Premier Access Insurance Company
Certificate of Insurance

Employer Name: Diocese of Stockton

Policy/Group Number: 100980

We certify that You are insured in accordance with the terms of the Group Insurance Policy (the Policy), issued to Your Employer by Us.

Your Member ID Number and Effective Date appear on the identification card provided by Premier Access Insurance Company for You and Your eligible Dependents. All terms and benefits are described in the Employer's Policy and this Certificate. In case of conflict, the terms of the Policy will apply. Benefits may be modified by Certificate Riders which may provide greater or lesser benefits. Any Certificate Riders issued with the Policy should be provided with this Certificate.

The Policy may be changed or canceled without the consent of covered Employees.

Please read Your Certificate carefully so that You will understand Your coverage.

TABLE OF CONTENTS

GENERAL DEFINITIONS

These definitions apply when the following terms are used in this Certificate, unless otherwise defined where they are used. Not all defined terms are used in their usual meaning and some have meanings that limit their application; therefore, please refer to this Definitions section and the following “Dental Definitions” section for a helpful understanding of the defined terms that are capitalized in this Certificate.

Actively at Work means working Full-time for the Employer or an Associated Company at your usual place of business.

Associated Company means a corporation or other business entity affiliated with the Employer through common ownership of stock or assets.

Benefit means Covered Services and Supplies provided to a Covered Person for which payment is made under the Policy.

Calendar Year means a 12-month period beginning on January 1 and ending on December 31 of that same year.

Children means Your natural children, legally adopted children from the moment of placement in Your home, Your step children and other children for whom the Employee or Employee’s spouse is a court appointed guardian, provided that they are solely supported by You and are residing in Your household.

Close Relative means: a) a Covered Person’s spouse, children, parents, brothers and sisters; and, b) any other person who is part of a Covered Person’s household.

Coinsurance means the percentage of covered services paid by Us after the deductible has been met.

Coordination of Benefits means ensuring that Benefits paid under the Policy, when the Covered Person has other insurance coverage, is paid in accordance with the rules for primary and secondary coverage.

Co-payments means the percentage of covered services paid by You after the deductible has been met.

Covered Charges means charges for Covered Services and Supplies. Covered Charges for a Preferred or Premier Choice Network Provider will not exceed the provider’s negotiated rate. Covered charges for a Non-Preferred Provider will not exceed Usual, Customary and Reasonable charges.

Covered Person means an Employee or his or her Dependent(s) who is covered under the Policy.

Covered Services and Supplies means Dentally Necessary services and supplies that are payable or eligible for reimbursement, subject to any benefit limitations or maximums, under the Policy.

Deductible means the amount of Covered Charges that must be paid by a Covered Person in each Plan Year before any payment is made by Us. The Deductible is applied to the Covered Charge, before coinsurance amounts are determined.

Example of Deductible Calculation: Covered Charge = $200, Coinsurance = 80%, Deductible = $25. Calculation: $200 (Covered Charge) - $25 (Deductible) = $175 x 80% (Coinsurance) = $140 (Coinsurance amount payable by Us)

Dependent means one of the following:

- Your spouse by legal marriage.

- Your unmarried child under 19 years of age.
- Your unmarried child age 19 or older (an Overage Dependent) who meets one of the following criteria:

(1) Age 19 or over but under age 25 and enrolled as a full-time student in an accredited college or university. Acceptable verification of a child's qualifying status is an accredited college or university transcript which states the start date of the academic period and the number of units being taken. A minimum of 12 units qualifies as full-time status. Verification is valid for 12 months following the academic period start date.

(2) Age 19 or over but under age 25 and an IRS Dependents (listed as a Dependent on Your last Federal Tax Return). Acceptable verification of a child's qualifying status is a copy of Your last Federal Tax return showing inclusion of the child as a dependent. Verification is valid for the tax year to which the return applies and for the following year, until the return for the following year is available.

(3) Age 19 or over and incapable of earning his or her own living by reason of mental retardation or physical handicap incurred prior to the limiting age, who is chiefly dependent upon the Employee or Employee's spouse for support and who was insured on the date just prior to the day his or her insurance would have ended due to age. The child must be listed as a dependent on the Employee's last Federal Tax Return. Acceptable verification of a child's qualifying status is a physician's written statement confirming the above conditions. Verification is valid during the child's enrollment under this Policy.

The term "Dependent" does not include any spouse or child who resides outside of the United States, or who is a member of the armed forces of any country.

Employee means a person who is employed by and receiving pay from the Employer, in the form of wage or salary, on a Full-time basis. It is also the individual whose status is the basis of Family Unit eligibility under this dental plan. He or she can also be an elected official of a government entity, except school board members, regardless of the number of hours worked. Employee does not include an independent contractor, or a person who is working for the Employer on a part-time or seasonal basis.

Employer means the Employer shown on your identification card.

Family Unit means You and Your Dependents covered under the Policy.

Full-time means You are Actively at Work and performing all the duties of Your occupation for the Employer for a certain number of hours per week, as specified in Your Employer's Group Insurance Policy.

Injury means an accidental bodily injury that is caused directly and independently of all other causes, by an accident. Injury does not include intentional self-inflicted injury or attempted self-destruction, whether sane or insane.

Late Enrollee means an otherwise eligible employee or dependent who does not enroll during the initial 30-day enrollment period or during the first 30 days after becoming eligible to enroll.

Lifetime Maximum Benefit means the total benefit payable under the Policy. This amount is limited to the benefits payable under this Policy less the actual benefits paid by a Prior Plan.

Medicaid means the program of medical coverage set forth in Title XIX of the Social Security Act, as amended by Public Law 89-97, including any amendments which may be enacted in the future.

Medicare means the program of medical coverage set forth in the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, Title 1, Part 1, of Public Law 89-97, including any amendments which may be enacted in the future.

Non-Preferred Provider means a provider that is not a contracted provider of Premier Access and has not agreed to accept a negotiated rate for Covered Services.

Other Plan means for the purpose of Coordination of Benefits, any dental plan, other than this Policy and any other plan offered by Us, providing benefits or services for medical or dental care or treatment, which benefits or services are provided by any group, blanket or franchise insurance, service plan contract, group, individual practice or other prepayment coverage or any coverage under labor management trustee plan, union welfare plan, employer organization plan, employee benefit organization plan, any other coverage under governmental programs, and any coverage required or provided by any statute.

Policy means the Group Policy issued to the Employer and the Certificate of Insurance.

Preferred Provider means a provider that has agreed to accept negotiated rates for services and supplies.

Premier Choice Network Provider means a provider that has agreed to accept negotiated rates for services and supplies.

Primary means for the purpose of Coordination of Benefits, the dental plan determined to be the plan which must pay for Covered Services first when the Covered Person is covered by Us and an Other Plan.

Prior Plan means the immediate prior plan/policy of group dental insurance that is replaced by the Employer by this Policy for Employees and Dependents who are eligible and become insured on the effective date of this Policy. This Policy must immediately replace the Prior Plan. A Prior Plan must have provided benefits the same as, or better than, the benefits provided under this Policy, as determined by Us
For Employees and Dependents who are eligible and become insured after the effective date of this Policy, **Prior Plan** means an Employer-sponsored group dental plan that was in effect within 30 days of enrollment under this Policy.

Schedule of Benefits means the benefit description attached to this Certificate and included in the Group Policy.

