DELTA DENTAL

deltadentalins.com

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

Our privacy practices reflect applicable federal law as well as state law. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plans will comply with the stricter law.

We are required by law to maintain the privacy and security of your Protected Health Information (PHI). Protected Health Information (PHI) is information that is maintained or transmitted by Delta Dental, which may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. We receive, use and disclose your PHI to administer your benefit plan as permitted or required by law.

We must follow the federal and state privacy requirements described that apply to our administration of your benefits and provide you with a copy of this notice. We reserve the right to change our privacy practices when needed and we promptly post the updated notice within 60 days on our website.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. Examples of this include processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers, determine your eligibility for services, billing you or your plan sponsor.

If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services on our behalf to administer your benefits. Any third-party affiliates performing services on our behalf has signed a contract agreeing to protect the confidentiality of your PHI and has implemented privacy policies and procedures that comply with applicable federal and state law.

Permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures made with your authorization

We will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.
You may access your PHI by providing a written request. Your request must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will only maintain PHI that we obtain or utilize in providing your health care benefits. We may not maintain some PHI, such as treatment records or x-rays after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that we do not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your PHI.
You have the right to ask that we limit how we use and disclose your PHI; however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency.

You have the right to correct or update your PHI.
You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal within 60 days. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your provider to amend your treatment chart or to your employer, if applicable, to amend your enrollment information.

You have rights related to the use and disclosure of your PHI for marketing.
We will obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the right to withdraw your authorization at any time. We do not use your PHI for fundraising purposes.

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT and WV. DeltaVision is administered by Vision Service Plan (VSP).

You have the right to request or receive confidential communications from us by alternative means or at a different address.

You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another accounting within 12 months.

You have the right to a paper copy of this notice.

A copy of this notice is posted on our website. You may also request that a copy be sent to you.

You have the right to be notified following a breach of unsecured protected health information.

We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

You have the right to choose someone to act for you.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS

You may file a complaint with us and/or with the U. S. Secretary of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

CONTACTS

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You may contact us by calling 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

This notice is effective on and after March 1, 2019.

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Gramm-Leach-Bliley (GLB) Financial Privacy Notice

We respect and understand that your privacy is important. We are committed to protecting the confidentiality of information about you. Under the Gramm-Leach-Bliley (GLB) Act, institutions must notify consumers about the information we collect, why we collect it, what we do with it, and how we protect your privacy.

PERSONAL INFORMATION WE COLLECT

We obtain non-public personal information about you through our business processes and the forms that you, your dentist and your group have completed, such as: enrollment forms, beneficiary designation/assignment forms and claim forms.

This information can include name, address, date of birth, phone number, Social Security Number, account number, plan identification number, marital status, gender, dependent information, and employment information. While this list is not exhaustive, it gives you an idea of the types of personal information we collect.

WHY WE COLLECT PERSONAL INFORMATION AND WHO WE SHARE IT WITH

We use this information to administer dental and/or vision benefits. This information is also compiled into databases for statistical, underwriting and audit purposes. We share information about you with your dental provider to validate your insurance eligibility and process your claims. We also share information with group policy holders for reporting and auditing purposes. And, we share your information with government or legal authorities as required by the law.
When third party administrators help us process claims, we require them to follow applicable privacy laws and hold them to the same standards for sharing and disclosing information.

SAFEGUARDING INFORMATION

Only those persons who require access to non-public personal information to perform their job or contractual responsibilities are authorized to access that information. We also maintain physical, electronic and procedural security measures to safeguard individually identifiable nonpublic personal information in our possession.

TO LIMIT OUR SHARING

You can opt out of having your information shared with non-affiliates for marketing purposes. Our contact information is provided below.

CONTACT US

Please contact us for additional information about our commitment to privacy, or to choose not to have your information shared with certain third parties

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Non-Discrimination Disclosure

Discrimination is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330
1-866-530-9675
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

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- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

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Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-866-530-9675 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-866-530-9675 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-866-530-9675 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-866-530-9675 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-866-530-9675 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-866-530-9675 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-866-530-9675 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-866-530-9675 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-866-530-9675 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-866-530-9675 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-866-530-9675 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-866-530-9675 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-866-530-9675 (TTY: 711). (Italian)

この文書をお読みになれますか？お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、 1-866-530-9675 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-866-530-9675 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-866-530-9675 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-866-530-9675 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-866-530-9675 (TTY: 711) (Thai)

