Dental Health Services

# Family Dental HMO
# Covered California
# for SmallBusiness

# Evidence of Coverage

**A Qualified Dental Plan which satisfies the pediatric dental Essential Health Benefit**

**Effective 01/01/2021 - 12/31/2021**

# Non-Discrimination Notice

Dental Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.

Dental Health Services:

- Provides free services for people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in large print, accessible electronic and other formats.

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services at 855-495-0905, 888-645-1257 (TDD/TTY).

If you believe that Dental Health Services has failed to provide these services or discriminated in any other way on the basis of race, color national origin, age, disability, or gender, you can file a grievance with the Dental Health Services Member Satisfaction Team, by mail: 3780 Kilroy Airport Way, Suite 750, Long Beach, California 90806 call 855-495-0905, 888-645- 1257 (TDD/TTY), fax 562-424-0150, or email membersatisfactionteam@dentalhealthservices.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal Available at http://https//ocrportal.hhs.gov/ocr/portal/ lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**English:**

This notice has important information. This notice has important information about your application or coverage through Dental Health Services. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-866-756-4259.

**Spanish:**

Este aviso tiene información importante. Este aviso tiene información importante acerca de su solicitud o cobertura por medio de Dental Health Services. Es posible que haya fechas clave en este aviso. Es posible que tenga que tomar medidas antes de ciertas fechas límite para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y ayuda en su idioma de forma gratuita. Llame al 1-866-756-4259

**Chinese:**

本通知包含重要資訊。本通知包含關於您的Dental Health Services申請或保險的重要資訊。本通知中可能包含重要日期。您可能需要在特定截止日期之前採取行動，以維持您的健康保險或幫助解決費用相關問題。您有權免費獲取本資訊與以您母語進行的幫助。致電1-866-756-4259

**Vietnamese:**

Thông báo này có các thông tin quan trọng. Thông báo này có các thông tin quan trọng về đơn yêu cầu hay bảo hiểm của quý vị thông qua Dental Health Services. Có thể có những ngày quan trọng trong thông báo này. Quý vị có thể cần hành động chậm nhất vào một số thời hạn cuối cùng để duy trì bảo hiểm y tế của quý vị hoặc để được trợ giúp với các chi phí. Quý vị có quyền nhận thông tin này và được trợ giúp miễn phí bằng ngôn ngữ của quý vị. Gọi 1-866-756-4259

**Tagalog:**

Ang paunawang ito ay nagtataglay ng mga mahahalagang impormasyon. Ang paunawang ito ay nagtataglay ng mga mahahalagang impormasyon tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Dental Health Services. Malamang na mayroong mga mahalagang petsa sa paunawang ito. Baka kailanganin ninyong magsagawa ng hakbang bago ang pagsapit ng mga partikular na deadline para mapanatili ang coverage ng inyong kalusugan o makatulong sa mga gastusin. Mayroon kayong karapatang makatanggap ng mga impormasyong ito at matulungan sa lengguahe nang walang bayad. Tumawag sa 1-866-756-4259

**Korean:**
본 안내문에는 중요 정보가 있습니다. 본 안내문에는 Dental Health Services를 통한 귀하의 보험 또는 신청서에 관한 중요 정보가 포함되어 있습니다. 본 안내문에 중요 날짜가 적혀 있을 수 있습니다. 본인의 건강 보험 또는 비용 보조를 유지하려면 특정 마감일까지 조치를 취하셔야 할 수도 있습니다. 관련 정보를 본인의 사용 언어로 무료로 받아볼 권리가 있습니다. 1-866-756-4259번으로 전화하십시오

**Armenian:**

Այս ծանուցումը կարևոր տեղեկատվություն է պարունակում: Այս ծանուցումը կարևոր տեղեկատվություն է պարունակում ձեր դիմումի կամ Dental Health Services-ի միջոցով տրամադրվող ապահովագրության մասին: Այս ծանուցումը կարող է պարունակել կարևոր

ամսաթվեր: Ձեզնից կարող է պահանջվել որոշակի վերջնաժամկետներում կոնկրետ գործողություն կատարել՝ ձեր առողջապահական ապահովագրությունը պահպանելու կամ ծախսերին աջակցելու համար: Դուք իրավունք ունեք անվճար ստանալ այս տեղեկատվությունը և օգնությունը ձեր լեզվով: Զանգահարեք 1-866-756-4259

**Persian:**

این اعلامیه حاوی اطلاعات مهمی است. این اعلامیه حاوی اطلاعات مهمی درباره درخواست شما و طرح پوشش بیمه Dental Health Services است. ممکن است تاریخ های مهمی در این اعلامیه عنوان شده باشد. ممکن است لازم باشد تا تاریخ خاصی اقداماتی را انجام دهید تا پوشش بیمه تان حفظ شود یا کمک مالی دریافت کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی ها را به زبان خودتان و به صورت رایگان دریافت کنید. با شماره 1-866-756-4259 تماس بگیرید

**Russian:**

Данное извещение содержит важную информацию. Данное извещение содержит важную информацию о Вашем заявлении или страховом покрытии услуг стоматологии. Извещение может содержать ключевые даты. Возможно Вам необходимо будет предпринять соответствующие действия в определенных временных рамках. Вы имеете право на получение данной информации и помощи на своем родном языке. Позвоните по телефону - 866-756-4259

**Japanese:**

本通知には、重要な情報が含まれています。本通知には、Dental Health Servicesによる、お客様の申請または保障に関する重要な情報が含まれています。 本通知には、重要な日付が含まれる場合があります。 お客様の医療保障を維持するため、または、費用を節約するため、特定の期限までに行わなければならない項目がある場合があります。 お客様には、無料で、この情報を取得し、お客様の言語でサポートを受ける権利があります。 1-866-756-4259にお電話をおかけください

**Arabic:**

هذا الإخطار يضم معلومات مهمة. يشتمل هذا الإخطار على معلومات مهمة تتعلق بطلبك وتغطيتك التي تتلقاها عبر Dental Health Services. وقد ترد تواريخ مهمة في هذا الإشعار. وقد تحتاج إلى اتخاذ إجراءات قبل حلول مواعيد نهائية معينة حتى تحتفظ بتغطيتك الصحية أو المساعدة في التكاليف. يحق لك الحصول على هذه المعلومات وكذلك المساعدة بأي لغة دون تكلفة. اتصل بالرقم 1-866-756-4259

