

**UNIVERSITY
OF
CALIFORNIA**

**DENTAL PPO
EMPLOYEE BENEFIT BOOKLET
For Employees, Retirees, and their Dependents**

January 1, 2026

**Group Numbers:
18066 (Employees & Retirees)
18067 (COBRA)**

Administered by:



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**AN EMPLOYEE BENEFIT BOOKLET OF THE DENTAL PROGRAM FOR ELIGIBLE
EMPLOYEES AND RETIREES OF THE UNIVERSITY OF CALIFORNIA**

This booklet is a Summary of the Dental Program ("Program") and has been prepared for participants who are employees of and retirees of the University of California.

This Program has been established and is maintained and administered in accordance with the provisions of group Dental **Contract No. 18066 and 18067** issued by Delta Dental of California ("Delta Dental") and this Summary Plan Description.

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website: <https://www1.deltadentalins.com/group-sites/uc.html>

IMPORTANT

This booklet is subject to the provisions of the University's Contract with Delta Dental and the University of California Group Insurance Regulations and cannot modify or affect these documents in any way, nor shall you accrue any rights because of any statement in or omission from this booklet. Some provisions of this Program may not apply to employees in certain exclusively represented bargaining units.

PLEASE READ THIS BOOKLET CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "HOW TO USE YOUR PROGRAM."

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

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

The telephone number at which you may obtain information about Benefits is 1-800-777-5854.

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UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2026

The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Complete Guide to Your UC Health Benefits.” A copy of this booklet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members.” A copy of this fact sheet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

DEFINITIONS

Certain words that you will see in this booklet have specific meanings. These definitions should make your dental program easier to understand.

Accepted Fee - the amount the attending Dentist agrees to accept as payment in full for services rendered to Enrollees.

Benefits - those dental services available under the Contract and which are described in this booklet.

By Report - documentation submitted to Delta Dental by the Dentist demonstrating the clinical need for the procedure.

Contract or Group Dental Contract - the written agreement between Delta Dental and the Employer to provide dental Benefits. The Contract, together with this booklet, form the terms and conditions of the Benefits you are provided.

Contract Benefit Level - the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied.

Covered Services - those dental services to which Delta Dental will apply Benefit payments, according to the Contract.

Deductible - the amount you must pay for dental care each year before Delta Dental's Benefits begin.

Delta Dental Premier[®] Dentist (Premier Dentist) - a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Dentist also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee - the fee for a Single Procedure covered under the Contract that a Premier Dentist has contractually agreed to accept as payment in full for covered services.

Delta Dental PPOSM Dentist (PPO Dentist) - a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for covered services provided under a PPO dental plan. A PPO Dentist also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee - the fee for a Single Procedure covered under the contract that a PPO Dentist has contractually agreed to accept as payment in full for covered services.

Dentist – a duly licensed Dentist legally entitled to practice dentistry when and where services are provided.

Dental Accident – an external blow or other trauma (fall, fist, car accident, gunshot wound, etc.) that would cause severe damage to the dentition, or an internal accident such as biting into glass or a stone that causes severe tooth damage.

Dependent - a Primary Enrollee's Dependent or an Eligible Retiree's Dependent who is eligible to be enrolled for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Effective Date - the date this program starts.

Eligible Retiree - any retiree who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this brochure.

Employer - The Regents of the University of California for whose employees and Eligible Retirees dental Benefits are provided.

Enrollee - a Primary Enrollee, Eligible Retiree or Dependent enrolled to receive Benefits or a person who chooses to pay for **OPTIONAL CONTINUATION OF COVERAGE**.

Maximum - the greatest dollar amount Delta Dental will pay for covered procedures in any calendar year (and during the Enrollees lifetime for Orthodontic Benefits and TMJ Benefits.)

Non-Delta Dental Dentist - a Dentist who is not a PPO Dentist or a Premier Dentist and is not contractually bound to abide by Delta Dental's administrative guidelines.

