COMBINED
EVIDENCE OF COVERAGE AND DISCLOSURE FORM
ISSUED BY

NEWPORT DENTAL PLAN
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This combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage. The Agreement, Evidence of Coverage and Disclosure Form, along with the Benefit Schedule must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Agreement and/or Benefit Schedule is provided with this EOC and can be furnished upon request.

Newport Dental Plan, as well as any solicitors and /or representatives of Newport Dental Plan, must provide a prospective plan member with a properly completed Combined Evidence of Coverage and Disclosure Form when presenting any plan contract for sale.

An applicant has the right to preview this Evidence of Coverage and Disclosure Form prior to enrollment.

Plan Benefit comparisons for both individual and group plans may be found on the last pages of this Combined Evidence of Coverage and Disclosure Form.

An applicant may contact the Plan at the above listed telephone numbers to receive additional information regarding the benefits of the plan they are evaluating.

This Evidence of Coverage and Disclosure Form should be read carefully and completely. If an enrollee has specific health care needs, they should read carefully those sections that apply to their situation.

Enrollees and provider in need of a language interpreter need only call the Plan and the Plan will coordinate this service for you. Please call 1-800-497-6453.

Miembros y proveedores con la necesidad de un interprete solamente necesitan llamar al Departamento de Plan y este coordinara este servicio para usted. Favor de llamar al 1-800-497-6453.

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I. DEFINITIONS

A. "AESTHETIC DENTISTRY" means any dental procedures that are performed purely for cosmetic purposes.

B. "AGREEMENT" OR "SUBSCRIBER AGREEMENT" OR “GROUP AGREEMENT” means the contract between the individual or employer group (Organization) and Newport Dental Plan. The completed enrollment form and Benefits Schedule under which the Member is enrolled, along with this Evidence of Coverage and Disclosure Form, constitutes the entire Agreement between and individual subscriber and the Plan. The Group Contract, Evidence of Coverage and Disclosure Form, Benefits Schedule and any amendments constitute the Agreement between a Group or Organization and the Plan.

C. “APPOINTMENT WAITING TIME” means the time from the initial request for health care services by an enrollee or the enrollee’s treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the Plan or completing any other condition or requirement of the plan or its network providers.

D. "BENEFITS AND COVERAGE" OR “COVERED DENTAL SERVICES” means the health care services available as listed as covered services in Section V and the Summary Benefit Schedule which are necessary for the dental health of the enrollee according to professionally recognized standards of practice.

E. "BENEFIT SCHEDULE" OR "SCHEDULE OF COPAYMENTS" Means the list of benefits specifically covered under each plan denoting the copayments required by the Member.

F. “CAPITATION” means a monthly or annual periodic payment based on a fixed or predetermined basis that is paid to the Professional Provider.

G. "COBRA" refers to the laws which allow members to continue group health coverage under certain circumstances where coverage would otherwise terminate. The Federal law pertaining to this coverage is the Consolidated Omnibus Budget Reconciliation Act of 1985, and related amendments (COBRA). COBRA applies to employers with twenty (20) eligible employees. The California state law is the California Continuation Benefits Replacement Act (Cal-COBRA). Cal-COBRA applies to California small employers with fewer than (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same, however some differences do exist as explained in Section XVII.

H. “CONTRACT FEE” refers to the fees agreed upon by a provider and Newport Dental Plan.

I. "COPAYMENT" or “CHARGES” means a specified dollar amount or percentage required to be paid by or on behalf of a Member in connection with benefits, if any, as set forth in the Benefits Schedule.

J. "DENTAL NECESSITY" means services that are appropriate and consistent with a diagnosis in accordance with professionally recognized standards of practice.

K. “DEPENDENT" shall mean the spouse, domestic partner, and children of a SUBSCRIBER or non-custodial parent, as defined herein under the Section entitled "Eligibility for Dental Coverage".

L. “ELECTIVE DENTISTRY" means any dental procedures, which are unnecessary to the dental health of the patient, as determined by the Professional Provider or Newport Dental Plan.

M. "ELIGIBLE PARTICIPANTS" shall mean employees, members, dependents or beneficiaries who are eligible to participate in the Plan under the eligibility requirement set forth by Organization and/or Newport Dental Plan and as enrolled during the appropriate enrollment period and for which premiums have been received by Newport Dental Plan.

N. “EMERGENCY DENTAL SERVICES" means service required for immediate alleviation of severe pain or bleeding associated with dental problems and/or immediate diagnosis and treatment of dental conditions which a reasonable person under the circumstances believes if not given immediate attention, may lead to disability, dysfunction or death. Emergency dental services are a covered benefit.

O. “EMERGENCY MEDICAL SERVICES” means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other Health Professionals, to determine if an emergency medical condition, psychiatric emergency medical condition, and/or active labor exists. If such conditions are determined to exist, the care and treatment to relieve or eliminate the emergency medical or psychiatric condition is not a covered benefit. This Plan does not provide emergency medical services and members are encouraged to **CALL 911** to access the emergency response system when a medical emergency requires an emergency response.

P. “EXCLUSION" means any provision of this Agreement whereby coverage for a specified hazard or condition is not covered by Newport Dental Plan nor the Professional Provider.

Q. “FRAUD” is a deception or misrepresentation with the knowledge that the deception or misrepresentation could result in some unauthorized benefit or payment. A false or fictitious claim may include, or be supported by false or fictitious statements.

R. "GENERAL PRACTITIONER" means a dentist who practices general dentistry and who does not hold himself out to be a specialist in a particular field of dentistry.

S. "LIMITATION" means any provision other than an Exclusion which restricts coverage under the Agreement.

T. "MEMBER" shall mean any Subscriber or Dependent who is enrolled (Enrollee) under the Agreement and entitled to the benefits available under the Agreement in return for the payment required to be made to Newport Dental Plan under such Agreement.

U. “OUT OF NETWORK PROVIDER” is a licensed professional not under contract with the Plan.

V. "ORGANIZATION or GROUP" shall mean the employer, trust fund, or association who has contracted with Newport Dental Plan to provide the benefits and coverages outlined herein.

W. "PLAN" is the Newport Dental Plan and shall include those benefits, coverages and other charges as set forth herein and in the Benefits Schedule under which the Member is enrolled.

X. "PREPAYMENT FEE or PREPAID PREMIUM" is the amount payable periodically on a prepayment basis by a Subscriber or the Organization (or both) to obtain benefits provided under the Agreement.

Y. "PREVAILING RATES OR UCR" are the Usual, Customary and Reasonable charges which dental providers usually or normally charge a majority of their patients for a particular service. A copy of such charges is to be kept at the Professional Provider's Office.

Z. "PREVENTIVE CARE" means health care provided for the prevention and early detection of disease, illness or injury, or another health condition.

AA. "PROFESSIONAL PROVIDER", "PARTICIPATING PROFESSIONAL PROVIDER", OR "PRIMARY CARE DENTIST" shall mean the dentist who is licensed by the State of California and who is contracted with Newport Dental Plan as a general practitioner, and/or a specialist to render services to Members in accordance with the provisions of the Newport Dental Plan Agreement under which a member is enrolled. Newport Dental Plan may contract with dental colleges to provide or arrange for the provision of dental care to enrollees of the Plan through the practice of dentistry or dental hygiene, operating under specified sections of the Business and Professions Code, or by bona fide clinicians or instructors operating under specified provisions of the Business and Professions Code. The names, locations, hours, or services and other information regarding the Plan's Provider facilities may be obtained by contacting the Plan office or the individual Professional Provider.

BB. "SENSITIVE SERVICES" means all health care services related to mental or behavioral health, sexual or reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

CC. "SPECIALIST" means a Dentist who is responsible for the specific specialized dental care of a Member in one specific field of dentistry such as pedodontics, endodontics, periodontics, oral surgery or orthodontics where the member is referred by Newport Dental Plan.

DD. "SUBSCRIBER" is the person who has entered into an Agreement and who is responsible for payment to Newport Dental Plan or whose employment or other status, except for family dependency, is the basis for eligibility in Plan.

EE. "TREATMENT IN PROGRESS" is any treatment, as identified by a specific ADA code, which has been started but not completed.

FF. "URGENT CARE" means health care for a condition that requires prompt attention.

II. COMMENCEMENT DATE

Coverage for Group Members shall commence on the date as specified in the Group Contract or Agreement for all Members enrolled in the Plan. Any applicable waiting period is as specified in the Agreement. If a contract start date is not specified, or there is no Group Contract, the coverage shall commence the first month after the payment and enrollment forms are received.

III. IDENTIFICATION CARD

In addition to the Evidence of Coverage and Disclosure Form and Benefits Schedule (Schedule of Copayments) Newport Dental Plan issues each Member an Identification Card to be presented at the time that services are to be rendered by the Professional Provider.

IV. ELIGIBILITY FOR DENTAL COVERAGE

A. **Eligibility**-Eligibility to participate in the Plan is determined by the Agreement between the group or individual. Any disputes or inquiries regarding eligibility, including rights regarding renewal, reinstatement and the like, if any, should be directed to Newport Dental Plan.

