WESTERN DENTAL
Total Rewards
Something to Smile About!

2020 Legally Required Notices

Each year there are legally required notices and disclosures that Western Dental is required to make to participants in the benefit plans. These notices and disclosures are for your information.

Notice or Disclosure

brident DENTAL & ORTHODONTICS

Western Dental® & Orthodontics

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

To assist you as you evaluate health insurance options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact Employee Benefits at 866-523-4359 or **employeebenefits@westerndental.com** The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] *An employer-sponsored health plan meets the "minimum essential value" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.*

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace Application.

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are: Employees working at least 30 hours/week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Your legal spouse, domestic partner and your dependent children up to age 26
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum essential value, and the cost of this coverage to you is intended to be affordable, based on employee wages.

*** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums. If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

3. Employer name (EIFN)	4. Employer Identification Number	
Western Dental Services, Inc.	33-0065869	
5. Employer address	6. Employer phone number	
530 S. Main Street	866-523-4359	
7. City	8. State	9. ZIP Code
Orange	CA	92868
10. Who can you contact at the job?		
Employee Benefits Department		
11. Phone number (if different from above)	12. Email address	
	employeebenefits@westerndental.com	

Medicare Part D Creditable Coverage Disclosure Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Western Dental/Brident and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Western Dental/Brident has determined that the prescription drug coverage offered by the Kaiser Permanente HMO is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Kaiser Permanente coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Kaiser Permanente coverage, be aware that you and your dependents will be able to get this coverage back if you elect coverage during Open Enrollment or experience a Qualifying Life Event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Kaiser Permanente and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

1. Visit **www.medicare.gov**
2. Call your State Health Insurance Assistance Program for personalized help
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Name of Entity/Sender:

Western Dental Employee Benefits Department
530 S. Main Street
Orange, CA 92868
Phone Number: 866-523-4359

REMEMBER: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under the Western Dental Services, Inc. Employee Benefits Plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Employee Benefits Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation cover-age will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Continuation Coverage Rights Under COBRA (continued)

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Western Dental
Employee Benefits Department
866-523-4359
employeebenefits@westerndental.com

Summary of Benefits and Coverage Availability

The health benefits that may be available to you represent a significant component of your compensation package. Health benefits provide important protection for you and your family in the case of illness or injury.

Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the UltiPro Homepage.

A paper copy is also available, free of charge, by calling Employee Benefits at 866-523-4359.

Note: If you have dependents in your household who are enrolled in a plan, please share this SBC information with them.

Kaiser Permanente Patient Practices Disclosure

Kaiser Permanente allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If you are enrolled on an HMO plan, until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier, Kaiser Permanente at 800-464-4000.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier, Kaiser Permanente at 800-464-4000.

Women's Health and Cancer Rights Act

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Newborns' and Mothers' Health Protection Act of 1996

In accordance with this Act, the plans may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Greater protections may be available in certain states.

Social Security Numbers Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, Western Dental will require that you provide Social Security numbers at the time of enrollment to assist its health plan administrators in complying with this requirement. If you need to add a dependent to your coverage who does not have a Social Security number, contact Employee Benefits at 866-523-4359,

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Employee Benefits at 866-523-4359 or **employeebenefits@westerndental.com**.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

State	Website	Telephone
Alabama – Medicaid	http://myalhipp.com/	1.855.692.5447
Alaska – Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1.866.251.4861
Arkansas – Medicaid	http://myarhipp.com/	1.855.692.7447
Colorado – Medicaid & CHIP	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus	1.800.221.3943/ State Relay 711 CHP+: 1.800.359.1991/ State Relay 711
Florida – Medicaid	http://flmedicaidtplrecovery.com/hipp/	1.877.357.3268
Georgia – Medicaid	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678.564.1162 x2131
Indiana – Medicaid	Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ All other Medicaid http://www.indianamedicaid.com	1.877.438.4479 Other Medicaid: 1.800.403.0864
Iowa – Medicaid	http://dhs.iowa.gov/hawki	1.800.257.8563
Kansas – Medicaid	http://www.kdheks.gov/hcf/	1.785.296.3512
Kentucky – Medicaid	http://chfs.ky.gov	1.800.635.2570
Louisiana – Medicaid	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	1.888.695.2447
Maine – Medicaid	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1.800.442.6003 TTY: Maine relay 711

