Evidence of Coverage

and Disclosure Statement

Group Dental Plan

Plan Name: Custom HN Value DHMO 115

University of California Postdoctoral Scholar Benefit Plan

Benefits provided by Dental Benefit Providers of California, Inc.

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EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Evidence of Coverage provides a detailed summary of how your dental plan operates, your entitlements, and the plan's restrictions and limitations.

However, this combined Evidence of Coverage and Disclosure Statement constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

You may obtain a copy of the health plan contract by requesting it from your Organization, or by writing to Health Net Dental, c/o Dental Benefit Providers of California, Inc., 3110 W. Lake Center Drive, Santa Ana, CA 92704, or by calling **(866) 249-2382**.

This Evidence of Coverage and Disclosure Statement is subject to Chapter 2.2 of Division 2 of the California Health and Safety Code (commonly referred to as the Knox-Keene Act) and the regulations issued thereto by the Department of Managed Health Care. Should either the law or the regulations be amended, such amendments shall automatically be deemed to be a part of this document and shall take precedence over any inconsistent provision of this contract. Any provision required to be in this Evidence of Coverage and Disclosure Statement by either law or the regulation shall automatically bind DBP.

Entire Contract

We typically contract with an Organization, such as your employer or association, to offer benefits to its employees or members. Your Organization's contract, together with the application, acceptance agreement, Enrollment Form, this Evidence of Coverage and any attachments or inserts including the Schedule of Benefits with Exclusions and Limitations, constitutes the entire agreement between the parties. To be valid, any change in the contract must be approved by us and attached to it. No agent may change the Contract or waive any of the provisions. Should any provision herein not conform to applicable laws, it shall be construed as if it were in full compliance thereof.

A STATEMENT DESCRIBING DBP'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF DENTAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Health Net Dental DHMO plans are provided by Dental Benefit Providers of California, Inc. ("DBP"). Obligations of DBP are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.

Evidence of Coverage and Disclosure Statement

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Who May Enroll

Your Organization determines how you may become eligible to join the Plan. You may enroll yourself and your dependents, provided each meets your Organization's eligibility requirements and/or the Service Area and Dependent Coverage requirements listed below.

Service Area

The Service Area is the geographical area in which we have a panel of Selected General Dentists and Specialists who have agreed to provide care to our members. To enroll, you must reside, live, or work in the Service Area, and the permanent legal residence of any enrolled dependents must be:

- The same as yours;
- In the Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where the Subscriber has legal responsibility for the health care of such dependents;
- In the Service Area under other circumstances where you are legally responsible for the health care of such dependents; or
- In the Service Area with your spouse.

Dependent Coverage

Your Organization is responsible for determining dependent eligibility. In the absence of such a determination, we define eligible dependents to be:

- Your lawful spouse or registered domestic partner. Benefits may be available for unregistered domestic partners if your Organization permits such coverage.
- Your unmarried children or grandchildren up to age 26 for whom you provide care (including adopted children, step-children, or other children for whom you are required to provide dental care pursuant to a court or administrative order).
- Your children who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition. At least 90 days prior to a disabled dependent reaching the limiting age, DBP will send notice to you, the Subscriber, that coverage for the disabled dependent will terminate at the end of the limiting age, unless proof of such incapacity and dependency is provided to DBP within 60 days of receipt of notice.
- Other dependents if your Organization provides benefits for these dependents.

Please check with your Organization if you have questions regarding your eligibility requirements.

When Coverage Begins

Coverage for you and your enrolled dependents will begin on the date determined by your Organization. Newborn children are covered the first day of the month following the date of birth and legally adopted children, foster children and stepchildren are covered the first day of the month following placement as long as we are notified within thirty (30) days and any prepayment fee is paid within that period.

Check with your Organization if you have any questions about when your coverage begins.

Choice of Provider

When you enroll, you and each enrolled family member must choose a Selected General Dentist from our network. Each family member may select a different dental office. Please refer to the Directory of Participating Dentists for a complete listing of Selected General Dentists.

Facilities

A complete list of contracted facilities is contained in the Provider Directory. You may obtain an updated Provider Directory by calling **(866) 249-2382** or at www.yourdentalplan.com/healthnet.

New Patient and Routine Services

As a member, you have the right to expect that the first available appointment time for new patient or routine dental care services is within four (4) weeks of your initial request. If your schedule requires that an appointment be scheduled on a specific date, day of the week, or time of day, the Selected General Dentist may need additional time to meet your special request.

Making an Appointment

Once your coverage begins, you may contact the Selected General Dentist you selected at enrollment to schedule an appointment. Selected General Dentists' offices are open in accordance with their individual practice needs. When scheduling an appointment, please identify yourself as a member. Your Selected General Dentist will also need to know your chief dental concern and basic personal data. Arrive early for your first appointment to complete any paperwork. There is an office visit co-payment on some plans and also be aware that there is a charge for missing your appointment. Your first visit to your dentist will usually consist of x-rays and an examination only. By performing these procedures first, your dentist can establish your treatment plan according to your overall health needs.

We recommend that you take this brochure with you on your appointment, along with the enclosed Schedule of Benefits. Remember, only dental services listed as covered benefits in the Schedule of Benefits and provided by a Selected General Dentist are covered.

Specialist Referrals

During the course of treatment, you may require the services of a Specialist. Your Selected General Dentist will submit all required documentation to us and we will advise you of the name, address, and telephone number of the Specialist who will provide the required treatment. These services are available only when the dental procedure cannot be performed by the Selected General Dentist due to the severity of the problem. Some plans require that specialty referrals be authorized in writing, while others incorporate a direct or self-referral process. Full information is contained in your plan Schedule of Benefits.

Changing Your Selected General Dentist

You have control over your choice of dental offices, and you can make changes at any time. If you would like to change your Selected General Dentist, please contact Customer Service at **(866) 249-2382**. Our associates will help you locate a dental office most convenient to you. The transfer will be effective on the first day of the month following the transfer request. You must pay all outstanding charges owed to your dentist before you transfer to a new dentist. In addition, you may have to pay a fee for the cost of duplicating your x-rays and dental records.