B. **Dependents**-Dependents may be enrolled in the Dental Plan at the time you enroll, during open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, or placement. The following provisions apply to Dependents who are enrolled in a Newport Dental Plan:

1. Dependents include all newborn infants whose coverage shall commence from the moment of birth, and all adopted, foster and step children whose coverage shall commence from the date of placement.

2. Dependents include all children under the age of 26 years who are dependent upon the Member for their support. Eligibility will be extended for children who are dependents. No one over the age of 26 years may be considered a dependent, except in special circumstances involving physical or mental handicaps.

3. Coverage shall not terminate while a Dependent child is and continues to be:

(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; AND
(b) Chiefly dependent upon the Member for support and maintenance, provided the Member furnished proof of such incapacity and dependency to Newport Dental Plan within 31 days of the dependent attaining the limiting age as set forth above and every two (2) years thereafter.

4. No person shall be eligible as a Dependent who is eligible as a Subscriber, nor may any person be an eligible Dependent of more than one Subscriber.

V. BENEFITS, LIMITATIONS AND EXCLUSIONS

The information below outlines your coverage and is intended to help you understand your Dental Plan. Included is information about covered services, services which are not covered and how much

services will cost you. If you have any questions about Newport Dental Plan, you can direct those to a Member Services Representative at the toll free number listed in the front of this document. They can help explain your benefits or matters relating to your dental office. For assistance with transfers, specialty referrals, eligibility, emergencies, charges, benefits schedules, ID cards, location of providers, termination or continuation coverage, then please call Member Services. If you have questions about your treatment we can arrange for a consultation or second opinion and respond to a complaint or grievance.

A. BENEFITS SCHEDULE

The benefits schedule, in conjunction with this Document, establishes the dental care services that are available without charge (designated as "No Charge" in the schedule), and those services for which Members are obligated to pay a copayment to the Professional Provider. Copayments are further explained in this EOC under the heading “Copayment and Other Charges”. The amount of the Copayment which the Professional Provider is permitted to charge for specific dental care services is specifically listed in the Benefits Schedule. Any procedures not listed in Section V of this EOC or the Summary Benefits Schedule are not Covered Services and if elected by the enrollee will be the enrollee’s financial responsibility.

IMPORTANT: If you opt to receive dental services that are not Covered Dental Services under this Plan, a Participating Professional 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 Covered Dental Services, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Member Services at 1-800-497-6453 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document and Benefit Schedule.

Listed below under the heading “Benefits and Coverage” is a description of each category of Covered Services that are set forth in the Benefits Schedule. Included below each description is important information regarding Limitations and/or Exclusions specific to each category of services which must be referenced to fully understand the coverage. The Benefits Schedule lists the Covered Services in the corresponding descriptive categories for ease of referencing the corresponding copayments. Additional Exclusions and Limitations are set forth in the “General Exclusions and Limitations” Sections of this Evidence of Coverage Booklet, which must also be consulted to determine the extent of Covered Services.

B. BENEFITS AND COVERAGE

NEWPORT DENTAL PLAN agrees to provide coverage to eligible Members as set forth in the Benefits Schedule under which the Member is enrolled, and as provided by a Practitioner contracted as a Primary Care Dentist.

DIAGNOSTIC – Clinical examinations, radiographs or x-rays, and other diagnostic tools used in conjunction with the Member’s health history in order to evaluate necessary dental treatment at the initial visit. Clinical examinations may include the following:

1. Comprehensive Oral Evaluation – A comprehensive evaluation of a Member’s dental health needs. This includes evaluating and recording a Member’s dental and medical history and a general health assessment, including such things as dental caries, missing or un-erupted teeth, restorations, occlusal relationship, periodontal

conditions (including periodontal charting), hard and soft tissue anomalies and oral cancer screening.

2. Periodic Oral Evaluation – An evaluation performed to determine any changes in a Member's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures.

3. Radiographs (x-rays)/Diagnostic Imaging – Radiographs are primarily for clinical purposes; they represent an important diagnostic aide. A radiographic exam is a combination of periapical, bitewing, panoramic films or other views selected for a Member based on need. The number and type of radiographs in any examination will vary according to the needs of the Member. Originals x-rays should be retained by the dentist and should not be used to fulfill requests made by patients or third parties for copies of records.

   Limitation: X-rays should be taken according to the frequency as recommended by the FDA , unless additional X-rays are determined by the treating Participating Provider to be necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

4. Pulp Vitality Test – Assessment of vitality of the pulp tissue which occupies the pulp cavity of the tooth.

PREVENTIVE – Those procedures that aid in the prevention of dental and oral disease. These may include the following:

1. Prophylaxis Adult and Child – These cleanings include scaling and polishing procedures to remove coronal plaque, calculus and stains above the gum line. It is not intended to be treatment for active periodontal disease where subgingival (beneath the gum line) scaling and root planing is usually required.

   Limitation: Prophylaxis cleanings are covered once every six months at Benefit Plan Copayments, unless additional cleanings are necessary for the dental health of a Member in accordance with professionally recognized standards of dental practice.

2. Topical Fluoride Treatment – Application of topical fluoride to aid in the prevention of caries formation.

   Limitation: Topical Fluoride Treatments are limited to one treatment in a 12 consecutive month period for all Members, unless the treating Participating Provider determines additional topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

3. Oral Hygiene Instruction – Instructions for home care. Examples include tooth brushing technique, flossing, and use of special oral hygiene aids.

   Exclusion: The Benefit Plan does not cover supplies used for oral hygiene and plaque control, such as dental floss, toothbrushes, tongue scrapers, fluoride products, toothpaste, mouth rinse, disclosing agents, and interproximal brushes.

5. Sealants – The application of sealants to pit and fissure areas as a measure in the prevention of caries.

6. Space Maintenance – passive appliances designed to prevent tooth movement.

RESTORATIVE – Those procedures used to repair and restore the natural teeth to healthy condition.

1. Amalgam and Resin-Based Composite Restorations – Those procedures that include amalgam or resin-based composite restorative material used to repair and restore the natural teeth to healthy condition.

   Limitation: Resin-based composite restorations on posterior teeth, unless specifically listed as a Covered Service of your Benefit Plan, are considered purely cosmetic dentistry, and as such, are not covered.

2. Crowns **–** Single Restoration Only – Those procedures that include predominantly base metal and porcelain fused to predominantly base metal in covering the tooth are the covered benefit. The definition of predominantly base metal is an alloy which is less than 25% gold, palladium or platinum.

   Exclusions:

   a) Crowns that are elective or needed for purely cosmetic reasons are not covered.
   b) Crowns that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered.
   c) Implant supported crowns and abutment supported crowns on a dental implant are not a Covered Service.
   d) Porcelain, composite or acrylic restorations on posterior teeth, are considered purely cosmetic dentistry, and are not covered unless specifically listed as a Covered Service in your Benefits Schedule. If the Member elects to receive a porcelain, composite or acrylic crown restoration that is not a Covered Service, the Member must pay the Participating Provider's charges that exceed a similar predominantly base metal crown.
   e) Precious and semi-precious metal crowns are not covered unless specifically listed as a Covered Service in your Benefits Schedule. If the Member elects to receive a precious or semi-precious metal crown that is not a Covered Service, the Member must pay the Participating Provider's charges that exceed the Copayment for a similar predominantly base metal crown.

   Limitations:

   a) Crowns are not covered when a filling can adequately restore the dental health of a Member in accordance with professionally recognized standards of dental practice.

3. Other Restorative Services –

   a) Recementation of crowns – Use of adhesive material to reattach a crown that is dislodged.
   b) Prefabricated Stainless Steel and Resin Crowns
   c) Sedative filling – Temporary restoration intended to relieve pain.

d) Prefabricated Post and Core– Material placed within the root canal or in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.

Limitation: Posts or pins are not covered except where insufficient coronal structure remains to retain a restoration according professionally recognized standards of practice. Posts and pins are covered if necessary for the dental health of the enrollee.

ENDODONTICS – Those procedures that involve treatment of the pulp, root canal and roots.

1. Pulp Capping – Procedure in which the exposed or nearly exposed pulp is covered with a protective dressing that protects the pulp and promotes healing and repair.
2. Therapeutic Pulpotomy – Removal of a portion of the pulp to maintain the vitality of the remaining portion by means of a protective dressing.
3. Root Canal Therapy – The treatment of diseases and injuries of the pulp and placement of the root canal filling.
4. Apicoectomy – A surgical procedure to remove the apex of the tooth.

Limitation: Apicoectomies are a covered benefit for the six anterior teeth or canine to canine.

PERIODONTICS– Those procedures that involve the treatment of the gum and bone supporting the teeth and the management of gingivitis and periodontal disease known as gum disease.