Non-routine exam - an examination for an emergency (for example, an injury or infection) or an examination for a specific dental problem (for example, a toothache or an exam to evaluate the need for oral surgery).

Participating Plan – Delta Dental and any other member of the Delta Dental Plans Association with whom Delta Dental contracts for assistance in administering your Benefits.

Patient Copayment – the portion of the Dentist's fee or allowances which is the Enrollee's responsibility.

Plan Year – the period from January 1st through December 31st.

PPO – a preferred provider organization dental product that allows Enrollees to choose any dentist, but offers less out of pocket expenses when Enrollees visit a contracted Delta Dental PPO dentist. See the definition above for Delta Dental PPO Dentists who participate in this program.

Primary Enrollee - any employee or Eligible Retiree who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Program Allowance - the amount determined for a set level of all charges for such services by Dentists in the same geographical area.

Routine exam - an initial exam with a new dentist or a periodic exam with your current dentist to generally assess your dental health.

Single Procedure – a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

Submitted Fee - the amount that the Dentist bills and enters on a claim for a specific procedure.

HOW TO USE YOUR PROGRAM

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

Delta Dental does not guarantee the availability of any particular dentist.

You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dental Dentist. This is because their fees are approved in advance by Delta Dental. Delta Dental Dentists have treatment claims on hand and will complete and submit the forms to Delta Dental free of charge.

If you choose a Delta Dental PPO Dentist, you will receive all of the advantages of going to a Delta Dental Dentist, and you may have lower out-of-pocket expenses for certain services.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society, which is listed in the local telephone directory.

If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists should be submitted to Delta Dental at the address listed in this brochure within twelve months from the date of service as submitted on your claim. It is your responsibility to give Delta Dental the required information necessary to evaluate your claim for dental benefits.

A list of Delta Dental PPO Dentists and Delta Dental Premier Dentists can be obtained by calling 1-800-427-3237 or by visiting our website, <https://www1.deltadentalins.com/group-sites/uc.html>. This list will identify those dentists who can provide care for individuals who have mobility impairments or have special health care needs. You can obtain specific information about Delta Dental PPO Dentists and Delta Dental Premier Dentists by using our website – <https://www1.deltadentalins.com/group-sites/uc.html> or by calling the Delta Dental Customer Service department. Please note that the lists of PPO and Premier Dentists may change, so it is important to check the applicable list whenever you obtain care to ensure that your dentist belongs to the applicable network.

Dentists located outside the United States are not Delta Dental Dentists. Claims submitted by out-of-country dentists are translated by Delta Dental staff and the currency is converted to U.S. dollars. Claims submitted by out-of-country dentists for Enrollees residing in California are referred to Delta Dental's processing department for review. Delta Dental may require a clinical examination to determine the quality of the services provided, and Delta Dental may decline to reimburse you for Benefits if Delta Dental finds the services to be unsatisfactory.

If you submit notice of a claim to Delta Dental, acknowledgment of its' receipt of your claim (and any claim forms) will be provided within 15 calendar days. Delta Dental will commence its investigation of your claim not more than 15 calendar days after receiving notice of your claim. You should receive timely notification from Delta Dental about whether Benefits will be received under the plan within 40 calendar days after Delta Dental's receipt of your claim. If Delta Dental needs more time to make a determination, you will be notified within 40 calendar days and told why. If Delta Dental needs additional information to determine your claim, the written notice will specify the additional information required and state any continuing reasons for Delta Dental's inability to make a determination. Notice will be provided every 30 calendar days until a determination is made.

Many dentists are familiar with Delta Dental Care Programs and have Delta Dental claim forms. If not, the Dentist may contact:

DELTA DENTAL OF CALIFORNIA

P.O. Box 997330
Sacramento, CA 95899-7330
Tel. No. (800) 777-5854

To obtain Benefits, your Dentist should submit a claim form to the Delta Dental San Francisco office.

Services from dental school clinics may be provided by students of dentistry or instructors who are not licensed by the state of California.