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-866-530-9675 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-866-530-9675 (TTY 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-866-530-9675 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ, សូមទូរស័ព្ទទៅ 1-866-530-9675 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען אײַך העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אָנקלינגען אָט די דאָזיקע נומער: 1-866-530-9675 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta’go bííníghah? Doo bííníghahgóó éí nich’į’ yídóołtahígíí nihee hóló̜. Díí naaltsoos t’áá Diné bizaad k’ehjí ályaago ałdó’ nich’į’ ádoolníįłgo bíighah. T’áá jíík’e shíká i’doolwoł nínízingo kojį’ béésh holdííłnih 1-866-530-9675 (TTY: 711) (Navajo)

Delta Dental's Language Assistance Program

Our Language Assistance Program (LAP) helps enrollees whose primary language is not English. Once you are a Delta Dental enrollee, you are entitled to receive free language assistance services including:

- Names and locations of dental offices that speak your language,
- Help communicating with us or your dental provider in your language and
- Access to vital documents in your language.

You may call Delta Dental for assistance:

- Delta Dental Premier® and Delta Dental PPO℠: 800-765-6003
- DeltaCare® USA: 800-422-4234

For more information, please visit our website at **deltadentalins.com**.

Programa de Asistencia en Otros Idiomas de Delta Dental

Nuestro Programa de Asistencia en Otros Idiomas (LAP, por sus siglas en inglés) brinda ayuda a los afiliados cuyo idioma principal no es el inglés. Una vez que esté afiliado a Delta Dental, usted tendrá el derecho de recibir servicios de asistencia gratuita en otros idiomas como los siguientes:

- nombre y ubicación de los consultorios dentales en donde hablan su idioma
- ayuda para comunicarse con nosotros o su proveedor dental en su idioma
- acceso a documentos vitales en su idioma.

Puede llamar a Delta Dental para obtener asistencia a los siguientes números:

- Delta Dental Premier® y Delta Dental PPO℠: 800-765-6003
- DeltaCare® USA: 800-422-4234

Para obtener más información, visite nuestro sitio web en **es.deltadentalins.com**

Delta Dental 語言協助計畫

我們的語言協助計畫（LAP）旨在幫助母語不是英語的投保人及其家庭成員。成為 Delta Dental 牙齒保險計畫成員後，您可以免費享用語言協助服務，其中包括：

- 提供會講您語言的牙科診所之名稱和地點的資料，
- 協助您與我們或與您的牙科服務提供者以您的語言進行轉譯溝通，並且
- 獲得提供以您的語言翻譯的重要文件。

欲取得協助，請致電 Delta Dental:

- Delta Dental Premier® 和 Delta Dental PPO℠: 800-765-6003
- DeltaCare® USA: 800-422-4234

如需詳細資訊，請瀏覽我們的網站，網址是 **deltadentalins.com**

Survey

Please complete this survey with information about yourself and each family member who requires language assistance. This will help us meet the written and spoken language needs of our enrollees.

Primary enrollee
The primary enrollee is the person under whose name dental coverage is provided.

First name: ______________________

Last name: ______________________

Birth date (mm/dd/yyyy): _____/_____/________

Primary enrollee ID number: ______________________

ZIP code: __________ Plan name (choose one):
- ☐ AARP
- ☐ DeltaCare USA
- ☐ Delta Dental Premier
- ☐ Delta Dental PPO

Written language: ______________________

Spoken language: ______________________

Eligible Family member

First name: ______________________

Last name: ______________________

Birth date (mm/dd/yyyy): _____/_____/________

Relationship to primary enrollee: ______________________

ZIP code: __________ Plan name: ______________ (see above)

Written language: ______________________

Spoken language: ______________________

For additional family members, please use another sheet of paper and include the same information as requested above. Please mail the completed survey to:

Delta Dental of California
Attn: LAP
P.O. Box 429086
San Francisco, CA 94142-9086

Privacy assurance: Your personal information will be cross-referenced with your dental insurance records and will not be used for other purposes. Delta Dental will make all reasonable efforts to protect your privacy.

Encuesta

Complete esta encuesta con información acerca de usted y de cada miembro elegible de su familia que necesite asistencia en otro idioma. Esto nos permitirá satisfacer las necesidades idiomáticas de escritura y expresión oral de nuestros afiliados

Afiliado principal
El afiliado principal es la persona a cuyo nombre se proporciona la cobertura dental.