State	Website	Telephone
Massachusetts – Medicaid & CHIP	http://www.mass.gov/eohhs/gov/departments/masshealth/	1.800.862.4840
Minnesota – Medicaid	http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1.800.657.3739
Missouri – Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573.751.2005
Montana – Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1.800.694.3084
Nebraska – Medicaid	http://www.ACCESSNebraska.ne.gov	855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178
Nevada – Medicaid	http://dhcfp.nv.gov	1.800.992.0900
New Hampshire – Medicaid	http://www.dhhs.nh.gov/oii/hipp.htm	603.271.5218 Toll free HIPP program: 1.800.852.3345 x5218
New Jersey – Medicaid & CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609.631.2392 CHIP: 1.800.701.0710
New York – Medicaid	http://www.health.ny.gov/health_care/medicaid/	1.800.541.2831
North Carolina – Medicaid	https://medicaid.ncdhhs.gov/	919.855.4100
North Dakota – Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1.844.854.4825
Oklahoma – Medicaid & CHIP	http://www.insureoklahoma.org	1.888.365.3742
Oregon – Medicaid	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1.800.699.9075
Pennsylvania – Medicaid	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm	1.800.692.7462
Rhode Island – Medicaid	http://www.eohhs.ri.gov/	855.697.4347 or 401.462.0311 (Direct RIte Share Line)
South Carolina – Medicaid	https://www.scdhhs.gov	1.888.549.0820
South Dakota – Medicaid	http://dss.sd.gov	1.888.828.0059
Texas – Medicaid	http://gethipptexas.com/	1.800.440.0493
Utah – Medicaid & CHIP	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1.877.543.7669
Vermont – Medicaid	http://www.greenmountaincare.org/	1.800.250.8427
Virginia – Medicaid & CHIP	Medicaid: http://www.coverva.org/programs_premium_assistance.cfm CHIP: http://www.coverva.org/programs_premium_assistance.cfm	Medicaid: 1.800.432.5924 CHIP: 1.855.242.8282
Washington – Medicaid	https://www.hca.wa.gov/	1.800.562.3022 ext 15473
West Virginia – Medicaid	http://mywvhipp.com/	1.855.699.8447
Wisconsin – Medicaid & CHIP	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1.800.362.3002
Wyoming – Medicaid	https://wyequalitycare.acs-inc.com/	307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notice of Privacy Practices

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.

This is the HIPAA Notice of Privacy Practices for participants in the Western Dental Services, Inc. Employee Benefits Plan (Plan). This Notice describes how we protect health information that we have about you ("Protected Health Information" or "PHI"), and how we may use and disclose this information. Protected Health Information is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care. This Notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this Notice to you by the federal laws known as the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH ACT"). We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. If you have any questions about this Notice or about the Plan's privacy practices, please reach out to the Contact Person listed at the end of this Notice.

We are required by law to:

- Maintain the privacy and security of your PHI;
- Provide you with certain rights with respect to your PHI;
- Provide you notice promptly if a breach occurs that may have compromised the privacy or security of your information;
- Provide you this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and
- Follow the terms of this Notice.

We reserve our rights to change the terms and policies described in this Notice at any time. We also reserve the right to make the revised or changed terms and policies effective for any Protected Health Information that we already have about you, as well as any Protected Health Information they may receive in the future. If we do make material changes to the terms and policies in this Notice, we will provide an updated version of this Notice, which will include the date that the new terms and policies are effective.

Permitted Uses and Disclosures of Your Protected Health Information

In order to provide you with medical benefits, we need personal information about you, and we may obtain that information from many different sources – from you, third-party administrators, insurers, HMOs or health care providers. In administering your health benefits, we may use and disclose this information in various ways, including:

- **For Treatment**: Treatment means the provision, coordination or management of your health care by one or more health care providers. We may disclose medical information about you to health care providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in your care. For example, we may send certain information to doctors for patient safety or other treatment-related reasons.
- **For Payment**: Payment means activities the Plan undertakes to pay for the health or dental care that has been provided to you, including determinations of eligibility and coverage. We may use and disclose your PHI to facilitate payment for treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may disclose Protected Health Information for payment related functions, such as eligibility determinations, resolution of benefit claims or to assist you with your inquiries or disputes.

