Combined Evidence of Coverage and Disclosure Form

Family Dental HMO Individual Dental Plan

A Qualified Dental Plan that satisfies the pediatric dental Essential Health Benefit
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Definitions

Acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Benefits/Coverage: the specific covered services that plan members and their dependents are entitled to use with their dental plan.

Child: eligible children include a biological child; adopted child; a child for whom the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; a stepchild; or a child for whom the subscriber or the subscriber’s spouse is the legal guardian.

Comprehensive exam: a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. Typically includes the evaluation of dental caries (cavities), missing or unerupted teeth, restorations, and occlusal relationships.

Copayments: the fees paid by you, the subscriber or member, directly to the participating Dental Health Services dentist at the time of service. The fees charged by a participating dentist according to your Schedule of Covered Services and Copayments.

Dependent coverage: coverage for family members of the policyholder, such as a spouse, domestic partner, and children.

dependents: a child or other individual for whom a parent, relative or other person may claim a personal exemption tax deduction.

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.

Emergency dental condition: a dental condition that is characterized by the sudden onset of acute symptoms of sufficient severity that in the absence of immediate dental attention could reasonably result in permanently placing the member’s health in jeopardy; causing other
serious dental or health consequences, or causing serious impairment of dental function.

**Enrollee:** a member who has completed an application and paid for their plan.

**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.

**Medically necessary:** health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of care.

**Member:** 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.

**Out-of-Pocket Maximum (OOPM):** The maximum amount of money that a pediatric age enrollee must pay for benefits during a calendar year. OOPM applies only to the Essential Health Benefits for pediatric age enrollees.

Copayments for covered services received from your participating dentist accumulate through the plan year toward your Out-of-Pocket Maximum. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes premium, prescriptions, or dental care your dental plan doesn’t cover. After the pediatric age enrollee meets their OOPM, they will have no further copayments for benefits for the remainder of the calendar year.

If more than one pediatric age enrollee is covered under the contract, the financial obligation for benefits is not more than the OOPM for multiple pediatric age enrollees. Once the amount paid by all pediatric age enrollees equals the OOPM for multiple pediatric age enrollees, no further copayments will be required by any of the pediatric age enrollees for the remainder of the calendar year.
Participating dental office: the office and facilities of the specific Dental Health Services dentist you selected to provide covered services.

Participating dentist: a licensed dental professional who has entered into a written contract/agreement with Dental Health Services to provide dental care services to members covered under the plan. The contract includes provisions in which the dentist agrees that the subscriber/member shall be held liable only for their copayments.

Pediatric Dental Benefits: One of the ten Essential Health Benefits required under the Affordable Care Act (ACA). In California, pediatric dental benefits cover dental care and services such as cleanings, x-rays, and fillings for those 18 years of age and under.

Qualified dental plan: an insurance product that is certified by a health benefit exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts) and meets other requirements. All Covered California dental plans are qualified dental plans.

Serious chronic condition: a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Special enrollment: the opportunity for people who experience a qualifying event, such as the loss of a job, death of a spouse or birth of a child, to sign up immediately in a health plan, even if it is outside of Covered California’s open enrollment period.

Specialty services: dental services provided by a Dental Health Services contracted or authorized dental specialist (endodontist, periodontist, pedodontist, oral surgeon, or orthodontist). All referrals for covered specialty services must be pre-authorized by Dental Health Services.
Subscriber: a person whose relationship as the primary enrollee is the basis for coverage under this agreement; account responsible.

Urgent care: Prompt care - within 72 hours - for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Your Personal Dental Plan

You are important to us, and so is your healthy smile. We want to keep you smiling by helping you protect your teeth and by saving you time and money. We are proud to offer you and your family excellent dental coverage that:

• Encourages treatment by eliminating the burdens of deductibles and plan maximums.
• Makes it easy to receive your dental care without claim forms for most procedures.
• Recognizes receiving regular diagnostic and preventive care with low, or no copayments is the key to better health and long term savings.
• Facilitates care by making all covered services available as soon as membership becomes effective.
• Simplifies access by eliminating pre-authorization for treatment from the general dentist selected from our network of participating dentists.
• Assures availability of care with high-quality, easy-to-find dental offices throughout California. Our network is continually expanding; please contact our office at 855-495-0905 or visit www.dentalhealthservices.com/CA for the latest listing of our participating dentists.
• Allows you to take an active role in your dental health and treatment by fully disclosing coverage and exact copayments prior to treatment.

