoplasty per quadrant
9473 Osseous and mucogingival surgery, per quadrant
9474 Gingivectomy or gingivoplasty treatment per tooth, (fewer than six teeth)

ENDODONTICS
(9500-9599)

9501 Therapeutic pulpotomy
9502 Vital pulpotomy
9503 Recalcification, includes temporary restoration, per tooth
9511 Anterior root canal therapy
9512 Bicuspid root canal therapy
9513 Molar root canal therapy
9530 Apicoectomy-surgical procedure in conjunction with root canal filling
9531 Apicoectomy (separate surgical procedure), per tooth
9534 Apexification/Apexogenesis (therapeutic apical closure), per treatment

RESTORATIVE DENTISTRY
(9600-9699)

Amalgam Restorations
9600 One surface, primary tooth
9601 Two surfaces, primary tooth
9602 Three surfaces, primary tooth
9603 Four or more surfaces, primary tooth (maximum)
9611 One surface, permanent tooth
9612 Two surfaces, permanent tooth
9613 Three surfaces, permanent tooth
9614 Four or more surfaces, permanent tooth (maximum)

Silicate, Composite, Plastic Restorations

9640 Silicate cement restoration
9641 Silicate restorations, two or more in a single tooth (maximum)
9645 Composite or plastic restoration
9646 Composite or plastic restorations, two or more in a single tooth (maximum)
9648 Pin retention, (per pin) maximum three per tooth

Crowns
9650 Crown, plastic (laboratory processed)
9651 Crown, plastic with metal
9652 Crown, porcelain
9653 Crown, porcelain fused to metal
9660 Crown, cast, full
9663 Crown, cast, three-quarters
9670 Crown, stainless steel, primary
9671 Crown, stainless steel, permanent
9672 Gold dowel post

PROSTHETICS
(9680-9799)
Pontics
9501 Therapeutic pulpotomy
9680 Fixed bridge pontic, cast metal
9681 Fixed bridge pontic, slotted facing
9682 Fixed bridge pontic, slotted pontic
9692 Fixed bridge pontic, porcelain fused to metal
9693 Fixed bridge pontic, plastic processed to metal

Recementing
9685 Recement inlay, facing, pontic
9686 Recement crown
9687 Recement bridge

Repairs, Crown and Bridge
9690 Repair fixed bridge
9694 Replace broken tru-pontic
9695 Replace broken facing, post intact
9696 Replace broken facing, post backing broken

Removable Prosthodontics
9700 Complete maxillary denture
9701 Complete mandibular denture

9702 Partial upper or lower denture with two assembled wrought wire or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base
9703 Partial upper or lower denture with cast chrome skeleton, two cast clasps, and necessary teeth
9704 Clasp, third and each additional clasp for procedure 9703
9705 Stress breaker, extra
9706 Partial upper or lower stayplate, acrylic-base fee, teeth and clasps extra
9708 Partial upper or lower denture, all acrylic, with two assembled wrought wire clasps having two clasp arms, but no rests, and necessary teeth
9709 Clasp, third and each additional for Procedure 9708
9712 Clasp, third and each additional for Procedure 9702
9716 Clasp or teeth, each for Procedure 9706
9720 Denture adjustment, per visit
9721 Reline-office, cold cure
9722 Reline-laboratory processed
9723 Tissue conditioning, per denture
9724 Denture duplication ("jump," "reconstruction") denture base including necessary tooth replacement, per denture

Repairs, Dentures, Acrylic
9750 Repair broken denture base only (complete or partial)
9751 Repair broken denture base and replace one broken denture tooth (maximum two)
9752 Each additional denture tooth replaced on 9751 repair (maximum two)
9753 Replace one broken denture tooth only (complete or partial)
9754 Each additional denture tooth replaced on 9753 repair (maximum two)
9755 Adding first tooth to partial denture to replace newly extracted natural tooth
9756 Each additional natural tooth replaced on 9755 repair (maximum two)
9757 Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and rest to an existing 9702 partial denture
9758 Each additional new or replacement clasp for repair 9757 (maximum two)
9759 Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 9708 partial denture
9760 Each additional new or replacement clasp for repair 9759 (maximum two)
9761 Reattaching clasp on partial denture, clasp intact, each (maximum two)
9762 Add a new or replace a broken cast chrome cobalt clasp with two clasp arms and rest to an existing 9703 partial denture
9763 Each additional new or replacement clasp for repair 9762 (maximum two)

MALOCCLUSION CASES

9550 Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 9112, and cephalometric head films)
9551 Initial Orthodontic Examination/Handicapping Labial-Lingual Deviation Index
9552 Banding and materials
9554 Per treatment visit-24 visits maximum. One visit maximum per calendar month

CLEFT PALATE CASES

Primary Dentition
9560 Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 9112, and cephalometric head films, procedure code 9956 and 9957 including tracing are separately payable at stated fee schedule)
9562 Banding and materials
9564 Per treatment visit-10 visits maximum. One visit maximum per calendar month

Mixed Dentition
9570 Banding and materials
9572 Per treatment visit-14 visits maximum. One visit maximum per calendar month

Permanent Dentition
9580 Banding and materials
9582 Per treatment visit-30 visits maximum. One visit maximum per calendar month

FACIAL GROWTH MANAGEMENT

9590 Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 9112, and cephalometric head films, procedure code 9956 and 9957 including tracing, are separately payable at stated fee schedule)
9592 Quarterly-observation, maximum six quarters
9594 Progress records prior to treatment
9596 Banding and materials
9598 Per Treatment visit-24 visits maximum. One visit maximum per calendar month