Usual, Customary and Reasonable mean the following:

- **Usual** - the "usual" charge is the charge normally made, for a given service or supply by a Dentist to his or her private patients.
- **Customary** - a charge is "customary" when it is within the range of the usual charges made by Dentists for the same service or supply, within the same specific and limited geographic area, as determined by Us through our professional review process.
- **Reasonable** - a charge is "reasonable" when it meets the above two criteria, or is justifiable, as determined by Us through our professional review process, in consideration of the special circumstances of the particular case in question.

We, Us and Our mean Premier Access Insurance Company.

You and Your mean the Employee or Dependent who has met all of the eligibility requirements for coverage.

DENTAL DEFINITIONS

Appliance means any dental device other than a Prosthetic device.

Benefit Waiting Period means the period of time that a Covered Person must be continuously covered for dental benefits under the Policy, before coverage is payable for certain classes of Covered Services and Supplies.

Dental Hygienist means a person who:

1. is licensed as such by the proper authorities of the state in which he or she practices;
2. is acting within the scope of such license; and
3. is acting under the supervision and direction of a Dentist.

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

Dental Treatment Plan means the Dentist's report of recommended treatment, on a form satisfactory to Us, that:

1. itemizes the dental procedures and charges required for the Dentally Necessary care of the mouth; and
2. includes supporting x-rays and other appropriate diagnostic materials required by Us.

Dentist means a person who:

1. is licensed as such by the proper authorities of the state in which he or she practices;
2. is acting within the scope of such license, and
3. is not a Close Relative of the Covered Person.

Emergency Dental Care means the services and supplies necessary to alleviate severe pain or Injury, resulting from an unforeseen event, that, in the opinion of the attending Dentist, if not immediately diagnosed and treated, could lead to further Injury. The attending Dentist is exclusively responsible for making these dental determinations and treatment decisions. However, reimbursement for Emergency Dental Care rendered will be conditioned on Our subsequent review and determination for consistency with professionally recognized standards

Experimental means:

1. services and supplies that are not recognized according to generally accepted professional dental standards as safe and effective for use in the treatment of an illness, Injury or condition at issue; or
2. services and supplies that have not received required approval by the federal government or any agency of it, or by a state agency before use.

Functioning Natural Tooth means the organic part of the tooth formed by the natural development of the human body that:

1. maintains arch length space;
2. is used for biting or chewing; and
3. has adequate support by the surrounding structures.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Prior Authorization means a Dental Treatment Plan which has been approved by Us before the provision of services or supplies.

Prosthetic means an artificial replacement which is used to replace missing or lost teeth or tooth structure.

ELIGIBILITY, EFFECTIVE DATES, TERMINATION

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

Eligibility for Coverage

You are eligible for coverage if:

1. You are an Employee as defined in the Definitions section of this Certificate;
2. You are in an Employee class that is eligible for coverage under the Policy; and
3. You have satisfied the group's eligibility waiting period specified in Your Employer's Group Policy.

You are eligible for coverage for your Dependents if:

1. You have one or more Dependents, as defined in the Definitions section of this Certificate; and
2. You enroll for Dependent coverage.

You cannot be covered as both an Employee and a Dependent under the Policy.

Effective Date of Coverage for You

We, or Your Employer, may impose a Benefit Waiting Period that You must satisfy before some or all of Your coverage becomes effective under the Policy.
The Benefit Waiting Period is shown in the Schedule of Benefits.
Your coverage will become effective once You have satisfied the eligibility waiting period specified in Your Employer's Group Policy.
In order for Your coverage to become effective, You must submit a written enrollment application to Us and pay any required premiums. The enrollment application must be signed and received by Us within 30 days of the date that You become eligible for coverage. If the enrollment application is not signed and received within these guidelines, You will be considered a Late Enrollee and will be enrolled effective the first of the month during which the enrollment application is received.

Deferred Effective Date of Your Coverage

If you are absent from work for any reason, other than a paid vacation, a legal holiday or a regularly scheduled day off, on Your effective date of coverage, coverage will not take place until You return to work on a Full-time basis.

Effective Date of Coverage for Your Dependents

To enroll Your Dependents who are eligible for coverage on Your effective date of coverage, You must submit a written enrollment application to Us for Dependent coverage and pay any required premiums. The enrollment application must be signed and received by Us within 30 days of the date that Your Dependents become eligible for coverage. If the enrollment application is not signed and received within these guidelines, Your Dependents will be considered Late Enrollees and will be enrolled effective the first of the month during which the enrollment application is received.

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

Any Dependents who are eligible for coverage after Your effective date of coverage (e.g., by marriage), will be covered on the first of the month after the date they become eligible. To enroll these Dependents, You must submit a written enrollment application to Us for any such Dependent and pay any required premiums. The enrollment application must be signed and received by Us within 30 days of the date that the Dependent becomes eligible for coverage. If the enrollment application is not signed and received within these guidelines, Your Dependent will be considered a late enrollee and will be enrolled effective the first of the month during which the enrollment application is received.

Verification of Overage Dependent Status

An Overage Dependent is a Dependent age 19 or over. The Dependent is eligible to be enrolled under the Policy if the Dependent is:

- age 19 or over but under age 25 and enrolled as a full-time student in an accredited college or university. Acceptable verification of a child's qualifying status is an accredited college or university transcript which states the start date of the academic period and the number of units being taken. A minimum of 12 units qualifies as full-time status. Verification is valid for 12 months following the academic period start date; or
- age 19 or over but under age 25 and an IRS Dependents (listed as a Dependent on Your last Federal Tax Return). Acceptable verification of a child's qualifying status is a copy of Your last Federal Tax return showing inclusion of the child as a dependent.Verification is valid for the tax year to which the return applies and for the following year, until the return for the following year is available; or
- age 19 or over and incapable of earning his or her own living by reason of mental retardation or physical handicap incurred prior to the limiting age, who is chiefly dependent upon the Employee or Employee's spouse for support and who was insured on the date just prior to the day his or her insurance would have ended due to age. The child must be listed as a dependent on the Employee's last Federal Tax Return. Acceptable verification of a child's qualifying status is a physician's written statement confirming the above conditions. Verification is valid during the child's enrollment under this Policy.

For eligible Dependents effective under this Policy prior to turning 19 years of age, We must receive verification of eligibility before he or she becomes an Overage Dependent. If verification is not received by this time, coverage will be terminated effective the end of the month in which the Dependent turns 19 years old.

For Overage Dependents effective under this Policy after reaching 19 years of age, We must receive verification of eligibility for the Overage Dependent to be enrolled. After verification has expired, We must receive updated verification documents for the Overage Dependent to remain enrolled.

Effective Date of Coverage for Newborn Children

Coverage for a child born to You or Your Dependent spouse, while Your coverage is in effect, will be effective on any first of the month date between the date of the birth and the child's 3rd birthday.

In order for coverage to be effective, You must submit a written enrollment application to Us to add the Dependent and pay any required premiums. The enrollment application must be signed and received by Us within 30 days of the date Your Dependent is eligible to be enrolled on the plan. If the enrollment application is not signed and received within these guidelines, Your Dependent will be considered a Late Enrollee and will be enrolled effective the first of the month during which the enrollment application is received.

Effective Date of Coverage for Adopted Children

Coverage for a child adopted by You or Your Dependent spouse, while Your coverage is in effect, will be effective on the date of placement in Your home.