In addition to your ongoing dental hygiene and care, the following are available for plan members:
• ToothTips™ oral health information sheets.
• Member Service Specialists to assist you by telephone, fax, or e-mail.
• Web access to valuable plan and oral health information at www.dentalhealthservices.com/CA.

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. Dental Health Services encourages individuals with special needs to carefully review this EOC. It is important to Dental Health Services that you select dental benefits that will provide the care that is required due to your condition. If you have any questions or would like to obtain copies of your plan contract, please contact Dental Health Services at 855-495-0905 to speak to your Member Service Specialist. You may also write to Member Services, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807.

About Dental Health Services

Dental Health Services is an employee-owned company founded in 1974 by a pioneering dentist whose vision was to provide patient-focused, innovative, quality dental coverage that emphasizes overall oral health and wellness. These core values continue to guide and set Dental Health Services apart in the dental health industry.

An alternative to traditional insurance (indemnity), Dental Health Services has been offering dental plans to groups and individuals throughout California for over 40 years. Dental Health Services continues to foster its mission of bringing quality, affordable dental care to those who need it. We are dedicated to ensuring your satisfaction and 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 service focus includes toll-free access to your knowledgeable Member Service Specialist, an automated member assistance and eligibility system, and access to our
website at www.dentalhealthservices.com/CA to help answer questions about your plan and its benefits.

Family Dental Benefit Matrix

This matrix is intended to be used to help you compare coverage benefits and is a summary only. Please refer to this Evidence of Coverage and your Schedule of Copayments and Covered Benefits for more information about services covered under your plan.

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>Out-of-Pocket Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Individual - $350</td>
</tr>
<tr>
<td></td>
<td>Family - $700</td>
</tr>
</tbody>
</table>

Professional Services

Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments. Categories of services include:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Copayment Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive</td>
<td>$0</td>
</tr>
<tr>
<td>Restorative</td>
<td>$10 - $300</td>
</tr>
<tr>
<td>Periodontic</td>
<td>$15 - $300</td>
</tr>
<tr>
<td>Prosthodontic</td>
<td>$5 - $300</td>
</tr>
<tr>
<td>Orthodontic</td>
<td>$350</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Copayment Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>No additional charge</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Copayment Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic</td>
<td>$350</td>
</tr>
</tbody>
</table>

Emergency Dental Coverage

Please refer to the Emergency Care section of this Evidence of Coverage.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Prescription</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Durable Medical Equipment

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

Chemical Dependency

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

Your Participating Dentist

Service begins with the selection of local, independently-owned, Quality Assured dental offices. Professional skill, commitment to prevention and wellness, convenience of location, and flexibility in appointment scheduling.
are some of the most important criteria involved in approving a participating dentist.

The ongoing member care of each dental office is monitored regularly through our rigorous Quality Assurance standards.

Your First Dental Appointment

Your initial appointment is an opportunity for you to meet the participating dentist you selected when you enrolled in your Dental Health Services plan. Your dentist will complete an oral examination and formulate a treatment plan for you based on his or her assessment of your oral health.

Your initial exam may require a copayment, and you may need additional diagnostic services (e.g., periodontal charting and x-rays). You may also be charged copayments for additional services as necessary. There is a copayment charged for each office visit regardless of the procedures performed.

After your initial visit, you may schedule an appointment for future care, such as cleanings or to complete your treatment plan. Reference your treatment plan with your Schedule of Covered Services and Copayments to determine the copayments for your scheduled procedures. Copayments are due in full at the time services are performed.