Second Opinions

You may request a second opinion if you have unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental treatment. Contact our Customer Service Department either by calling **(866) 249-2382** or sending a written request to the following address:

Health Net Dental

c/o Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

In addition, your Selected General Dentist may also request a second opinion on your behalf. There is no second opinion consultation charge to you. You will be responsible for the office visit co-payment as listed on your Schedule of Benefits.

Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If you question the reasonableness or necessity of recommended surgical procedures.

(2) If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving your dental condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

Requests for second opinions are processed within five (5) business days of receipt of such request, except when an expedited second opinion is warranted; in which case a decision will be made and conveyed to you within 24 hours. Upon approval, we will contact the consulting dentist and make arrangements to enable you to schedule an appointment. All second opinion consultations will be completed by a contracted dentist with qualifications in the same area of expertise as the referring dentist or dentist who provided the initial examination or dental care services. You may obtain a copy of the second dental opinion policy by contacting our Customer Service Department by telephone at the toll-free number indicated above, or by writing to us at the above address.

No co-payment is required for a second opinion consultation. Some plans do require a co-payment for an office visit.

Your Financial Responsibility:

Prepayment Fee

Your Organization prepays your coverage on a monthly basis. If you are responsible for any portion of this prepayment fee, your Organization will advise you of the amount and how it is to be paid. Please refer to the copayment section, below, for information relating to your co-payments under this plan. The prepayment fee is not the same as a co-payment.

The exact premium charge is contained in the health plan contract between DBP and your Organization. You may obtain a copy of the health plan contract from your Organization, or by writing to Health Net Dental, c/o Dental Benefit Providers of California, Inc., 3110 W. Lake Center Drive, Santa Ana, CA 92704, or by calling **(866) 249-2382**

Co-payments

When you receive care from either a Selected General Dentist or Specialist, you will pay the co-payment described on your Schedule of Benefits enclosed with this Evidence of Coverage. When you are referred to a Specialist, your co-payment may be either a fixed dollar amount, or a percentage of the dentist's usual and customary fee. Please refer to the Schedule of Benefits for specific details. When you have paid the required co-payment, if any, you have paid in full. If we fail to pay the contracted provider, you will not be liable to the provider for any sums owed by us. If you choose to receive services from a non-contracted provider, you may be liable to the non-contracted provider for the cost of services unless specifically authorized by us or in accordance with emergency care provisions. We do not require claim forms.

Other Charges

All other charges you may be required to pay under this plan are listed in the Schedule of Benefits.

Coordination of Benefits

We do not coordinate benefits with any other carrier. If you have coverage with another carrier, please contact that carrier to determine whether coordination of benefits is available.

Customer Service

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your dental office. Customer Service can be reached Monday through Friday at **(866) 249-2382** from 5:00 a.m. to 6:00 p.m. Pacific Standard Time. Automated service is also provided after hours for eligibility verification and dental office transfers.

Emergency Dental Services

Emergency dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a reasonably prudent layperson possessing average knowledge of dentistry to believe that immediate care is needed.

All Selected General Dentists provide emergency dental services twenty-four (24) hours a day, seven (7) days a week and we encourage you to seek care from your Selected General Dentist. **If you require emergency dental services, you may go to any dental provider, go to the closest emergency room, or call 911 for assistance, as necessary. Prior Authorization for emergency dental services is not required.**

Your reimbursement from us for emergency dental services, if any, is limited to the extent the treatment you received directly relates to emergency dental services - i.e. to evaluate and stabilize the dental condition. All reimbursements will be allocated in accordance with your plan benefits, subject to any exclusions and limitations. Hospital charges and/or other charges for care received at any hospital or outpatient care facility that are not related to treatment of the actual dental condition are not covered benefits.

If you receive emergency dental services, you will be required to pay the charges to the dentist and submit a claim to us for a benefits determination. If you seek emergency dental services from a provider

located more than 25 miles away from your Selected General Dentist, you will receive emergency benefits coverage up to a maximum of $50, less any applicable co-payments.

To be reimbursed for emergency dental services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible to do so. Please include your name, family ID number, address and telephone number on all requests for reimbursement.

If you do not require emergency dental services and a delay in receiving treatment would not be detrimental to your health, please contact your Selected General Dentist or our Customer Service Department at **(866) 249-2382** to make reasonable arrangements for your care.

Grievance Procedures

If you or one of your eligible dependents has a grievance with us or your dentist, you may orally submit such grievance by calling our Customer Service Department at **(866) 249-2382**. We will permit grievances which are filed within 180 days of the occurrence or incident that is the subject of the grievance.

You may also submit a completed written grievance form (available by calling the Customer Service number) or a detailed summary of your grievance to:

Health Net Dental

c/o Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

Please be sure to include your name (patient's name, if different), Member Identification Number, facility (or Selected General Dentist) name and number on all written correspondence.

We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the plan. We will confirm receipt of your complaint in writing within five (5) calendar days of receipt. We will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-866-249-2382 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.

In the event of an urgent grievance, which involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, you are not required to participate in our grievance process and may directly contact the California Department of Managed Health Care, as referenced above, for review of the urgent grievance.

Arbitration

Each and every disagreement, dispute or controversy which remains unresolved concerning the construction, interpretation, performance or breach of this contract, or the provision of dental services under this contract after exhausting our complaint procedures, arising between the organization, a member or the heir-at-law or personal representative of such person, as the case may be, and our company, its employees, officers or directors, or participating dentist or their dental groups, partners, agents, or employees, shall be submitted to binding arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability or malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this contract but which gives rise to a claim after the termination of this contract. Arbitration shall be initiated by written notice to Health Net Dental, c/o Dental Benefit Providers of California, Inc., 3110 W. Lake Center Drive, Santa Ana, CA 92704. The notice shall include a detailed description of the matter to be arbitrated.

BY PARTICIPATING IN THE PLAN, YOU AGREE TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE AND/OR OTHER DISPUTES RELATED TO THE DELIVERY OF SERVICES UNDER THE PLAN DECIDED BY NEUTRAL, BINDING ARBITRATION PURSUANT TO THE TERMS OF THE CONTRACT, AND YOU GIVE UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Changes To Your Coverage:

Termination of Benefits

Your coverage may be cancelled for any reason, after not less than 60 days written notice by either us or your Organization.

