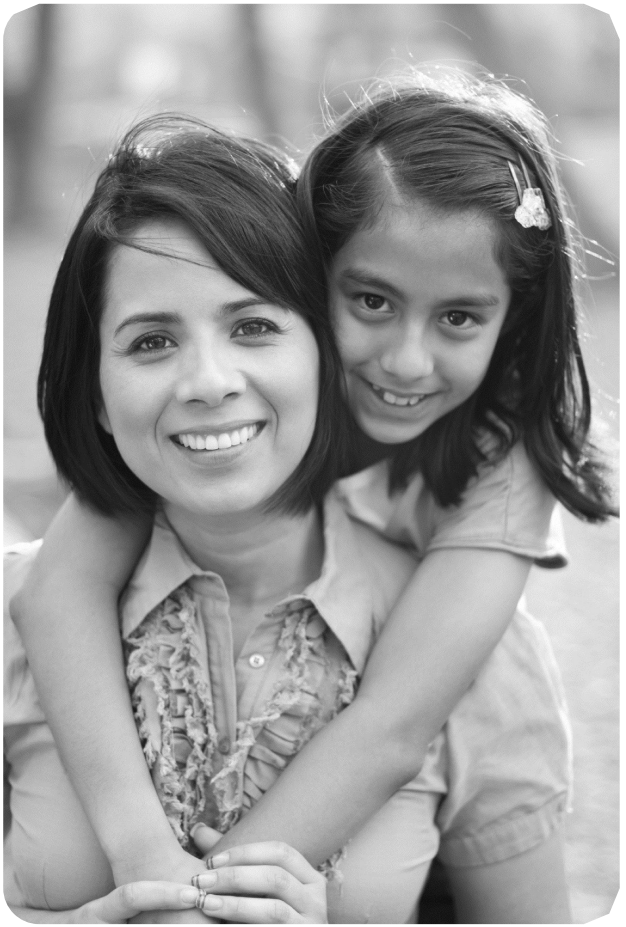
Combined Evidence of Coverage and Disclosure Form



Dental Health Services

0620M600 V2

Mission Statement

To consistently deliver high quality, affordable, value-driven dental service through a caring staff and an accountable provider network committed to member satisfaction.

Dental Health Services

English
IMPORTANT: If English is your secondary language, you may obtain this information written in your language. For free help, please call 866-756-4259. Dental Health Services has a toll free TTY line 1-888-645-1257 for the hearing and speech impaired.

Spanish
IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-866-756-4259. Dental Health Services' también tiene una línea TTY 1-888-645-1257 para personas con dificultades de audición o de hablar.

Table of Contents

Welcome to Dental Health Services!
We are glad to have you as a valued member of our special dental care organization. You are important to us, and so is your healthy smile. We want to keep you smiling by helping you protect your teeth, saving you time and saving you money. As a member of Dental Health Services, you and your family are entitled to some important and valuable benefits.

Your *Evidence of Coverage and Disclosure Form* (EOC) discloses the terms and conditions of coverage. You have a right to view this EOC prior to enrollment. Your EOC should be read completely, and individuals with special dental care needs should read carefully those sections that apply to them. You may receive additional information about the benefits of your Plan by calling Dental Health Services at 800-637-6453 and requesting to speak to your Member Service Specialist. You may also write to Member Service Department, Dental Health Services, 3780 Kilroy Airport Way Suite 750, Long Beach, CA 90806.

You will find your *Health Plan Benefits and Coverage Matrix* on the enclosed Schedule of Covered Services and Copayments.

This EOC summarizes the principal provisions of the contract between your group and Dental Health Services. The group contract should be consulted to determine the exact terms and conditions of coverage.

Your Prepaid Dental Plan
Dental Health Services offers you a prepaid, direct service dental care program. Your specialized dental plan has been designed to provide the maximum benefits at low cost to you and your family. Convenience of location, availability of services (many at no cost to you), and a minimum of paperwork make it easy to receive quality dental care.