Your Member Service Specialist

Please feel free to call, fax, or send an e-mail to membercare@dentalhealthservices.com. You may also write us anytime with questions or comments. We are ready to help you. Each of our Member Service Specialists is trained in dental terminology or has experience working in a dental office. They can answer your plan and dental questions. Your Member Service Specialist can be reached through any of the following ways:
Eligibility

As the subscriber, you may enroll yourself, your spouse or your domestic partner (unless legally separated), and/or dependent children who are under 26 years of age. Enrollees are not required to have children to enroll in this Family Dental HMO.

Children 26 years of age and over are eligible if the child is and continues to be both (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance.

A family must enroll all children in a family in the pediatric dental benefit for any one child in the family to be eligible for benefits under the plan.

For disabled dependents, Dental Health Services will provide notice to the subscriber at least 90 days prior to the dependent’s attainment of the limiting age. Coverage for their disabled dependent will terminate upon the dependent’s attainment of 26 years of age, unless proof of incapacity or dependency is provided to Dental Health Services within 60 days from the date the subscriber received the notice.

Dental Health Services may require ongoing proof of the dependent’s incapacity or dependency, but not more frequently than annually after the two-year period following the child’s attainment of 26 years of age.

Disabled dependents enrolling for new coverage may initially be required to show proof of incapacity and dependency, and then not more than annually to ensure the dependent continues to meet the conditions above. Proof must be provided within 60 days of such request.
Failure to do so may result in termination of your dependent’s eligibility. Disabled dependent must have been enrolled as a dependent under the subscriber or spouse/domestic partner under a previous health plan at the time the dependent reached the limiting age.

**Enrollment**

Enrollment rates are based on a term of one year and continue until terminated according to procedures contained in this brochure.

Dependents must be added at the time of initial enrollment or during open enrollment. If you experience a qualifying event, you may be eligible for a sixty (60) day special enrollment period. You must report this event within 60 days of the event to Covered California through their web portal at www.coveredca.com for consideration of a sixty (60) day special enrollment period. In the case of birth, adoption or placement for adoption, you have sixty (60) days to report the event to Covered California through the web portal. Covered California may grant you a special enrollment period due to one of the following circumstances:

1. A qualified individual or dependent loses minimum essential dental health benefits. (This excludes loss of coverage due to non-payment);
2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
3. An individual who previously was not a citizen of the United States is granted citizenship;
4. Enrollment or non-enrollment in Covered California is erroneous and/or unintentional as a result of an error made by either HHS or the Covered California;
5. An individual is able to adequately demonstrate to Covered California that the individual’s current qualified dental plan substantially violated material provisions of the existing contract between the individual and the qualified dental plan;
6. An individual becomes eligible or ineligible for advance payment of the premium tax credit or change in eligibility for cost sharing reductions;

7. A permanent move has given the individual access to a new qualified dental plan;

8. An individual is a member of a federally recognized American Indian Indian or Alaska Native Tribe. Individuals may enroll in or change qualified dental plans one time each month;

9. An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value; and

10. An individual demonstrates to Covered California that in accordance with guidelines provided by HHS the individual meets other exceptional circumstances as Covered California may provide.

For complete detailed enrollment provisions set forth by Covered California in accordance with the guidelines provided by HHS, please go to the Covered California web portal at www.coveredca.com.

**Coverage Effective Dates**

Coverage effective dates are determined during your application and enrollment with Covered California and can be affected by any medical policy you purchase. Your Dental Health Services coverage will begin once the enrollment process is complete, premium payment is received, and the effective date is communicated to Dental Health Services by Covered California.

Your Dental Health Services’ Member Services Specialists are ready to assist you with communicating to Covered California. Please contact us at 855-495-0905 or connect with us at www.dentalhealthservices.com/CA.

**Loss of Medi-Cal or Job-Based Coverage:**

If you experience of loss of Medi-Cal or job-based coverage, and use a special enrollment period, coverage would begin on the first day of the next month
following your plan selection, regardless of the date during the month you select coverage.

**New Dependent Additions:**

New dependent enrollments are subject to the rules established by Covered California. Enrollment requests for newly acquired dependents must be submitted to Covered California in a timely manner, according to their policies and procedures. Covered California will determine the effective date of the dependent’s plan according to the date the enrollment request was submitted.