- **For Health Care Operations**: Health care operations are the support functions of a medical plan, such as quality assessment and improvement activities, case management, receiving and responding to participant complaints, business planning, development, management and administrative activities. We may use and disclose your PHI to enable them to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. We will not use your genetic information for underwriting purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chance of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

Other Uses and Disclosures of Protected Health Information

We also may disclose your Protected Health Information, without your authorization, as permitted or required by HIPAA, including, without limitation, to the following persons or entities for the following reasons:

- **Plan Administration** – to the Plan Administrator or Plan Sponsor, as specified in the Plan documents, for purposes of Plan administrative activities. Unless authorized by you in writing, your Protected Health Information: (1) may not be disclosed by us to any employee, official or department other than those individuals involved in Plan administrative activities, and (2) will not be used for any employment-related actions and decisions or in connection with any other employee benefit plan. In addition, we may disclose "summary health information" to obtain premium bids or modify, amend or terminate the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced under a group health plan, and does not include information that would identify any individual.
- **Business Associates** – to persons or entities that provide services to the Plan. Examples of business associates include third party administrators, data processing companies, or companies that provide general administrative services. For example, we may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, we will disclose your PHI to their business associates so they can perform their claims payment functions. However, we will require our business associates, through written contract, to appropriately safeguard your health information.
- **Treatment Alternatives or Health-Related Benefits and Services** – to you about treatment alternatives or other health-related benefits and services that might be of interest to you.
- **As Required by Law** – to a person or entities as required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.
- **Law Enforcement, Legal Proceedings** – to federal, state and local law enforcement officials, or in response to a court or administrative order. We may also disclose your Protected Health Information in response to a subpoena, discovery request, or other lawsuit process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.
- **Public Health Risks or To Avert a Serious Threat to Health or Safety** – to someone able to help prevent a serious threat to your health and safety, or the health and safety of the public or another person. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.
- **Workers' Compensation, Public Health Activities and Welfare and Industry Regulation** – to Workers' Compensation officials, to address matters of public health or public interest as required or permitted by law (e.g., child abuse and neglect, serious threats to your or public health

and safety, to coroners and medical examiners), or to state insurance departments, the U.S. Department of Labor, the U.S. Department of Health & Human Services and other government agencies that may regulate the Plan.

- **Military, and National Security and Intelligence** – if you are a member of the armed forces, to the armed forces to provide information as required by military command authorities, or to authorized federal officials to conduct intelligence, counterintelligence, or other national security activities.
- **Organ and Tissue Donation** – if you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funeral Directors** – to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duty.
- **Inmates** – if you are an inmate of a correctional institution or are in the custody of a law enforcement official, to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Research** – to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your Protected Health Information.
- **Government Audits** – to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.
- **Your Personal Representatives** – to your personal representative in accordance with applicable state law (e.g., to parents of unemancipated children under 18, to those with unlimited powers of attorney, or health care proxies etc.). Under HIPAA, we do not have to disclose information to a personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (ii) treating such person as your personal representative could endanger you; and (iii) in the exercise of personal judgment, it is not in your best interest to treat the person as your personal representative.
- **Individuals Involved in Your Care or Payment For Your Care** – to a family member involved in or who helps pay for your health care, but only to the extent relevant to that family member's involvement in your care or payment for your care and such disclosures will not be made if you request in writing that we do not make these types of disclosures and we have agreed to such request.

The Plan may disclose your PHI to the Plan Sponsor for the Plan for purposes related to payment of benefits, plan operations, and other matters pertaining to administration of the Plan that involve the Plan Sponsor, for example in connection with appeals that you file following a denial of a benefit claim. When disclosing PHI to the Plan Sponsor, the Plan will make reasonable efforts not to disclose more than the minimum necessary amount of PHI to achieve the particular purpose of the disclosure. In accordance with the plan documents, the Plan Sponsor has agreed not to use or disclose your PHI: (1) other than as permitted in this notice or as required by law, (2) with respect to any employment-related actions or decisions, or (3) with respect to any other benefit plan sponsored by or maintained by the Plan Sponsor.

In addition, the Plan may disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the benefits provided under the Plan. Summary health information summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information in accordance with federal privacy rules.

Special Situations

In all situations other than those described above, you must provide us with your written authorization before we use or disclose Protected Health Information about you. For example, we will not share your information for marketing purposes or sell your information unless you give us written authorization. In addition, most uses of and disclosures of psychotherapy notes requires your authorization. If you have given us an authorization, you may revoke it in writing at any time. Your revocation will not apply to any disclosure we have already made in reliance on your previous authorization. However, we will not make any further disclosures until a new authorization is received. If you have questions regarding authorizations, please call the Contact Person at the end of this Notice.

The plans are prohibited by law from using or disclosing PHI that is genetic information of an individual for underwriting purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chance of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

If a use or disclosure of health information is prohibited or materially limited by other applicable state law, it is the Plan's intention to meet the requirements of the more stringent state law. For instance, special privacy protections may apply to certain sensitive information, HIV-related information, alcohol and substance abuse treatment information, and mental health information. If you would like more information, contact the Contact Person at the end of this Notice.