Your plan offers:

- Your choice of dental offices within the Dental Health Services network
- Unlimited number of visits
- No claim forms
- No "deductible" costs
- Professional service in a friendly atmosphere
- Conveniently located dental offices
- Specialist referral system

Definitions
Copayment: the fee paid by the member to the Dental Health Services dentist for covered services as disclosed in this *Evidence of Coverage*.

Designated Dental Center: the office and facilities of the specific Dental Health Services dentist selected by you to provide covered services.

Dental Health Services Dentist (Participating Provider): a licensed dentist who contracts with Dental Health Services to

provide covered services to enrollees.

Domestic Partners: two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring and who file a Declaration of Domestic Partnership with the Secretary of State.

Urgent Dental Condition: a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient's dental health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Exclusion: any provision in the agreement whereby coverage for a specified procedure or condition is entirely eliminated.

Limitation: any provision in this agreement that restricts coverage.

Member or Enrollee: a person who is entitled to receive dental care services under this agreement. The term includes both subscribers and those family members for whom a subscriber has paid a premium.

Specialty Services: dental services provided by a Dental Health Services contracted or authorized dental specialist (Endodontist, Periodontist, Pedodontist, Oral Surgeon, Orthodontist). All referrals for covered specialty services must be pre-authorized by the Dental Health Services.

Subscriber: a person whose relationship to the group (employee) is the basis for coverage under this agreement.

Eligibility

As the subscriber, you can enroll alone, with your spouse, domestic partner, and/or with children who are under 26* years of age.

Eligible children include a natural child, an adopted child, a child for whom the subscriber assumes legal obligation for total or partial support in anticipation of adoption, a stepchild, and a foster child for whom you or your spouse are the legal guardian. Children 26 years of age and older are only eligible while the child is and continues to be both:

1. incapable of sustaining employment by reason of developmental disability or physical handicap, and
2. is chiefly dependent upon the subscriber for support and maintenance. Proof of incapacity and dependency must be furnished to Dental Health Services by the subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by Dental Health Services, but not more frequently than annually after the two-year period following the child's attainment of 26 years of age.

For disabled dependents, Dental Health Services will provide notice to the subscriber at least 90 days prior to the date the child attains limiting age.

Dental Health Services may require proof of the above, which the subscriber must furnish within 60 days of such a request. Failure to do so may result in termination of your child's eligibility.

**Dependent coverage includes children under the age of 26 unless the group policy specifies a lower age.*

Beginning Coverage
Complete your enrollment card when you become eligible. Newly acquired dependants become eligible immediately, but they must be enrolled within 30 days of acquisition. Newborn children are covered from birth, but must be enrolled within 30 days of birth to continue coverage.

If your eligibility is approved by the 10th of the month, coverage begins on the first day of the following month. If your eligibility is approved after the 10th of the month, coverage begins on the first day of the second month following eligibility approval. If you are in the middle of acute dental care when your coverage begins, please contact your Member Service Specialist at 800-637-6453 to assure continuity of care. You may also request a copy of the Dental Health Services policy describing the process for continuity of care, including review of request to continue care with your existing provider (dentist).

Choosing Your Dentist
Please read the following information so you will know from whom or what group of providers health care may be obtained.
Covered services are only provided by dentists/providers who are contracted by Dental Health Services. Simply select a dental office from your *Directory of Participating Dentists* and include the information on your enrollment card. If you did not select a dentist when you enrolled, a dentist may be selected for you. Please call your Member Service Specialist at 800-637-6453.

Our dentists are compensated by periodic payments based on membership and/or supplemental copayments based on procedures completed. Except for shared risk arrangements involving specialty services, financial bonuses or incentives for performing or withholding professionally approved services are not used. If you wish to know more about these issues, you may request additional information from your Member Service Specialist or your Dental Health Services contracted dentist.

Making an Appointment
You may make an appointment with your selected dentist as soon as you receive confirmation of your eligibility. For your convenience, call your dental office directly to schedule appointments. Routine appointments will be scheduled within a reasonable time. Your plan covers care provided only by your selected dentist, except in case of an out-of-area emergency. Medically necessary covered benefits will be provided. All referrals for specialist services must be pre-authorized by

Dental Health Services. Treatment is approved and rendered by the dental office according to plan benefits. If treatment authorization is denied, you may contact Dental Health Services (see *Grievance Procedure*).