In order for coverage to be effective, You must submit a written enrollment application to Us to add the Dependent and pay any required premiums. The enrollment application must be signed and received by Us within 30 days of placement in Your home. If the enrollment application is not signed and received within these guidelines, Your Dependent will be considered a Late Enrollee and will be enrolled effective the first of the month during which the enrollment application is received.

Court Ordered Coverage for a Dependent

If a court has ordered You to provide coverage for a spouse or minor child, coverage will be effective the first of the month following the date of the court order.

In order for coverage to be effective, You must submit a written enrollment application to Us to add the spouse or minor child and pay any required premiums. The enrollment application must be signed and received by Us within 30 days of the date Your Dependent becomes eligible for coverage. If the enrollment application is not signed and received within these guidelines, Your Dependent will be considered a Late Enrollee and will be enrolled effective the first of the month during which the enrollment application is received.

Deferred Effective Date of Dependent Coverage

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

Benefit Waiting Period For Timely Applicants

If the enrollment application for You or Your Dependents is submitted according to the guidelines set forth in this Policy, You or Your Dependents are timely applicants. Under the Benefit Waiting Period for timely applicants, We will not pay benefits for specified services until You or Your Dependents have been continuously insured under this Policy for a stated period of time. Please refer to the Schedule of Benefits for the Benefit Waiting Period on this Policy. For a service that has a Benefit Waiting Period, only the portion of the treatment rendered after the end of the Benefit Waiting Period will be considered a Covered Service and Supply.

Effect of Prior Plan on Benefit Waiting Period

The provision below applies for Employees and Dependents who are eligible and become insured on the effective date of this Policy, unless otherwise specified below.

Any Benefit Waiting Period for timely applicants will be waived for any class of dental services covered under the Prior Plan and this Policy if You or Your Dependents (all of the following conditions must be met):

- were covered under the Prior Plan on the day before the Prior Plan was replaced by this Policy;
- are eligible on the effective date of this Policy for dental insurance; and
- You elect dental insurance for You and Your Dependents under this Policy before or within 30 days of the effective date of this Policy.

The Benefit Waiting Period may not be waived if the Schedule of Benefits states the wait is applicable regardless of prior coverage.

You and Your Dependents will be subject to the Benefit Waiting Period if both of the following apply, even if You apply for dental insurance for You and Your Dependents under this Policy during the initial 30-day enrollment period:

- You and Your Dependents were eligible but not covered under the Prior Plan on the day before the Prior Plan was replaced by this Policy; and
- You and Your Dependents are eligible on the effective date of this Policy for dental insurance.

The provision below applies for Employees and Dependents who are eligible and become insured after the effective date of this Policy unless otherwise specified below.

Any Benefit Waiting Period for timely applicants will be waived for any class of dental services covered under a Prior Plan and this Policy if You or Your Dependents:

- were covered under a Prior Plan within thirty (30) days of Your or Your Dependents effective date under this Policy; and
- You elect dental insurance for You and Your Dependents under this Policy before or within 30 days of Your eligibility date under this Policy.

The Benefit Waiting Period may not be waived if the Schedule of Benefits states the wait is applicable regardless of prior coverage.

Late Enrollee Waiting Period

We will not cover charges incurred by a Late Enrollee for:

- Class II Basic Services until 6 months from the date You or Your Dependents are insured under this Policy.

- Class III Major Services and all Policy riders until 12 months from the date You or Your Dependents are insured under this Policy.

Charges not covered due to this provision are not considered Covered Services and Supplies and cannot be used to satisfy this Policy's Deductible.

However, if an Employee or Dependent enrolls after the initial 30-day enrollment period, he or she will not be considered a Late Enrollee in the following situations:

1. he or she was covered under another dental plan during his or her initial enrollment period, and
   a. certified during his or her initial enrollment period that coverage under another employer dental plan was the reason for declining enrollment;
   b. has lost or will lose coverage under another employer dental plan as a result of: i) termination of employment of the person; ii.) change in employment status of the person; iii) termination of the other plan's coverage; iv) cessation of an employer's premium contribution toward an employee's or dependent's coverage; or v) death of a spouse, or divorce, and
   c. requests enrollment within 30 days after termination of coverage or employer contribution under another employer dental benefit plan; or
2. a court orders coverage be provided for a spouse or child of an insured Employee and request for enrollment under this plan is made within 30 days of the issuance of the court order; or
3. he or she is employed by an Employer that offers multiple dental plans and the Employee elects a different plan during an open enrollment period.

Termination of Coverage

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

1. The date the Policy, issued to Your Employer by Us, is canceled.
2. The date that You or the Employer fails to make a required contribution or payment for Your insurance.
3. The last day of the month in which Your employment with the Employer terminates.
4. The last day of the month in which You are no longer in an Employee class that is eligible for coverage under the Policy or You no longer meet the definition of Employee.
5. The last day of the month in which You enter active duty with the armed forces of any country.
6. The last day of the month in which You are no longer employed on a Full-time basis by the Employer.
7. The date a Covered Person becomes covered under another dental plan which is sponsored by the Employer.
8. Upon notice from Us if We determine that a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage.
9. Upon notice from Us if a Covered Person permits any other person to use his or her identification card to obtain services under this dental plan.
10. Upon notice from Us if a Covered Person assaults or threatens bodily injury to one of Our Employees or an affiliate or an Employee of a provider.

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

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

Under certain conditions, when coverage terminates, You and Your Dependents may be eligible to have dental coverage continued. Please refer to the "Continuation Options" section of this Certificate for details.

If You or Your Dependent have a change in eligibility status that would result in termination of coverage, the Employer must submit written notice within 30 days of the change. If We do not receive notice within 30 days, the termination will be effective a maximum of 30 days prior to the date notification is received by Us.

Exceptions to Termination of Coverage
Your coverage will not terminate solely because You cease to be at work on a Full-Time basis, if;

1. Your absence from work is due to illness or Injury. In such event Your coverage can be continued for up to 6 months if the Employer continues premium payments for Your coverage; or
2. Your absence from work is due to a leave of absence approved by the Employer. In such event Your coverage can be continued for up to 6 months if the Employer continues premium payments for Your coverage.

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

Coverage for the Dependent child may be continued as long as the disability and dependency exist and You remain covered under the Policy. You must continue to pay any required premiums for the Dependent's coverage. Proof of the disability or dependency must be furnished as stipulated in the definition of Dependent.

BENEFIT AUTHORIZATION AND PAYMENT

Preferred Provider Plan
Covered Charges are payable under the Policy for services and supplies given by Premier Choice Network Providers, Preferred Providers and non-Preferred Providers.

If a Covered Person receives services and supplies from a Premier Choice Network Provider or Preferred Provider, Covered Charges will be paid at negotiated rates, according to the percentages shown in the Schedule of Benefits.

However, if a Covered Person receives services and supplies from a non-Preferred Provider, Covered Charges may be less than a non-Preferred Provider's submitted charges. You will be responsible for the amount above the Covered Charge.

Certain Covered Charges may be payable under the Policy only if the service or supply is furnished by a Preferred Provider or Premier Choice Network provider. If this is the case, it will be indicated in the Schedule of Benefits.

IT IS THE COVERED PERSON'S RESPONSIBILITY TO DETERMINE IF A DENTIST IS A PREFERRED PROVIDER AT THE TIME THAT THE SERVICE OR SUPPLY IS PROVIDED.