**Newborn and Adoptive Children:**

A newborn, or a child placed for adoption is eligible for coverage from the moment of birth or placement. You must apply through Covered California to enroll your new dependent. If enrollment is not completed according to the rules established by Covered California, the new dependent will be effective according to the open enrollment rules established by Covered California.

**Dependent Additions Due to Marriage:**

The effective date for dependents acquired through marriage will be effective the first day of the next month following your plan selection submitted to Covered California regardless of when during the month you make your plan selection. If enrollment is not completed according to the rules established by Covered California, the new dependent will be effective according to the open enrollment rules established by Covered California.

**On a Case By Case Basis:**

Covered California may start coverage earlier on a case by case basis.

**Receiving Dental Care**

Upon enrollment, a participating dentist should be selected to provide dental care. You can find a list of Dental Health Services’ Participating Dentists online.

You may make an appointment with your dentist as soon as your eligibility has been confirmed. Simply call the telephone number as it appears online with the dental office address or in Dental Health Services’ Directory of Participating Dentists, and request an appointment. Routine appointments will be scheduled within a reasonable time; in non-emergency cases, reasonable time shall not be more than three weeks. You are only eligible for services at your participating dentist’s office, except in an emergency situation or for pre-authorized specialty care provided by a participating specialist.

All referrals for specialist services must be requested by your participating dentist and pre-authorized by Dental Health Services. Please see the Authorization, Modification, or Denial of Services section of this document for additional information. If treatment authorization is denied, you have the right to appeal the denied determination.

Each dental office is independently-owned and establishes its own policies, procedures, and hours. If you need to cancel your appointment, please call your dental office at least 24 hours’ prior to your scheduled appointment time. A penalty may be assessed if your dental appointment is cancelled with less than 24 hours notice. For your participating dentist’s policies and procedures, please contact the dentist office directly.

Language and Communication Assistance

Good communication with Dental Health Services and with your dentist is important. If English is not your first language, Dental Health Services provides interpretation services and translation of certain written materials.

To ask for language services, or if you have a preferred language, please notify us of your personal language needs by calling Dental Health Services at 855-495-0905.
If you are deaf, hard of hearing, or have a speech impairment, you may also receive language assistance services by calling Dental Health Services at 888-645-1257 (TDD/TTY).

Working With Your Dentist

PLEASE READ THE FOLLOWING INFORMATION SO YOU KNOW FROM WHOM OR WHAT GROUP OF DENTISTS YOUR DENTAL CARE MAY BE OBTAINED.

Covered services are only provided by participating dentists who are contracted with Dental Health Services.

Dental Health Services values its members and participating dentists. Providing an environment that encourages healthy relationships between members and their dentists helps to ensure the stability and quality of your dental plan.

Participating dentists are responsible for providing dental advice or treatment independently, and without interference from Dental Health Services or any affiliated agents. If a satisfactory relationship between Member and Participating Dentist cannot be established, Dental Health Services, the Member, or the Participating Dentist, reserves the right to request a termination of that relationship.

Any request to terminate a specific member/dentist relationship should be submitted to Dental Health Services and shall be effective the first day of the month after receipt of the request. Dental Health Services will always put forth its best effort to place the member with another dentist.

Quality Assurance℠

We’re confident about the care you’ll receive because our dentists meet and exceed the highest standards of care 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 Service Specialists regularly meet
and work with our dentists to maintain excellence in dental care.

**Dentist Access Standards – Primary Care**

Dental Health Services strives to ensure you have access to a Quality Assured primary care dentist close to your home or business. We have established availability standards based on whether plan members reside or work in urban, suburban, rural or mountain areas.

If you are not able to locate a dentist, please contact Member Services at 855-495-0905. We’re happy to assist you in finding a Quality Assured dentist close to you that falls within Dental Health Services’ access standards. If no dentist is available who meets company access standards, out-of-area access may be authorized. In the event of an emergency, please see the Emergency Care: Out-of-Area Benefits section for guidelines.