Periodontal Services-Non-surgical.

a) Scaling and Root Planing - Instrumentation of the crown and root surface of the teeth to remove plaque, calculus or tartar, and contaminated connective tissue and to smooth the root surface of the teeth.

Limitation: Subgingival Scaling and Root Planing is covered once every six months, unless necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

b) Full Mouth Debridement – Removal of plaque and calculus that obstruct the ability to perform an evaluation.

Exclusions: All Surgical Periodontal Services, including those listed below that are not specifically identified in the Benefits Schedule, are not covered.

a) Gingivectomy – Removal of part of the gingival margin resulting in exposure of more tooth structure.
b) Crown Lengthening – Surgical procedure involving the removal of gingiva and supporting bone to expose more tooth structure in preparation for a crown procedure.
c) Osseous Surgery – Surgical procedure involving the reshaping of the bone to achieve a more healthy and physiologic status.
d) Bone Grafts – Use of various forms of graft to stimulate bone formation.

e) Soft Tissue Graft – Use of gingiva as a graft to repair a gingival defect or an exposed root.

PROSTHODONTICS, REMOVABLE– Replacement of lost teeth by a removable prosthesis and the maintenance of those appliances.

1. Complete and Partial Dentures – Full or partial dentures are a Covered Service when dentures are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

   Exclusions:

   a) Lost, stolen, or damaged appliances, due to Member abuse are not covered.
   b) Enhancements for dentures such as copings for over dentures, specialized connectors used for retention to retained roots, precious metals, or porcelain teeth are not covered benefits.
   c) Dentures to change the vertical dimension which is the separation of the jaws.
   d) Implant supported prostheses are not a covered benefit.
   e) Overdentures, which are dentures that overlay a retained tooth root or dental implant, are not a covered benefit.

   Limitations: Replacement of an existing appliance will be covered if the existing appliance cannot be made serviceable consistent with professionally recognized standards of dental practice.

2. Repairs to Existing Dentures – Repairs are a covered benefit when required because of the loss of natural teeth, the replacement of missing or broken denture teeth and/or breakage to the denture base.

   Limitation: Repair of appliances damaged due to Member abuse is not covered.

3. Relines and Rebase – The process of refitting a denture by resurfacing the tissue side of the denture, or by replacing the base material of the denture. Relining and rebasing existing dentures are covered benefits.

   Limitation: Relines of full or partial dentures are limited to twice per calendar year, unless the treating Participating Provider determines that additional relines are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

4. Interim Prosthesis – A provisional prosthesis designed for use over a limited period of time, after which it will be replaced by a more definitive restoration. Interim dentures are a benefit as replacement for extracted teeth during healing for adult patients when the teeth can not be added to an existing partial denture.

PROSTHODONTICS, FIXED OR FIXED PARTIAL DENTURES (Bridge or Bridgework)**–** Replacement of lost teeth with a fixed prosthesis made up of crowns cemented on natural teeth and pontics to replace missing teeth are a covered benefit.

1. Fixed Partial Denture Pontics (an artificial tooth on the Fixed Partial Denture) and Abutment Crowns (an artificial crown made to support a Fixed Partial Denture, and which is attached to the Fixed Partial Denture Pontic via a retainer commonly referred to as a bridge) used in the fabrication process of Fixed Partial Dentures are Covered Services. Those procedures that include predominantly base metal and porcelain fused to predominantly base metal in covering the tooth are the covered benefit. The CDT-4 definition of predominantly base metal is an alloy which is less than 25% gold, palladium or platinum.

   Exclusions:

   a) Bridges to change the vertical dimension, which is the separation of the jaws, are not covered.
   b) Distal extension posterior cantilever pontics which are supported at one end only are not covered.
   c) Implant supported prostheses are not covered.
   d) Prosthesis for purely cosmetic reasons are not covered.
   e) Precious metal or full porcelain Fixed Partial Dentures are not covered unless specifically listed as a Covered Service in your Benefits Schedule. If the Member elects to receive a precious metal or full porcelain Fixed Partial Denture when it is not a Covered Service, then the Member must pay the Participating Provider's charges that exceed the copayment for a predominantly base metal Fixed Partial denture.
   f) Stress Breaker or non-rigid connector between the abutment and the pontic is not covered unless specifically listed in the Benefits Schedule.

2. Fixed Partial Denture Services (bridges) –

   a) Recementation of Fixed Partial Dentures – Use of adhesive material to reattach a Bridge that is dislodged.

ORAL SURGERY – Those procedures that involve the extraction of teeth and other surgical procedures.

1. Extractions – Removal of teeth or parts of teeth.
2. Alveoplasty in Conjunction with Extractions-per quadrant -The process of reshaping the bone during extractions according to professionally recognized standards of care.
3. Alveoplasty Not in Conjunction with Extractions-per quadrant -The process of reshaping the bone usually in preparation of a prosthesis.
4. Frenectomy or Frenulectomy - The process of elimination of muscle fibers attaching the cheek, lips, and tongue to associated dental mucosa.
5. Incision and Drainage (I&D) - The process of drainage of an abscess through an incision.

   Limitations: Extractions are a covered benefit when the procedure is performed to remove teeth that are diseased or otherwise unrestorable consistent with professionally recognized standard of dental practice.

   Exclusions: The following Oral Surgery procedures are excluded as Covered Services as is any procedure not specifically listed in the Benefits Schedule.

a) Biopsy – The process of removing tissue for histologic evaluation.
b) Removal of Tori and Exostosis – The process of removal of overgrown bony protuberances.
c) Excision of Hyperplastic Tissue – The process of removing overgrown soft tissue from the oral cavity.

ORTHODONTICS – The purpose of the Plan's orthodontic benefit is to cover basic Orthodontic treatment, aimed at resolving malocclusion, and may involve the transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan.

The following Orthodontic treatments are covered for the Copayments set forth in the Benefits Schedule, subject to the orthodontic Exclusions and Limitations described in this Section:

Comprehensive Orthodontic Treatment: The goal of the comprehensive orthodontic treatment is improvement of the alignment of the teeth, establishment of optimal occlusion, and improvement of functional and esthetic relationships of teeth and jaw. Comprehensive Orthodontic treatment is a benefit for treatment of all ages. Treatment plans, initial records and retention are included in the costs of Comprehensive and Interceptive Orthodontic treatment. Retention includes all treatment needed six months after debanding.

1. Orthodontic Copayments-Patient charges for orthodontic care are based upon 24 months of comprehensive and/or interceptive treatment. Treatment diagnosed in excess of 24 months must be based upon the training and expertise of the orthodontist and documented in writing with the reason, and signed by the Member or responsible party prior to banding. Treatment in excess of 24 months (extended treatment) will be calculated at 1/24th the charges of a standard two-year case and are not payable until after 24 months of treatment. In cases where documented non compliance results in extended treatment beyond that established at the initial diagnosis, then the patient will be responsible for a monthly fee of 1/24th the charges for a two year case.

   The charge for Comprehensive and/or Interceptive Treatment is based upon the charge for such services at the time of your visit for Treatment Plan and Records, but such treatment must be initiated within 90 days or a later change in patient charges may apply. Orthodontic treatment commenced before the Member enrolled in this Benefit Plan is covered at a participating provider at the copayment as described in the Benefits Schedule.

2. Orthodontic Treatment After Termination-If a Member is terminated for any reason and is receiving any orthodontic treatment at the time of termination, the Member and not the Plan will be responsible for payment of any balances due and/or any copayments due to the professional provider to continue treatment. The copayment will be the maximum amount payable by the Member unless the treatment extends beyond the normal 24 month period, and charges for extended treatment were not included in the Member's original estimate.

   If the Member relocates to an area outside the geographic area served by Newport Dental Plan and is unable to receive treatment from a participating Orthodontist, coverage under this program will cease and it will become the obligation of the Member to pay the Usual and Customary Fee of the Orthodontist where treatment is completed.

Interceptive Orthodontic Treatment: The goal of interceptive orthodontic treatment is to intervene in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require future comprehensive treatment.

Exclusions: The following services are not included in the Limited Orthodontic Treatment or Comprehensive Orthodontic Treatment Copayments, and they are not Covered Services unless specifically identified in the Benefits Schedule.

a) Services Required Because of Non-Cooperation – Additional services required because Member's cooperation does not meet the minimum level necessary to complete the treatment on time, or is damaging to the teeth, are not included in the Limited, Interceptive or Comprehensive Orthodontic Treatment Copayments. (See Orthodontic Copayments above for additional charges for extended treatment due to documented non-compliance).
b) Costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
c) Adjunctive services which are not typically included in orthodontic treatment such as, maxillofacial surgery, nasopharyngeal surgery, cleft palate surgery, myofunctional or speech therapy, TMJ therapy and restorative or periodontal care unless specifically listed in the benefits schedule.

GENERAL SUMMARY OF EXCLUSIONS-Limitations and exclusions are explained for each specific category of dental services under the heading "V. Benefits, Limitations and Exclusions" in this EOC. Several general exclusions which are applicable to all covered services should be understood to completely understand the covered services under your benefits schedule.