Preferred Providers and Premier Choice Network Providers have agreed to accept Our determination and payment of Negotiated Rates as payment in full for Covered Services and Supplies. The Covered Person will have no further financial responsibility for these charges, except for any applicable Deductible and Copayment amounts that may apply.

A directory of Preferred Providers and Premier Choice Network providers is available from Us.

Identification Card
A Covered Person must present his or her identification card to a Preferred Provider or Premier Choice Network Provider before receiving services.

Notice and Proof of Claim
Written notice of a claim must be given to Us within 30 days after the occurrence or commencement of any Covered Service or Supply, or as soon thereafter as reasonably possible, but no later than 6 months from the date of service. Claims submitted more than 6 months after the date of service will not be considered for payment. Claims must be sent to Us at:

Premier Access Insurance Company
Claims Department
P.O. Box 659010
Sacramento, California, 95865-9010.

Payment of Claims

Claims for Covered Services and Supplies provided by Preferred Providers or Premier Choice Network providers, will be paid directly to the Preferred Provider or Premier Choice Network provider. All other claims for Covered Services will be paid directly to the member, unless otherwise indicated in the Schedule of Benefits. We cannot require that services be rendered by a particular provider.

Any accrued benefits, payable to you, unpaid at Your death will be paid to your estate, except as may be provided in any specific benefits of this Certificate, or on any attached Certificate Riders or Endorsements.

If a provider is identified by Us to be out of compliance with Our standards under Utilization or Quality review, We reserve the right to pay You directly for services.

Payment Requirements

Subject to the Exclusions and Limitations that follow, We will pay the Covered Charge for Covered Services and Supplies incurred by a Covered Person, up to the Maximum Benefit Limit shown in the Schedule of Benefits. Covered Services and Supplies received by You or Your Dependent, must be:

1. Dentally Necessary;
2. performed or ordered by a Dentist; or performed by a Dental Hygienist acting under the supervision and direction of a Dentist;
3. not in excess of the charges for any less expensive alternate procedure (as described under Alternative Dental Treatment);
4. not in excess of the Covered Charge;
5. for the Classes of Covered Services and Supplies that are shown in this Certificate;
6. started and completed while You or a Dependent are insured, except as otherwise provided in the Coverage for Treatment in Process provision;
7. submitted for payment based on standard dental procedure codes. If a Covered Service(s) can be reflected by a single dental procedure code, but is separated into multiple procedure codes for billing purposes, the Covered Charge for the Service(s) is based on the single dental procedure code that accurately represents the treatment performed; and
8. submitted for payment within 6 months after the date of service.

We will pay claims for Covered Persons at the Covered Charge, after You or Your Dependents satisfy any applicable Deductible and Copayment amounts that may apply. We will pay claims for Covered Persons after We have received premiums from the Employer for the coverage month in which the date of service occurs.

Individual Deductible Amount

Covered Persons may be required to satisfy a Deductible amount each Plan Year. This is the amount that must be paid before any benefits are paid by Us for Covered Services and Supplies under the Policy. This Deductible amount will apply separately to You and each of Your Dependents. The amount of the Deductible is shown in the Schedule of Benefits.

Individual Deductible Amounts Met under a Prior Plan

During the first Plan Year of enrollment for You and Your Dependents covered under a Prior Plan, We will credit this Policy's Deductible by the amount applied to the Prior Plan's Deductible.

To be credited to this Policy's Deductible, the Deductible amount applied to the Prior Plan must:

be for Covered Charges incurred by You and Your Dependents; and

1. have been applied for the same Plan Year as Your or Your Dependents first Plan Year of enrollment under this Policy.

If a Deductible amount was applied under a Prior Plan, prior to the first Plan Year of enrollment for You or Your Dependents, We will not credit this Policy's Deductible by the amount applied to the Prior Plan's Deductible.

If a Deductible amount is credited from the Prior Plan, all Covered Charges applied to the Plan Year Maximum Benefit under the Prior Plan will also be applied to the Plan Year Maximum Benefit under this Policy. You must provide Us with proof (i.e., an explanation of benefits) that these Covered Charges were incurred. This Policy must immediately replace the Prior Plan.

Family Deductible Amount
The family deductible is shown in the Schedule of Benefits. It indicates the number of people in Your Family Unit who must each satisfy an individual Deductible in order to satisfy the family Deductible. Once that number of persons has satisfied a Deductible for a Plan Year, we will consider the Deductible to be satisfied for each person in Your Family Unit for that Plan Year.

Maximum Benefit Limit
The total amount of Covered Charges payable for any Covered Person in each PlanYear will not exceed the Maximum Benefit Limit shown in the Schedule of Benefits. This Maximum Benefit applies even if coverage for You or a Dependent ends and starts again within the same Plan Year.

If Your Policy includes a rollover provision for Maximum Benefit Limit, a portion of Your Maximum Benefit may be carried over to the subsequent Plan Year.

Treatment Outside of the United States
No dental benefits are payable under the Policy for dental services and supplies obtained outside the United States, except for Covered Charges incurred for emergency treatment.

Maximum Benefit Limit for Services Performed Outside the United States
The Maximum Benefit Payable to any person during a Plan Year for Covered Services and Supplies related to Emergency Dental Care performed outside the United States is $100.

Percentage Payable
The Percentage Payable is determined by the Class of Covered Service or Supply and its corresponding percentage shown on the Schedule of Benefits.

Favorable Results Treatment
Benefits will be considered only for treatment that We determine to have a reasonably favorable prognosis.

Prior Authorization of Benefits
A Dental Treatment Plan must be submitted to Us by the Dentist before any treatment begins for all Major services (Class III) and Third Molar Extractions (Class II). If a provider is identified to be out of compliance with Our standard of quality, as determined by Us, We reserve the right to require a Dental Treatment Plan for all non-diagnostic and non-emergency treatment before treatment begins.

We will review the Dental Treatment Plan and advise the Dentist of the amount of benefits (if any) expected to be payable under the Policy. We may recommend an Alternative Dental Treatment that will achieve a satisfactory result. If You choose a more costly method, the excess amount will not be considered a Covered Dental Charge.

Completion of all or a part of a Dental Treatment Plan without Prior Authorization may result in a reduction in benefits payable or in some cases denial of payment. Prior Authorization is not an agreement for payment of charges. It tells the Covered Person and the Dentist, in advance, what We would pay for Covered Services and Supplies named in the Dental Treatment Plan. Prior authorized Dental Treatment Plans are valid for 90 days and are subject to Your eligibility under the Policy on the date that the proposed services are performed. Treatment rendered after the 90 day period is subject to denial of payment.

A Dental Treatment Plan must include:

1. a description of the planned treatment, including an itemization of procedures and charges required for the Dentally Necessary care; and
2. supporting x-rays and other appropriate diagnostic materials.

Prior Authorization of a Dental Treatment Plan issued by a Covered Person's Prior Plan will be accepted by Us provided:

1. the Prior Authorization was issued within 60 days of the Covered Person's effective date with Us;
2. the coverage under the Prior Plan was the same or better than coverage under Us;
3. the treatment for which the Prior Authorization was issued is a Covered Service or Supply under this Policy; and
4. a copy of the Prior Authorization is submitted with the claim.

Benefits will be allowed up to the Covered Charge for each procedure submitted on the Prior Authorization.