**Punjabi:**

ਇਸ ਸੰਦੇਸ਼ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਦਿੱਤੀ ਗਈ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿਚ ਤੁਹਾਡੀ ਅਰਜ਼ੀ ਜਾਂ Dental Health Services ਬਾਰੇ ਜਾਣਕਾਰੀ ਦਿੱਤੀ ਗਈ ਹੈ। ਇਸ ਸੂਚਨਾ ਵਿਚ ਵਿਸ਼ੇਸ਼ ਮਿਤੀਆਂ ਦਿੱਤੀਆਂ ਹੋ ਸਕਦੀਆਂ ਹਨ। ਤੁਹਾਨੂੰ ਆਪਣੀ ਸਿਹਤ ਕਵਰੇਜ ਅਤੇ ਕੀਮਤਾਂ ਵਿਚ ਮਦਦ ਲਈ ਕੁੱਝ ਸਮਾਂ ਸੀਮਾਵਾਂ ਅੰਦਰ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪੈ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਸ ਸੂਚਨਾ ਨੂੰ ਪ੍ਰਾਪਤ ਕਰਨ ਅਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਹੱਕ ਹਾਸਿਲ ਹੈ। 1-866-756-4259 ‘ਤੇ ਕਾਲ ਕਰੋ।

**Cambodian:**

ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗ។ ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗអំពីពាក្យសុំរបស់លោកអ្នក ឬការធានារ៉ាប់រងតាមរយៈ Dental Health Services ។ អាចមានកាលបរិច្ឆេទសំខាន់ៗនៅក្នុងការ

ជូនដំណឹងនេះ។ លោកអ្នកអាចចាំបាច់ត្រូវចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ដើម្បីទុកការធានារ៉ាប់រងសុខភាពរបស់លោកអ្នក ឬជួយខាងថ្លៃចំណាយ។ លោកអ្នក មានសិទ្ធិដើម្បីទទួល បានព័ត៌មាននេះ ហើយជួយជាភាសាលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅ 1-866-756-4259
1-866-756-4259

**Hmong:**

Tsab ntawv ceeb toom no muaj lus qhia tseem ceeb. Tsab ntawv ceeb toom no muaj lus qhia tseem ceeb txog koj cov ntaub ntawv thov kev pab los yog kev pab them nqi kho mob uas koj tau txais los ntawm Dental Health Services. Tej zaum nws kuj yuav muaj qee hnub uas tseem ceeb nyob rau tsab ntawv ceeb toom nod. Koj yuav tsum tau ua raws nraim li cov sij hawm uas teem tseg txhawm rau ceev kom tau koj cov kev pab them nqi kho mob los yog cov kev pab uas muaj pab rau koj. Koj muaj cai tau txais cov lus qhia no thiab kev pab txhais hais ua koj hom lus pab dawb rau koj. Hu rau tus xov tooj 1-866-756-4259

**Hindi:**

इस नोटिस में महत्वपूर्ण जानकारी दी गई है। इस नोटिस में Dental Health Services के जटरए आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में महत्वपूर्ण तितियाँ हो सकिी हैं। आपको कुछ समयसीमाओं के भीिर कारणवाई करनी पडेंगी ि◌ाकक आपकी हेर्ि कवरेज या सशुल्क सहायिा जारी रह सके। आपको यह अतिकार है कक यह जानकारी और सहायिा अपनी भाषा में तबना ककसी शुलक के प्राप्त करें। इस नंबर पर कॉल करें: 1-866-756-4259

**Thai:**

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลสำคัญเกี่ยวกับการใช้งานหรือความคุ้มครองของ Dental Health Services อาจมีวันที่สำคัญในประกาศนี้

คุณอาจต้องดำเนินการภายในกำหนดเวลางเพื่อรักษาสภาพความคุ้มครองด้านสุขภาพของคุณหรือรับความช่วยเหลือด้านค่าใช้จ่าย คุณมีสิทธิ์ได้รับข้อมูลนี้และความช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่าย โทร 1-866-756-4259

# Language and Communication Assistance

Good communication with Dental Health Services and with your dentist is important. Dental Health Services' Language Assistance Program (LAP) provides free translation and interpreter services even if you have a family member or friend who can assist you. Should you decide to decline translation or interpreter services, Dental Health Services will respectively and proactively note your request to decline LAP services to your account for reference.

Dental Health Services' network of Quality Assured Dentists also comply with the LAP program. Please review the Directory of Participating Dentists to connect with a dentist of your preferred language.

If English is not your first language, Dental Health Services provides free interpretation services and translation of certain written materials including enrollment materials and plan information.

To ask for language services, or if you have a preferred language, please notify us of your personal language needs by calling 855-495-0905.

If you are deaf, hard of hearing, or have a speech impairment, you may also receive language assistance by calling Dental Health Services at 888-645-1257 (TDD/TTY).

# Table of Contents

# Your Personal Dental Plan

Welcome to Dental Health Services!

We want to keep you smiling by helping you protect your teeth, saving you time and money. We are proud to offer you and your family excellent dental coverage that offers the following advantages:

- 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 that 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 your Designated Participating Primary Dentist you've selected from our network.
- Assures availability of care with high quality easy-to-find dental offices throughout our Service Area.
- Sets no age limits or enrollment restrictions because dental maintenance is always important.
- Allows you to take an active role in your dental health and treatment by fully disclosing coverage and exact Copayments prior to receiving treatment.

In addition to your ongoing dental hygiene and care, the following are available for plan Members:

- ToothTips[sm] oral health information sheets
- Member Services Specialists to assist you by telephone, fax, or email

- Web access to valuable plan and oralhealth information at www.dentalhealthservices.com/CA

# About Dental Health Services

Dental Health Services is an employee-owned company founded 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.

Dental Health Services has been offering dental benefits along the West Coast to groups and individuals for over forty years. We are dedicated to assuring 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 Services Specialists, 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 help you compare pediatric Essential Health Benefits coverage and is a summary only.