Delta Dental shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases or compel your dentist to be tested for HIV or to disclose test results to Delta Dental, or to you. Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this issue. If you have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

SECOND OPINIONS

Delta Dental obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta Dental will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a

complaint regarding the quality of care provided. Delta Dental will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, it will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose and claims for the examination may be submitted to Delta Dental for payment. Delta Dental will pay such claims in accordance with the Benefits of the program.

GRIEVANCE PROCEDURE AND CLAIMS APPEAL

If an Enrollee has any questions about the services received from a Delta Dental Dentist, Delta Dental recommends that he or she first discuss the matter with the Dentist. If he or she continues to have concerns, the Enrollee may call or write Delta Dental. Delta Dental will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between the Enrollee and the group. If an Enrollee has any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, he or she may call Delta Dental toll-free at 1-800-777-5854, contact Delta Dental on the Internet through the website: <https://www1.deltadentalins.com/group-sites/uc.html> or write Delta Dental at P. O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If an Enrollee's claim has been denied or modified, the Enrollee may file a request for review (a grievance) with Delta Dental within 180 days after receipt of the denial or modification. If in writing, the correspondence must include the group name and number, the Primary Enrollee's name and nine-digit member identification number, the inquirer's telephone number and any additional information that would support the claim for benefits. The correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, Delta Dental will provide the Enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of Delta Dental's regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta Dental's review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and Delta Dental will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract terms, Delta Dental shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta Dental will provide the Enrollee a written acknowledgment within 5 days of receipt of the request for review. Delta Dental will make a written decision within 30 days of receipt of the request for review, or inform the Enrollee of the pending status if more information or time is

needed to resolve the matter. Delta Dental will respond, within 3 days of receipt, to complaints involving severe pain and imminent and serious threat to a patient's health.

Decisions made by Delta Dental regarding grievances and appeals for claims are final and binding on all parties.

PUBLIC POLICY PARTICIPATION BY ENROLLEES

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Delta Dental of California, Customer Service department, P. O. Box 997330, Sacramento, CA 95899-7330.

COORDINATION OF BENEFITS (DUAL COVERAGE)

If a group insurance policy or any other group health Benefits program, including another Delta Dental program, entitles a person to receive or be reimbursed for the cost of dental services, which are also Benefits under this program, and if this program is "primary" under the rules described below, Delta Dental will provide Benefits as if the other program did not exist. If the other program is "primary" under these rules, then Delta Dental will provide Benefits under this program only to the extent that the other program does not fully provide the dental services.

If the other program mainly covers services or expenses other than dental care, this program is "primary." Otherwise, Delta Dental will use the following rules to determine which program is "primary":

- (a) The program which covers the person as other than a Dependent is primary over the program which covers the person as a Dependent, with the following exception:

If the person is also a Medicare Beneficiary and Medicare is:

- (i) secondary to the program covering the person as a Dependent; and
- (ii) primary to the program covering the person as other than a Dependent (for example, a retired employee);

then the Benefits of the program covering the person as a Dependent are determined before the Benefits of the program covering the person as other than a Dependent.

- (b) The program which covers a child as a Dependent of a parent whose birthday occurs earlier in a calendar year is primary over the program which covers a child as a Dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in (c) below).

- (c) In the case of a dependent child whose parents are legally separated or divorced:
 - (i) If the parent with custody has not remarried, the program which covers the child as a Dependent of the parent with custody is primary over the program which covers the child as a Dependent of the parent without custody.
 - (ii) If the parent with custody has remarried, the program which covers the child as a Dependent of the parent with custody is primary over the program which covers the child as a Dependent of the step-parent, and the program which covers the child as a Dependent of the step-parent is primary over the policy or program which covers the child as a Dependent of the parent without custody.
 - (iii) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this program, then notwithstanding (i) and (ii), the program which covers the child as a Dependent of the parent with such financial responsibility is primary over any other program which covers the child.

The Benefits of a program covering a laid-off or retired employee (or Dependent of such person) shall be determined after the Benefits of any other program covering such person as an employee.