Alternative Dental Treatment

If We determine that other procedures, services or courses of treatment could be done to correct a dental condition, coverage will be limited to the least costly procedure that We determine will produce a professionally satisfactory result. In order to make a determination, We may request x-rays and any other appropriate information from the Dentist.

Coverage for Treatment in Process (Extension of Benefits)

We will pay benefits for any program of dental treatment already in process on the day You or Your Dependents become insured under this Plan, if one of the following conditions apply:

- You or Your Dependents become insured on the effective date of this Policy and were covered under the Prior Plan on the day before it was replaced by this Policy; or
- You or Your Dependents become insured after the effective date of this Policy and were covered under a Prior Plan within thirty days of Your effective date.

The expenses must be Covered Dental Charges under this Policy and the Prior Plan. If a Benefit Waiting Period applies for the type of treatment in process, We will not pay for any portion of the treatment.

We will not pay for treatment if:

- the Prior Plan has an extension of benefits provision;
- the treatment charges were incurred under the Prior Plan; and
- the treatment was completed during the extension of benefits.

We will pro-rate payment for treatment based on the percentage of treatment performed while insured under the Prior Plan if:

- the Prior Plan has no extension of benefits when that plan terminates;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was completed while insured under this Policy.

We will pro-rate benefits based on the percentage of treatment performed while insured under the Prior Plan and during the extension of benefits if:

- the Prior Plan has an extension of benefits provision;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was not completed during the Prior Plan's extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Policy.

Covered Services and Supplies will be considered started:

1. For full and partial dentures, on the date that the final impression is taken.
2. For a fixed bridge and crown, on the date the teeth are first prepared.
3. For root canal therapy, on the date the pulp chamber is first opened.
4. For periodontal surgery, on the date the surgery is performed.
5. For all other treatment, on the date treatment is rendered.

Covered Services and Supplies will be considered completed as follows:

1. For full or partial denture, on the date a final completed Appliance is first inserted in the mouth.
2. For a fixed bridge and crown, on the date an Appliance is cemented in place.
3. For root canal therapy, on the date a canal is permanently filled.

CLASSES OF COVERED SERVICES AND SUPPLIES

Coverage is provided for the dental services and supplies described in this section.

Please note the age and frequency limitations that apply for certain procedures. All frequency limits specified are applied to the day.

For Your Policy, specific Covered Services and Supplies may fall under a Class category other than what is stated below. If Your Policy has Class categorizations different from below, it is specified on the Schedule of Benefits.

Class I: Preventive Dental Services

- Comprehensive exams, periodic exams, evaluations, re-evaluations or periodontal evaluations . Limited to 1 per 6 month period.
- Dental prophylaxis (cleaning and scaling) for adults and Dependent children (children under age 14). Limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period. (During the 6 month period, benefits include either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both.)
- Topical fluoride treatment for Dependent children under age 14.
    - Limited to 1 per 6 month period.
    - Topical fluoride varnish is not covered.
- X-rays:
    - Intraoral complete series x-rays, including bitewings and 10 to 14 periapical x-rays, or panoramic film.
      Limited to 1 per 60 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a Plan year.
    - Bitewing x-rays (two or four films).
      Limited to 1 per 12 month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a Plan year.
- Other X-rays:
    - Intraoral periapical x-rays.
    - Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a Plan year.
    - Intraoral occlusal x-rays, limited to 1 film per arch per 6 month period.
    - Extraoral x-rays, limited to 1 film per 6 month period.
    - Other x-rays (except film related to orthodontic procedures or temporomandibular joint dysfunction).
- Sealants, Limited to 1 application to an unrestored occlusal surface of a permanent molar tooth per 36 month period for Dependent children under age 14.

Class II: Basic Dental Services

- Limited oral exams (emergency oral exams), considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit.
- Space maintainers, including all adjustments made within 6 months of installation. Limited to Dependent children under age 14.
- Stainless steel crowns, limited to 1 per 12 month period for teeth not restorable by an amalgam or composite filling for Dependent children to age 19.

- Pulpotomy (primary teeth only).
- Root canal therapy:
  - Including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care
  - Limited to 1 time on the same tooth per 12 month period.
  - Limited to permanent teeth only.
- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde filling - per root.
- Root amputation - per root.
- Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy.
- Periodontal scaling and root planing, limited as follows:
  - Four teeth or more per quadrant, limited to a minimum of 5mm pockets on at least four teeth per quadrant, 1 time per quadrant per 24 month period.
  - 1 to 3 teeth per quadrant, limited to minimum of 5mm pockets on one to three teeth, limited to 1 treatment per area per 24 month period.

  Root planing is generally not a benefit in the same quadrant for at least a 24 month period following the completion of active therapy. Under unusual circumstances, additional documentation can be submitted to Us for review. Root planing is not a benefit until 36 months after surgery in the same area.
- Periodontal maintenance procedure (following active treatment), limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per 6 month period. (During the 6 month period, benefits include either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both.)
- Periodontal maintenance procedures (periodontal prophylaxis) may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than three months thereafter. The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary.
- Periodontal related services as listed below, limited to 1 time per quadrant of the mouth in any 36 month period with charges combined for gingivectomy, gingival flap procedure, pedicle grafts, soft tissue grafts, subepithelial tissue grafts, or osseous surgery performed in the same quadrant within the same 36 month period.

  - Gingival flap procedures.
  - Gingivectomy procedures.
  - Osseous surgery.
  - Pedicle tissue grafts.
  - Soft tissue grafts.
  - Subepithelial tissue grafts.
  - Bone replacement grafts.
  - Guided tissue regeneration.
  - Crown lengthening procedures - hard tissue.

- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:
    - Simple extraction.
    - Surgical extractions, including extraction of symptomatic third molars (wisdom teeth)
    - Alveoloplasty.
    - Vestibuloplasty.
    - Removal of exostosis - maxilla or mandible.
    - Frenulectomy (frenectomy or frenotomy).
    - Excision of hyperplastic tissue - per arch.
- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus, limited to permanent teeth only.
- Root removal - exposed roots.
- Biopsy.
- Incision and drainage.
- Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the same visit.
- General anesthesia and intravenous sedation, limited as follows:
    - Considered for payment as a separate benefit only when medically necessary (as determined by Us) and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Policy.
    - Oral sedation is not a covered benefit.
- Nitrous oxide limited to Dependent Children through age 6.
- Consultation, including specialist consultations, limited as follows:
    - Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date.
    - Benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.
- Amalgam and composite restorations, limited as follows:
    - Multiple restorations on one surface will be considered a single filling.
    - Multiple restorations on different surfaces of the same tooth will be considered connected.
    - Benefits for replacement of an existing restoration will only be considered for payment if at least:
        - 12 months have passed since the existing restoration was placed if the Covered Person is under age 19, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; or
        - 36 months have passed since the existing restoration was placed if the Covered Person is age 19 or older, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy.
    - Additional fillings on the same surface of a tooth in less than 12 months for patients up to age 19 or in less than 36 months for patients age 19 or over, by the same office or same Dentist are not a benefit, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy.
    - Sedative bases and copalite are considered part of the restorative service and are not paid as separate procedures.
    - Composite restorations are also limited as follows:
        - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations on anterior teeth will be considered single surface restorations
        - Acid etch is not covered as a separate procedure.
        - Benefits limited to anterior teeth only.
        - **Based on Network Type**, benefits for composite resin restorations on posterior teeth **may** be limited to the benefit for the corresponding amalgam restoration.