Primer nombre: ______________________

Apellido: ______________________

Fecha de nacimiento (mm/dd/aaaa): _____/_____/________

N.º de identificación del afiliado principal: ______________________

Código postal: __________ Nombre de su plan(elija uno):
- ☐ AARP
- ☐ DeltaCare USA
- ☐ Delta Dental Premier
- ☐ Delta Dental PPO

Idioma que escribe: ______________________

Idioma que habla: ______________________

Miembro de la familia

Primer nombre: ______________________

Apellido: ______________________

Fecha de nacimiento (mm/dd/aaaa): _____/_____/________

Parentesco con el afiliado principal: ______________________

Código postal: __________ Nombre de su plan: ______________ (vea arriba)

Idioma que escribe: ______________________

Idioma que habla: ______________________

Para agregar miembros elegibles de la familia, utilice otra hoja de papel e incluya la misma información que se solicitó anteriormente. Envíe la encuesta completada a:

Delta Dental of California
Attn: LAP
P.O. Box 429086
San Francisco, CA 94142-9086

Garantía de privacidad: Se realizará una referencia entre su información personal en los registros del seguro dental, y dicha información no se utilizará con otros fines. Delta Dental hará todos los esfuerzos posibles para proteger su privacidad.

語言協助計畫問卷

請在這份語言協助計畫問卷表格填寫您本人及需要語言協助的每一位受保家庭成員的資料。這些資料將有助於我們幫助投保人及其受保家庭成員在書面和口頭語言方面的轉譯。

主要投保人的語言資料 (主要投保人係指在承保時所用姓名與身份證號碼的受保人)

姓（請用英文字母輸入）: ______________________

名（請用英文字母輸入）: ______________________

出生日期（月/日/年）: _____/_____/________

主要投保人身份證明號碼： ______________________

地址郵政區: ______________________

請選擇投保人的保險計畫:
- ☐ AARP
- ☐ DeltaCare USA
- ☐ Delta Dental Premier
- ☐ Delta Dental PPO

書面語言 ______________________

口頭語言： ______________________

受保家庭成員的語言資料

姓（請用英文字母輸入）: ______________________

名（請用英文字母輸入）: ______________________

出生日期（月/日/年）: _____/_____/________

與主要投保人的關係: ______________________

地址郵政區: ______________________

請選擇投保人的保險計畫: ______________________

書面語言: ______________________

口頭語言: ______________________

若還有其他的受保家庭成員，請另附紙頁填寫以上他們的語言資料。請將填妥的語言協助計畫問卷表格寄至:

Delta Dental of California
Attn: LAP
P.O. Box 429086
San Francisco, CA 94142-9086

隱私權保護: 您在本問卷中提供的個人資料只會是用於與您的牙科保險記錄相互參照，而不會用於其他用途。Delta Dental 將盡一切合理的安全措施來保護您的隱私權。

California Financial Privacy Notice

IMPORTANT PRIVACY CHOICES FOR CALIFORNIA CONSUMERS
You have the right to control whether we share some of your personal information.
Please read the following information carefully before you make your choices below.

We respect and understand that your privacy is important. We are committed to protecting the confidentiality of information that we maintain about you. Our business is to pay claims for dental care within the scope of your dental plan benefits contract.

YOUR RIGHTS

You have the right to restrict the sharing of your personal and financial information with our affiliates (companies we own or control) and outside companies with whom we do business. We are not prohibited from sharing information necessary for us to comply with the law or, as the law allows, providing you with the best possible service, which may include sending you information about our products and services.

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT and WV. DeltaVision is administered by Vision Service Plan (VSP).

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California Financial Privacy Notice

Opt-Out Request Form

YOUR CHOICES

Restrict information sharing with affiliated companies we do business with to provide financial products and services: Unless you respond "No," we may share personal and financial information about you with other companies.

[ ] NO, please do not share my personal and financial information with affiliated companies.

Restrict information sharing with other companies we do business with to provide financial products and services: Unless you respond "No," we may share personal and financial information about you with outside companies we contract with to provide financial products and services.

[ ] NO, please do not share my personal and financial information with outside companies you contract with to provide financial products and services.

TIME SENSITIVE REPLY

You may make your privacy choice(s) at any time. Your choice(s) will remain in effect until you state otherwise. However, if we do not hear from you, we may share your information with affiliated companies and other companies with whom we have contracts to provide products and services. To exercise your choices, do one of the following:

- Call our contact center and speak with a Customer Service representative for assistance, or you may complete this form and mail to us at Delta Dental, PO BOX 997330, Sacramento, CA, 95899-7330.