**Dentist Access Standards – Specialists**

As a Dental Health Services member, you have access to over 2,000 Quality Assured specialists, including orthodontists, oral surgeons, endodontists, pediatric dentists, and periodontists. You may receive care from any participating specialist with a referral from your primary care dentist. For more information about Dental Health Services’ referral process, please refer to the Receiving Dental Care section of this brochure.

If access to a specialist is not within reasonable proximity of your business or residence, Dental Health Services will work with your Primary Care Dentist to authorize out-of-area access. In addition, the company will seek recruitment of dentists who meet our Quality Assurance Standards and are close to you. In the event of an emergency, please see the Emergency Care: Out-of-Area Benefits section for guidelines.
Changing Dental Offices

If you wish to change dentists, you must notify Dental Health Services. This may be done by phone, in writing, by email, by fax, or online. Requests can be made by calling your Member Service Specialist at 855-495-0905 or by sending via fax to 562-424-6088. Online changes can be done through www.dentalhealthservices.com/CA.

Requests received by the 10th of the current month become effective the first day of the following month. Changes made after the 10th become effective the first day of the second month following receipt.

Obtaining a Second Opinion

If you believe you need a second opinion for any reason, Dental Health Services can arrange for you to be seen by another participating dentist. You should bring your x-rays to this consultation. If no x-rays are necessary, you will pay only your office visit and second opinion copayment ($20).

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

After you receive your second opinion, you may return to your initial participating dental office for treatment. If, however, you wish to select a new dentist you must contact Dental Health Services directly, either by phone, online or in writing, before proceeding with your treatment plan.

Treatment Authorization

Dental Health Services works closely with our providers to deliver quality dental care and to protect our members. Authorization and utilization management specialists verify eligibility, authorize services, and facilitate the delivery of dental care to members. Services are authorized based on the benefits, limitations, and exclusions listed in each plan’s Combined Evidence of Coverage and Disclosure Form.
Specialty services, if covered by your plan, require pre-authorization by Dental Health Services. The pre-authorization should be requested by your participating dentist. Your treatment is approved and rendered according to your plan benefits. If treatment authorization is denied, you have the right to appeal the denied determination.

Authorization, Modification, or Denial of Services

Dental Health Services does not make authorization decisions based on medical necessity. Decisions to approve, delay, modify, or deny care, are based on the following criteria:

• Member eligibility for services.
• Benefits are a covered service of the member’s plan.
• Dentists selected to provide services are in-network or are approved out-of-network providers.
• Status of any applicable maximums.
• Requested submission of necessary clinical documentation.
• Submission of proper procedure coding.
• Accurate submission of referral as explained in the Provider Manual.

If Dental Health Services is unable to complete a review within the required time frame, it will immediately, upon the expiration of the require time frame or as soon as the plan become aware that it will not meet the time frame, whichever occurs first, notify the provider and enrollee in writing:

• That it is unable to make the decision within the required time frame because the plan does not have all reasonably necessary information requested or requires an expert consultation or additional examination;
• What specific information has been requested but not received, or any additional examination or test required, or specifying the expert reviewer to be consulted; and
• Of the anticipated date when a decision will be made (notice to enrollee only).

Concurrent care will not be discontinued until the provider has been notified of the decision and a plan of care has been agreed upon for the member.

Prior authorization is not required for emergency or urgent services. Please see the following sections in this document for specifics: Emergency Care: In-Area, Emergency Care: Out-of-Area, Urgent Care.

Your Financial Responsibility

You are liable to pay your participating dentist for copayments and incidental broken appointment penalties or interest charges. Please be aware that you are also liable for any other amounts owed for non-covered services. All dental treatment copayments are to be paid at the time of service directly to your participating dental office.

As stated under the Emergency Care: Out-of-Area section of this booklet, for services rendered by a non-contracted dentist, Dental Health Services will reimburse up to $100 per occurrence for the cost of emergency care beyond your copayment. You are liable for any other costs.

Please refer to your Schedule of Covered Services and Copayments for the benefits specific to your dental plan.

Covered California - Coordination of Benefits

Covered California’s standard benefit design requires that stand alone dental plans offering the pediatric dental benefit, such as this Dental Health Services plan, whether as a separate benefit or combined with a family dental benefit, cover benefits as a secondary payer.