| **Pediatric Dental EHB Up to Age 19** | |
|---|---|
| Emergency Dental Care | Please refer to the Emergency Care section of this Evidence of Coverage |
| Office Copay | $0 |
| Waiting Period | None |
| Deductible | None |
| Annual Benefit Limit | None |
| Out-of-Pocket Maximum | Individual - $350<br>Family - $700 |
| **Diagnostic & Preventive Services** | |
| Oral Exam | No Charge |
| Preventive-Cleaning | No Charge |
| Preventive X-Rays | No Charge |
| Sealants per Tooth | No Charge |
| Topical Fluoride Application | No Charge |
| Space Maintainers-Fixed | No Charge |
| **Basic Services** | |
| Restorative Procedures | $20-$310 |
| Periodontal Maintenance | $30 |
| **Major Services** | |
| Periodontics (other than maintenance) | $10-$350 |
| Endodontics | $20-$365 |
| Crowns and Casts | $65-$350 |
| Prosthodontics | $20-$350 |
| Oral Surgery | $30-$350 |
| **Orthodontia** | |
| Medically Necessary Orthodontia | $350 |
| Outpatient Services | No Additional Charge |

| | |
|---|---|
| Hospitalization Services | Not Covered |
| Ambulance Services | Not Covered |
| Prescription Drug Coverage | Not Covered |
| Durable Medical Equipment | Not Covered |
| Mental Health Services | Not Covered |
| Professional Services | Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments. |

| **Adult Dental Age 19 and Older** | |
|---|---|
| Emergency Dental Care | Please refer to the Emergency Care section of this Evidence of Coverage |
| Office Copay | $0 |
| Waiting Period | None |
| Deductible | None |
| Annual Benefit Limit | None |
| Out-of-Pocket Maximum | Not Applicable |
| **Diagnostic & Preventive Services** | |
| Oral Exam | No Charge |
| Preventive-Cleaning | No Charge |
| Preventive X-Rays | No Charge |
| Sealants per Tooth | No Charge |
| Topical Fluoride Application | No Charge |
| Space Maintainers-Fixed | No Charge |
| **Basic Services** | |
| Restorative Procedures | $20-$310 |
| Periodontal Maintenance | $30 |
| **Major Services** | |
| Periodontics (other than maintenance) | $10-$350 |
| Endodontics | $20-$365 |
| Crowns and Casts | $165-$400 |

| | |
|---|---|
| Prosthodontics | $20-$400 |
| Oral Surgery | $35-$1,200 |
| **Orthodontia** | |
| Medically Necessary Orthodontia | Not Covered |
| | |
| Outpatient Services | No Additional Charge |
| Hospitalization Services | Not Covered |
| Ambulance Services | Not Covered |
| Prescription Drug Coverage | Not Covered |
| Durable Medical Equipment | Not Covered |
| Mental Health Services | Not Covered |
| Professional Services | Copayments vary by procedure and can be found on your Schedule of Covered Services and Copayments. |

# Your Member Services Specialist

Please feel free to call, fax, send an email to membercare@dentalhealthservices.com, or write us anytime with questions or comments. We are ready to help you! Your Member Services Specialists can be reached through any of the following ways:

Phone: 855-495-0905, 888-645-1257 (TDD/TTY)
Fax: 562-424-6088
Email: membercare@dentalhealthservices.com
Web: www.dentalhealthservices.com/CA
Mail: Dental Health Services
3780 Kilroy Airport
Way, Suite 750
Long Beach, CA 90806

# Eligibility

As the Subscriber, you can enroll alone, with your spouse/domestic partner and/or with Children who are under twenty-six (26) years of age. Members are not required to have Children to enroll in this Family Dental HMO Dental Plan through Covered California for Small Business.

Subscribers must live or work within Dental Health Services' Service Area in order to enroll in this Family Dental HMO Dental Plan. Dependents may live outside Dental Health Services' Service Area but will only receive coverage at a Dental Health Services' Participating Dentist (and Participating Specialists for Members up to age 19), except in the event of an emergency.

Members up to age 19 are eligible for pediatric coverage under this plan until their nineteenth (19th) birthday month. At the end of their nineteenth (19th) birthday month, the Member will automatically be transferred to adult coverage. For example, if a Member's nineteenth (19th) birthday is July 15, on August 1st, the Member will automatically receive adult dental plan coverage. There is no lapse in coverage during this time.

Adult Members will be covered for Benefits included under the adult Covered Services and Copayments section of the Schedule of Covered Services and Copayments included with this booklet. Once adult coverage is in effect, the pediatric Out-of-Pocket Maximum will no longer apply. An enrolled dependent Child who reaches ages 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the dependent Child becomes ineligible.

Eligible children are children of the Subscriber, Subscriber's spouse, or Subscriber's domestic partner. Eligible children include a biological Child; a stepchild; an adopted Child; a Child for whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner assumes a legal obligation for total or partial support in anticipation of adoption; and a Child for

whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner is the legal guardian.

Children twenty-six (26) years of age and older are only eligible for coverage as a Dependent while 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. Is chiefly dependent upon theSubscriber for support and maintenance

A family must enroll all pediatric Children in a family for any one Child in the family to be eligible for Benefits under this plan.

For disabled Dependent children, Dental Health Services will provide notice to the Subscriber at least 90 days prior to the Dependent Child's attainment of the limiting age.

Coverage for a disabled Dependent Child will terminate upon the Dependent Child's attainment of twenty-six (26) years of age, unless proof of incapacity or dependency is provided to Dental Health Services within sixty (60) from the date the Subscriber received the notice.

Dental Health Services may require ongoing proof of the Dependent Child's incapacity or dependency, but not more frequently than annually after the two-year period following the Child's attainment of twenty-six (26) years of age.

Disabled Dependent Child 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 Child continues to meet the conditions above. Proof must be provided within sixty (60) days of such request. Failure to do so may result in termination of your Dependent Child's eligibility. The disabled Dependent Child must have been enrolled as a dependent under the Subscriber or spouse/domestic partner under a previous dental plan at the time the Dependent Child reached the limiting age.

# Enrollment

This is a Qualified Dental Plan offered exclusively through Covered California. Qualified Dental Plans expire each calendar year. Enrollment rates are valid for the calendar year or until terminated according to the procedures contained in this booklet.

Administration of these plan designs must comply with requirements of the Pediatric Dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

The requirement set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to this Covered California for Small Business dental plan design.

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 sixty (60) days of the event to Covered California through their web portal at 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 their web portal. California may grant you a Special Enrollment Period due to one of the follow 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/domestic partnership, 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 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 agreement 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 to a new area has given the individual access to a new Qualified Dental Plan;

8. An individual is a member of a federally recognized American 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 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 purchased.

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 in communicating with Covered California. Please contact us at 855-495-0905 or connect with us at dentalhealthservices.com/CA.

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

If you experience 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 effective date the enrollment request was submitted.

**Newborn and Adoptive Children**

A newborn, or a Child placed for adoption is eligible 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 the first day of the 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.

# Your Participating Dentist

Service begins with the selection of local, independently owned, Quality Assured[sm] 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 Primary Dentist.

The ongoing Member care at each dental office is monitored regularly through our rigorous Quality Assurance[sm] standards.

# Your First Dental Appointment

Your initial appointment is an opportunity for you to meet your Participating Dentist. Your dentist will complete an oral examination and formulate a treatment plan for you based on their clinical assessment of your oral health.

Your initial exam may require a Copayment and you may need additional diagnostic services such as periodontal charting or x-rays. You may also be charged Copayments for additional services as necessary.