Your coverage may be cancelled after not less than 30 days written notice for:

- Failure to establish a satisfactory dentist-patient relationship and if it is shown that DBP has, in good faith, provided you with the opportunity to select an alternative dentist.
- Neither residing, living, or working in the service area or area for which DBP is authorized to do business.

Your coverage may be cancelled after not less than 15 days written notice for:

- An intentional misrepresentation, except as limited by statute.

- Fraud in the use of services or facilities, or on the part of the Organization.
- Such other good cause as is agreed upon in the contract.

Your coverage may be cancelled immediately:

- For non-payment of amounts due under the contract, if you have been notified and billed for the charge and at least 15 days have elapsed since the date of notification.
- Subject to continuation of coverage and conversion privilege provisions, if applicable, if you do not meet eligibility requirements other than the requirements that you live or work in the service area.
- For any misconduct detrimental to safe plan operations and the delivery of services.
- Upon termination of the health plan contract between us and your Organization, if expired and not renewed.

If your Organization fails to pay the prepayment fees through and including the final month of the contract, all coverage may be terminated at the end of the grace period, and you may be responsible for the usual and customary fees for any services received from your Selected General Dentist or Specialist during the period the prepayment fees went unpaid, including the grace period.

If you terminate from the plan while the contract between us and your Organization is in effect, your coverage will extend to the end of the month following notice of termination. Your Selected General Dentist must complete any dental procedure started on you before your termination, abiding by the terms and conditions of the plan.

Enrollment will be cancelled as of the last day for which payment has been received, subject to compliance with notice requirements.

In the event your enrollment is cancelled, we will send such notification to your Organization, which will, in turn, notify you. Your Organization will also send you notice when your actual coverage is terminated.

Orthodontic treatment is governed by the orthodontic limitations listed on your schedule of benefits. If you terminate coverage from the plan after the start of orthodontic treatment, you will be responsible for any additional incurred charges for any remaining orthodontic treatment.

Renewal Provisions

Your Organization has contracted with us to provide services for the time period specified in the contract between the parties. Your coverage under the plan is guaranteed for that time period so long as you meet the eligibility requirements under the plan. When the contract expires, it may be renewed. If renewed, it is possible that the terms of the plan may have been changed. If changes to benefits, co-payments or premiums have been made to a renewed contract, your Organization will notify you not less than thirty (30) days before the effective date.

Reinstatement

Receipt by us of the proper prepaid or periodic payment after cancellation of the contract for non-payment shall reinstate the contract as though it had never been cancelled if such payment is received on or before the due date of the succeeding payment.

An enrollee or subscriber who alleges that his or her enrollment has been canceled or not renewed because of his or her health status or requirements for health care services may request a review by the Director of the California Department of Managed Health Care. If the Director determines that a proper complaint exists, the Director shall notify us. Within 15 days after receipt of such notice, we shall either request a hearing or reinstate the enrollee or subscriber. If, after a hearing, the Director determines that the cancellation or failure to renew is improper, the Director shall order us to reinstate the enrollee or

subscriber. A reinstatement pursuant to this provision shall be retroactive to the time of cancellation or failure to renew and we shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or non-renewal to and including the date or reinstatement.

Conversion Privilege

Contact our Customer Service Department at **(866) 249-2382** to check availability of a conversion plan in your area.

Continuity of Care:

Current Members

Current members may have the right to the benefit of completion of care with their Terminated Provider for certain specified dental conditions. Please call us at **(866) 249-2382** to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your Terminated Provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your Terminated Provider on the terms regarding your care in accordance with California law.

New Members

New members may have the right to the benefit of completion of care with their Non-Participating Provider for certain specified dental conditions. Please call us at **(866) 249-2382** to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your Non-Participating Provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your Non-Participating Provider on the terms regarding your care in accordance with California law. This policy does not apply to new members of an individual subscriber contract.

You may obtain a copy of our policy on continuation of care, which contains the specific information relating to the required qualifying events for receiving continuation of care, or you may receive information regarding your rights to continuation of care from our Customer Service Department by calling **(866) 249-2382**. If you have further questions, you are encouraged to contact the California Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov.

Individual Continuation of Benefits

You and your eligible dependents may be eligible to retain coverage in accordance with COBRA (Consolidated Omnibus Budget Reconciliation Act) and/or Cal-COBRA (California Continuation of Benefits Replacement Act) requirements. You and your dependents may also be eligible for Medicare benefits. If you go through a divorce or legal separation, have your hours reduced, have a death in the family, or have a child who is no longer an eligible dependent, you must notify your employer or you will lose your right to continued coverage. For COBRA qualifying events, you must notify your employer within 60 days. For Cal-COBRA, you must notify your employer within 30 days. Failure to make such notification within the required time period will disqualify you from receiving continuation coverage. See your Organization for more details.

Upon election, you will be able to continue this plan, subject to the terms and conditions of the Organization contract and the requirements of COBRA or Cal-COBRA.

The continuation of your coverage will only be provided for the balance of the period that you would have remained covered under your prior plan.

Member Rights

During the term of the contract between us and your Organization, we guarantee that it will not decrease any benefits, increase any co-payment, or change any exclusion or limitation. We will not cancel or fail to renew your enrollment in this Plan because of your health condition or your requirements for dental care. Your Selected General Dentist is responsible to you for all treatment and services, without interference from us.

However, your Selected General Dentist must follow the rules and limitations set up by us and conduct his or her professional relationship with you within the guidelines established by us. If our relationship with your Selected General Dentist ends, your dentist is obligated to complete any and all treatment in progress. We will arrange a transfer for you to another dentist to provide for continued coverage under the Plan. As indicated on your enrollment form, your signature authorizes us to obtain copies of your dental records, if necessary.

As a member, you have the right to...

- Be treated with respect, dignity and recognition of your need for privacy and confidentiality.
- Express complaints and be informed of the complaint process.
- Have access and availability to care and access to and copies of your dental records.
- Participate in decision-making regarding your course of treatment.
- Be provided information regarding Selected General Dentists.
- Be provided information regarding the services, benefits and specialty referral process.

Member Responsibilities

As a member, you have the responsibility to...