Exclusions:

1. Any procedure not specifically listed as a covered benefit
2. Procedures that are purely of a cosmetic or elective nature
3. Procedures started after termination of eligibility
4 Treatment by a non-plan dentist except for emergency treatment as provided in Section V.E or treatment which has been authorized by the Plan.
5. Supplies used for dietary counseling, oral hygiene, plaque control, or chemical analysis.
6. Charges for medical treatment, prescriptions or other related charges incurred (even if related to dental conditions) and all services performed by someone other than a licensed dentist, hygienist, x-ray technician or dental lab personnel performing under the supervision of a licensed dentist.
7. General anesthesia including intravenous (I.V.) and inhalation sedation unless specifically listed as a benefit or determined to be of Dental Necessity (see definition Sec I.).
8. Treatment of disturbances of the Temporomandibular Joint (T.M.J.) unless specifically listed as a benefit or determined to be of Dental Necessity.

SPECIALTY CARE- Your general dentist has primary responsibility for your professional dental care. Specialty care is available to Members in the following general categories

subject to the exclusions and limitations as described in this EOC for the same procedures as performed by a general dentist.

Endodontics-Root canal treatment
Periodontics-Treatment of the gums and bone
Oral Surgery-Complex extractions and surgical procedures
Orthodontics-Braces or tooth straightening
Pedodontics-Children's dentistry

Newport Dental operates a specialty referral system to ensure appropriate specialty care is provided to Plan Members. Newport Dental has specific guidelines and procedures to process and authorize payment for specialty referrals. There are no financial penalties to the general dentist for specialty services that are authorized. The Plan has no desire to influence the diagnosis or treatment plan of a treating dentist, and the primary care dentist has the responsible to provide a range of services in accordance with covered benefits under the contract and the standards of generally accepted dental practice. Dentists are expected to follow the May 1992 General Guidelines for Referring Dental Patients as published by the ADA Council on Dental Practice. It is the policy of the Plan to track utilization, verify eligibility, and determine covered benefits for all Specialty Referrals submitted by contracted providers. The Specialty Referral Guidelines are published in the Provider Manual and conform to current medical and scientific information, which assures that medically necessary specialty services are being provided according to professionally, recognized standards of practice. The Specialty Referral criteria will be formally reviewed and updated, if necessary, on an annual basis by the Quality Assurance Committee. The primary care dentist is responsible for communicating the proposed treatment plan and the dental benefits to the Member during the examination.

General dentists who identify the need for more complex dental procedures other than can be provided by a general dentist must fill out a Specialty Referral/Second Opinion Form. The general dentist must provide all the necessary patient information, types of services required and necessary x-rays. The referral form has four copies. The appropriate copy is intended for each of the following: the specialist, the patient record in the general dentists' office, the patient, and the Plan. Members, who choose to see a specialist without a referral, may contact a Provider Relations Department Representative who will complete the form to facilitate a consultation with a specialist. Members will be financially responsible for specialty care if the enrollee fails to obtain the Plan's prior authorization

Specialty referrals for emergency or urgent situations where the enrollee faces an imminent or serious threat to his or her health do not require prior authorization, and verbal approval can be obtained by calling the Plan. These will be approved or denied on the day requested if possible, but always within 72 hours after the Plan receives information to reasonably make the determination.

A complete copy of the Specialty Referral Policy or Specialty Referral Guidelines is available upon request from Member Services at the 800 number and address listed on the first page of this EOC.

SPECIALTY REFERRALS AND UTILIZATION REVIEW- Decisions to approve modify or deny requests for authorization prior to or concurrent with treatment shall be

communicated to the requesting provider within 24 hours of the decision and to the Member within two business days. All communication regarding requests made prior to, retrospectively or concurrent with treatment shall indicate the specific services approved. Any decisions to deny, delay or modify services shall be based only upon coverage determinations and will be communicated to providers by phone or fax and to Members in writing.

If the authorization for payment is denied, the Plan will inform the parties of their right to file a grievance with the Plan. The grievance will be reviewed, and a response will be provided within 30 days of the request for non-urgent situations and 72 hours for urgent situations or in a timely fashion appropriate for the nature of the enrollee's condition. Processed claims will be paid within 30 working days of receipt by the Plan, or the Plan will be subject to a charge of 15% per annum whether or not the claim is contested. If the Plan fails to automatically pay interest, then the Plan will pay a $10.00 charge in addition to the interest, starting with the first calendar day after the 30-day period. The Plan does not delegate utilization management to contracted dentists.

Procedures may be prescribed, ordered or recommended by a provider, but this does not, in itself, determine Dental Necessity. Newport Dental Plan may limit or exclude procedures that are not of Dental Necessity as defined in the Definitions section of this document. The member can seek a second opinion or have such a determination reviewed through the grievance system. See Section G below for Second Opinions and refer to Section XV for the Grievance Procedures.

C. COPAYMENTS AND OTHER CHARGES

In addition to the monthly premium, Members will pay an additional charge for those procedures listed in the "Copayment Schedule or Benefit Schedule". All copayments are paid directly to the Professional Provider. Any copayment for a covered procedure provided by the treating or consulting provider for the diagnosis, consultation or treatment of a Member via telehealth will be the same as any copayment for a covered in-person service, and that coverage is not limited only to services delivered by select third-party corporate telehealth providers.

Any procedure not listed in the Benefits Schedule if elected is the financial responsibility of the Member

D. CONTINUITY OF CARE FOR NEW AND EXISTING MEMBERS

1. Continuation of Services with Terminated or Nonparticipating Provider

Upon request of a current or newly covered enrollee, Plan must provide for the completion of covered services for treatment of certain specified conditions if (a) the services were being provided by a terminated provider at the time of termination of the provider's contract, or (b) the covered services were being provided by a nonparticipating provider to a newly covered enrollee at the time his or her coverage became effective. Enrollees are entitled to continuation of services from such providers for the following circumstances and timeframes:

Acute Conditions: The duration of an acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or

other dental problem that requires prompt dental attention and that has a limited duration).

Newborn Children between Birth and Age 36 Months: Plan shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the provider's contract or 12 months from the effective date of coverage for a newly covered enrollee.

Surgery or Other Procedure: Performance of surgery or other procedure authorized by Plan as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current enrollees or 180 days from the effective date of coverage for newly covered enrollees.

The Plan is not required to provide benefits that are not otherwise covered under the terms and conditions of the subscriber contract. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

The Plan is not required to provide for completion of covered services by a provider whose contract has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in Section 805(a)(6) of the Business and Profession Code, or fraud or other criminal activity.

2. Enrollee Process to Request a Review Under this Policy

Information regarding how to request continuation of care will be provided to enrollees in the Plan's Evidence of Coverage, the new member packet given to new enrollees, and by written notice when the enrollee's provider is terminated. Enrollees may request continuation of care by calling Plan's Member Services Department at 1-800-497-6453 during normal business hours, or by sending a written request to the Plan. The Plan may obtain copies of the enrollee's medical record from the enrollee's provider in order to evaluate the request.

The Dental Director (or his/her designee) will determine if the enrollee is eligible for continuation of care under this policy and the California Knox-Keene Act. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

(a). Whether one of the circumstances described in paragraph D.1. above, exists;

(b). Whether the requested services are covered by Plan; and

(c). The potential clinical effect that a change of providers would have on the enrollee's treatment.

The Plan shall provide the enrollee with the Dental Director's decision in writing within 30 days of receipt of the enrollee's request for continuation of services. The written notice shall inform the enrollee how to file a grievance in the event the enrollee is dissatisfied with the decision.

In order to facilitate the continuity of care, all enrollees are encouraged to select a contracted dental provider at the time of initial enrollment and upon termination of a contracted provider. If an enrollee does not select a contracted dental provider within 30 days, Plan will assign the enrollee to a provider who is located within the geographic access standards established by the DMHC. The Plan will notify enrollee by sending new identification card with information of the new provider. If the assigned dental provider is not acceptable to the enrollee, the enrollee may request a transfer to another contracted dental provider.

3. Arrangements With Provider

Plan requires the terminated or nonparticipating provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Plan is not required to continue the services a provider is providing to an enrollee if the provider does not agree to comply or does not comply with these contractual terms and conditions.

Unless Plan and provider agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by Plan for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Plan is not required to continue the services a provider is providing to an enrollee if the provider does not accept the payment rates provided for in this paragraph.

4. Co-payments, Deductibles, or Other Enrollee Cost-Sharing

The amount of, and the requirement for payment of, co-payments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by Plan.

5. Notification to Existing Members of the Termination of Professional Providers.

If the Plan terminates a Participating Professional Provider, that provider is still obligated under his/her contract to complete such professional services which he/she has commenced, unless the Plan makes such reasonable and appropriate provisions for the assumption of such services by another contracting Professional Provider. The Plan shall notify Members that the Plan intends to terminate a Professional Provider sixty (60) days prior to the Professional Provider's termination. The Member shall have sixty (60) days to select a new Professional Provider from the options available to him/her from the listing of currently active Professional Providers. In the event the Member fails to select a new Professional Provider voluntarily, the Plan will assign the Member to a Professional Provider within close proximity to the Member's former Provider.