After your initial visit, you may schedule an appointment for future care, such as cleanings, to

complete your treatment plan. Cross-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.

## Quality Assurance

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

## Timely Access to Care

Upon enrolling in Dental Health Services' Family Dental HMO plan, a Participating Primary Dentist should be selected from our Covered California plan network of Quality Assured Participating Dentists. To search for Participating Dentists online, visit Dental Health Services' website at dentalhealthservices.com/CA or through coveredca.com.

If you prefer a printed directory, please call 855-495-0905 and a directory will be mailed to you.

You may make an appointment with your dentist as soon as your eligibility has been confirmed. Simply call the telephone number as it appears in the online directory, or in the printed Directory of Quality Assured Participating Dentists and request an appointment. Routine, non-emergency appointments will be scheduled within a reasonable time period; no more than three weeks.

You are only eligible for services at Dental Health Services' Participating Primary Dentists (and Participating Specialist office for Members up to age nineteen (19). Pre-authorization from Dental Health

Services is required for services provided by a Participating Specialist), except in an emergency situation or when pre-authorized by Dental Health Services.

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 twenty-four (24) hours prior to your scheduled appointment time. A penalty may be assessed if your dental appointment is canceled with less than twenty-four (24) hours' notice. For your Participating Dentist's appointment cancellation policy and procedures, please contact the dentist office directly.

- **Dentist Access Standards – Primary Dentists**

  Dental Health Services strives to ensure you have access to a Quality Assured Participating Primary 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 Participating Primary 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 Dental Health Services' access standards, out-of-area access may be authorized. In the event of an emergency, please see the Emergency Care section for guidelines.

- **Dentist Access Standards – Participating Specialists**

  As a Dental Health Services Member, you have access to over 2,000 Quality Assured Participating Specialists, including orthodontists, oral surgeons, endodontists, pediatric dentists, and periodontists. You may receive care from any Participating Specialist with a referral from your Primary Dentist. For

more information about Dental Health Services' referral process, please refer to the Pre- Authorization Submission section of this booklet.

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

- **Emergency Care**

  If you have a medical emergency, receive care immediately by calling 911 or by going to the nearest hospital emergency room.

  You are covered for dental emergencies at all times both inside and outside of Dental Health Services' Service Area.

  Pre-authorization is not required to receive palliative emergency treatment.

  Palliative Care is treatment to relieve pain or alleviate a symptom without dealing with the underlying cause. Palliative Care for Emergency Dental Conditions in which acute pain, bleeding, or dental infection exist, is a benefit according to your Schedule of Covered Services and Copayments.

  If you have a dental emergency and need immediate care, please follow the steps below:

1. Call your selected Participating Dentist.

   Dental offices maintain twenty-four (24) hour emergency communication accessibility and are expected to see you within twenty-four (24) hours of initial contact or within a lesser period of time as may be medically necessary.

2. If your Participating Dentist is not available, call your Member Services Specialist at 855-494-0905, 888-645-1257 (TDD/TTY).

   Your Member Services Specialist will assist you in scheduling an emergency dental appointment with another Quality Assured[sm] dentist in your area.

3. If you are out of Dental Health Services' Service Area or both Dental Health Services and a Participating Dentist cannot be reached, seek emergency palliative treatment from any licensed dentist practicing in the scope of their license.

   Dental Health Services requires that after receiving treatment of an Emergency Dental Condition, the covered patient be transferred to a Participating Dentist's office for post-Emergency Dental Condition treatment. Follow-up care that is a direct result of the emergency must be obtained within Dental Health Services' usual terms and conditions of coverage.

4. You will only be responsible for applicable Copayments for emergency treatment when services are provided by a Participating Dentist.

   When services are provided by an Out-of-Network Dentist, you will be responsible for the entire bill. Dental Health Services will then reimburse you up to $50 per occurrence for the cost of emergency care beyond your applicable Copayment(s)for dental work done to eliminate pain, swelling, or bleeding.

   To be reimbursed for any amount over the applicable emergency Copayments, you must submit the itemized dental bill from the dental office that provided the emergency services with a brief explanation, and your Member number to Dental Health Services within one hundred eighty (180) days of the date the dental treatment was rendered to:

Dental Health Services
Attn: Claims Department
3780 Kilroy Airport Way, Suite 750
Long Beach, CA 90806

If you do not submit this information within one hundred eighty (180) days, Dental Health Services reserves the right to refuse payment.

If services for the treatment of an Emergency Dental Condition are authorized by any employee of Dental Health Services, we may not deny the responsibility of Member reimbursement beyond all applicable Copayments, unless approval was based on misrepresentation about the covered Member's condition made by the dentist performing the emergency treatment.

- **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 seventy-two (72) hours. If an urgent dental situation occurs, please contact your Participating Primary Dentist or Member Services Specialists at 855-495-0905 for an urgent referral.

- **Teledentistry**

Dental Health Services provides coverage for services appropriately delivered through teledentistry services on the same basis and to the same extent that Dental Health Services is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

# 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 must be provided by your Designated Participating Primary Dentist except in an emergency situation or when pre-authorized by 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 cannot be established between Members and their Designated Participating Primary Dentist, Dental Health Services, the Member, or the Participating Dentist reserves the right to request the Member's affiliation with the dental office be terminated.

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 following receipt of the request. Dental Health Services will always put forth its best effort to swiftly place the Member with another Participating Dentist.

# Changing Dental Offices

If you wish to change Primary Dentists, you must notify Dental Health Services. Requests can be made by calling your Member Services Specialist at 855- 495-0905, 888-645-1257 (TDD/TTY) or by sending a fax to 562-424-6088. Online requests can be done through our website at dentalhealthservices.com/CA.

Requests made by the twentieth (20th) of the current month become effective the first (1st) day of the following month. Changes made after the twentieth

(20th) of the month become effective the first (1st) day of the second month following receipt of your request. For example, if you request to change your dentist on or before August 20th, your new dentist selection will become effective September 1st. If you make your dentist change request on or after August 21st, your dentist change request will become effective October 1st.

## 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 Primary Dentist or Out-of-Network Dentist if necessary.

Arrangements will be made within five (5) days for routine second opinions, within seventy-two (72) hours for serious conditions, and immediately for emergencies.

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 Copayments.

After you receive your second opinion, you may return to your initial Designated Participating Dentist's office for treatment. If, however, you wish to select a new Participating Primary Dentist you must contact Dental Health Services directly, either by phone in writing, by fax, or online before proceeding with your treatment plan.

## Treatment Authorization

Dental Health Services works closely with our Participating Dentists 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 Evidence of Coverage booklet.