- Identify yourself to your Selected General Dentist as a member. If you fail to do so, you may be charged the dentist's usual and customary fees instead of the applicable co-payment, if any.
- Treat the dentist and his or her office staff with respect and courtesy and cooperate with the prescribed course of treatment. If you continually refuse a prescribed course of treatment, your Selected General Dentist or Specialist has the right to refuse to treat you. We will facilitate second opinions and will permit you to change your Selected General Dentist; however, we will not interfere with the dentist-patient relationship and cannot require a particular dentist to perform particular services.
- Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.
- Make co-payments at the time of service. If you do not, the dentist may collect those co-payments from you at subsequent appointments and in accordance with their policies and procedures.
- Notify us of changes in family status. If you do not, we will be unable to authorize dental care for you and/or your family members.
- Be aware of and follow your Organization's guidelines in seeking dental care. If you do not, your Organization may not have sufficient information to report your eligibility to us, which could result in a denial of care.

Public Policy Committee

The Public Policy Committee provides our clients with the opportunity to participate in the review of quality improvement activities. Representatives of organizations such as yours, contracting dentists, and our staff Members, meet quarterly to discuss quality improvement activities and policies. If you are interested in being a representative to the Committee meeting, please contact us at **(866) 249-2382** and ask for the Director of Quality Management.

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are non-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 each service. If you would like more information about dental coverage options, you may call member services at **(866) 249-2382** or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

For purposes of this section, “covered services” or “covered dental services” means dental care services for which the plan is obligated to pay pursuant to an enrollee’s plan contract, or for which the plan would be obligated to pay pursuant to an enrollee’s plan contract but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations or alternative benefit payments.

A member's loss of program eligibility and disenrollment from the plan. Reason for termination of benefits may be termination of the group contract, termination of the subscriber's employment with the Organization or dependent status change as set forth herein.

The following definitions are used in this Evidence of Coverage.

Arbitration

A non-court proceeding which is used to solve legal disputes. It is usually held before an attorney or judge who weighs the evidence and renders a binding decision, which has the force of law. Arbitration is an efficient alternative to a trial court proceeding for resolving legal disputes.

Co-payment

The amount listed on the Schedule of Benefits for covered services that the member is required to pay at the time of treatment.

Dental Records

A single complete record kept at the site of your dental care. Dental records refers to diagnostic aids, such as intraoral and extra-oral radiographs, written treatment records including, but not limited to, progress notes, dental or periodontal chartings, treatment plans, specialty referrals, consultation reports or other written material relating to an individual's medical and dental history, diagnosis, condition, treatment and/or evaluation.

Dependent

Eligible family members of a subscriber who is enrolled in the dental plan. (See Dependent Coverage).

Emergency Dental Services

Dental services rendered for the relief of acute pain, bleeding, infection, fever, or for conditions that may result in disability or death, and where delay of treatment would be medically unadvisable.

Medically Necessary

Covered services that are necessary and meet professionally recognized standards of practice. The fact that a dentist may prescribe, order, recommend or approve a service or material does not, in itself make it medically necessary, or make it a covered service and material even though it is not listed in this Policy or the Schedule of Benefits as an exclusion.

Member

An individual enrolled in the dental plan.

Non-Participating Provider

A dentist who has no contract to provide services for the Plan.

Organization

An employer or other entity that has contracted with us to arrange for the provision of dental care benefits.

Plan

Coverage for specified dental care services purchased by an Organization for its members for a fixed, periodic payment made in advance of treatment. Such plans often include the use of fixed co-payments to clarify the financial obligation of covered dental care, and are subject to Exclusions and Limitations.

Prepayment Fee

The monthly fee paid to us by your Organization. The prepayment fee is not the same as a co-payment.

Provider

A dentist providing services under contract with the Plan.

Selected General Dentist

A contracted dentist who agrees in writing to provide dental services under special terms, conditions and financial reimbursement arrangements with us.

Service Area

The Service Area is the geographical area in which there is a panel of Selected General Dentists and specialists who have agreed to provide care to members.

Subscriber

The person, usually the employee, who represents the family unit in relation to the dental benefit program. Also known as: certificate holder, enrollee.

Terminated Provider

A dentist who formerly delivered services under contract that is no longer associated with the Plan.

Termination of Benefits

A member's loss of program eligibility and disenrollment from the plan. Reason for termination of benefits may be termination of the group contract, termination of the subscriber's employment with the Organization or dependent status change as set forth herein.

DIRECT REFERRAL DENTAL PLAN
HN VALUE DHMO 115
SCHEDULE OF BENEFITS

University of California Postdoctoral Scholar Benefit Plan
Benefits provided by Dental Benefit Providers of California, Inc.

This document describes the Covered Services of this Health Net of California dental plan, as well as Co-payment requirements, Limitations of Benefits and Exclusions. Covered Services are also subject to the terms and conditions stated in the Evidence of Coverage and the Group Agreement.

Except for Emergency Dental Care as described in the Evidence of Coverage and Orthodontia as described below, all of the following services must be provided by the Member's Primary Dentist in order to be Covered Services under this dental plan unless prior approval is obtained for referral to a specialist. For more information, visit www.healthnet.com

Code	Service	Member Co-payment
Diagnostic		
D0120	Periodic oral evaluation	$0
D0120	Periodic oral evaluation – pregnant member **	$0
D0140	Limited oral evaluation - problem focused	$0
D0140	Limited oral evaluation – problem focused – pregnant member **	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0150	Comprehensive oral evaluation – pregnant member **	$0
D0170	Re-evaluation - limited, problem focused, (established patient; non-post-operative visit)	$0
D0170	Re-evaluation – limited problem focused – pregnant member **	$0
D0171	Re-evaluation – post operative visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0180	Comprehensive periodontal evaluation – pregnant member **	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	extraoral - 2D projection radiographic image created using a stationary radiation	$0
D0251	extra-oral posterior dental radiographic image	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0
D0351	3D photographic image	$0
D0391	Interpretation of diagnostic image by a practitioner not associated with image	$0
D0431	Adjunctive pre-diagnostic test to aid in detection of mucosal abnormalities	$20
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$15
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0