When your primary dental benefit plan is coordinating its benefits with Dental Health Services, your primary dental benefit plan will pay the maximum amount required by its plan contract with you.
This means that when a primary dental benefits plan is coordinating benefits with your Dental Health Services plan, Dental Health Services will pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or your total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under your Dental Health Services plan.

Quality remains the utmost concern at Dental Health Services. If you are wishing to coordinate coverage with your primary dental benefits carrier, please call Member Services at 855-495-0905.

Your participating dentist submits Utilization and Encounter Forms for services provided, on a monthly basis. Submission of these reports allows Dental Health Services to both monitor your treatment, and ensure supplement payments, when appropriate, are made to your participating dentist. Claims for pre-authorized specialty services are submitted by your Specialist to Dental Health Services for processing and payment.

Out-of-Pocket Maximum

Out-of-pocket maximum is the total amount of copayments you’ll need to pay on your own before your plan benefits are paid in full. Once you’ve met the out-of-pocket maximum for a plan year, you will not be required to pay further copayments for covered dental services under your Dental Health Services plan. Please see the Definitions section of this document for a full description of Out-of-Pocket Maximum.

Dental Health Services monitors your out-of-pocket payments over the course of your plan year. When those payments reach the Out-of-Pocket Maximum for your plan, we will send a letter to both you and your selected Quality Assured dentist to ensure that you are not responsible for copayments for future services.

You are encouraged to track your Out-of-Pocket expenses by retaining receipts for all of the services you received that are covered under your Dental Health Services plan through the plan year. Never hesitate to
ask your participating Quality Assured dentist for an itemized receipt of services provided during your visit.

Liability of Subscriber for Payment

You will be liable for the cost of non-covered services performed by a participating dentist and for any services performed by a non-participating dentist that Dental Health Services does not pre-approve or pay. You are not liable for any sums owed by Dental Health Services to a participating dentist.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at 855-495-0905. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document.

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.

Emergency Care: In-Area

Palliative (pain relief) care for emergency dental conditions (see Emergency Dental Condition under Definitions) such as acute pain, bleeding, or swelling is a benefit according to your Schedule of Covered Services
and Copayments. Prior authorization is not required for emergency care services.

If you have a dental emergency and need to seek immediate care, first call your participating Dental Health Services dentist. Participating dental offices maintain 24-hour emergency communication accessibility and are expected to see you within 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 Member Service Specialist. If both the dental office and Dental Health Services cannot be reached, you are covered for emergency care at another participating dentist, or from any dentist. You will be reimbursed for the cost of emergency palliative treatment less any copayments that apply. Contact your selected provider for follow-up care as soon as possible.

If you have a life-threatening medical emergency, you should get care immediately by calling 911 or going to the nearest hospital emergency room.

**Emergency Care: Out-of-Area**

Out-of-area emergency care is emergency palliative dental treatment required while an enrollee is anywhere outside of Dental Health Services’ service area and provided by an out-of-network provider. Prior authorization is not required for out-of-area emergency care, 24 hours a day.

Your benefit includes up to $100.00 reimbursement per enrollee per incident, after copayments are deducted. You must submit an itemized receipt from the dental office that provided the emergency service with a brief explanation, and your subscriber ID number, to Dental Health Services within 180 days of the date dental treatment was rendered. After 180 days, Dental Health Services reserves the right to refuse payment. Contact your selected provider for follow-up care as soon as possible.
Urgent Care

Urgent care includes conditions that do not necessarily require immediate attention, but should be taken care of as soon as possible, such as lost or cracked fillings, or a broken tooth or crown.

Urgent care situations should be taken care of within 72 hours. If an urgent dental situation occurs, please contact Your Participating Dentist or Member Services at 855-495-0905 for an urgent referral. Prior authorization is not required for urgent services.

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 the right to keep your current dentist for a designated period of time. Please contact your Member Service Specialist at 855-495-0905 or www.dentalhealthservices.com/CA 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 non-participating provider to a newly covered enrollee at the time his or her coverage became effective. If you currently have coverage with Dental Health Services and are switching to a different Dental Health Services plan, please see the following section.