Facilities
Each dental office establishes its own policies, procedures and hours. Provider Directories are available from your benefits administrator or directly from your Member Service Specialist.

Changing Dentists
If you wish to change your dentist at any time, simply contact your Member Service Specialist by the 10th of the current month to become eligible with your new office as of the 1st of the following month. Changes called in after the 10th of the month will be effective as of the 1st of the second month. If a covered family member wishes to receive care from a Dental Health Services dentist different than yours, please call your Member Service Specialist about our split-facility option.

Urgent Care: In-Area
Palliative (pain relief) care for Urgent dental conditions (see Urgent Dental Conditions under *Definitions*) such as acute pain, bleeding, or swelling is a benefit according to your *Schedule of Covered Services and Copayments*.

If you have a dental emergency and need to seek immediate care, first call your Dental Health Services dentist. Participating dental offices maintain 24-hour emergency communication accessibility and are expected to see you with 24 hours of contacting the dental office or within such lesser time as may be medically indicated. If your dentist is not available, call your Dental Health Services Member Service Specialist. If both the dental office and Dental Health Services cannot be reached, you are covered for urgent care at another Dental Health Services dentist or from any dentist. You will be reimbursed for the cost of urgent palliative treatment less any copayments that apply. Contact your assigned dentist for follow-up care as soon as possible. If you have a medical emergency, you should get care immediately by calling 9-1-1 or going to the nearest hospital emergency room.

Urgent Care: Out-of-Area
Out-of-area urgent care is emergency palliative dental treatment required by an enrollee when more than 50 miles from any Dental Health Services dental center. Your benefit includes up to $50.00 per enrollee per incident, after copayments are deducted. You must submit an itemized receipt from the dental office that provided the Urgent service with a brief explanation, and your subscriber ID number, to Dental Health Services within 180 days. After 180 days, Dental Health Services reserves the right to refuse payment.

Copayments
Copayments are your portion of treatment costs for certain services described in the *Schedule of Covered Services and Copayments*. You are responsible for the copayments for services provided to you and your family. Copayments are payable directly to the dentist when the service is rendered (unless other arrangements are made).

Quality Assurance
We're confident about the care you'll receive because our dentists meet and exceed the highest standards of care – standards demanded by our Quality Assurance program. Before we contract with our dentists, we visit their offices to make sure your needs will be met. Dental Health Services' Professional Services Representatives regularly meet and work with our dentists to maintain excellence in dental care.

Liability of Subscriber for Payment
You are not liable for any sums owed by Dental Health Services to a participating dentist. You will be liable for the cost of non-covered services performed by a participating dentist and for services performed by a non-participating dentist (unless previously approved by Dental Health Services).

Important: If you opt to receive dental services that are not covered services under your plan, a participating dentist may charge you his or her usual and customary fees for those services. Prior to providing you with dental services that are not covered services, the dentist should provide you with a treatment plan that includes each anticipated service to be provided, and the estimated cost of each service. If you would like more information about your dental coverage options, you may call Dental Health Services' Member Services Department at 800-637-6453 or your insurance broker . To fully understand your coverage, you may wish to carefully review this Evidence of Coverage booklet.

Optional Treatment
If you choose a more expensive elective treatment in lieu of a covered benefit, the elective treatment is considered optional. You are responsible for the cost difference between the covered and optional treatment on a fee-for-service basis. If you have any questions about optional treatment or services you are asked to pay additional for, please contact your Member Service Specialist BEFORE you begin services or sign any agreements.

Second Opinions
Second dental opinions are a covered benefit with a $20.00 copayment. All requests will be approved. Please contact your Member Service Specialist if you wish to arrange for a second dental opinion. If a second opinion is at the request of Dental Health Services, the copayment is waived. Appointment

arrangement will be made within five days for routine second opinions, within 72 hours for serious conditions and immediately for emergencies.