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D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0600	Non-ionizing diagnostic procedure	$0
D0601	Caries risk assessment with a finding of low	$0
D0602	Caries risk assessment with a finding of medium	$0
D0603	Caries risk assessment with a finding of high	$0

Preventive

D1110	Prophylaxis - adult	$0
D1110	Prophylaxis - adult – pregnant member **	$0
D1110	Prophylaxis - adult (in addition to one allowed every six months)	$40
D1120	Prophylaxis - child	$0
D1120	Prophylaxis - child (in addition to one allowed every six months)	$25
D1208	Topical application of fluoride	$0
D1310	Nutritional counseling for control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$5
D1352	Preventive resin restoration – permanent tooth	$5
D1353	Sealant repair - per tooth	$5
D1354	Interim caries arresting medicament application	$15
D1510	Space maintainer - fixed - unilateral	$20
D1515	Space maintainer - fixed - bilateral	$20
D1520	Space maintainer - removable - unilateral	$20
D1525	Space maintainer - removable - bilateral	$20
D1550	Re-cementation of space maintainer	$5
D1575	Distal shoe space maintainer - fixed unilateral	$20

Restorative

D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$0
D2331	Resin-based composite - two surfaces, anterior	$0
D2332	Resin-based composite - three surfaces, anterior	$0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite - one surface, posterior - primary	$15
D2392	Resin-based composite - two surfaces, posterior - primary	$20
D2393	Resin-based composite - three surfaces, posterior - primary	$30
D2394	Resin-based composite - four or more surfaces, posterior - primary	$30
D2391	Resin-based composite - one surface, posterior	$65
D2392	Resin-based composite - two surfaces, posterior	$75
D2393	Resin-based composite - three surfaces, posterior	$80
D2394	Resin-based composite - four or more surfaces, posterior	$80
D2510	Inlay - metallic - one surface*.	$115
D2520	Inlay - metallic - two surfaces*	$115
D2530	Inlay - metallic - three or more surfaces*	$115
D2542	Onlay - metallic - two surfaces*	$115
D2543	Onlay - metallic - three surfaces*	$115

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** Procedure codes with asterisks (**) apply to pregnant members

D2544	Onlay - metallic - four or more surfaces*	$115

Crowns - Single Restorations Only

D2740	Crown - porcelain/ceramic substrate	$200
D2750	Crown - porcelain fused to high noble metal*	$115
D2751	Crown - porcelain fused to predominantly base metal	$115
D2752	Crown - porcelain fused to noble metal*	$115
D2780	Crown - 3/4 cast high noble metal*	$115
D2781	Crown - 3/4 cast predominantly base metal	$115
D2782	Crown - 3/4 cast noble metal*	$115
D2783	Crown - 3/4 porcelain/ceramic	$115
D2790	Crown - full cast high noble metal*	$115
D2791	Crown - full cast predominantly base metal	$115
D2792	Crown - full cast noble metal*	$115
D2794	Crown - titanium*	$115
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2940	Sedative filling	$0
D2941	Interim therapeutic restoration-primary dentition	$0
D2950	Core buildup, including any pins*	$15
D2951	Pin retention - per tooth, in addition to restoration*	$10
D2952	Cast post and core in addition to crown*	$25
D2953	Each additional cast post - same tooth*	$25
D2954	Prefabricated post and core in addition to crown	$25
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2962	Labial veneer (porcelain laminate) - laboratory	$450
D2983	Veneer repair necessitated by restorative material failure	$450
D2990	Resin infiltration of incipient smooth surface lesions	$0

Endodontics

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$10
D3310	Anterior (excluding final restoration)	$70
D3320	Bicuspid (excluding final restoration)	$80
D3330	Molar (excluding final restoration)	$150
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3346	Retreatment of previous root canal therapy - anterior	$80
D3347	Retreatment of previous root canal therapy- bicuspid	$100
D3348	Retreatment of previous root canal therapy - molar	$200
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$65

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D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption,etc.)	$65
D3355	Pupal regeneration-initial visit	$65
D3356	Pupal regeneration-medicament replacement	$65
D3357	Pupal regeneration-completion of treatment	$65
D3410	Apicoectomy/periradicular surgery - anterior	$90
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$90
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100
D3426	Apicoectomy/periradicular surgery - (each additional root)	$90
D3427	Periradicular surgery without apicoectomy	$90
D3430	Retrograde filling - per root	$90
D3450	Root amputation - per root	$95
D3920	Hemisection (including any root removal), not including root canal therapy	$90

Periodontics

D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces - per quadrant	$35
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces - per quadrant	$35
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces - per quadrant	$150
D4249	Clinical crown lengthening - hard tissue	$125
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$275
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces - per quadrant	$275
D4270	Pedicle soft tissue graft procedure	$300
D4277	Free soft tissue graft (including donor site surgery)	$300
D4278	Free soft tissue graft procedure each addtl contiguous tooth	$0
D4273	Subepithelial connective tissue graft procedures	$300
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$50
D4283	Autogenous connective tissue graft procedure each addtl implant	$300
D4341	Periodontal scaling and root planing - four or more teeth – per quadrant	$25
D4341	Periodontal scaling and root planning – pregnant member **	$0
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$25
D4342	Periodontal scaling and root planning – pregnant member **	$0
D4346	Scaling in presence of generalized moderate or severe inflammation	$15
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15
D4355	Full mouth debridement – pregnant member **	$0
D4381	Localized delivery of chemotherapeutic agent via controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance	$15
D4910	Periodontal maintenance – pregnant member **	$0
D4921	Gingival irrigation – per quadrant	$0
D4999	Periodontal charting for treatment planning of periodontal disease	$0

Prosthodontics (Removable)

D5110	Complete denture - maxillary	$125
D5110	Complete denture - maxillary (Comfort Flex (complete upper denture) acetyle resin homopolymer)	Co-payment + $400
D5120	Complete denture -mandibular	$125