Specialty services, if covered by your plan, require pre-authorization by Dental Health Services. The pre-authorization should be requested by your Participating Primary Dentist. Your treatment is

approved and rendered according to your plan Benefits. If treatment authorization is denied, you have the right to Appeal the Adverse Determination through the Grievance process.

## 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 re- view within the required time frame, it will immediately, upon the expiration of the required time frame or as soon as the plan becomes aware that it will not meet the time frame, whichever occurs first, notify the dentist and Member in writing:

- That we are 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 Member 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.Pre-authorization is not required for emergency or urgent services. Please see the Timely Access to Care sections, Emergency Care and Urgent Care sections in this document for specifics.

# Your Financial Responsibility

You are responsible to 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 provided by a Participating Dentist or Out-of-Network Dentist that Dental Health Services did not pre-approve for payment. All dental treatment Copayments are to be paid at the time of service directly to your Participating Dentist office. You are not liable for any sums owed by Dental Health Services to a Participating Dentist.

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

As stated under the Emergency Care section of this booklet, for services rendered by an Out-of-Network Dentist, Dental Health Services will reimburse up to $50 per occurrence for the cost of emergency care beyond your Copayment. You are responsible for any other costs.

# Exclusions and Limitations

**This Evidence of Coverage describes your dental plan Benefits. It is the responsibility of the Members to review this booklet carefully and to be aware of its Exclusions and Limitations of Benefits.**

Please reference the Exclusions and Limitations of Coverage described in your Schedule of Covered Services and Copayments included with this booklet. Procedures described in the Exclusions and Limitations of Coverage section are considered non-

covered services even if they are medically necessary or are recommended by a dentist.

Pediatric Dental services apply to Members up to age 19.

# Out-of-Pocket Maximum (OOPM)

Out-of-Pocket Maximum (OOPM) is the total amount of Copayments you'll need to pay on your own before your plan benefits are paid in full for the plan year. Once you've met the Out-of-Pocket Maximum for a plan year, you will not be required to pay further Essential Health Benefit Copayments for covered dental services under your Dental Health Services plan for the remainder of the plan year. **Please see the definitions section of this booklet for a full description of Out-of-Pocket Maximum.**

OOPM applies only to the Essential Health Benefits for Pediatric Age (up to age 19) Members.

Essential Health Benefit 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 Member meets their OOPM, they will have no further Copayments for Essential Health Benefits services for the remainder of the plan year.

For families with more than one Pediatric Age Member, Copayments made by each individual Child for Essential Health Benefits services contribute to the family Out-of-Pocket Maximum. Once the Copayments paid by all Pediatric Age Member for Essential Health Benefits services meets the family Out-of-Pocket Maximum, no further Copayments for Essential Health Benefits services will be required by any of the pediatric age Members for the remainder of the plan year.

Dental Health Services monitors your out-of-pocket copayments over the course of your plan year. When your copayments reach the Out-of-Pocket Maximum for your plan, we will send a letter to both you and your Designated Participating Primary Dentist to ensure that you are not responsible for Essential Health Benefit Copayments for the remaining plan year.

You are encouraged to track your out-of-pocket expenses by retaining receipts for all of the covered services you receive under your Dental Health Services plan through the plan year. Never hesitate to ask your Participating Dentist for an itemized receipt for services provided during your visit.

## Your Financial Responsibility for Non-Covered Services

You will be liable for the cost of non-covered services performed by a Participating Dentist and for any services performed by an Out-of-Network Dentist that Dental Health Services does not pre-approve for payment. 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 Dentist may charge you their Usual, Customary, and Reasonable 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 your Member Services Specialist at 855-495-0905. 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 Services Specialist before you begin services or sign any agreements.

## 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 your Member Services Specialist 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 Participating Specialist to Dental Health Services for processing and payment.

# Specialty Care Coverage and Pre-authorization

All plans include specialty care coverage.

All treatment received from Participating Specialists must be pre-authorized.

When pre-authorized by Dental Health Services, you will never be required to pay more than your Copayment amount. Plan Members are referred to a Participating Specialist if one is available in your area. In cases where there is no Participating Specialist in your area, Dental Health Services will arrange for care with an Out-of-Network Specialist at no additional cost to you.

- **Pre-Authorization for Specialty Care**
  In order to see a Dental Health Services Participating Specialist, you must first be referred by your Designated Participating Primary Dentist. Dental Health Services will review the request for pre-authorization and notify the Participating Dentist and Participating Specialist of the pre-authorized services.

- **Pre-Authorization Submission**

  Your Participating Dentist or Participating Specialist will submit a pre-authorization request for your services. You, your Participating Dentist and your assigned Participating Specialist will be notified whether your pre-authorization is approved or denied within five (5) business days of Dental Health Services receiving the request. This five (5) day period may be extended one (1) time, for up to an additional fifteen (15) days, provided such extension is necessary due to circumstances beyond Dental Health Services' control. If an extension is necessary, Dental Health Services will notify you and the referring Participating Primary Dentist/Specialist of the circumstances requiring this extension within five (5) days of receiving the request.

If your request for pre-authorization is not submitted according to the procedures outlined in this booklet, you and the referring Participating Primary Dentist/Specialist will be notified of the procedural failure and the proper procedures to be followed in submitting your request within five (5) days following Dental Health Services' discovery of any procedural error. Notification may be oral, written, or electronic.

- **Adverse Determinations**
  If all or part of the claim for your services is denied, Dental Health Services will notify you in writing of this Adverse Determination. The notification will include the actual reason(s) for the determination, and the instructions for obtaining an Appeal of the decision through the Grievance process.
  If you wish to Appeal the Adverse Determination of your Urgent Care pre-authorization, a decision regarding your Appeal will be made within seventy-two (72) hours. The result of your Appeal will be communicated to you by phone/oral notification as well as written or electronic communication.

# Continuity of Care

If you are in the middle of treatment and your current Designated Participating Primary Dentist is terminated or you are joining Dental Health Services as a new Member, you may have the right to keep your current dentist for a designated period of time.

Please contact your Member Services 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 Out-of-Network Dentist. Your request must be made within thirty (30) days of enrolling. If a good cause exists, an exception to the thirty (30) day

time limit will be considered. Dental Health Services, at the request of a Member, will provide the completion of covered services for treatment of certain qualifying conditions if the covered services were being provided by an Out-of-Network Dentist to a newly covered Member at the time their 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 Dentist in the event that the provider's contract is terminated. Dental Health Services, at the request of a Member, 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 thirty (30) days of enrolling. If a good cause exists, an exception to the thirty (30) day time limit will be considered.