6. Return of Enrollee to Provider

If, after sending the notice to enrollees, the Plan reaches agreement with the provider to continue a contractual relationship, the Plan shall offer each affected enrollee, either

verbally or by written notice, the option to return to that provider. However, if the affected enrollee does not affirmatively exercise this option, the Plan must reassign the enrollee to another contracting provider. If an enrollee has already been reassigned to another contracting provider, the Plan must keep the enrollee with the new provider unless the enrollee specifically requests a return to his or her prior provider.

E. EMERGENCY DENTAL SERVICES

Emergency dental services are available to a Member, 24 hours a day, seven days a week. The Member should first contact their primary care dentist. The Plan also maintains an 800 emergency number to handle emergency and acute care needs if the Member's assigned provider is not available. The 800 number is listed on the first page of this EOC. The Plan will direct the Member to a provider to provide emergency services to control bleeding, infection or take care of the immediate relief of pain and to stabilize the condition. The Member normally returns to their assigned provider to assume regular dental treatment. The Plan's Member Services Department will coordinate with the Member to return to their former provider or select the new provider for continuity of care.

A Member requiring emergency services may have such emergency dental service rendered by any licensed dentist in the area where such emergency occurs. Newport Dental Plan will cover up to $50.00 per occurrence for the cost of emergency services rendered by the non-participating dentist. A non-participating dentist must submit a claim within one hundred eighty (180) days of the date of services. In the event a non-participating dentist refuses to submit claims, then the Member can submit for reimbursement directly from the Plan. The Member must within one hundred eighty (180) days from date of service, send a bill itemizing incurred services as a result of an emergency, less the applicable copayment, with evidence of payment, to Newport Dental Plan in order to receive reimbursement. The address for the Plan is on the first page of this EOC. There are no other claims forms to be submitted. The Plan will not cover the cost of services which do not meet the definition of emergency services as definition Section "I Definitions" of this EOC. The Plan will coordinate with the member to return to their former contracted provider who must continue treatment or the Member will be given the option to select a new contracted provider.

F. OTHER COVERAGE - In the case of a service which is reimbursable by insurance or covered under another group or health service Plan, the Professional Provider shall provide the services at the time of need; but the Member shall execute such documents necessary for the Professional Provider to be reimbursed for such services. Also See Section VI-Coordination of Benefits.

G. SECOND OPINION-The Plan allows any Member or Participating Provider that requests a second opinion to obtain such an opinion concerning treatment diagnosed or performed. The second opinion may be provided by a Newport Dental Plan Participating Provider or a Non Participating Provider selected by the member. The Plan will not deny a request for a second opinion, and the benefit will be paid at 50% of the provider's UCR fee for a Non-Participating Provider and Plan copayments for a Participating Provider. Second opinions are coordinated by the Provider Relations Department, and second opinions will be computer tracked as a category of specialty referrals. The Provider Relations Department will provide the patient a copy of the Second Opinion Referral form following receipt of the request within one working day. For emergency or urgent situations, the Plan may be called for verbal approval. The form will notify the patient of a Participating Provider willing to perform a second opinion or

provide authorization to access a Non-Participating Provider selected by the Member. The provider will be an “appropriately qualified health care professional” who is a general dentist or specialist acting within the scope of his/her practice. The completed referral form is taken to the provider as authorization for the service. If the second opinion is completed and the matter is not resolved to the patient’s satisfaction, then the matter will be reviewed by the Dental Director. Otherwise, the Provider Relations Representative will coordinate the return of the patient to their original provider or arrange for a transfer to another provider upon request.

H. WORKER'S COMPENSATION - Should any benefit or service rendered resulting from a Worker's Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to Newport Dental Plan or to the Professional Provider who rendered the service.

I. HEARING IMPAIRED AND DISABLED PERSONS - The Plan makes every effort to contract with providers who are accessible to Members with disabilities such as the hearing impaired or those needing wheelchair accessibility. Members should contact the Plan if a provider is not accessible for any reason. Members who are hearing impaired can contact the Plan through the California Relay Services at 1-800-735-2922 (TTY). The Plan will make every effort to refer a patient to a contracted provider who is accessible to patients with disabilities, if the patient should encounter a provider who is not accessible to patients with disabilities. In the rare contingency that there is not another contracted provider within a reasonable distance (15 miles or 30 minutes) who is accessible to patients with disabilities, then the Plan will arrange and approve an out of network provider within a reasonable distance. The out of network provider will be paid by the Plan on a fee for service basis minus any applicable copayments owed by the Member for the covered benefits.

VI. COORDINATION OF BENEFITS

Some Members have health coverage in addition to the coverage provided under this EOC. When this is the case, the following guidelines will determine which plan has primary responsibility for payment and which plan has secondary responsibility for payment. The benefits paid by the primary plan may be considered by the secondary plan when determining its benefits.

In the event the Member has additional benefits, primary coverage will be as follows:

A. Whether the coverage is a group or non-group prepaid program, the Member may obtain covered services from a participating Professional Provider on either Plan, not both, and be subject to the appropriate copayments.

B. If the Professional Provider is a participating dentist for two or more prepaid plans in which a Member is enrolled, the Member will be charged the lesser of the two plan's copayments applicable to the services rendered.

C. If the other coverage is a non-group insurance program, the participating Professional Provider will provide covered services to the Member at the copayments specified in the Program of Benefits or the amount received from the other coverage, whichever is greater. The participating Professional Provider shall submit for insurance "claims" at his Usual and Customary Rates.

D. If the other coverage is a group insurance program, the Professional Provider shall determine which Plan is primary and which is secondary in accordance with (NAIC)* rules and standards. If the Newport Dental Plan is primary then the Professional Provider may use his usual and customary fees for submitting insurance claims, but he may not collect more, from both the insurance payments and the Member payments combined, than the copayments specified in the Benefits Schedule. If the Newport Dental Plan is secondary, then the Professional Provider may accept any insurance payment in excess of the copayment for a specified covered service. If this is insufficient to cover the Members total copayment obligation, as specified in the Benefit Schedule, then the Member may be responsible for the difference.

*(NAIC, National Association of Insurance Commissioners Group Coordination of Benefits Model Regulation. This model regulation specifically applies to group programs and does not include individual or family policies or individual or family subscriber agreements.)

E. When a husband and wife are both employed as employees, and both have enrolled themselves and their eligible family members under a group health care service plan provided by their respective employers, and each spouse is covered as an employee under the terms of the same master contract, each spouse may claim on his or her behalf, or on behalf of his or her enrolled dependents, the combined maximum contractual benefits to which an employee is entitled under the terms of the master contract, not to exceed in the aggregate 100 percent of the charge for the covered expense or service.

VII. CHOICE OF PROVIDER AND PROFESSIONAL PROVIDER COMPENSATION

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

A. CHOICE OF PROVIDER

Each Member shall be entitled to select from Newport Dental Plan's most current Provider Directory, the Professional Provider he/she wishes to use for the services provided for herein. For a Provider Directory or assistance, contact a Member Services Representative at the 800 number or address listed on the first page of this EOC. The choice shall be made by designation on the Member's enrollment form. Thereafter, to obtain services, the member need only contact the selected Professional Provider. In the event a Member is dissatisfied with any Professional Provider selected, for any reason, and desires to transfer to another, the Member may do so by contacting Newport Dental Plan and may transfer, with 30 days Notice and PLAN APPROVAL to another Professional Provider, effective the first day of the month following approval. The Plan may restrict the number of transfers a member may make.

It is your responsibility to confirm that the Dentist/Specialist where you seek treatment is a Participating Professional Provider. If you are in doubt about the status of any Dentist or facility you are going to visit for treatment, then call Newport Dental Member Services for verification at the 800 number listed on the first page of this EOC.

If a group plan Member has a general practitioner with whom they would like to continue services, they may send that request to the Plan to the attention of the Plan at the address

listed on page one of this EOC. The Plan will consider the addition of that general practitioner as a contracted provider subject to:

1. The Plan having the need for additional providers in the requested service area,
2. The doctor meets the Plan's credentialing and Quality Assurance standards
3. The doctor signs a contract with the Plan that he/she will comply with all contractual requirements.

B. PROFESSIONAL PROVIDER COMPENSATION

In consideration of the performance by the Professional Provider of all services required to be provided pursuant to the Subscriber Agreement and Benefits Schedule for each Plan Member, the compensation to the Professional Provider shall be; 1) the copayments paid directly to the Plan Provider by the member as set forth in the Benefits Schedule and this Evidence of Coverage, and 2) the Capitation paid to the Professional Provider by the Plan and/or 3) any direct reimbursement by the Plan based on specific services provided as allowed by the Dental Services Agreement with the Professional provider. In staff model (Plan operated) facilities, the professional staff may be paid as an employee on a fixed per diem rate and/or other compensation and/or incentive program The Plan will reimburse the treating or consulting provider for the diagnosis, consultation or treatment of a Member via telehealth on the same basis and to the same extent that the Plan would reimburse the same covered in-person service.