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D5120	Complete denture -mandibular (Comfort Flex (complete lower denture) acetyle resin homopolymer)	Co-payment + $400
D5130	Immediate denture - maxillary	$125
D5130	Immediate denture - maxillary (Comfort Flex (complete upper denture) acetyle resin homopolymer)	Co-payment + $400
D5140	Immediate denture -mandibular	$125
D5140	Immediate denture -mandibular (Comfort Flex (complete lower denture) acetyle resin homopolymer)	Co-payment + $400
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	$150
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) (Comfort Flex (upper partial denture) acetyle resin homopolymer)	Co-payment + $425
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	$150
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) (Comfort Flex (lower partial denture) acetyle resin homopolymer)	Co-payment + $425
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$175
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex (upper partial denture) acetyle resin homopolymer)	Co-payment + $425
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$175
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex (lower partial denture) acetyle resin homopolymer)	Co-payment + $425
D5221	Immediate maxillary partial denture - resin base	$40
D5222	Immediate mandibular partial denture - resin base	$40
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases	$40
D5224	immediate mandibular partial denture-cast metal framework with resin denture bases	$40
D5410	Adjust complete denture - maxillary	$10
D5411	Adjust complete denture - mandibular	$10
D5421	Adjust partial denture - maxillary	$10
D5422	Adjust partial denture - mandibular	$10
D5511	Repair broken complete denture base, mandibular	$15
D5512	Repair broken complete denture base, maxillary	$15
D5520	Replace missing or broken tooth - complete denture (each tooth)	$15
D5611	Repair resin partial denture base, mandibular	$15
D5612	Repair resin partial denture base, maxillary	$15
D5621	Repair cast partial framework, mandibular	$15
D5622	Repair cast partial framework, maxillary	$15
D5630	Repair or replace broken clasp	$15
D5640	Replace broken teeth - per tooth	$15
D5650	Add tooth to existing partial denture	$15
D5660	Add clasp to existing partial denture	$15
D5710	Rebase complete maxillary denture	$50
D5711	Rebase complete mandibular denture	$50
D5720	Rebase maxillary partial denture	$50
D5721	Rebase mandibular partial denture	$50
D5730	Reline complete maxillary denture (chairside)	$25
D5731	Reline complete mandibular denture (chairside)	$25

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D5740	Reline maxillary partial denture (chairside)	$25
D5741	Reline mandibular partial denture (chairside)	$25
D5750	Reline complete maxillary denture (laboratory)	$50
D5751	Reline complete mandibular denture (laboratory)	$50
D5760	Reline maxillary partial denture (laboratory)	$50
D5761	Reline mandibular partial denture (laboratory)	$50
D5810	Interim complete denture (maxillary)	$60
D5811	Interim complete denture (mandibular)	$60
D5820	Interim partial denture (maxillary)	$40
D5821	Interim partial denture (mandibular)	$40
D5850	Tissue conditioning, maxillary	$10
D5851	Tissue conditioning, mandibular	$10
D5863	Overdenture-complete maxillary	$125
D5864	Overdenture-partial maxillary	$125
D5865	Overdenture-complete mandibular	$175
D5866	Overdenture-complete mandibular	$175

Prosthodontics (Fixed)

D6210	Pontic - cast high noble metal*	$115
D6211	Pontic - cast predominantly base metal	$115
D6212	Pontic - cast noble metal*	$115
D6214	Pontic – titanium*	$115
D6240	Pontic - porcelain fused to high noble metal*	$115
D6241	Pontic - porcelain fused to predominantly base metal*	$115
D6242	Pontic - porcelain fused to noble metal*	$115
D6245	Pontic - porcelain / ceramic	$115
D6740	Crown - porcelain / ceramic	$200
D6750	Crown - porcelain fused to high noble metal*	$115
D6751	Crown - porcelain fused to predominantly base metal*	$115
D6752	Crown - porcelain fused to noble metal*	$115
D6780	Crown - 3/4 cast high noble metal*	$115
D6781	Crown - 3/4 cast predominantly base metal	$115
D6782	Crown - 3/4 cast noble metal*	$115
D6790	Crown - full cast high noble metal*	$115
D6791	Crown - full cast predominantly base metal*	$115
D6792	Crown - full cast noble metal*	$115
D6794	Crown – titanium*	$115
D6930	Recement fixed partial denture	$0

Oral and Maxillofacial Surgery

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (extraction - each additional tooth)	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal - exposed roots)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$20
D7220	Removal of impacted tooth - soft tissue	$35
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$95
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$130
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50

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D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Surgical access exposure of an unerupted tooth	$175
D7285	Biopsy of oral tissue - hard (bone,tooth)	$15
D7286	Biopsy of oral tissue - soft (all others)	$25
D7310	Alveoplasty in conjunction with extractions, per quadrant	$20
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$7
D7320	Alveoplasty not in conjunction with extractions, per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$14
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$0
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$10
D7963	Frenuloplasty	$10
D7971	Excision of pericoronal gingiva	$40

Orthodontics

D8050	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment, primary dentition	$725
D8060	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment, transitional dentition	$725
D8070	Comprehensive orthodontic treatment transitional dentition	$1,950
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,950
D8090	Comprehensive orthodontic treatment of the adult dentintion	$2,250
D8660	Pre-orthodontic treatment visit	$0
D8670	Periodontic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer (s))	$250
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	$250
D8999	Start-up fee (including exam, beginning records, x-rays, tracings, photos and models)	$250
D8999	Post-treatment records	$150
D8999	Monthly orthodontic fee (for comprehensive treatment beyond 24 months)	$35

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9215	Local anesthesia	$0
D9219	Evaluation for deep sedation or general anesthesia	$0
D9222	Deep sedation/general anesthesia - first 15 minutes	$60
D9223	Deep sedation/general anesthesia – each subsequent 15 minutes	$60
D9239	Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	$60
D9243	Intravenous conscious sedation/analgesia - each subsequent 15 minutes	$60
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$0
D9311	Consultation with a medical care professional	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15

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D9940	Occlusal guard, by report	$100
D9942	Repair and/or reline of occlusal guard	$50
D9943	Occlusal adjustment	$10
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	$0
D9972	External bleaching-per arch-performed in office	$125
D9975	External bleaching for home application-per arch	$125
D9999	Record transfer - transfer of all materials with or without an x-ray	$15

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Materials Upgrades for Non-Elective Dental Services (in addition to co-payment for service)