Continuity of Care
If you are currently in the middle of treatment and your current participating dentist is terminated or you are joining Dental Health Services as a new enrollee, you may have a right to keep your current dentist for a designated period of time. Please contact your Member Service Specialist at 800-637-6453 or www.dentalhealthservices.com for assistance and to request a copy of Dental Health Services' Continuity of Care Policy.

New Members: You may request continuation of covered services for certain qualifying conditions from your non-participating provider. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of certain qualifying conditions if the covered services were being provided by a nonparticipating provider to a newly covered enrollee at the time his or her coverage became effective. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

Current Members: You may request continuation of covered services for certain qualifying conditions from your participating provider in the event that provider's contract is terminated. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of qualifying conditions if the services are provided by a dental office that is no longer contracted with Dental Health Services. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered.

Qualifying Conditions: The enrollee has a right to complete covered services if their condition falls within one of the qualifying categories listed below:

- Completion of covered services shall be provided for the duration of an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration;
- Completion of covered services for an enrollee newborn child between birth and age 36 months, not to exceed 12 months from the contract termination date for current enrollees or 12 months from the effective date of coverage for a newly covered enrollee;
- Performance of a surgical or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the provider's contract termination for current enrollees or 180 days

from the effective date of coverage for newly covered enrollees.

All services are subject to Dental Health Services' consent and approval, and agreement by the terminated provider, consistent with good professional practice. You must make a specific request to continue under the care of your current dental provider. Dental Health Services is not required to continue your care with the provider if you are not eligible under our policy or if we cannot reach agreement with the provider on the terms regarding your care in accordance with California law. If you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 888.466.2219, at a TDD number for the hearing impaired at 877.688.9891, or online at www.dmhc.ca.gov.

Termination of Coverage

Coverage of an individual member may be terminated for any of the following reasons:

- Termination of the Group Service Agreement;
- Failure of a member to meet the eligibility requirements;
- Material misrepresentation (fraud) in obtaining coverage;
- Failure of the subscriber to pay applicable copayments when due;
- Failure to establish a satisfactory dentist/patient relationship with a Dental Health Services dentist as determined by the inability and/or refusal of two different Dental Health Services dentists to treat the member;
- Permitting the use of a Dental Health Services membership card by another person, or using another person's membership card to obtain care to which one is not entitled;
- Failure of the group to pay premium in a timely manner;

Coverage for a subscriber and his/her dependents will terminate at of the end of the month during which the subscriber leaves the employment of the group or otherwise ceases to be eligible for coverage, except for any of the reasons above, when termination may be mid-month. Notice will be given by Dental Health Services to the subscriber at least 15 days prior to canceling the coverage or the group representative will provide adequate notice of termination to the subscriber. In the event coverage is terminated, the member shall become liable for charges resulting from treatment received after termination. If you lose eligibility, you may qualify for continuing coverage through Cal-COBRA (see *COBRA*) or Dental Health Services SmartSmile Individual Dental Plan (see *SmartSmile Individual Coverage*).

Termination Due to Nonpayment
Benefits under this plan depend on premium payments being current. Enrollment will be cancelled as of the last day for which payment has been received, subject to compliance with notice requirements. Any service(s) then "in progress" will be completed within 30 days with the member's cooperation. Member will remain liable for the scheduled copayment, if any. We encourage you to make individual arrangements with your dentist for continuing the diagnosed services if group benefits are terminated. You may also contact your Member Service Specialist to receive information about Dental Health Services' SmartSmile℠ Individual Dental Plan.

Review of Termination
If you believe your membership was terminated by Dental Health Services because of ill health or your need for care, you may request a review of the termination from Dental Health Services' corporate office. You may also request a review from the Department of Managed Health Care.

Renewal Provisions
The group contract may be extended or renewed from year-to-year after its initial period by the execution and exchange of a memorandum between Dental Health Services and your group. The renewed contract will reflect any changes in terms and/or conditions as agreed upon by Dental Health Services and your group. This may affect your copayment and/or premium fees. You may obtain information about these charges, if any, from your Group Service Specialist during your open enrollment period or by contacting your Member Service Specialist at 800-637-6453.