Current Members: You may request continuation of covered services for certain qualifying conditions from your participating provider in the event that the 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 who is a 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-HMO-2219, at a TDD number.
for the hearing impaired at 877-688-9891, or online at www.hmohelp.ca.gov.

Termination of Benefits

Covered California determines eligibility and continued eligibility for coverage. Notices or questions regarding cancelling or termination of coverage should be directed to Covered California at 800-300-1506.

Upon cancelling any member’s dental benefits plan, Dental Health Services will notify the subscriber in writing of the reason(s) for cancelling the coverage, by mail, at least 30 days prior to cancelling their coverage.

Dental Health Services may terminate coverage of an individual member may be terminated for the following reasons:

• If information contained in the application or otherwise provided to Dental Health Services by the subscriber or member or anyone acting on their behalf, was intentionally or materially incomplete or inaccurate.

• If the subscriber no longer lives or works in the Dental Health Services service area.

• If the subscriber or member is fraudulent or deceptive in obtaining, or attempting to attain, benefits for themselves, or for another person, under this plan.

See the Termination of Benefits for Nonpayment section of this document for specific details about termination due to unpaid premiums.

Coverage for the member and his/her dependents will terminate at the end of the month during which the subscriber/member ceases to be eligible for coverage, except for any of the reasons above, when termination may be mid-month. Dental Health Services will issue a Notice of Termination to the subscriber by mail at least 30 days prior to cancelling the coverage.
Termination Due to Nonpayment

Benefits under this plan depend on premium payments being current. Dental Health Services will issue a Notice of Termination to a subscriber, employer, or contract holder for nonpayment. Dental Health Services will provide you a 30-day grace period, which begins after the last day of paid coverage. Although you will continue to be covered during this 30-day grace period, you will be financially responsible for the premium for the coverage provided during the 30-day grace period.

During the 30-day grace period, you can avoid cancellation or non-renewal by paying the premium you owe to Dental Health Services. If you do not pay the premium by the end of the 30-day grace period, your coverage will be terminated at the end of the 30-day grace period. You will still be legally responsible for any unpaid premiums you owe to Dental Health Services.

Any service(s) then “in progress” can be completed within the 30-day grace period, with the member’s cooperation. The member is responsible for any scheduled copayments, if any. We encourage you to make individual arrangements with your dentist for continuation of diagnosed services if benefits are terminated.

If you wish to terminate your coverage immediately, contact Member Services at 855-495-0905 as soon as possible.

Review of Termination

If you believe your membership was terminated by Dental Health Services solely because of ill health or your need for care, you may request a review of the termination from Dental Health Services’ Dental Director. You may also request a review from the Department of Managed Health Care.
Termination of Coverage by Enrollee

The enrollee may cancel their plan through the Covered California web portal under the following circumstances:

1. Enrollee obtains other essential dental health benefits through another qualified dental plan during an open enrollment or special enrollment period.

2. Death of the enrollee.

In the event of cancellation due to death, the cancellation date will be the date the event occurred.

Cancellation Policy

If subscribers wish to cancel their plan prior to their first year renewal period, they will be subject to a $35.00 cancellation fee to cover the administrative and healthcare costs of the cancellation process. If applicable, any unearned premiums, less any cancellation fees, will be refunded within 30 days.

Subscribers may be required to communicate cancellation requests directly to Covered California. If you wish to cancel your dental benefits, please contact us at 855-495-0905. Cancellation requests must be received in writing and must be signed by the subscriber.

Cancellation requests received by the 15th of the current month will be effective the first of the following month.

Re-enrollment

Re-enrollment will be facilitated through the Covered California web portal according to terms and conditions thereunder. All payments in arrears must be satisfied prior to re-enrollment. Please go to www.coveredca.com for additional information regarding your re-enrollment rights.
Grievance Procedure

A grievance is a written or oral expression of your dissatisfaction regarding Dental Health Services and/or a participating dentist, including your concerns about quality of care. Complaints, disputes, requests for reconsideration or appeal made by you or someone who is authorized to represent you on your behalf are all considered grievances.