**Qualifying Conditions:** The Member 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 a Member who is a newborn Child between birth and age thirty-six (36) months, not to exceed twelve (12) months from the contract termination date for current Members or

  twelve (12) months from the effective date of coverage for a newly covered Member;
- 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 dentist to occur within one hundred eighty (180) days of the provider's contract termination for

current Members or one hundred eighty (180) days from the effective date of coverage for newly covered Members.

- All services are subject to Dental Health Services' consent and approval, and agreement by the terminated dentist, 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 dentist if you are not eligible under our policy or if we cannot reach agreement with the dentist 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

Covered California determines eligibility and continued eligibility for coverage. Members are required to give at least fourteen (14) days notice when choosing to end coverage before the end of the policy term. This notice can be provided to Dental Health Services or Covered California.
Upon cancelling any Member's dental Benefits plan, Dental Health Services shall notify the Subscriber in writing of the reason(s) for canceling the coverage, by mail, at least thirty (30) days prior to canceling their coverage.

Coverage of an individual Subscriber and their Dependents may be terminated for any of the following reasons:

1. Failure of the Subscriber to make premium payments in a timely manner. (See Termination Due to Nonpayment).

2. Material misrepresentation (fraud) in obtaining coverage.

3. The Member relocates outside of the state of California or outside of Dental Health Services' Service Area.

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

Coverage for the Subscriber and their 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 Subscriber shall become liable for charges resulting from treatment received after termination. If you lose eligibility, you may qualify for continuing coverage through COBRA (see Individual Continuation of Benefits) or special enrollment through Covered California (see Special Enrollments).

# Termination of Coverage by Member

A Member may terminate their coverage by contacting Covered California or Dental Health Services. If you wish to cancel your dental Benefits, please contact us at 855-495-0905 and your Member Services Specialist will facilitate your contact with Covered California.

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

1. If a member obtains other essential dental health benefits through another qualified dental plan during an open enrollment or Special Enrollment Period.

2. Death of the Member.

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

# Termination of Coverage Due to Non-Payment

Benefits under this plan depend on premium payments being current. Dental Health Services will issue a notice of termination to the Subscriber, employer, or contract holder for non-payment.

Dental Health Services will provide you a thirty (30) day grace period, which begins after the last day of paid coverage. Although you will continue to be covered during this thirty (30) day grace period, you will be financially responsible for the premium for the coverage provided during the thirty (30) day grace period.

During the thirty (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 thirty (30) day grace period, your coverage will be terminated at the end of the thirty (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" must be completed within the thirty (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.

# Individual Continuation of Benefits

Individual Continuation of Benefits

Continuation of Coverage COBRA Benefits Consolidated Omnibus Budget Reconciliation Act (COBRA)

**Federal Cobra**

COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.

It is the sole responsibility of the group to determine compliance and eligibility under COBRA (Federal), as well as to administer all notification requirements and premium collection functions associated with and required by the Act.

COBRA may allow subscribers and their enrolled dependents to keep coverage for up to 18 or 36 months, depending on qualifying events and other circumstances.

Each qualified person may independently enroll in COBRA. A parent or legal guardian may elect COBRA for a minor Child.

COBRA participants will receive the same dental benefits as current employees enrolled in a Dental Health Services' plan.

**Important deadlines for electing/ enrolling in COBRA coverage with Dental Health Services**

**Employer Deadlines:**

1. Notification of Qualifying Event - Employer must notify Dental Health Services within thirty (30) days of the following qualifying events:

• Employee's termination of benefits

• Employee's hours are reduced

• Employee becomes eligible for Medicare benefits

• Death of employee

**Employee Deadlines:**

COBRA enrollees must notify the group and Dental Health Services within sixty (60) days after any of the following qualifying events:

1. Employee divorces or legally separates

2. A Child or other dependent no longer qualifies as a dependent under the plan rules

**Notifications:**

*Election Notice:* Generally, the group must send an election notice no later than 14 days after Dental Health Services has been notified that a qualifying event has occurred.

*Election Period:* The employee has 60 days to notify Dental Health Services in writing that the employee wants to elect /enroll in COBRA coverage. The 60 days starts on the later of the following two dates:

1. The date the employee receives the election notice

2. The date coverage ended

**Premium Payment:**

The first COBRA premiums must be received by Dental Health Services within 45 days after COBRA is elected. The first premium will cover the time period between the employee's loss of coverage due to a qualifying event up to the day of COBRA enrollment. COBRA premiums will continue monthly as long as COBRA coverage is continued.

**The employee will lose COBRA coverage if:**

• Premium payments are not made on time

• Employee moves outside of Dental HealthServices' Service Area

• Group terminates group dental plan with Dental Health Services

• Former employee becomes Medicaid eligible

• Employee enrolls in another dental plan

• Employee commits fraud, which means the former employee intentionally deceived Dental Health

Services or misrepresented themselves or allowed someone else to do so in order to get dental services.

For more information on COBRA, call the Federal Employee Benefits Security Administration (EBSA) toll free at 866-444-3272.

## Cal-COBRA

THE CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT

U.S. and California laws protect your right and your dependents' right to continue your health coverage under certain circumstances or qualifying events. This is called continuation health coverage or continuation of benefits.

The California Continuation Benefits Replacement Act (Cal-Cobra) became effective on January 1, 1998. Cal-COBRA is a California law that is similar to Federal COBRA. Unlike Federal COBRA, Cal-COBRA requires that Dental Health Services provide continuation of coverage for employer groups which employ 2 to 19 employees on at least 50% of its working days during the preceding calendar year.

Like Federal COBRA, employees become eligible for Cal-COBRA once they experience a loss of coverage due to a qualifying event.

Qualifying events for Cal-COBRA include:

a. Death of an employee

b. Termination of Employment (other than gross misconduct)

c. Reduction in hours

d. Divorce or legal separation of a covered spouse from a covered employee

e. Dependent ceases to be eligible as a dependent

f. Covered employee's eligibility of coverage under Medicare

Upon a qualified beneficiary's exhaustion of federal COBRA, typically the qualified beneficiary would be eligible to continue their coverage through Cal-COBRA for an additional 18 months, not to exceed a total of 36 months. Because Dental Health Services is a specialized health care service plan, offering dental-only plans, qualified beneficiaries are not able to continue their coverage upon exhaustion of federal COBRA under Cal-COBRA through Dental Health

Services. Dental only plans are excluded from offering the eighteen (18)-month extension after COBRA through Cal-COBRA.

Each qualified person may independently enroll in Cal-COBRA. A parent or legal guardian may elect Cal-COBRA for a minor Child.