The Plan does not have, in any contract and/or agreement with a Professional provider or other licensed health care professional, any such Compensation Agreement term that includes a specific payment or compensation made directly, in any type or form, as an inducement to deny, reduce, limit or delay, any specific, dentally necessary, or appropriate services.

The Plan does not delegate lien rights to providers. Contracted providers must accept the Plan's payments on behalf of the enrollee and will not assert against the enrollee statutory or other lien rights that may exist.

VIII. FACILITIES

A list of Newport Dental Plan's participating Professional Providers will be available to the Member upon request by calling or writing Member Services at the 800 number or address listed on the first page of this EOC. These Professional Providers are open during normal business hours. Should a Member have a question regarding the days and/or hours of the Professional Provider's facility he/she may write or call either the Professional Provider at the address and telephone number listed on the listing or Newport Dental Plan at the address and telephone number listed on the first page of this EOC.

IX. PREPAYMENT FEE

The Group and/or Subscriber agree that Newport Dental Plan shall provide services at the rates as specified in the Agreement and the Benefits Schedule located in the back of this EOC upon payment of the monthly or annual Prepayment Fee. The Fee shall be sent to Newport Dental Plan by the Group for members who receive benefits through their employer and by the member when purchasing an individual plan. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

X. LIABILITY OF MEMBER FOR PAYMENT

A. By statute, every contract between Newport Dental Plan and a Professional Provider shall provide that in the event Newport Dental Plan fails to pay the Professional Provider, the member shall not be liable to the Professional Provider for any sums owed by Newport Dental Plan.

B. In the event Newport Dental Plan does not pay non-contracting providers, the member may be liable to the non-contracting provider for cost of services.

C. Enrollees will be responsible for all supplementary charges including co-payment, deductibles and procedures not covered as Plan Benefits.

XI. RENEWAL REINSTATEMENT AND CHANGES IN BENEFITS

Newport Dental Plan has contracted to provide professional services for a period of one year or as specified in the Agreement. Thereafter the contract may be renewed with or without amendments by Newport Dental Plan and the Subscriber or Organization. Failure by Newport Dental Plan, the Subscriber, or Organization to terminate this contract, by giving the other party sixty (60) days written notice prior to the termination date of this contract, shall automatically renew this contract for a period of time equal to the period as specified in the Agreement.

Members have no individual rights to renewal for reinstatement of the Subscriber Agreement if it is terminated by Newport Dental Plan because the Group or Individual Subscriber fails to make monthly payments when due or otherwise breaches the Agreement. See Section XVII, Continuation Coverage, for further information.

The Plan reserves the right to change, or alter in any manner the benefits stated in the contract. Effect of such changes of services shall take place at least sixty (60) days from and after notice of such, except no change or amendment can be implemented within ninety (90) days of the renewal date.

XII. REFUNDS

A refund of all fees paid by an individual subscriber, may be requested within 21 days from the effective date of coverage. No refunds requested after 21 days will be made.

XIII. TERMINATION OF BENEFITS

Termination of benefits to a Member may occur due to (A) termination of Member's relationship with the Organization, (B) non-payment on the part of the subscribing Organization, (C) actions taken by Members, or (D) administrative reasons. Pursuant to Section 1365(b) of the Knox-Keene Act, any Member who alleges his/her enrollment has been canceled or not renewed because of his/her health status or requirements for services may request review by the Director of the Department of Managed Health Care.

A. TERMINATION OF BENEFITS BASED ON END OF MEMBER'S RELATIONSHIP WITH THE ORGANIZATION

Upon termination of a Member's employment or membership with the Organization, that Member, as well as his/her Dependents, shall continue to be eligible to receive service until the last day of the month in which the member's termination occurred. (See Section XIX for continuation under COBRA if applicable.)

B. TERMINATION OF BENEFITS BASED ON THE ORGANIZATION'S NON-PAYMENT

1. The Plan may terminate the contract with the Organization upon fifteen (15) days written notice should the Organization fail to remit the monthly premiums and charges to the Plan by the due date delineated in the group contract. Termination shall be effective the last day of the month during which the fifteen (15) day period expires.

   (a). Notice to Subscribers-The Group is required to send written notice of cancellation to each subscriber. The notice of cancellation must be in writing and dated, it must reference the clause of the Plan contract giving rise to the right of cancellation, the time when the cancellation is effective and the conditions for reinstatement stated in B.2. below.

   (b). Notice to Plan-The Group is required to send a copy of the notice sent to subscribers to the Plan, a list of the individuals notified and certification that they were mailed within the fifteen day period. Proof of mailing will be an invoice or similar receipt from the US Mail or similar service indicating the number of letters sent. If the Group fails to provide such notice to enrollees and proof of mailing to the Plan, then the Plan will send notification to all enrollees and the Group will be charged for the costs associated with the mailing and any additional premium due as a result of the Plan having to notify enrollees. Termination shall then be effective the last day of the month during which the fifteen (15) day period expires calculated from the date of the letter of notification sent to enrollees by Newport Dental. The notice to enrollees with comply with the same requirements for such notice as described in (a) above.

2. The original group contract can be reinstated at the option of the Plan if the Group pays the premium on or before the due date of the succeeding prepaid or periodic payment. If not reinstated the premium will be refunded to the Group within 20 business days:

C. TERMINATION BASED ON ACTIONS TAKEN BY MEMBERS

The Plan may terminate a Member's enrollment under any of the following circumstances.

1. Fraud or deception in the use of the Plan facilities or in the permitting of such fraud or deception by another shall be basis for cancellation of that Members membership by the Plan. Termination is effective immediately on the date the Plan mails notice of termination. In the event of termination the Plan or the Professional Provider shall

complete any procedure upon which work has commenced. The Member is required to pay all fees and premiums due.

2. If Member fails to pay any required Copayments, Coinsurance, or other charges owed to the Plan or providers within 30 days from the date the Plan sends written notice of termination to Member, and the Member does not make payment arrangements within the 30 day written notice. To be subject to termination under this provision, you must have been billed by the Provider or Plan for two different billing cycles and have failed to pay or make appropriate payment arrangements with the provider or Plan.

D. TERMINATION BASED ON ADMINISTRATIVE REASONS

Benefits may be terminated if (1) the Plan ceases to provide or arrange for dental services in the state, provided that 180 days notice is provided as required by law; or (2) if the Dental Plan withdraws a plan from the market, provided that 90 days notice is provided as required by law, and that any other plan offered is made available to the Organization.

E. CANCELLATIONS, RESCISSIONS OR NONRENEWALS

Grievance

An enrollee, subscriber, or group contract holder who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the enrollee, subscriber, or group contract holder alleges to be improper to submit a grievance to the Plan. An enrollee, subscriber, or group contract holder may also submit a grievance to the Director.

If the enrollee, subscriber, or group contract holder submits a grievance to the plan regarding a cancellation, rescission, or nonrenewal, the Plan shall provide the Department and the enrollee, subscriber, or group contract holder with a disposition or pending status on the grievance within three (3) calendar days of receipt of the grievance.

An enrollee, subscriber, or group contract holder's grievance to the Director shall be processed to determine if a proper complaint exists, including a determination if the grievance is timely, complete, and within the Director's jurisdiction. If a proper complaint does exist, the Director shall notify the enrollee, subscriber, or group contract holder, and the Plan that the grievance has been accepted within 48 hours of the determination that the grievance is a proper complaint.

Within 24 hours of receipt of the Director's notice of acceptance of proper complaint, the plan shall provide the Director with a copy of all information the plan used to make its determination and all other relevant information necessary for the Director's review.

If an enrollee, subscriber, or group contract holder submits a grievance before the effective date of a cancellation, rescission, or nonrenewal, the plan shall continue to provide coverage.

Within 30 calendar days of the receipt of a grievance, or longer if the Director determines in his or her discretion that additional time is necessary to review the cancellation, rescission, or nonrenewal, the Director shall, send written notice of the final determination and reasons for the determination to the enrollee, subscriber, or group contract holder, and to the Plan.

If the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, the Director shall order reinstatement or direct the Plan not to cancel coverage.

If the Director finds the cancellation, rescission, or nonrenewal was proper, but the effective date was in violation of the statutory requirements, the Director may exercise his or her discretion and adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the enrollee, subscriber, or group contract holder, as well as the Plan of the adjusted cancellation date.

Continuation of Coverage

If the enrollee. subscriber, or group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, the plan shall continue to provide coverage to the enrollee, subscriber, or contract holder pursuant to the terms of the Plan contract while the grievance is pending with the Plan and/or Director.