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 855-495-0905, mailing a letter to Member Services, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807, or by emailing grievance-web@dentalhealthservices.com.

You have 180 calendar days following any incident or action that is the subject of your dissatisfaction to file your grievance. Grievances are addressed immediately and responded to in writing within five days. Every effort will be made by Dental Health Services to resolve grievances within 30 business days of receiving the grievance or notification. Urgent grievances are addressed immediately and responded to in writing within 3 calendar days. Should you be unhappy with the decision, you may request a review by notifying Dental Health Services in writing.

Voluntary mediation is available by submitting a request to Dental Health Services. In cases of extreme hardship, Dental Health Services may assume a portion or all of an enrollee’s or subscriber’s share of the fees and expenses of the neutral arbitrator.

The following is the exact language and notice as required by the DMHC (Department of Managed Health Care) and it is important to note that, although this refers to “Health Plans,” it also includes your dental plan.

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 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Confidentiality and Privacy Notice

Dental Health Services is required by law to maintain the privacy and security of your protected health information. This notice describes how your medical and dental information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is updated effective April 1, 2014.

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 permit-
ted or required by law, or authorized in writing by you. 
Additionally, Dental Health Services will not use your 
member information for marketing purposes.

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 Pro-
tected Health Information (PHI). Please note that your 
dentist maintains your dental records, including pay-
ments 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, saf-
eguards to protect the privacy of your PHI and the train-
ing 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 Hu-
man Services (HHS) when it is conducting an investi-
gation 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 or subpoena;
- a board, commission or administrative agency pur-
suant to its lawful authority;
- 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 Limited Health Care Service Contractor, and includes reviewing the qualifications and competence of your dentist; evaluating the quality of his/her services; providing subscriber services such as referrals for specialists, 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:
  - preventing or reducing a serious threat to the public’s health or safety;
  - 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?

- 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 emergency 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 the right to have the person you’ve assigned medical power of attorney, or your legal guardian, exercise your rights and make choices about your health information. We will ensure the person has this authority and can act for you before we take any action.

- 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

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 Privacy 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, 3833 Atlantic Avenue, Long Beach, CA 90807 by any of the following means:

• personal delivery;
• email delivery to: membercare@dentalhealthservices.com;
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 let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- 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 by Dental Health Services prior to the effective date of the new terms. Each time Dental Health Services makes a revised Notice, it shall 1) post it on its website, www.dentalhealthservices.com and 2) distribute a written copy personally by First Class U.S. Mail to each of its subscribers who are enrolled with Dental Health Services during the period that such revised Notice remains effective.

What if I am dissatisfied with Dental Health Services’ compliance with HIPAA (Health Insurance Portability and Accountability Act) privacy regulations?

You have the right to express your dissatisfaction or objection to Dental Health Services and to the Secretary of HHS if you believe your privacy rights have been violated. You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington DC, 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Grievances to Dental Health Services must be made in writing to Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807 Attn:
Privacy Officer. Your written dissatisfaction must describe the acts or omissions you believe to be in violation of the provisions of this Notice or applicable laws. Your written objection to HHS or Dental Health Services must be filed within 180 days of when you knew or should have known of the act or omission. You will not be penalized or retaliated against for communicating your dissatisfaction. We are eager to assist you.

Who should I contact if I have any questions regarding my privacy rights with Dental Health Services?

You may obtain further information regarding your PHI privacy rights by contacting your Dental Health Services Member Service Specialist at 855-495-0905 during regular office hours or through www.dentalhealthservices.com.

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 in membership of the committee or would like to comment, send your request in writing to the Public Policy Committee Coordinator, Dental Health Services, 3833 Atlantic Avenue, Long Beach, CA 90807-3505.

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 by visiting your local DMV office for a donor card.
IMPORTANT: Can you read this? If not, we can have someone help you read it. You may also be able to get this information written in your language. For free help, please call right away at 1-866-756-4259. Dental Health Services has a toll free TTY line 1-888-645-1257 for the hearing and speech impaired.