- Pins, in conjunction with a final amalgam restoration.

Class III: Major Dental Services

- Inlays and onlays (metallic), limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Limited to persons age 16 and above.
  - Inlays and onlays on teeth which may be restored with an amalgam or composite resin filling are not covered.
  - Build-up procedure is not covered as a separate service.
  - Benefits based on the date of cementation.

- Porcelain restorations on anterior teeth, limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Limited to permanent teeth. Porcelain restorations on over-retained primary teeth are not covered.
  - Limited to persons age 16 and above.
  - Porcelain restorations on teeth which may be restored with an amalgam or composite resin filling are not covered.
  - Build-up procedure is not covered as a separate service.
  - Benefits based on the date of cementation.

- Cast crowns, limited as follows:
  - Covered only when the tooth cannot be restored by an amalgam or composite filling.
  - Covered only if more than 5 years have elapsed since last placement.
  - Limited to permanent teeth. Cast crowns on over-retained primary teeth are not covered.
  - Limited to persons age 16 and above.
  - Crowns on third molars where adjacent first and second molars are present or where there is no occlusion with opposing are not covered.
  - Crowns on teeth which may be restored with an amalgam or composite resin filling are not covered.
  - Build-up procedure is not covered as a separate service.
  - Benefits based on the date of cementation.

- Crown lengthening, limited to single site when contiguous teeth are involved.

- Recementing inlays, crowns and bridges, limited to three per tooth.

- Post and core:
  - Covered only for endodontically treated teeth requiring crowns.
  - One post and core is covered per tooth.
- Full dentures, limited as follows:
  - Limited to 1 full denture per arch.
  - Replacement covered only if 5 years have elapsed since last replacement AND the full denture cannot be made serviceable (please refer to the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions).
  - Service includes any adjustment or reline performed within 12 month of initial insertion.
  - We will not pay additional benefits for personalized dentures or overdentures or associated treatment.
  - Benefits for dentures are based on the date of delivery.
- Partial dentures, including any clasps and rests and all teeth, limited as follows:
  - Limited to 1 partial denture per arch.
  - Replacement covered only if 5 years have elapsed since last placement AND the partial denture cannot be made serviceable (please refer to the denture or bridge replacement/addition provision under exclusions and limitations for exceptions).
  - Service includes any adjustment or reline performed within 12 months of initial insertion.
  - There are no benefits for precision or semi-precision attachments.
  - Benefits for partial dentures are based on the date of delivery.

- Denture adjustments, limited to:
    - 1 time in any 12 month period; and
    - Adjustments made more than 12 months after the insertion of the denture.
- Repairs to full or partial dentures, bridges, and crowns, limited to repairs or adjustments performed more than 0 life times after the initial insertion.
- Rebasing dentures, limited to 1 time per 12 month period.
- Relining dentures, limited to:
    - 1 time per 12 month period; and
    - Relines performed more than 12 months after initial insertion of the denture.
- Tissue conditioning, limited to repairs or adjustment performed once in a 12 month period.
- Fixed bridges (including Maryland bridges) limited as follows:
    - Limited to persons age 16 and above.
    - Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:
        - Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision under Exclusions and Limitations for exceptions); and
        - Cannot be made serviceable.
    - A fixed bridge replacing the extracted portion of a hemisected tooth is not covered.
    - Placement and replacement of cante-lever bridges on posterior teeth will not be covered.
    - Benefits for bridges are based on the date of cementation.
- Recementing bridges limited to repairs or adjustment performed more than 12 months after the initial insertion.
- Endodontic endosseous implant and endosseous implant, limited as follows:
    - Benefits for the replacement of an existing implant are payable only if the existing implant is more than 60 months old and cannot be made serviceable.
- Implant supported prosthetics, allowance includes the treatment plan and local anesthetic:
    - Abutment supported crown.
    - Implant supported crown.
    - Abutment supported retainer for fixed partial denture.
    - Implant supported retainer for fixed partial denture.
    - Implant/abutment supported fixed denture for completely edentulous arch.
    - Implant/abutment supported fixed denture for partially edentulous arch.

EXCLUSIONS AND LIMITATIONS

Missing Teeth Limitation

We will not pay benefits for replacement of teeth missing on Your or Your Dependents effective date of coverage for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date will be considered for coverage if the tooth was extracted within 12 months of the effective date of coverage under the Policy and while You or Your Dependent was covered under a Prior Plan.

Denture or Bridge Replacement/Addition

- Replacement of a full denture, partial denture, or fixed bridge are not covered benefits unless:
  - 5 years have elapsed since last replacement of the denture or bridge; and
  - the denture or bridge cannot be made serviceable; or,
  - the denture or bridge was damaged while in the Covered Person's mouth when an Injury was suffered while insured under this Policy, and it cannot be made serviceable.

  However, the following exceptions will apply:
  - Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth that cannot be added to the existing partial denture.
  - Benefits for the replacement of an existing fixed bridge is less than 5 years old will be payable if there is a Dentally Necessary extraction of an additional Functioning Natural Tooth, and the extracted tooth was not an abutment to an existing bridge.
- Replacement of a lost bridge is not a Covered Benefit.
- A bridge to replace extracted roots when the majority of the natural crown is missing is not a Covered Benefit.
- Placement and replacement of cante-lever bridges on posterior teeth will not be covered.
- Replacement of an extracted tooth will not be considered a Covered Benefit if the tooth was an abutment of an existing Prosthesis that is less than 5 years old.
- Replacement of an existing partial denture, full denture, crown or bridge with more costly units/different type of units, are limited to the corresponding benefit for the existing unit being replaced.

General Exclusions

Covered Services and Supplies do not include:

1. Treatment which: a) is not included in the list of Covered Services and Supplies; b) is not Dentally Necessary; or c) is Experimental in nature.
2. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the Policy.
4. Replacement of a lost or stolen Appliance or Prosthesis.
5. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
6. Completion of claim forms.
7. Missed dental appointments.
8. All services for which a claim is submitted more than 6 months after the date of service.
9. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
10. Treatment for a jaw fracture.
11. Services or supplies provided by a Dentist, Dental Hygienist, denturist or doctor who is: a) a Close Relative or a person who ordinarily resides with You or a Dependent; b) an Employee of the Employer; c) the Employer.
12. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
13. Services and supplies obtained while outside the United States, except for Emergency Dental Care.
14. Services or supplies resulting from or in the course of Your or Your Dependent's regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.
15. Any Charges which are:
    a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Supplies.
    b. Not imposed against the person or for which the person is not liable.
    c. Reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify Us that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively at Work Employee and/or his or her spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.
16. Services and supplies provided primarily for cosmetic purposes.
17. Services and supplies which may not reasonably be expected to successfully correct the Covered Person's dental condition for a period of at least three years, as determined by Us.
18. Orthodontic services, supplies, appliances and Orthodontic-related services, unless an Orthodontic rider was included in the Policy.
19. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
20. Replacement of stayplates.
21. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
22. Temporary tooth stabilization, other than covered space maintainers, is not covered.
23. Oral sedation and nitrous oxide analgesia are not covered, except for Dependent Children through age 6.
24. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes.

25. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The Covered Charge for the Services is based on the single dental procedure code that accurately represents the treatment performed.
26. Diagnostic casts.
27. Therapeutic drug injection.

COORDINATION OF BENEFITS (COB)

A Covered Person may be covered for dental benefits by more than one plan. For instance, he or she may be covered by Us as an Employee and by another plan as a Dependent of his/her spouse. This provision allows Us to coordinate what We pay with what another plan pays so that no more than the allowed expenses will be covered under the combined benefits of all plans.

We will coordinate Your dental benefits with benefits payable under an Other Plan. The Other Plan is one that provides services in connection with dental care or treatment through:

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

How COB Works

One of the plans involved will pay the benefits first. That plan is Primary. The Other Plan will pay benefits next. That plan is Secondary.
If We are Primary, We will pay benefits first. Benefits under Our plan will not be reduced due to benefits payable under an Other Plan.
If We are Secondary, benefits under Our plan may be reduced due to benefits paid under the Primary Plan. The amount of Our payment will be determined first. Then the amount of benefits paid by plans Primary to Our plan will be subtracted from the submitted amount. We will pay the difference between the submitted amount and the amount paid by the Primary Plan, but no more than the amount We would have paid without this provision.

Determining Which Plan is Primary

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

1. A plan that has no coordination of benefits provision will be Primary to a plan that does have a coordination of benefits provision.
2. A plan that covers the person as an Employee will be Primary to the plan that covers the same person as a Dependent.
3. The plan that covers the person as a Dependent of the person whose birthday is earlier in the Calendar Year will be Primary to a plan which covers that person as a Dependent of a person whose birthday is later in the Calendar Year. The Covered Person's year of birth is ignored.

For a dependent child, if both parents have the same birthday, the plan which has covered the parent longer will be Primary to the plan that has covered the other parent for the shorter period of time.
If the Other Plan does not have a rule based on birthdays, then this rule will not apply, and the rule of the Other Plan will determine which plan is Primary.
However, the person may be covered as a Dependent under two or more plans of divorced or separated parents. In that case, the plan of the parent with custody will be Primary to the plan of the parent without custody. Further the parent with custody may have remarried. In that case, the order of payment will be as follows:

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

There may be a court decree that has specific terms giving one person financial responsibility for the dental or other health expenses of the Dependent child. If We have been provided with notice of those terms, benefits of that plan will be determined first.
A plan may cover a person as an Employee who is not laid off or retired, or as a Dependent of that Employee. This plan will be Primary to any plan that covers the person as a laid off or retired Employee, or as a Dependent of that Employee. The Other Plan may not have a rule for laid off or retired Employees similar to this rule. In this case, this rule will not apply.
If none of the above rules apply, the plan that covered the person for the longest time will be Primary to all Other Plans.
We may obtain or release any information needed to carry out the intent of the Coordination of Benefits provision. You must inform Us of Your coverage under an Other Plan when You make a claim. We have the right to recover from You, or any other organization or person, any amounts that are overpaid.

CONTINUATION OPTIONS - Not Applicable, Please see Addendum

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

DEFINITIONS APPLICABLE TO COBRA

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

Cal-COBRA means California COBRA rights applicable to Employers with fewer than 20 eligible Employees on at least 50% of its working days during the preceding Calendar Year who are subject to the requirements of California Senate Bill 719, known as the CONTINUATION BENEFITS REPLACEMENT ACT, or “Cal-COBRA”, which became effective January 1, 1998. Cal-COBRA is applicable for Group Policies issued in the State of California only.

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

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

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

1. You, the Employee.
2. An Employee’s spouse.
3. An Employee’s former spouse (or legally separated spouse).
4. A Dependent child.

GENERAL COBRA PROVISIONS

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

If the Employer is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, the Employer is responsible for meeting all of the obligations under COBRA, including

notifying all covered Employees and Dependents of their rights under COBRA. If the Employer fails to meet its obligations under COBRA, We will not be liable for any claims incurred by You or any of Your covered Dependents after termination of coverage.

Continuing Coverage under COBRA and Cal-COBRA

If You choose continuation coverage, Your coverage will be identical to the coverage provided under the Policy to similarly situated Employees and Dependents to whom a Qualifying Event has not occurred. You do not have to show that you are insurable to choose continuation coverage. Coverage will continue until the earliest of the following dates:

- 18 months from the date that the Qualified Beneficiary's coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled at the time that the Employee's employment stopped or work hours were reduced. That Qualified Beneficiary may elect an additional 11 months of coverage, subject to the following conditions:
  - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18 months; and
  - The Qualified Beneficiary must agree to pay any increase in the required premium necessary to continue the coverage for the additional 11 months.
- 36 months from the date coverage would have stopped due to a Qualifying Event other than those described above.
- The date that this Policy stops being in force.
- The date that the Qualified Beneficiary fails to make the required payment for coverage.
- The date that the Qualified Beneficiary becomes entitled to benefits under Medicare.
- The date that the Qualified Beneficiary, after electing this continuation, becomes covered under any other group dental plan. (This does not apply if the other group dental plan excludes or limits coverage for a Qualified Beneficiary's pre-existing condition.)

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

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

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

Notification Requirements Under COBRA
A Qualified Beneficiary must notify the Employer or plan administrator within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

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

Notification Requirements Under Cal-COBRA
Under Cal-COBRA, a Qualified Beneficiary has the responsibility to inform Us of a Qualifying Event. This notification must be made within 60 days of the date of the Qualifying Event that would cause a loss of coverage. The notice must be in writing, and include:

a. The name of the Qualified Beneficiary.

b. The date of the Qualifying Event.
c. The specific applicable Qualifying Event from the Qualifying Event list.
d. The name of the Employer.
e. The group dental plan number.
f. The name and address of all Qualified Beneficiaries.

Upon receipt of Your notice, We will send you a notice of your rights to choose continuation of coverage under Cal-COBRA, along with an enrollment application form.

Election Period

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

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

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

Coverage Effective Date

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

Termination of Coverage Due to Non-Election

If You do not elect coverage and pay the premium, Your group dental insurance coverage will terminate in accordance with the provisions outlined in the Policy.

Required Premium

The cost of continuation of coverage under COBRA and Cal-COBRA will be 102% of the applicable group rate (including any portion previously paid by the Employer). However, for Qualified Beneficiaries determined by the Social Security Administration to have been disabled at the time that the Employee's employment stopped or work hours were reduced, the cost will be 150% of the applicable group rate (including any portion previously paid by the Employer) for the additional 11 months.

Premium Payments under Cal-COBRA

You must submit Your first premium payment to Us within 45 days of delivering the completed enrollment form. The payment must cover the period from the last day of Your prior coverage to the present. There can be no gap between Your prior coverage and Cal-COBRA continuation coverage.
All subsequent payments must be made on the first day of each month. If Your Payment is late, You will be allowed a grace period of 30 days. If we have not received your payment for the month within fifteen days from the due date (the first of the month), We will send You a letter warning that Your coverage will terminate 15 days from the date on the letter. The termination effective date will be the last day of the month for which full premium was received.
It is the responsibility of the Qualified Beneficiary to make the premium payment in a timely manner, even if the Qualified Beneficiary does not receive a premium statement for the charges. A premium statement is a courtesy provided by Us and is not a requirement under Cal-COBRA guidelines.