D2750	Porcelain on molar crowns	$75
D2999	Semi or precious metal for crowns	lab cost
D2740	Leucite-reinforced pressed crown/Empress	$300 + co-payment
D2750	Gold composite reinforced crown/Captek	$300 + co-payment
D5110	Comfort Flex Complete Upper Denture/acetyle resin homopolymer	$400 + co-payment
D5120	Comfort Flex Complete Lower Denture/acetyle resin homopolymer	$400 + co-payment
D5211	Comfort Flex Upper Partial Denture/acetyle resin homopolymer	$425 + co-payment
D5212	Comfort Flex Lower Partial Denture/acetyle resin homopolymer	$425 + co-payment
D6240	Pontic-porcelain fused to high noble metal (gold composite reinforced crown/Captek)	$300 + co-payment
D6245	Pontic - porcelain/ceramic (Leucite-reinforced pressed crown/Empress)	$300 + co-payment
D6740	Crown - porcelain/ceramic (Leucite-reinforced pressed crown/Empress)	$300 + co-payment
D6750	Crown - porcelain fused to high noble metal (Gold composite reinforced crown/Captek)	$300 + co-payment

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Cosmetic Dentistry Services (Elective Services)

D2330	Resin based-composite - one surface, anterior	$80
D2331	Resin based-composite - two surfaces, anterior	$95
D2332	Resin based-composite - three surfaces, anterior	$105
D2335	Resin based-composite, four or more surfaces or involving incisal angle (anterior)	$125
D2391	Resin based-composite - one surface, posterior	$85
D2392	Resin based-composite - two surfaces, posterior	$100
D2393	Resin based-composite - three surfaces, posterior	$110
D2394	Resin based-composite - four or more surfaces, posterior	$130
D2740	Leucite-reinforced pressed crown/Empress	$700
D2750	Cosmetic crown-porcelain fused to predominately base/noble/ high noble crown	$500
D2962	Labial veneer/porcelain laminate	$450
D5110	Comfort Flex (complete upper denture) acetyle resin homopolymer	$650
D5120	Comfort Flex (complete lower denture) acetyle resin homopolymer	$650
D5211	Comfort Flex (upper partial denture) acetyle resin homopolymer	$725
D5212	Comfort Flex (lower partial denture) acetyle resin homopolymer	$725
D9972	External bleaching - per arch	$125

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** Procedure codes with asterisks (**) apply to pregnant members

Exclusions and Limitations

Exclusions
Listed below are those services or expenses NOT covered under the plans that become the responsibility of the member at the dentist's Usual and Customary fee.

1. Services not listed on the Schedule of Benefits.
2. Services provided by a non-participating provider without prior approval, except in emergencies.
3. Services related to any injury or illness covered under Workers' Compensation, occupational disease or similar laws.
4. Services provided or paid through a federal or state government agency or authority, political subdivision or public program other than Medicaid.
5. Services relating to injuries which are intentionally self-inflicted.
6. Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared act of war.
7. Cosmetic dentistry unless specifically listed as a covered benefit.
8. Prescription drugs.
9. Procedures, appliances or restorations if the purpose is to, a) change vertical dimension, or b) diagnose or treat abnormal conditions of the temporomandibular joint.
10. The completion of crown and bridge, dentures, root canal treatment, and orthodontics already in progress on the date the member becomes eligible under the plan.
11. Services associated with the placement or prosthodontic restoration of a dental implant.
12. Services considered to be unnecessary or experimental in nature.
13. Procedures or appliances for minor tooth guidance or to control harmful habits.
14. Hospitalization, including any associated incremental charges for dental services performed in a hospital.
15. Services to the extent the member is compensated for them under any group medical plan, no fault insurance policy or insured.
16. Crowns and bridges used solely for splinting.
17. Resin bonded retainers and associated pontics.

Orthodontic Benefit Limitations & Exclusions

1. Orthodontic benefits are available only at Participating Orthodontic offices.
2. If the Member relocates to an area and is unable to receive treatment with the original Participating Orthodontist, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Fee of the orthodontist where the treatment is completed.
3. Covered treatment cannot be transferred by the Member from one Participating Orthodontist to another Participating Orthodontist.
4. No benefit will be paid for an orthodontic treatment program that began before the Member enrolled in the Orthodontic Plan.
5. If the Member becomes ineligible during the course of treatment, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Fees incurred for the entire remaining balance of treatment.

6. Orthognathic surgery cases and cases involving cleft palate, micrognathia, macroglossia, hormonal imbalances, temporomandibular joint disorders (T.M.J.), or myofunctional therapy are excluded.
7. Re-treatment of orthodontic cases, changes in treatment necessitated by an accident of any kind, and treatment due to neglect or non-cooperation are excluded.
8. The following are not included in the orthodontic benefits and the orthodontist's Usual and Customary charges apply:
    - Lingual or clear brackets
    - Replacement of lost or broken appliances, bands, brackets or orthodontic retainers.

If there are any conflicts in the provisions of the Evidence of Coverage and this Schedule of Benefits, the provisions of the Evidence of Coverage shall govern.

Health Net Dental DHMO plans are provided by Dental Benefit Providers of California, Inc. ("DBP"). Obligations of DBP are not the obligations of or guaranteed by Health Net of California or its affiliates.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact customer service at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact customer service at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the customer service representative can provide you with the address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after Dental Services have been received.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require notification or benefit confirmation prior to receiving Dental Services.

How to Request an Appeal

If you disagree with either a pre-service request for benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and id number from the ID card

  The date(s) of Dental Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Dental Provider with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, dental experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge (and sufficiently in advance of the due date of the response to the adverse benefit determination).

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for benefits, see *Urgent Appeals that Require Immediate Action below.*

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for benefits as identified above, the appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for benefits.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending Dental Service is necessary or appropriate. That decision is between you and your Dental Provider.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The urgent appeal process applies only to pre-service requests.

Important Notice

Should a dispute concerning a claim or appeal arise, contact us at the phone number below. If the dispute is not resolved, contact the California Department of Insurance..

Call us at 1-800-445-9090..