If a person whose coverage is provided under federal or state law requiring continuation is covered under more than one program, Benefits order shall be determined as follows:

- (a) The Benefits of the program covering the person as an employee or Dependent shall be primary.
- (b) The Benefits under continuation coverage shall be secondary.

If the primary program cannot be determined by the rules described in this Article 6, the program which has covered the person longer shall be primary.

An Enrollee will provide Delta Dental with any information about the person that is needed to administer this Coordination of Benefits section, and Delta Dental may release any information to or obtain any information from any insurance company or other organization in order to coordinate the Benefits of an Enrollee. Delta Dental in its sole discretion will determine whether any reimbursement is warranted to an insurance company or other organization under this provision, and it is agreed that any such reimbursement paid by Delta Dental will be Benefits under this Contract. Delta Dental has the right to recover the value of any Benefits provided by Delta Dental which exceed its obligations under the terms of this provision from a Delta Dental Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses.

AMENDMENT AND TERMINATION

While the University intends to maintain the Dental Program indefinitely, the University may amend or terminate the Dental Program in whole or in part at any time in its sole discretion. Upon cancellation of the Program, individual employees and their Dependents have no right to renewal or reinstatement.

BENEFITS PROVIDED BY THE PROGRAM

Your program covers the following services when they are provided by a licensed Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. See also **LIMITATIONS AND EXCLUSIONS**. These services are covered after the Deductible is met and up to Maximum amounts as outlined in the section **AMOUNT OF BENEFITS PAYABLE**.

The fees covered by the plan, as listed below, are based on the Maximum Contract Allowance. Please refer to the section entitled **COVERED FEES** for additional details.

I. **DIAGNOSTIC & PREVENTIVE BENEFITS –** **100% of the PPO Dentists' fees** **100% of the Premier Dentists' fees** **100% of the Non-Delta Dental Dentists' fees**

Diagnostic & Preventive – prophylaxis (cleaning); fluoride treatment; space maintainers; oral examinations; x-rays; diagnostic casts; palliative (emergency) treatment of dental pain only.

Cone Beam Images – only when received in conjunction (same day) with implants, endodontics, and/or TMJ.

Note on additional Benefits during pregnancy. If you are pregnant, Delta Dental will pay for additional services to help improve your oral health during pregnancy. The additional services each calendar year while you are eligible for this Delta Dental plan include one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant. Written confirmation of your pregnancy must be provided by you or your dentist when the claim is submitted.

OTHER PREVENTIVE BENEFITS – **100% of the PPO Dentists' fees** **80% of the Premier Dentists' fees** **80% of the Non-Delta Dental Dentists' fees**

Pit and fissure sealants – see limitation (i).

II. BASIC BENEFITS –
80% of the PPO Dentists' fees
75% of the Premier Dentists' fees
75% of the Non-Delta Dental Dentists' fees

Restorative - amalgam, silicate, or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).

General Anesthesia or IV Sedation – when administered by a licensed Dentist for covered Oral Surgery or selected endodontic and periodontal surgical procedures. General Anesthesia or IV sedation may be allowed in conjunction (same day) with additional procedures for a disabled person.

Prosthodontic appliance repair

III. OTHER BASIC BENEFITS –
80% of the PPO Dentists' fees
80% of the Premier Dentists' fees
80% of the Non-Delta Dental Dentists' fees

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care.

Endodontic - treatment of the tooth pulp, including root canal therapy.

Periodontic - treatment of gums and bones that support the teeth.

IV. CROWNS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS –
50% of the PPO Dentists' fees
50% of the Premier Dentists' fees
50% of the Non-Delta Dental Dentists' fees

Crowns, Inlays, Onlays, and Cast Restorations are Benefits only if they are provided to treat cavities that cannot be restored with amalgam, silicate, or direct composite (resin) restorations.

V. PROSTHODONTIC BENEFITS –
50% of the PPO Dentists' fees
50% of the Premier Dentists' fees
50% of the Non-Delta Dental Dentists' fees

Construction of fixed bridges, partial dentures, and complete dentures are Benefits if provided to replace missing, natural teeth.