Individual Coverage with SmartSmile℠
Your coverage ceases on the last day of the month in which you are eligible and for which premiums have been paid. When membership ceases due to loss of eligibility, you may join Dental Health Services' SmartSmile℠ Individual Dental Plan, without evidence of acceptability, by contacting your Member Service Specialist. Dental Health Services will issue an individual membership plan application. The effective date of individual coverage shall commence at the time the group membership coverage ends if timely premium is received. Please call your Member Service Specialist for information about Dental Health Services' Individual Dental Plan.

COBRA *(Consolidated Omnibus Budget Reconciliation Act)*
If you qualify for continuing coverage through COBRA, Dental Health Services can provide ongoing benefits through your employer. Please contact your employer or Dental Health Services for additional information.

COBRA Definitions:

Continuation Coverage: extended coverage under the Dental

Health Services Dental Plan in which an Eligible Employee or Eligible Dependent is currently enrolled, or, in the case of a termination of the dental plan or an employer open enrollment period, extended coverage under the group dental plan currently offered by the employer.

Eligible Employee: a person eligible to participate as a subscriber in the Dental Health Services health plan contracted by his employer.

Eligible Dependent: a person, other than the covered employee, qualifying for coverage as an enrollee under the terms of such a group contract.

Qualified Beneficiary: any individual who, on the day before the occurrence of a "qualifying event" is an enrollee in a Dental Health Services dental plan and has one or more of the following occur:

- Death of the covered employee;
- Loss of eligible employee status by termination or reduction in hours of employment, except that termination for gross misconduct is not a qualifying event;
- Divorce or legal separation of the covered employee from the covered employee's spouse;
- Loss of dependent status by a dependent enrolled in a Dental Health Services dental plan;
- With respect to a covered dependent, the covered employee's entitlement to benefits under Medicare.

If you are eligible as a qualified beneficiary and desire continuation coverage with Dental Health Services, you must request the continuation coverage in writing. In order to qualify, Dental Health Services must receive the notice within 60 days following the latter of:

- the date your coverage under the Dental Health Services dental plan terminated or will terminate by reason of a qualifying event, or
- the date you were sent notice from Dental Health Services or from the employer setting forth necessary premium information, enrollment forms and other information necessary to allow you to formally elect continuation coverage.

If you elect continuation coverage you must pay the appropriate premium to the employer within 45 days from the date you gave notice of your election to continue coverage. Your payment must equal an amount sufficient to pay all premiums due at that time. Failure to submit the correct premium amount within the 45-day period will disqualify you and your dependents from receiving continuation coverage.

If you are a qualified beneficiary and receiving continuation coverage from a dental plan, and if that coverage terminates because the dental plan contract with your employer is terminated, you may continue coverage under the successor plan for the balance of the period that you would have remained covered under the terminated plan. However, continuation coverage shall terminate if you fail to comply with the requirements pertaining to enrollment in and payment of

premiums to the new dental plan within 30 days of receiving notice of termination of the prior dental plan.

Your group contract with Dental Health Services may contain provisions whereby Dental Health Services contracts with your employer to perform administrative functions in connection with continuation coverage. If you experience a qualifying event you should, as a precaution, send the required notification to both Dental Health Services and your employer. If you have any questions concerning continuation of coverage, please contact your Member Service Specialist at 800-637-6453.

Member Services

Dental Health Services is dedicated to assuring your satisfaction and we are committed to keeping your plan as simple and clear as possible. As employee-owners, we have a vested interest in the well being of our plan members. Part of our dedication to serving you includes easy, toll-free access to your knowledgeable Member Service Specialist to help answer any of your questions about your plan and coverage. Please feel free to call or write us with any questions or comments. We will do everything possible to help you. Your Member Service Specialist can be reached at:

Dental Health Services Member Services
Department 3780 Kilroy Airport Way
Suite 750
Long Beach, CA 90806 800-637-6453

The majority of inquiries can and will be responded to immediately including those regarding and affecting urgent services. Should Dental Health Services need to acquire additional information, a decision regarding urgent care will be made within 72 hours and decisions affecting routine services are made within five business days. When Dental Health Services is unable to receive all the information necessary for a decision, the member and the provider are notified within five business days of the progress.