Your Rights

The following are your various rights concerning your Protected Health Information. If you have questions about any of your rights, please contact the Contact Person at the number listed below.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on Protected Health Information that we are otherwise permitted to use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on your Protected Health Information that the Plan uses or discloses to someone who may be involved in your care or payment for your care, such as a family member or friend. **You should note that we are not required to agree to your request.** To request a restriction, you must make your request in writing to the Contact Person. You must advise: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply – for example, disclosures to your spouse.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about Protected Health Information in a certain way or at a certain location if communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Contact Person and specify how or where you wish to be contacted. We will accommodate reasonable requests.
- **Right to Inspect and Copy Your Protected Health Information.** In most cases, you have the right to inspect and obtain a copy of the Protected Health Information that the Plan maintains about you. To inspect and copy Protected Health Information, you must submit your request in writing to the Contact Person. To receive a copy of your Protected Health Information, you may be charged a fee for the costs of preparing, copying, mailing or other supplies associated with your request. If the information you requested is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request; if the information cannot be readily produced in that form and format, we will provide you with a paper copy. In limited circumstances, we may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial by submitting a written request to the Contact Person.

- **Right to Amend Your Protected Health Information.** If you believe that your Protected Health Information is incorrect or that an important part of it is missing, you have the right to ask the Plan to amend your Protected Health Information while it is kept by or for the Plan. You must provide your request and your reason for the request in writing to the Contact Person. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Protected Health Information that:
  - — is accurate and complete;
  - — was not created by the Plan, unless the person or entity that created the Protected Health Information is no longer available to make the amendment;
  - — is not part of the Protected Health Information kept by or for the Plan; or
  - — is not part of the Protected Health Information which you would be permitted to inspect and copy.
- **Right to a List of Disclosures.** You have the right to request a list of the disclosures of Protected Health Information about you that we have made. This list will not include disclosures made for treatment, payment, or health care operations, for purposes of national security, made to law enforcement personnel, made pursuant to your authorization, made to family or friends in your presence or because of an emergency, or made directly to you. To request this list, you must submit your request in writing to the Contact Person. Your request must state the time period for which you want to receive a list of disclosures, which time period shall be no more than six years from the date on which the list is requested. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Be Notified of a Breach.** You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured PHI.
- **Right to a Paper Copy of the Notice.** You have the right to a paper copy of this notice. You may write to the Contact Person to request a written copy of this notice at any time.
- **Changes to this Notice.** The Plan reserves its rights to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future.

Complaints

If you believe that your privacy rights have been violated, you may contact the Plan's Contact Person in writing at the address below. You may also file a complaint with the Secretary of the United States Department of Health and Human Services Office of Civil Rights at: 200 Independence Ave., S.W., Washington, D.C. 20201, or calling 877-696-6775,, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.

We will not retaliate against you if you file a complaint.

Contact Information

If you have any questions, or would like further information about the policies described in this notice, or would like a paper copy of this notice, please contact:

Employee Benefits Department
Western Dental Services, Inc.
530 S. Main Street
Orange, California 92868
Telephone: 866-523-4359

Summary Annual Report for Western Dental Services, Inc. Welfare Benefits Plan

This is a summary of the annual report of the WESTERN DENTAL SERVICES, INC. WELFARE BENEFITS PLAN, a health, life insurance, dental, vision, and long-term disability plan (Employer Identification Number 33-0065869, Plan Number 502), for the plan year 0101/2018 AND 12/31/2018. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Security Act of 1974 (ERISA).

Insurance Information

The plan has insurance contracts with KAISER FOUNDATION HEALTH PLAN, INC, RELIANCE STANDARD LIFE INSURANCE COMPANY VISION SERVICE PLAN, WDS EMPLOYEE DENTAL PLAN and GERBER LIFE INSURANCE COMPANY to pay certain Health, Long-term disability, Vision, Life insurance, AD&D, VOLUNTARY ACCIDENT INSURANCE, AD&D, Dental claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2018 were $9,022,830.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1) Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of KEVIN SIMES, who is a representative of the plan administrator, at 530 SOUTH MAIN STREET, 6TH FLOOR, ORANGE, CA 92868 and phone number 714-571-3415. The charge to cover copying costs will be $5.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan: 530 SOUTH MAIN STREET, 6TH FLOOR, ORANGE, CA 92868, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.