Call the California Department of Insurance at:

- [1-800-927 HELP (1-800-927-4357)] if you reside in the State of California.
- [213-897-8921] if you reside outside of the State of California.
- You may contact the California Department of Insurance at:

  California Department of Insurance

  Claims Services Bureau, 11th Floor

  300 South Spring Street

  Los Angeles, CA 90013

  http://www.insurance.ca.gov

  Important Notice - Network Provider Accessibility Complaints

If you have a complaint regarding your ability to access Covered Dental Services from a Network Dentist in a timely manner, call Customer Service at the telephone number shown on your ID card. If you would rather send your complaint to us in writing, the Customer Service representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance at the address above.

Important Notice - Directory of Network Providers

The current directory of Network Dental Providers is available online at [www.healthnet.com]. You may obtain a paper copy of the Network Dental Provider directory at no cost by contacting Customer Service at the telephone number shown on your ID card.

This amendment is subject to applicable terms and conditions of the Policy. All other provisions of the Policy remain unchanged.

DENTAL NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your dental plan website, such as www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

Health Net collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services,* if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - 1. HIV/AIDS;
    - 2. Mental health;
    - 3. Genetic tests;
    - 4. Alcohol and drug abuse;
    - 5. Sexually transmitted diseases and reproductive health information and
    - 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your dental plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your dental plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Dental Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on the back of your dental plan ID card or you may contact the Health Net *Customer Call Center* Representative at 1-800-445-9090 (TTY 711).
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

Health Net

Dental HIPAA - Privacy Unit

PO Box 30978

Salt Lake City, UT 84130

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.

We will not take any action against you for filing a complaint.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2017

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on the back of your dental plan ID card or contact the Health Net Customer Call Center at 1-800-445-9090 (TTY 711).

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers Health Net.

DENTAL PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2017

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- show the categories of health information that are subject to these more restrictive laws; and
- give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ and SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA

Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, NY, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration.*

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description.* The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA,* there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored,

in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor,* or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,* 200 Constitution Avenue, N.W., Washington,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your identification card, Monday through Friday, 7 a.m. to 10 p.m. CST.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Nondiscrimination Notice and Access to Communication Services

We do not exclude, deny Covered Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Services under, any of its Plans, whether carried out by Us directly or through a Network Group or any other entity with which we arrange to carry out Covered Services under any of its Plans.

Free services are available to help you communicate with us. Such as, letters in other languages, or in other formats like large print. Or, you can ask for an interpreter, at no charge. To ask for help, please call the toll-free number listed on your plan ID card.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your plan ID card, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

English

IMPORTANT LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: 1-800-445-9090 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

Spanish

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud al 1-800-445-9090 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

Chinese

重要語言資訊：

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：1-800-445-9090 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

Arabic

معلومات مهمة عن اللغة:

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنكَ الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: 1-800-445-9090 / TTY: 711. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

Armenian

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ 1-800-445-9090 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

Cambodian

ព័ត៌មានសំខាន់អំពីភាសា៖

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាកាបកប្រែ ដោយឥតគិតថ្លៃ។ **ព័ត៌មានដែលបានសុរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។** ដើម្បីទទួលជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ៖ 1-800-445-9090 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینهدریافت کنید. اطلاعات کتبی ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: به شماره 1-800-445-9090 /TTY: 711. تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

Hindi

भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते ह। आपको मुफ़्त में दभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती ह। कछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती ह। अपनी भाषा में सहायता प्राप्त करने के लिए, कपया अपने स्वास्थ्य प्लान को यहाँ कॉल कर: 1-800-445-9090 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO
Help Line को 1-888-466-2219 पर कॉल कर।

Hmong

COV NTAUB NTAWV LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: 1-800-445-9090 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO
Help Line ntawm tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ：

お客様には、以下権利があり、必要なサービスをご利用いただける可能性があります。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください。 1-800-445-9090 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean

중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. 1-800-445-9090 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀ ਹੇਠਾਂ ਦੱਤਿ ਅਧਕਿਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀ ਬਨਿਾ ਕਸਿ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਖਿਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸਾਵਾਂ ਵਚਿ ਬਨਿਾ ਕਸਿ ਖਰਚੇ ਦੇ ਮਲਿ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਰਿਪਾ ਕਰਕੇ ਆਪਣੀ ਸਹਿਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰ: 1-800-445-9090 / TTY: 711। ਜੇ ਤੁਹਾਨ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

Russian

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: 1-800-445-9090 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: 1-800-445-9090 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO
Help Line sa 1-888-466-2219.

Thai

ขอมลสาคญเกยวกบภาษา :

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : 1-800-445-9090 / สาหรบผมความบกพรองทางการฟง : 711 หากตองการความชวยเหลอเพมเตม โปรดโทรศพทถงศนยใหความชวยเหลอเกยวกบ HMO ทหมายเลขโทรศพท 1-888-466-2219

Vietnamese

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: 1-800-445-9090 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

Dental Benefit Providers of California, Inc.

Contract Amendment

As described in this Amendment, the Contract is modified to include the Timely Access to Care provision.

Covered health care services are provided and arranged in a timely manner appropriate for the nature of the Covered Person's condition consistent with good professional practice. Provider Networks, policies, procedures and quality assurance monitoring systems and processes are established and maintained to ensure compliance with clinical appropriateness standards.

All network and provider processes necessary to obtain covered dental care services, including but not limited to prior authorization processes, are completed in a manner that assures covered dental care services are provided to Covered Persons in a timely manner appropriate for the Covered Person's condition.

When it is necessary for a provider or a Covered Person to reschedule an appointment, the appointment will be promptly rescheduled in a manner that is:

i) Appropriate for the Covered Person's health care needs,

ii) Ensures continuity of care consistent with good professional practices; and

iii) Meets the California standards regarding the accessibility of provider services in a timely manner.

Interpreter services are coordinated with scheduled appointments for health care services in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards without imposing an undue delay on the scheduling of the appointment.

Contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in (C) below; and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

Telephone triage or screening services are provided in a timely manner appropriate for the insured's condition. During normal business hours, the waiting time for a Covered Person to speak by telephone with a customer service representative knowledgeable and competent regarding the Covered Person's questions and concerns will not exceed ten minutes.

This amendment is subject to applicable terms and conditions of the Contract. All other provisions of the Contract remain the same.

Dental Benefit Providers of California, Inc.