Grievance Procedure

You should, but it is not required, first discuss any grievance regarding treatment or treatment costs with your dentist. For assistance you may contact your Member Service Specialist by calling 800-637-6453, mailing a letter to Member Services, Dental Health Services, 3780 Kilroy Airport Way Suite 750, Long Beach, CA 90806, or by submitting electronically through dentalhealthservices.com.

Dental Health Services will resolve the grievance, including all levels of appeal within 30 calendar days of receiving the grievance or notification. Grievances involving urgent care are addressed immediately and responded to in writing within three (3) days. Any further appeal must be directed to the Department of Managed Health Care. Voluntary mediation is available by submitting a request to Dental Health Services.

The following is the exact language and notice as required by the Department of Managed Health Care (DMHC) and it is important to note that, although t his refers to "Health Plans", it also includes your dental plan - Dental Health Services. We are here to help you. Please contact us and allow one of our caring and helpful Member Service Specialists to assist you.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-637-6453** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's **Internet website http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

For additional information, please contact your Member Service Specialist or your group benefits administrator.

Confidentiality and Privacy Notice

Dental Health Services is devoted to protecting your privacy and the confidentiality of your dental, medical, and personal health information that we may obtain or to which we have access. We do not sell our client information. Your personal information will not be disclosed to nonaffiliated third parties, unless permitted or required by law, or authorized in writing by you.

Throughout this Notice, unless otherwise stated, your medical and dental health information refers to only health information

created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). Please note that your dentist maintains your dental records, including payments and charges. Dental Health Services will have a record of this portion of your PHI only in special or exceptional circumstances.

Dental Health Services' privacy policies describe who has access to your PHI within the organization, how it will be used, when your PHI may be disclosed, safeguards to protect the privacy of your PHI and the training we provide our employees regarding maintaining and protecting your privacy.

Under what circumstances must Dental Health Services share my PHI?

Dental Health Services is required to disclose your PHI to you, and to the U.S. Department of Health and Human Services (HHS) when it is conducting an investigation of compliance with legal requirements. Dental Health Services is also required to disclose your PHI, subject to certain requirements and limitations, if the disclosure is compelled by (any of the following):

- a court order
- a board, commission or administrative agency pursuant to its lawful authority;
- a party to a proceeding pursuant to a subpoena,
- subpoena duces tecum, or other authorized discovery in a proceeding before a court or an administrative agency;
- an arbitrator or panel of arbitrators in a lawfully-requested arbitration;
- a search warrant;
- a coroner in the course of an investigation; or by other law.

When may Dental Health Services disclose my PHI without my authorization?

Dental Health Services is permitted by law to use and disclose your PHI, without your authorization, for purposes of payment and health care administration.

Payment Purposes include activities to collect premiums and to determine or maintain coverage. These include using PHI in billing and collecting premiums, and related data processing including how your dentist obtains pre-authorization for certain dental services. For example, Dental Health Services periodically conducts quality assurance inspections of your dentist's office and during such visits may review your dental records as part of this audit.

Health Care Administration means basic activities essential to Dental Health Services' function as a licensed Health Care Service Plan, and includes reviewing the qualifications and competence of your dentist; evaluating the quality of his/her services; providing subscriber services and information including answering enrollee inquiries but without disclosing PHI. Dental Health Services may, for example, review your

dentist's records to determine if the copayments being charged by the office comply with the contract under which you receive dental coverage.

In addition, Dental Health Services is permitted to use and disclose your PHI, without your authorization, in a variety of other situations, each subject to limitations imposed by law. These situations include, but are not limited to, the following uses and disclosures:

- public health activities;
- concerning victims of abuse, neglect or domestic violence;
- health oversight agency;
- judicial and administrative proceedings including the defense by Dental Health Services of a legal action or proceeding brought by you;
- law enforcement purposes, subject to subpoena or law;
- Workers' Compensation purposes;
- parents or guardians of a minor; and
- persons or entities who perform services on behalf of Dental Health Services and from whom Dental Health Services has received contractual assurances to protect the privacy of your PHI.