During the period of continued coverage, the enrollee, subscriber, or group contract holder remains responsible for paying premiums and any repayments, coinsurance, or deductible obligations as required under the Plan contract

If the Director determines the cancellation or nonrenewal is consistent with existing law, the plan may terminate the Plan contract no earlier than the end of the paid coverage period or grace period, whichever is longer. The enrollee, subscriber, or group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.

If the Director determines the rescission is consistent with existing law, the Plan shall return all premiums paid by the enrollee, subscriber, or group contract holder. The enrollee, subscriber, or group contract holder is responsible for the cost of all medical services received after the effective date of the rescission

Grace Period

Enrollees subject to cancellations and nonrenewals for nonpayment of premiums will be sent a Notice of Start of Grace Period. These enrollees are entitled to a grace period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated, prior to cancellation, as follows:

- The grace period may not begin sooner than the day after the last date of paid coverage.
- A plan shall provide coverage pursuant to the terms of the contract during the entire grace period.
- Upon determining that an enrollee, subscriber, or group contract holder has failed to make a premium payment by the due date, the plan shall send a Notice of Start of Grace Period to the enrollee, subscriber, or group contract holder, notifying the recipient that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated.
- The plan shall continue the enrollee, subscriber, and/or group contract holder's coverage uninterrupted pursuant to the plan contract upon payment of all outstanding premium amounts at any time before the expiration of the grace period.
- The enrollee, subscriber, or group contract holder is financially responsible for any and all premiums and any copayments, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.

The plan shall send a Notice of Start of Grace Period to each subscriber in a group contract unless:

- The plan contract requires the group contract holder to promptly send any such notice to each subscriber; and
- The plan sends the notice to the group contract holder designated in the plan contract.

In the event the plan, after compliance with all timing and notice requirements of this section, fails to receive all outstanding premium amounts from the enrollee, subscriber, or group contract holder on or before the last day of the grace period, as specified in the Notice of Start of Grace Period, coverage may be cancelled prospectively only after the expiration of the entire grace period.

Reinstatement of Coverage

If the Director determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the enrollee, subscriber, or group contract holder submitted the grievance after the Plan contract was cancelled, rescinded, or not renewed, the Director shall order the Plan to reinstate the enrollee, subscriber, or contract holder, retroactive to the effective date of cancellation, rescission, or nonrenewal.

Within 15 days after receipt of the order for reinstatement, the Plan shall either request an administrative hearing from the Director or reinstate the enrollee, subscriber, or contract holder.

If the Director orders reinstatement, the plan shall be liable for the expenses incurred by the enrollee, subscriber, or group contract holder for covered health care services, less any applicable deductibles, repayments, or coinsurance pursuant to the enrollee, subscriber, or group contract holder's Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The Plan shall contact providers to reconcile any completed claims in order to reimburse the enrollee, subscriber, or group contract holder for any out-of-pocket expenses incurred by the enrollee, subscriber, or contract holder pursuant to this paragraph within 30 days of the order of reinstatement.
The enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal.

XIV. COMPLAINTS AND DISPUTES

Newport Dental Plan is very interested in your satisfaction, and you are invited to direct any concerns to our internal grievance process. Any information, dispute or complaint should be directed to Newport Dental Plan as follows:

NEWPORT DENTAL PLAN
100 SPECTRUM CENTER DRIVE, #1500
IRVINE, CALIFORNIA 92618

Telephone calls should be made to Newport Dental Plan at the following numbers:

1-(714) 668-1300
1-(800) 49 SMILE
1-(800) 497-6453

XV. GRIEVANCE PROCEDURES

Any complaint you have should initially be brought to the attention of your Professional Provider. If it is not resolved to your satisfaction, you are encouraged to contact Newport Dental Plan at the telephone number listed herein regarding any problems that are encountered while obtaining services. Newport Dental Plan maintains a Member Grievance procedure to deal with Member problems and complaints. Member complaints or grievances can be made in person, at any Professional Provider's office or by obtaining a grievance form by calling Newport Dental Plan at the 800 number listed above. Members can also obtain one by going to the Plan's website at **www.newportdental.com**, under Plan Info, click on "Grievance Form:" to complete and submit your grievance on line, or choose "PDF-format Form:" to download and print a grievance form by mail. There will be a representative at the Plan Provider's office or at the Plan's main business office to aid the member in filing the grievance. Completed grievance forms must be mailed to Newport Dental Plan at the address listed above. Members will receive a written acknowledgement of their complaint within five (5) calendar days and written notification within thirty (30) calendar days as to disposition of the complaint or measures taken to correct any problems. If you have an urgent grievance, defined as a serious and imminent threat to your health, you have, the right to immediately contact the Department of Managed Health Care at the numbers listed below. Cases, which present an imminent or serious threat to the patient's health, require an expedited review and written notification of the disposition or the pending status of the grievance within three (3) calendar days of receipt of the grievance.

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 **(800) 49-SMILE** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech Impaired. The department's Internet Web site htt**p://www.HealthHelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If a member suspects an incident of fraud or abuse occurring as described in the "definitions" of this Evidence of Coverage and Disclosure Form, they are encouraged to call the Plan's Fraud Hotline number at **(800) 497-6453, Extension 1353**.

XVI. BINDING ARBITRATION

In the event of any controversy or dispute between Newport Dental Plan or Individuals and the Members and/or their Dependents, whether involving a claim in tort, contract or otherwise, and

including disputes which are not adequately resolved by Newport Dental Plan's grievance procedures, said disputes shall be submitted to binding arbitration. Either party may initiate such arbitration, but if the matter in dispute is one that is subject to review under Newport Dental Plan's grievance procedures, disputes or arbitration may not be initiated until the completion of such procedures. All such claims, controversies and disputes shall be submitted to binding arbitration in accordance with the applicable rules of The National Arbitration Forum. The Plan will assume all or part of the Enrollee's share of the fees and expenses of the neutral arbitrator if the Member can demonstrate "extreme hardship". Judgment upon any award rendered by the arbitrator may be duly entered in any court in the State of California, having jurisdiction thereof. The prevailing party shall be entitled to court costs and reasonable attorney's fees.

XVII. CONTINUATION COVERAGE

COBRA" refers to the laws which allow members to continue group health coverage under certain circumstances where coverage would otherwise terminate. The Federal law pertaining to this coverage is the Consolidated Omnibus Budget Reconciliation Act of 1985, and related amendments (COBRA). COBRA applies to employers with twenty (20) eligible employees. The California state law is the California Continuation Benefits Replacement Act (Cal-COBRA). Cal-COBRA applies to California small employers with fewer than (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same, however some differences do exist as explained below.

A. COBRA Continuation Coverage

Pursuant to COBRA legislation, this information will serve to advise enrollee of certain rights which their family members may have to continuation of coverage under Newport Dental Plan which you have as an employee benefit, in the event of a termination of eligibility due to one of the following qualifying events:

a. Death of a covered employee;
b. Termination of covered employee (other than for gross misconduct) or reduction in covered employee's hours of employment.
c. Divorce or legal separation of the covered employee from the employee's spouse;
d. Entitlement to Medicare benefits by the covered employee;
e. A dependent child ceases to be eligible for coverage as a dependent child under the Plan.

For widows, divorced spouses, spouses, eligible employees, and dependent children who become ineligible under the Plan, continuation coverage may be available for up to 36 months. Continuation coverage for terminated or reduced hour employees, and their eligible dependents, may also be available for up to 18 months. You must pay a monthly premium to Newport Dental Plan through your employer for the continuation coverage. The premium will be determined at the time of eligibility and will be subject to change; however, the premium charged to you will not exceed 102% of the premium charged for active employees and/or dependents in a comparable status. The continuation coverage will be the same as the coverage available for continuing employees, regardless of your health at the time. Coverage under COBRA must begin on the date of the qualifying event.

Continuation coverage will **not** be available to you after:

a. You fail to make timely premium payments; OR,
b. You or your spouse or dependent is covered under any other group health plan as the result of employment, reemployment or remarriage; OR,
c. You or your spouse or dependent becomes entitled to Medicare benefits; OR,
d. Your employer or former employer ceases to maintain the Plan for employees.

At the time of eligibility for continuation coverage the employer is responsible for providing an election form to the Member. The form must be completed and returned to your employer by the date noted. You and your dependent must notify your employer of a divorce, legal separation, or loss of eligibility of a dependent child upon the occurrence of such event. If you should have any questions about this benefit, please direct them to your employer.

B. Cal-COBRA

Cal-COBRA refers to the California Continuation of Benefits Replacement Act ("Cal-COBRA") which is meant to provide continued access to health insurance coverage to employers with 2 to 19 eligible employees who are not currently offered continuation coverage under federal COBRA. In most respects, Cal-COBRA is very similar to the provisions of the federal COBRA program for employers of 20 or more eligible employees. See your Organization or Group for administration of federal COBRA. Under Cal-COBRA a eligible Member may elect to continue this Plan in certain circumstances where coverage would otherwise terminate under the same terms and conditions as active employees covered under this Plan.