CONTINUATION OF COVERAGE DURING FAMILY AND MEDICAL LEAVE

If the Employer is subject to the requirements of The Family and Medical Leave Act of 1993 (FMLA), You may be eligible to continue coverage during a family leave. Consult Your Employer for details.

GENERAL PROVISIONS

Waiver of Rights

If We fail or choose not to enforce any provision of this Certificate, such omission will not affect Our right to do so at a later date, or to enforce any other provision.

Physical Exam

We have the right to have any Covered Person examined at Our expense while a claim is pending payment.

Premium Contributions

Because this group insurance is provided through Your Employer, Your Employer must pay the required premiums to Us as they become due. Your Employer may, in turn, require You to contribute toward the cost of Your insurance. Failure of Your Employer to pay any required premium to Us will result in termination of Your insurance.
We retain the right to change the premium rates for the insurance coverage provided to You and other Employees of Your Employer from time to time. Changes in the cost of Your insurance that are not due to a premium rate change (such as a change in cost due to a change in Your age or a change in Your coverage) will occur automatically.

Right of Recovery

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

Refund of Overpayment of Benefits

If We pay benefits for expenses incurred on behalf of You or Your Dependents, You or any other person or organization that was paid must make a refund to Us if:

- All or some of the expenses were not paid by You or Your Dependent or did not legally have to be paid.
- All or some of the payment made by Us exceeded the benefits under the Policy.
- All or some of the expenses were recovered from or paid by a source other than this Policy. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

The refund shall equal the amount We paid in excess of the amount which should have been paid under the Policy. In the case of recovery from or payment by a source other than this Policy, the refund shall equal the amount of the recovery or payment up to the amount that We paid.

If the refund is due from another person or organization, You or Your Dependent agree to help Us get the refund when requested.

If You, or any other person or organization that was paid, do not promptly refund the amount, We may reduce the amount of any future benefits that are payable under the Policy. The reduction will equal the amount of the required refund.

Right of Recovery for Benefits Paid after Termination of Coverage

If We pay Benefits for Covered Services or Supplies provided to, or on behalf of, You or Your Dependents after coverage has terminated, including retroactive termination, We have the right to recover the full amount paid from You.

GRIEVANCE PROCEDURES

General Information

If a Covered Person is not satisfied with the manner in which We have made a determination under the Policy, such as denial of a claim, he or she is required to initiate grievance procedures through Our internal grievance procedures. A Covered Person is also advised to contact the Employer's agent or broker for assistance in resolving such matters. These procedures must be completed before requesting arbitration for final and binding resolution of the grievance.
If a grievance concerns potential malpractice on the part of a Dentist or the quality of care given by a Dentist, a Covered Person should, if appropriate, attempt to resolve the grievance directly with the Dentist.

First Level Review

If, after discussion with Our Member Service Department, a Covered Person is dissatisfied with Our determination, he or she may appeal the determination by writing Our Grievance Unit at the following address:

Premier Access
Grievance Unit
P.O. Box 659010
Sacramento, CA 95865-9010
Phone: 888-715-0760

We can assist You in writing Your grievance or We can provide You with a grievance form. The grievance should include any additional information that We should consider and an itemized statement as to the amount in dispute.

We will notify the Covered Person in writing of the results of Our review and the basis of Our decision within 30 days of receipt of the grievance.

Second Level Review - Final Determination

The final internal level of review available to a Covered Person is a second level review.

Requests for a second level review must be made in writing within 45 days of Our notification to the Covered Person of Our first level determination. The second level review determination will be made by the Chief Executive Officer or designee.

We will advise the Covered Person of the second level review determination within 30 days of receipt of the request for the second level review.

Independent Medical Review

The Policy includes a provision for a Covered Person to seek independent medical review. This provision applies only for grievances resulting from the denial, modification, or delay of oral surgery benefits due to non-medical necessity. This provision does not apply for benefits other than oral surgery. A Covered Person can contact the Member Service line for information on the process of Independent Medical Review.

Department of Insurance Consumer Communications Bureau

If a Covered Person is not satisfied with the resolution of a matter after following the First and Second Level Review process, the Covered Person can submit a request for review to the Department of Insurance at the following address:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Phone: (800) 927-4357

Neutral, Binding Arbitration

If a Covered Person does not agree with Our final determination, he or she can request neutral, binding arbitration in accordance with the California Arbitration Act, provided that arbitration may not be requested prior to the expiration of 60 days after written Proof of Claims has been furnished. Additionally, arbitration may not be requested after a period of 3 years (or the period required by law, if longer) after the time limits stated in the Proof of Claim section.

Arbitration is the final process for resolving any dispute between a Covered Person and Us, which arises out of or relates to coverage under the Policy.

As a condition of coverage under the Policy, the Covered Person agrees that disputes will be decided by neutral arbitration, and also agree to give up their right to a jury or court trial for the settlement of disputes. The decision of the arbitrator shall be final and binding. This provision applies only to disputes under this Policy and does not apply to medical malpractice claims.

Arbitration will follow the Commercial Rules of the American Arbitration Association. A Covered Person can begin this process by giving written notice to each party with whom the Covered Person wants to arbitrate, explaining the dispute and the amount involved, if any, and the solution desired. A Covered Person must then file a copy of the notice with the American Arbitration Association's regional office in Los Angeles (phone: 213-383-6516), or San Francisco (phone: 415-981-3901), along with the fee required by the American Arbitration Association. A case may be filed by telephoning the nearest American Arbitration Association office with the Covered Person's information.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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

This Notice tells you about the ways Premier Access Insurance Company ("*Premier Access*") may collect, store, use and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

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

Uses and Disclosures of Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (dentists) in your diagnosis and treatment.
- **Health Care Operations.** We may use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities, or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for underwriting or determining premiums.
- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the dental plan.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose your protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners or Funeral Directors.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures With an Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding your Protected Health Information

You may have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right to Amend Your Protected Health Information.** If you feel that your protected health information maintained by P*remier Access* is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask us to amend information that was not created by *Premier Access* or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures.** You have the right request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Officer. See the end of this Notice for the contact information.

Health Information Security

Premier Access requires its employees to follow its security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, *Premier Access* maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to This Notice

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

Complaints

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

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:

Terri Abbaszadeh, Privacy Officer
Premier Access Insurance Company
P. O. Box: 659010
Sacramento, CA 95865-9010

Phone: (916) 922-5000
Fax: (916) 646-9000
Email: terri@premierlife.com

PREMIER ACCESS INSURANCE COMPANY
P.O.BOX 659010
SACRAMENTO, CA 95865-9010

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Name of Member: _____I.D. Number:_____

Address of Member: _____

I authorize **Premier Access Insurance Company** to use and disclose a copy of the specific health and dental information described below regarding:

For the Purpose of:

Please disclose my dental records for the purpose of: (check one)

□ Claims Status □ Eligibility □ Prior Authorizations □ All Listed

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

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

□ Spouse _____ □ Mother _____ □ Father _____

□ Employer _____ □ Dental Provider_____

□ Other _____

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

□ Until issue or claim is resolved □ 1 year □ Until Eligibility terminates

□ Other _____

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

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

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request .

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

By:_____ Date: _____
Member's Signature

Or By:_____ Date: _____
Member's Representative's Signature ***(such as a parent of a minor, guardian, foster parent)***

Description of Representative's Authority _____

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

FOR INTERNAL USE ONLY:

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