Is Dental Health Services ever required to get my permission before sharing my PHI?
Uses and disclosures of PHI other than those required or permitted by law will be made by Dental Health Services only with your written authorization. You may revoke any authorization given to Dental Health Services at any time by written notice of revocation to Dental Health Services, except to the extent that Dental Health Services has relied on the authorization before receiving your written revocation. Uses and disclosures beyond those required or permitted by law, or authorized by you, are prohibited.

Does my employer have the right to access my PHI?
If you are an enrollee under a plan sponsored by your employer, Dental Health Services will not disclose PHI to your employer except under the following conditions:

- you sign an authorization for release of your medical/dental information, or
- health care services were provided with specific prior written request and expense of the employer, and are relevant in a grievance, arbitration or lawsuit, or describe limitations entitling you to leave from work or limit work performance.

Any such disclosure is subject to Dental Health Services' "*minimum necessary*" disclosures policy.

What is Dental Health Services' "*Minimum Necessary*" Policy?

Dental Health Services uses reasonable efforts to limit the use and disclosure of your PHI to the minimum necessary to

accomplish the purpose of the use or disclosure. This restriction includes requests for PHI from another entity, and to requests made by Dental Health Services to other entities. This restriction does not apply to requests by:

- your dentist for treatment purposes;
- you; or
- disclosures covered by an authorization you provided to another entity.

What are my rights regarding the privacy of my PHI?
Your rights respecting your PHI, and how you may exercise these rights are summarized here.

You may request Dental Health Services to restrict uses and disclosures of your PHI in the performance of its payment or health care operations. However, a written request is required. Your health is the top priority and Dental Health Services is not required to agree to your requested restriction. If Dental Health Services agrees to your requested restriction, the restriction will not apply in situations involving urgent treatment by a health care provider.

Dental Health Services will comply with your reasonable requests that you wish to receive communications of your PHI by alternative means or at alternative locations. Such requests must be made to Dental Health Services in writing.

You have a right, subject to certain limitations, to inspect and copy your PHI. Your request must be made in writing. Dental Health Services will act on such request within 30 days of receipt of the request.

You have the right to amend your PHI. The request to amend must be made in writing, and must contain the reason you wish to amend your PHI. Dental Health Services has the right to deny such requests under certain conditions provided by law. Dental Health Services will respond to your request within 60 days of receipt of the request and, in certain circumstances may extend this period for up to an additional 30 days.

You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to 6 years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to:

- disclosures made for payment or health care operations purposes, and
- disclosures occurring prior to February 26, 2002

Your request must be made in writing. Dental Health Services will provide the accounting within 60 days of your request but may extend the period for up to an additional 30 days. The first accounting requested during any 12-month period will be made without charge. There is a $25 charge for each additional accounting requested during such 12-month period. You may withdraw or modify any additional requests within 30 days of the initial request in order to avoid or reduce the fee.

You have the right to receive a copy of this Notice, and any

amended Notice, upon written or telephone request made to Dental Health Services.

All written requests for the purposes described in this section, and all other written communications to Dental Health Services desired or required by this Notice, must be delivered to Dental Health Services, 3780 Kilroy Airport Way Suite 750, Long Beach, CA 90806 by any of the following means:

- personal delivery;
- e-mail delivery to membercare@dentalhealthservices.com
- first class or certified U.S. Mail; or
- overnight or courier delivery, charges prepaid

What duties does Dental Health Services agree to perform?

Dental Health Services will maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices with respect to PHI.

Dental Health Services will abide by the terms of this Notice and any revised Notice, during the period that it is in effect.

Dental Health Services reserves the right to change the terms of this Notice or any revised notice Any new terms shall be effective for all PHI that it maintains including PHI created or received prior to the effective date of the new terms.

New Members: you may request continuation of covered services for certain qualifying conditions from your non-participating provider. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of certain qualifying conditions if the covered services were being provided by a nonparticipating provider to a newly covered enrollee at the time his or her coverage became effective. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

Current Members: You may request continuation of covered services for certain qualifying conditions from your participating provider in the event that provider's contract is terminated. Dental Health Services, at the request of an enrollee, will provide the completion of covered services for treatment of qualifying conditions if the services are provided by a dental office that is no longer contracted with Dental Health Services. Your request must be made within 30 days of enrolling. If a good cause exists, an exception to the 30-day time limit will be considered.