Cal-COBRA participants will receive the same dental benefits as current employees enrolled in a Dental Health Services' plan.

**Important deadlines for electing/enrolling in Cal-COBRA coverage with Dental Health Services**

**Employer Deadlines:**

1. Notification of Qualifying Event - The employer must notify Dental Health Services within thirty (30) days of the following qualifying events:

   a. Employee's termination of benefits

   b. Employee's hours are reduced

**Employee Deadlines:**

Cal-COBRA enrollees must notify Dental Health Services within sixty (60) days after any of the following qualifying events:

   a. Death of employee

   b. Employee divorces or legally separates

   c. A Child or other dependent no longer qualifies as a dependent under the plan rules

   d. Employee becomes eligible for Medicare benefits

**Notifications:**

*Election Notice*: Dental Health Services will send an election notice no later than fourteen (14) days after Dental Health Services has been notified that a qualifying event has occurred.

*Election Period*: The employee has sixty (60) days to notify Dental Health Services in writing that employee wants to elect/enroll in Cal-COBRA coverage. The sixty (60) days starts on the later of the following two dates:

a. The date the employee receives the election notice

b. The date coverage ended

**Premium Payment:**

The first Cal-COBRA premiums must be received by Dental Health Services within forty-five (45) days after Cal-COBRA is elected. The first premium will cover the time period between the employee's loss of coverage due to a qualifying event up to the day of Cal-COBRA enrollment. Cal-COBRA premiums will continue monthly as long as Cal-COBRA coverage is continued.

**Employee will lose Cal-COBRA coverage if**:

a. Premiums payments are not made on time

b. Employee moves outside of Dental Health Services' Service Area

c. Group terminates group dental plan with Dental Health Services

d. Former employee becomes Medicaid eligible

e. Employee enrolls in another dental plan

f. Employee commits fraud, which means the former employee intentionally deceived Dental Health Services or misrepresented themselves or allowed someone else to do so in order to get dental services.

# Re-enrollment

Re-enrollment will be facilitated through Covered California according to the terms and conditions thereunder. All payments due must be satisfied prior to re-enrollment. Please go to Covered California for additional information regarding your re-enrollment rights and processes.

# Grievance Process

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.

Dental Health Services can assist you with working out any issues you may have with a Participating Dentist or your plan. For assistance, you may contact your Member Service Specialist by calling 855-495-0905, mailing a letter to Member Services, Dental Health Services, 3780 Kilroy Airport Way, Suite 750, Long Beach, CA 90806, or by emailing embersatisfactionteam@dentalhealthservices.com.

You have one hundred-eighty (180) calendar days following any incident or action that is the subject of your dissatisfaction to file your Grievance. Grievances are acknowledged by Dental Health Services in writing within five (5) days of receipt. Every effort will be made by Dental Health Services to resolve Grievances within thirty (30) business days of receiving the Grievance or notification. Urgent Grievances are addressed immediately and responded to in writing within three (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 a Member's or Subscriber's share of the fees and expenses of the neutral arbitrator.

If you choose to dispute an Adverse Determination of a pre-authorization or a claim for a procedure that has been denied, modified, or delayed in whole or in part due to a finding that the service is not Medically Necessary, you may seek an Independent Medical Review with the Department of Managed Health Care within 180 days of exhausting the Grievance process.

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 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 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.**

## 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

## 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, 3780 Kilroy Airport Way, Suite 750, Long Beach, CA 90806.

## 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.

# Your Privacy & Confidentiality 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 access and control your information. Please review it carefully. This notice is updated effective June 1, 2020.**

Dental Health Services is devoted to protecting your privacy and the confidentiality of your dental, medical, and personal health information. We do not sell our Member 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 only to information created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). Examples of PHI include your name, address, phone number, email address, birthdate, treatment dates and records, enrollment and claims information. 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.

# 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 or subpoena
- A board, commission or administrative agency pursuant 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 treatment, payment, and health care administration.

Treatment purposes include disclosures related to facilitating your dental care.

Payment purposes include activities to collect Premiums, to determine or maintain Coverage and related data processing, including pre-authorization for certain dental services. Health Care Administration means basic activities essential to Dental Health Services' function as a Limited Health Care Service Contractor, and includes reviewing the qualifications, competence, and service quality of your dental care provider; and providing referrals for Specialists.

In some situations, Dental Health Services is permitted to use and disclose your PHI without your authorization, subject to Limitations imposed by law. These situations include, but are not limited to:

- 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.

## 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 the 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 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 request 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 the 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 thirty (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 sixty (60) days of receipt of the request and, in certain circumstances may extend this period for up to an additional thirty (30) days.

You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to six (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 sixty (60) days of your request but may extend the period for up to an additional thirty (30) days. The first accounting requested during any twelve (12) month period will be made without charge. There is $25 charge for each additional accounting requested during such twelve (12) month period. You may withdraw or modify any additional requests within thirty (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 by contacting Dental Health Services at 855-494-0905, 888-645-1257 (TDD/TTY). This notice is always available at dentalhealthservices.com/privacy.

All written requests 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;
- Email 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 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 revises this Notice, it will promptly post the notice on its website and distribute a new version within sixty (60) days of revision.

## 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.

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 one hundred (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.

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/.

You may express dissatisfaction about Dental Health Services' privacy policy in writing to Dental Health Services, 3780 Kilroy Airport Way Suite 750, Long Beach, CA 90806 Attn: Member Satisfaction Assurance Specialist. 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 Member Services Specialist at 855-494-0905, 888-645-1257 (TDD/TTY) during regular office hours or by email at Membercare@dentalhealthservices.com or anytime through dentalhealthservices.com. We are eager to assist you.

# Glossary

**Adverse Determination:** A denial, reduction, or termination of the benefit for services received after a claim is filed or for pre-authorized services which were denied. To appeal an Adverse Determination, see the Grievance Process section of this document.

**Amalgam Filling/Restoration:** A restoration or filling composed of metallic alloy formed mostly of silver, tin and copper, mixed with mercury, into a soft malleable material that sets hard after placement inside a tooth cavity.

**Appeal:** A request for reconsideration of an Adverse Determination rendered by Dental Health Services. An Appeal is processed as a Grievance.

**Benefits/Coverage:** The specific covered services that plan Members and their Dependents are entitled to with their dental plan.

**Child(ren):** Eligible children are children of the Subscriber, Subscriber's spouse, or Subscriber's domestic partner. Eligible children include a biological Child; a stepchild; an adopted Child; a Child for whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner assumes a legal obligation for total or partial support in anticipation of adoption; and a Child for whom the Subscriber, Subscriber's spouse, or Subscriber's domestic partner is the legal guardian

**Composite Filling/Restoration:** A restoration or filling composed of plastic resin material that resembles the natural tooth.