  Last name: (please print) ______________________________

  First name: (please print) ______________________________

  Account number: ______________________________

  Street address: ______________________________

  City: ______________ State: __________ ZIP: __________

DELTA DENTAL

deltadentalins.com

ENROLLEE GRIEVANCE PROCESS

Option 1: Talk to your provider

We urge you to communicate directly with your provider if you are dissatisfied with the service he or she provided. We are confident that the provider will welcome the opportunity to address your questions and concerns.

Option 2: Contact Customer Service

If you are dissatisfied after speaking with your provider, or have questions about your plan and claims payment, please contact Customer Service for assistance. If the Customer Service team is unable to resolve your concerns to your satisfaction, you may file a formal grievance.

Option 3: File a formal grievance

You may file a grievance in several ways:

- Online: You can complete a form online at: https://secure1.ddpdelta.org/ddpca_secure/%21complaint.asp
- In writing: You can obtain a form from the Customer Service representative or from your provider.
- Verbally: You may ask the Customer Service representative to take your grievance over the phone.

Include the following information with your grievance:

- Your name and enrollee identification number
- Your provider's name
- A detailed written description of your concern so that we may fully understand and respond to it. Include documentation, such as receipts or treatment records that will support your concern.

Fax or mail your written grievance to:
Delta Dental of California
Quality Management
P.O. Box 997330
Sacramento, CA 95899-7330
Customer Service: 888-335-8227
Fax Number: 916-631-6374

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT and WV. DeltaVision is administered by Vision Service Plan (VSP).

We will send you a written determination within 30 days of receipt of your grievance. Submissions involving severe pain and/or imminent and serious threat to your health will be reviewed immediately and responded to within three days of receipt.

Option 4:
The California DMHC is responsible for regulating health care service plans. If you have a grievance against your health plan, you are encouraged to contact your health plan and use your health plan's grievance process before contacting the California DMHC (although this is not a required first step). Utilizing DMHC's grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the California DMHC for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The California DMHC also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.dmhc.ca.gov** has complaint forms online.

Independent Medical Review (IMR) has limited application to your program. You may request IMR only if your provider claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

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DELTA DENTAL

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Timely Access to Care

California law requires health plans to provide timely access to care. This law sets limits on how long enrollees have to wait to get appointments and telephone assistance. Enrollees have the right to appointments and care within the following time frames:

a. Emergency care is available 24 hours a day, 7 days per week. An active after-hours mechanism, such as an answering machine, answering service, a cell phone, or a pager, is available at provider offices for 24-hour/7-day contact or instructions.

b. Urgent care is provided within 72 hours when consistent with the patient's individual needs and required by generally accepted standards.

c. Non-urgent appointments for initial visits or for routine and specialty care are available within 36 business days of the enrollee's request.

d. Preventative care appointments are available within 40 business days of the enrollee's request.

e. If an enrollee calls our plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours.

Additionally, provider facilities should meet Americans with Disabilities Act (ADA) access guidelines, including wheel-chair accessibility. Enrollees are entitled to full and equal access to covered services, including for enrollees who are disabled (compliance with Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973).

If an enrollee is having trouble communicating with their provider at their appointment, we will arrange interpretation services to help via telephone or in-person, at no cost.

If you are unable to obtain a timely referral to an appropriate provider, you can contact Customer Service. You can also file a complaint with the California Department of Insurance at 1-800-924-4357 or 1-800-482-4833 (TTY for the hearing and speech impaired).

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT, and WV. DeltaVision is administered by Vision Service Plan (VSP).

DELTA DENTAL

deltadentalins.com

Organ and Tissue Donation

Why donate?

Donating organs and tissue provides many societal benefits. Currently, the need for organ transplants far exceeds the availability of donated organs and tissue. You could potentially save as many as eight lives through organ donation and tissue donation. Unfortunately, thousands die each year waiting for an organ donation that never arrives. You have the power to change that.

How to become a donor

The most important thing to do is to sign up as an organ and tissue donor in your state's donor registry. In addition to signing up in your state's donor registry, you should consider also doing the following:

- Designate your donation decision on your driver's license.
- Tell your family about your donation decision.
- Tell your physician, faith leader, and friends.
- Include your donation decision in your advance directives, will, and living will.

What can be donated?