Qualifying Conditions: The enrollee has a right to complete covered services if their condition falls within one of the qualifying categories listed below:

- Completion of covered services shall be provided for the duration of an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical

problem that requires prompt medical attention and has a limited duration;

- Completion of covered services for an enrollee newborn child between birth and age 36 months, not to exceed 12 months from the contract termination date for current enrollees or 12 months from the effective date of coverage for a newly covered enrollee;
- Performance of a surgical or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the provider's contract termination for current enrollees or 180 days from the effective date of coverage for newly covered enrollees.

All services are subject to Dental Health Services' consent and approval, and agreement by the terminated provider, consistent with good professional practice. You must make a specific request to continue under the care of your current dental provider. Dental Health Services is not required to continue your care with the provider if you are not eligible under our policy or if we cannot reach agreement with the provider on the terms regarding your care in accordance with California law. If you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 888.466.2219, at a TDD number for the hearing impaired at 877.688.9891, or online at www.dmhc.ca.gov.

Public Policy Committee
As a member of Dental Health Services, your concerns about benefits and services that Dental Health Services offers are important to us. Dental Health Services' Public Policy Committee reviews member needs and concerns, and recommends improvements to the Plan. You are invited to participate in the Public Policy Committee. If you are interested or would like to comment, send your request in writing to the Dental Health Services' Public Policy Committee.

Organ Donation
Dental Health Services is committed to promoting the life-saving practice of organ donation. We encourage all of our members to give the gift of life by choosing to become organ donors. Valuable information on organ donation and related health issues can be found on the Internet at www.organdonor.gov or visit your local DMV office for a donor card.

Dental Health Services

3780 Kilroy Airport Way
Suite 750
Long Beach, CA 90806
800-637-6453
dentalhealthservices.com

A Great Reason to Smile[sm]

Dental Health Services
Supplemental Information to the Member Handbook

The following information is attached to this Member Handbook, representing your Combined Evidence of Coverage and Disclosure Form, in compliance with the Knox-Keene Health Care Service Plan Act of 1975, as amended. **The following sections of your Member Handbook are either deleted from, added to, deleted and replaced or amended and restated as follows upon the effective date indicated.**

A. Dental Health Services Address – Effective May 2020:

The Dental Health Services address referenced in the Member Handbook is removed and replaced with the address set forth below:

New Address:
Dental Health Services
3780 Kilroy Airport Way, Suite 750,
Long Beach, California 90806

B. Department of Managed Health Care (DMHC) Contact Information – Effective April 2020:

The DMHC's website and phone number referenced in the Member Handbook is removed and replaced to change the DMHC's internet website from http://www.hmohelp.ca.gov to http://www.dmhc.ca.gov, and toll-free telephone number from 1-888-HMO-2219 to 1-888-466-2219 as set forth below:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at **855-495-0905** and use your health plan's Grievance process before contacting the Department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, Coverage decisions for treatments that are experimental or investigative in nature and payment disputes for emergency or urgent medical services. The department also has a toll- free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

C. Grievance Process for Cancellation of Coverage – Effective April 2020

The following language is added to the "Grievances" section of the Member Handbook:

Cancellation Grievance Process

If you believe your Plan coverage or contract has been or will be improperly canceled, rescinded, or not renewed; you have at least 180 days from notice of cancellation to file a grievance with Dental Health Services or the Department of Managed Health Care.

Dental Health Services will treat such a grievance as an 'urgent grievance' providing you and the DMHC with an acknowledgement within three (3) calendar days of the receipt of such a grievance.

If the DMHC determines a proper grievance exists, the DMHC will notify Dental Health Services within two (2) business days that the complaint is a proper grievance. Within one (1) business day of the receipt of this notice from the DMHC, Dental Health Services shall provide a copy of all information used to make its coverage cancellation decision with the DMHC.

The DMHC will deliver their final determination to you and Dental Health Services within thirty (30) calendar days or at their discretion.