**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 the Subscriber or Member, directly to the Participating Dentist or Specialist at the time of service. The fees charged by a Participating Dentist or Specialist according to your plan's Schedule of Covered Services and Copayments.

**Dependent:** An individual for whom coverage is obtained by a parent, relative, or other person. Eligible dependents may include a legal spouse, domestic partner, or Children of the Subscriber or the Subscriber's spouse/domestic partner.

**Designated Participating Primary Dentist:** The Participating Primary Dentist you have designated to provide your dental care.

**Domestic Partnership:** An interpersonal relationship between two individuals who live together and share a common domestic life but are not married to each other or to anyone else.

**Emergency Dental Condition:** is determined by a Member's reasonable belief that sudden onset of symptoms in the absence of immediate medical attention could result in permanently placing their health in jeopardy, causing other serious dental or health consequences, or causing serious impairment of dental function.

**Endodontics:** The branch of dentistry concerned with the treatment of disease or inflammation of the dental pulp or nerve of the tooth.

**Exclusion:** Treatment or coverage not included as a benefit under this plan.

**Grievance:** A written or oral expression of your dissatisfaction regarding Dental Health Services and/or a Participating Dentist or Participating Specialist, including your concerns about quality of service and care or an Appeal of an Adverse Determination of a pre-authorization or claim.

**Limitation:** A provision that restricts coverage under this plan.

**Medically Necessary:** Dental services and supplies provided by a Participating Dentist appropriate to the evaluation and treatment of disease, condition, illness or injury and consistent with the applicable standard of care. This does not include any service that is cosmetic in nature.

**Member/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.

**Optional Treatment:** Treatment considered optional or unnecessary for the Member's dental health by the treating dentist. If a Member chooses an Optional Treatment, the Member is responsible for fee-for-service rates for the Optional Treatment. This does not apply to standard, covered, restorative procedures which offer a choice of material.

**Out-of-Network Dentist:** A dentist for whom Dental Health Services has pre-authorized to provide Benefits to Members under this Plan.

**Out-of-Network Primary Dentist** – A dentist for whom Dental Health Services has pre-authorized to provide general dental services to Members covered under this plan.

**Out-of-Network Specialist:** A dentist for whom Dental Health Services has pre-authorized to provide Specialty Services to Members cover under this plan.

**Out-of-Pocket Maximum (OOPM):** The maximum amount of money that a Pediatric Age Member must pay for benefits during a plan year. OOPM applies only to the Essential Health Benefits for pediatric aged Members. 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 Member meets their OOPM, they will have no further Essential Health Benefits Copayments for the remainder of the plan year.

For families with more than one Pediatric Age Member, Essential Health Benefit Copayments made by each individual Child for Essential Health Benefits contribute to the family Out-of-Pocket Maximum. For families with more than one Pediatric Age Member, Copayments made by each individual child for out-of-network covered services do not accumulate to the family Out-of-Pocket Maximum.

Once the Essential Health Benefits Copayments paid by all Pediatric Age Members meets the family Out-of-Pocket Maximum, no further Essential Health Benefits Copayments will be required by any of the Pediatric Age Members for the remainder of the plan year.

**Palliative Care:** An action that relieves pain, swelling, or bleeding. This does not include routine or postponable treatment.

**Participating Dentist:** A licensed dental professional who has entered into a written agreement with Dental Health Services to provide dental care services to Subscribers and their Dependents covered under the plan. The agreement includes provisions in which the dentist agrees that the Subscriber shall be held liable only for their Copayment.

**Participating Orthodontist:** A Licensed Dentist who specializes in orthodontics and has signed an agreement with Dental Health Services to provide Benefits to Members under this Plan.

**Participating Primary Dentist:** A Licensed Dentist who has signed an agreement with Dental Health Services to provide general dental services to Members covered under this Plan.

**Participating Specialist:** A Licensed Dentist who provides Specialty Services to Members under this Plan, upon referral by a Participating Primary Dentist.

**Pediatric Age Members:** Members up to age 19.

**Pediatric Dental Benefits:** One of the ten Essential Health Benefits required under the Affordable Care Act (ACA). Pediatric Dental Benefits cover dental care and services such as cleanings, x-rays, and fillings for those up to age 19.

**Plan Year:** The Plan Year for Qualified Dental Plans corresponds to the calendar year. Your coverage ends December 31st even if your coverage started after January 1st. Any changes to your Qualified Dental Plan's Benefits or rates are made at the beginning of the calendar year.

**Qualified Dental Plan:** A dental benefit plan that is certified by a health benefit exchange which provides Essential Health Benefits, follows established limits on cost-sharing (like deductibles, Copayments and Out-of-Pocket Maximum amounts) and meets other requirements.

**Service Area:** Dental Health Services' Service Area includes the following full counties: Alameda, Contra

Costa, Kings, Madera, Marin, Merced, Napa, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Stanislaus, Tulare, Ventura and Yolo.

Dental Health Services' Service Area also includes parts of the following counties: El Dorado, Fresno, Imperial, Kern, Los Angeles, Mariposa, Monterey, Placer, Riverside, San Benito, San Bernardino, San Luis Obispo, and Sonoma.

**Special Enrollment Period:** A time outside the yearly Open Enrollment period when consumers can sign up for dental benefits coverage. Consumers qualify for a Special Enrollment Period if they've experienced certain life events, including losing health coverage, moving into or out of a covered Service Area, getting married, having a baby, or adopting a Child.

**Specialty Services:** Dental services provided by a Dental Health Services Participating Specialist (endodontist, oral surgeon, orthodontist, pedodontist/pediatric dentist, or periodontist). All referrals for covered Specialty Services must be pre-authorized by Dental Health Services.

**Subscriber:** A person who is responsible for the account, whose name is on the application, resides in Dental Health Services' Service Area and meets plan eligibility requirements.

**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.

**Urgent Grievance** – A grievance that shall include expedited review when involving an imminent and serious threat to the health of the enrollee including but not limited to severe pain, potential loss of life, limb or major bodily function; or the potential improper cancellation, rescission, or nonrenewal of an enrollment or subscription.

**Usual, Customary & Reasonable:** The base amount that is treated as the standard or most common charge for a particular dental service.

English

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.

Spanish

IMPORTANTE: ¿Puedes leer esto? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta información escrita en su propia 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.

Dental Health Services

**3780 Kilroy Airport Way, Suite 750, Long Beach, California 90806**

855-495-0905
888-645-1257 (TDD/TTY)

dentalhealthservices.com/CA

An Employee-Owned Company