Organs

Currently, the kidneys, heart, lungs, liver, pancreas, and intestines are organs that can be donated. Donated organs must be used within hours of removal from the donor's body. Although most donated organs come from individuals who have died, a living individual can donate a kidney, part of the pancreas, part of a lung, part of the liver, or part of the intestine.

Tissue

Corneas, the middle ear, skin, heart valves, bone, veins, cartilage, tendons, and ligaments can be stored in tissue banks and used to restore sight, cover burns, repair hearts, replace veins, and mend damaged connective tissue and cartilage in recipients.

Stem cells, blood and platelets

Stem cells, blood, and platelets of healthy individuals of a certain age can also be donated, depending on the match between the donor and recipient.

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Annual Deductible and Out-of-Pocket Maximum Accrual Balances

California law requires health plans to provide enrollees with up-to-date accrual balances towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. Enrollees have the right to request their most up-to-date accrual balance from the health plan at any time.

You can request your accrual balance by contacting Customer Service at 866-530-9675 or by logging into your online account at deltadentalins.com.

Accrual updates will be mailed to you unless you elect to opt out of the mailed notice and receive accrual notifications electronically. To opt out of paper mailings, contact Customer Service or log in to your online account and update your delivery preferences.

Once you have selected to receive electronic communications, they will be provided either (1) by accessing the Delta Dental website with your username and password, or (2), via email. Documents sent to you through one of these methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this disclosure and any other document that is important to you.

You may opt out of electronic delivery by withdrawing your consent to transact business electronically at any time by updating your delivery preferences in your online account at deltadentalins.com or by calling Customer Service at 866-530-9675.

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deltadentalins.com

Request Confidential Communications

You may request to receive communications about Your protected health information from Us at an alternate location or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, email it to departmentriskethicsandcompliance@delta.org, mail it to the address below or visit our website. Your request will be valid until You cancel it or submit a new one.

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

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ENROLLEE NOTICES

Federal and state laws require enrollees to be notified on a periodic basis about enrollee rights and privacy practices. Below is a summary of the notices that are available under the legal or privacy section of our webpage. To access the most current version and the full text of each notice, please visit our website at deltadentalins.com.

Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP):** Federal regulations require insurance plans to share information about the company's privacy practices. This is called a "Notice of Privacy Practices (NPP)" and should be read when an individual first becomes an enrollee and reviewed at least every three years thereafter.

- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe how demographic and financial information is collected and shared. California requires a state specific notice called the California Financial Privacy Notice, which is described below under the State Notices section.

- **Notice of Non-Discrimination:** We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

- **Language Assistance Notice and Survey:** We provide phone interpretation to callers who do not speak English. In California, we will also provide, on request, a translated copy of certain vital documents in either Spanish or Chinese. In Maryland and Washington DC, enrollees may receive grievance materials in Spanish or Chinese.

State Notices:

- **CA Financial Privacy Notice:** This notice to Californians describes our demographic and financial information collection and sharing practices. It is similar to the Gramm-Leach-Bliley (GLB) notice described above.

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- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.

- **CA Timely Access to Care:** California law requires health plans to provide timely access to care. This law sets limits on how long enrollees must wait to get appointments and telephone assistance.

- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.

- **CA Annual Deductible and OOP Max Accrual Balances:** California law requires health plans to provide enrollees with up-to-date accrual balances towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. Enrollees have the right to request their most up-to-date accrual balance from the health plan at any time.

- **CA Request Confidential Communications:** This notice informs subscribers of methods of contacting the plan when there is a need or desire to provide and alternative address to received protected health information. Users may also choose to use the "Request for Confidential Communication" form when submitting such request.

For questions concerning the notices, please contact us at 866-530-9675. You may also write to us at:

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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Request for Confidential Communications Form

Date:

I would like to request that you send communications about my protected health information at an alternate location or by an alternate method. Reasonable requests for confidential communications will be accommodated and we will make every effort to communicate information using the submitted alternative means.

Please complete this form and email it to DepartmentRiskEthicsandCompliance@delta.org or mail the form using the address below.

Primary Enrollee's Name: ______________________________

Your Name (if not the Primary Enrollee): ______________________________

Member ID number: ______________________________

Date of Birth:

Telephone Number:

Requested alternate location or method of communication:

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We will communicate with you at the alternate address or use the alternate method until we receive a request from you to terminate the alternative communication or to change the alternate location or means of communication.

Should your circumstances change, and you no longer need confidential communications to be sent to you at an alternate location or method, please notify us at:

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330

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