Eligibility and Qualification-In order to be eligible for Cal-COBRA continuation coverage, a Member must not be covered under another group health plan, entitled to Medicare, or covered under federal COBRA continuation coverage, and the Member's coverage must terminate as the result of one of the following qualifying events:
1. Death of the Member
2. Termination of employment or reduction in work hours for reasons other than gross misconduct.
3. Divorce or legal separation of the Member from the Member's spouse.
4. Loss of Dependent status by a Dependent enrolled in the group benefit plan.
5. With respect to a Dependent, Member's entitlement to Medicare.

Notification of Qualifying Events- An eligible Member must notify the employer of a qualifying event listed above within 60 days of the date of the qualifying event with exception of termination or reduction in work hours.

Within 14 days of receiving notification of a qualifying event, the employer will mail a Cal-COBRA package to the last known address of the eligible Member. This package will contain benefits information, premium information, enrollment forms, and instructions on how to formally elect continuation coverage. The forms must be completed and returned within the specified time periods.

An eligible Member must request continuation coverage in writing and deliver it, by first-class mail or other reliable means of delivery, to the employer within the 60-day period following the later of (1) the date of the qualifying event, (2) the date the eligible Member is given notice by the employer of the ability to continue coverage under this Plan, or (3) the date coverage under this Plan terminates. Failure to make such notification to the employer will disqualify the eligible Member from receiving continuation coverage.

Premium Payments- An eligible Member electing continuation coverage must pay to the Plan through the employer the required monthly premiums. The premium will not exceed 110% of the premium charged for active employees and/or Dependents in a comparable status. If an eligible Member is determined to be disabled for Social Security purposes, the eligible Member shall pay a premium no greater than 150% of the group rate after the first 18 months of continuation coverage.

An eligible Member's first premium payment shall be delivered by certified mail, or other reliable means of delivery, to the employer within 45 days of the date the eligible Member provided written notice to the employer of the election to continue coverage. The first premium payment must satisfy all required premiums and all premiums due. Failure to submit the correct premium amount within this 45-day period will disqualify the eligible Member from receiving continuation coverage.

Termination of Cal-COBRA Coverage- Continuation coverage may be available up to 36 months for all qualifying events. Continuation coverage will terminate earlier if the eligible Member fails to timely pay the required premium.

If the employer ceases to maintain this Plan, continuation coverage will terminate. However, if the employer obtains another group health plan, an eligible Member may continue Cal-COBRA coverage under the new group health plan for the balance of the period that the eligible Member would have remained covered under this Plan had this Plan not terminated. The new group benefit plan will send the eligible Member instructions including requirements for election and payment. Continuation coverage shall terminate if the eligible Member fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group health plan within 30 days of receiving notice of the termination of this Plan. The employer will notify Cal-COBRA Members at least 30 days prior to terminating this Plan and will provide such Members with instructions for enrolling in any subsequent group health plan.

A Member who is eligible for continuation coverage due to a loss of employment or reduction in hours worked, and determined for Social Security purposes to be disabled at any time during the first 60 days of continuation of coverage, and the spouse or dependent has elected coverage, then the spouse or dependent is eligible for 36 months of Cal-COBRA coverage beginning from the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified Member shall notify the Organization or Group of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 18-month continuation coverage period. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event, or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify the plan, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

If you have any questions about this benefit, please direct them to the employer. You also have the option of obtaining coverage.

XIX. OTHER

A. DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records (including any personal or privileged information, medical records, patient charts, etc.) shall remain confidential. Please note that enrollment in Newport Dental Plan allows the release of patient records to Newport Dental Plan or its designee for health plan operations. Such information may also be made available to the Department of Managed Health Care, the Dental Board and the Plan's legal representative or other agency as required by law. The Plan shall, upon request, provide to enrollees and subscribers a written statement that describes how the contracting organization or health care service plan maintains the confidentiality of medical information obtained by and in the possession of the contracting organization or the health care service plan.

B. ACCESS TO RECORDS

Plan member may request access to, or a copy of personal information and medical records. Written consent for release of patient information and records is required to be signed by the patient, along with the appropriate fee as allowed by law, before any records will be released. The Plan will respond to such a request within fifteen (15) days after receipt of the appropriate executed forms and fees. A STATEMENT DESCRIBING NEWPORT DENTAL PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Please contact the Member Services Department at the 800 number or address listed on the first page of this EOC.

C. CONFIDENTIAL COMMUNICATIONS

The Plan does not require a protected individual to obtain the primary subscriber's or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care. 'Protected individual' is defined as any adult covered by the subscriber's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. 'Protected individual' does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. 'Sensitive services' means all health care services related to mental or behavioral health, sexual or reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section. Subscribers and enrollees may request a confidential communication from the Plan via electronic, telephonic, or written submission. Electronic requests can be made using the 'Contact Us' link on the Plan's Internet website at www.newportdental.com. Telephone requests can be made by calling the Plan at **1-800-497-6453**. Written submissions should be sent to the Plan's Corporate office at the address listed in this Evidence of Coverage booklet. The Plan will acknowledge receipt of the confidential communications request and advise the subscriber or enrollee of the status of implementation of the request if a subscriber or enrollee contacts the health care service plan.

The Plan will implement confidential communication requests within 7 calendar days of receipt of electronic or telephonic request or within 14 calendar days of receipt by first-class mail. The request for confidential communication will be valid until the subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted. The Plan permits subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations. The request should include a statement that the request pertains to either medical information related to the receipt of sensitive services or that disclosure of all or part of the medical information could endanger the subscriber or enrollee. The request does not need an explanation as to the basis for a subscriber's or enrollee's statement that disclosure could endanger the subscriber or enrollee.

The Plan will direct all communications regarding a protected individual's receipt of sensitive services directly to the protected individual receiving care as follows: (A) to the protected individual's designated alternative mailing address, email address, or telephone number; or (B) if the protected individual has not designated an alternative mailing address, email address, or telephone number, in the name of the protected individual at the address or telephone number on file. Confidential communication requests will apply to all communications that disclose medical information or provider name and address related to the receipt of medical services by the individual requesting the confidential communication. Communications shall include the following written, verbal or electronic communications related to the receipt of sensitive services:

- Bills and attempts to collect payment.
- A notice of adverse benefits determinations.
- An explanation of benefits notice.
- A plan's request for additional information regarding a claim.
- A notice of a contested claim.
- The name and address of a provider, description of services provided, and other information related to a visit.
- Any written, oral, or electronic communication from the plan that contains protected heath information.

The Plan shall not disclose medical information related to sensitive health care services provided to a protected individual to the policyholder, primary subscriber, or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

D. TIMELY ACCESS TO CARE

The Plan shall provide or arrange for the provision of health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. The Plan shall ensure that providers 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, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice.

(B) Nonurgent appointments shall be offered within 36 business days of the request for appointment.

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

Interpreter services shall be coordinated with scheduled appointments for health care services at the time of the appointment without imposing delay on the scheduling of the appointment.

If it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice.

Member shall contact the plan by telephone, toll-free, at **1-800-497-6453** to obtain assistance if the Member is unable to obtain a timely referral to an appropriate provider. Additionally, the Member may contact the Department of Managed Health Care (DMHC) for assistance by telephone, toll-free, at **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech Impaired.

E. ORGAN DONATIONS

Donating organs and tissue provides many societal benefits. Organ and tissue donations can save lives and allow recipients to live longer, healthier and more meaningful lives. There is a great need for organ donors; therefore, it is imperative that you inform family members of your decision to be a donor and speak with a physician if you are considering donating potential organs or tissue in the event your own life comes to term. To learn more on how you can be an organ donor, the following sources can provide additional information.

Request donor information from your local Department of Motor Vehicles (DMV)

On the Internet, contact:

All About Transplantation and Donation (www.transweb.org)

Department of Health and Human Services (www.organdonor.gov)

Sign the donor card in your family's presence.

Have your family sign as witnesses and pledge to carry out your wishes.

Keep the card with you at all times, where it can be easily found.

Keep in mind that even if you have signed a donor card, you must tell your family so they can act on your wishes.

F. CUSTOMER SERVICE

The Plan shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a Plan customer service representative knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten minutes.

NOTICES

***If the Professional Provider fails to comply with the Terms and Conditions of this Agreement, the Member should advise the Plan of the Professional Provider's breach of the Agreement. If a member suspects an incident of fraud or abuse occurring as described in the "definitions" of this Evidence of Coverage and Disclosure Form, he/she is encouraged to call the Plan's Fraud Hotline number at* (800) 497-6453, Extension 1226.**

PUBLIC POLICY COMMITTEE

Newport Dental Plan has a Public Policy Committee that reviews and approves all actions of the Quality Assurance Committee. This Committee reports to the Board of Directors. The Public Policy Committee is composed of at least 51% subscribers, enrollees, and health care providers. Subscribers, enrollees or providers who would like to participate on this committee should submit their request to the Plan at the number or address listed on the first page of this EOC.

www.newportdental.com

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