RETENTION (MALOCCLUSION, CLEFT PALATE, AND FACIAL GROWTH MANAGEMENT CASES)

9556 Quarterly-observation-six quarters maximum
9599 Retainer, removable, for each upper and lower

SPACE MAINTAINERS
(9800-9899)

9800 Fixed, unilateral band type (including band)
9801 Removable plastic with two stainless steel round wire clasps or rests
9802 Each additional clasp or rest (for 9801 only)
9811 Fixed, unilateral stainless steel crown type (including crown, Procedure 9670 or 9671)
9812 Fixed, bilateral lingual or palatal bar type
9832 Fixed or removable appliance to control harmful habit

FRACTURES AND DISLOCATIONS
(9900-9999)
(Includes Usual Follow-up Care)

9900 Maxilla, open reduction, simple
9901 Maxilla, closed reduction, simple
9902 Mandible, open reduction, simple
9903 Mandible, closed reduction, simple
9904 Maxilla, closed reduction, compound
9905 Maxilla, open reduction, compound
9906 Mandible, closed reduction, compound
9907 Mandible, open reduction, compound
9913 Reduction of dislocation of temporormandibular joint
9915 Treatment of malar fracture, simple, closed reduction
9916 Treatment of malar fracture, simple or compound depressed, open reduction

DIAGNOSTIC SERVICES

9950 Clinical Examination and Consultation, Including Study Models
9952 Prosthetic Evaluation and Treatment Plan, Including Study Models
9955 TMJ Series radiographs
9956 Cephalometric Head Film, single, first film, Including tracing
9957 Cephalometric Head Film, Each Additional Film, Including tracing

MAXILLOFACIAL PROSTHETIC SERVICES

9960 Speech appliance transitional with or without pharyngeal extension
9962 Speech appliance, permanent, edentulous, with or without pharyngeal extension
9964 Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension
9966 Palatal lift, interim
9968 Palatal lift, permanent, cast framework
9970 Obturator immediate surgical, routine
9971 Obturator immediate surgical, complex
9972 Obturator permanent, complex
9973 Resection prosthesis, permanent edentulous, complex
9974 Resection prosthesis, permanent edentulous, routine
9975 Resection prosthesis, permanent, partially edentulous, complex
9976 Repositioner, mandibular, two piece
9977 Removal facial prosthesis
9978 Splints and stents
9979 Radiation therapy fluoride carrier
9980 Repairs, maxillofacial prosthesis
9981 Rebase, laboratory processed, maxillofacial prosthesis
9982 Balancing (opposing) maxillofacial appliance

MAXILLOFACIAL SURGICAL PROCEDURES

9985 Maxillofacial surgical procedures

TEMPOROMANDIBULAR JOINT DYSFUNCTION MANAGEMENT

9990 Occlusal analysis, including report and/or models
9992 Occlusal adjustments, limited centric and excursive adjustments including records and/or models
9994 Occlusal balancing, altering centric relations, including records and/or models
9995 Orthopedic stabilizing appliance, disocclusion splint
9996 Postoperative visits, symptomatic care and counseling
9998 Unlisted therapeutic services

ATTACHMENT B

BENEFITS FOR MEMBERS OVER THE AGE OF 21

Federally Required Adult Dental Services (FRADS)

The following procedure codes will continue as reimbursable procedures for Medi-Cal beneficiaries 21 years of age and older beginning July 1, 2009.

***Please note**: The CDT-4 procedure codes marked with an asterisk (D0220, D0230, D0250, D0260, D0290, D0310 and D0330) are only payable for Medi-Cal beneficiaries age 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

Table 1

CDT-4 Code	CDT-4 Code Description
D0220*	Intraoral - periapical first film
D0230*	Intraoral - periapical each additional film
D0250*	Extraoral - first film
D0260*	Extraoral - each additional film
D0290*	Posterior - anterior or lateral skull and facial bone survey film
D0310*	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330*	Panoramic film
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2910	Recement inlay
D2920	Recement crown
D2940	Sedative filling
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
CDT-4 Code	**CDT-4 Code Description**
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6930	Recement fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft (all others)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greaterthan 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm

D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	D7465 Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7520	Incision and drainage of abscess - extraoral soft tissue
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body

CDT-4 Code	CDT-4 Code Description
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrostomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: discectomy
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical - per sextant or quadrant
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7955	Repair of maxillofacial soft and hard tissue defect
D7971	Excision of pericoronal gingiva
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	Non-intravenous conscious sedation
D9410	House/Extended care facility call
D9420	Hospital call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic drug injection, by report
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 2: Allowable Procedure Codes for Pregnant Women

CDT-4 Code	CDT-4 Code Description
D0120	Periodic oral evaluation
D0150	Comprehensive oral evaluation - new or established patient
D1110	Prophylaxis - adult
D1204	Topical application of fluoride (prophylaxis not included) – adult
D1205	Topical application of fluoride (including prophylaxis) - adult
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant
D4920	Unscheduled dressing change (by someone other than treating dentist)
D9951	Occlusal adjustment - limited

ATTACHMENT C

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 (888) 414-4110 or any Plan provider representative.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: (____) ____-____

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & USE THE BACK OF THIS FORM 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 **(1-800-707-6453)** 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 95865-5039

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

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

ATTACHMENT D

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 the appropriate section 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
- ☐ Associate of Arts
- ☐ Graduate School
- ☐ High School Graduate
- ☐ College Graduate

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
8890 Cal Center Drive
Sacramento, CA 95826

Place stamp here

ACCESS DENTAL PLAN
8890 CAL CENTER DRIVE
SACRAMENTO, CA 95826