Implant surgical placement and removal and for implant-supported prosthetics, including implant repair and re-cementation.

VI. ORTHODONTIC BENEFITS –
50% of the PPO Dentists' fees
50% of the Premier Dentists' fees
50% of the Non-Delta Dental Dentists' fees

Procedures using appliances to straighten or realign teeth, which otherwise would not function properly.

VII. TEMPOROMANDIBULAR JOINT (TMJ) BENEFITS –
50% of the PPO Dentists' fees
50% of the Premier Dentists' fees
50% of the Non-Delta Dental Dentists' fees

Covered procedures for the treatment of TMJ dysfunction are limited to:

- occlusal guards – for treatment of grinding, crunching or bruxing of teeth
- occlusal orthotic devices

Since these are the only covered procedures for this specific condition, it is strongly suggested you obtain a predetermination of treatment from Delta Dental to determine the patient's share.

LIMITATIONS AND EXCLUSIONS

LIMITATIONS

- a) Oral examinations are limited to two per calendar year while you are eligible under any Delta Dental Program. This includes routine exams, non-routine exams, or any combination of the two. See Note on additional Benefits during pregnancy.
- b) Benefits under this program will include only the first two prophylaxes, or Single Procedure which includes prophylaxes, or combination thereof, provided to a patient in a calendar year while he or she is an Enrollee under any Delta Dental program. Additional cleanings may be allowed By Report if documentation demonstrates that the procedure is clinically necessary. See Note on additional Benefits during pregnancy.
- c) Fluoride treatments include prophylaxis and are covered twice in a calendar year.
- d) Unless special need is shown, full-mouth x-rays are a Benefit once in a five-year period while you are eligible under any Delta Dental program.

Delta Dental pays for a panoramic x-ray provided as an individual service only after five years have elapsed since any prior panoramic x-ray was provided under any Delta Dental plan.

- e) Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over, while you are eligible under any Delta Dental program (including non-University Delta Dental programs).

- f) Emergency palliative treatment is limited to three visits per calendar year for treatment of the same problem.
- g) Space maintainers are limited to children through age 12 and only once every five years while you are eligible under any Delta Dental program.
- h) Pit and fissure sealant Benefits include the application of sealants only to permanent first molars through age 9 and second molars through age 15 if they are without caries (decay), or restoration on the occlusal surface.
- i) Periodontal limitations:
 - i. Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
 - ii. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
 - iii. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
 - iv. If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
 - v. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Dentist's office.
 - vi. Periodontal procedures which include prophylaxis are limited under Limitation c). See Note on Additional Benefits during pregnancy.
- j) Crowns, Inlays, Onlays, and Cast Restorations are Benefits on the same tooth only once every seven years, while you are eligible under any Delta Dental program, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care by the dentist, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.
- k) Prosthodontic appliances (including but not limited to, fixed bridges and partial or complete dentures) and implants are Benefits only once every seven years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory. Delta Dental will replace an implant, a prosthodontic appliance or an implant-supported prosthesis you received under another dental plan if we determine it is unsatisfactory and cannot be made satisfactory. We will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

- l) Delta Dental will pay its percentage of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture. A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.
- m) If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee.

For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

- n) If orthodontic treatment is begun before you become eligible for coverage, Delta Dental's payments will begin with the first payment due to the dentist following your eligibility date.
- o) Orthodontic Benefits will be provided in two payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than \$500.00 or when the treatment plan is 12 months or less, one payment will be made.
- p) Delta Dental's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed, or the termination date of the Contract, whichever shall occur first.
- q) X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits but may be covered under Diagnostic & Preventive or Basic Benefits.
- r) Dental services associated with treatment of TMJ dysfunction which are not listed as TMJ Benefits may be covered under Diagnostic & Preventive or Basic Benefits.
- s) Charges for replacement of lost, missing, or stolen devices are not covered.
- t) Occlusal guards or occlusal orthotic devices will be repaired or replaced only after three years have elapsed following any prior provision of such appliances under this program, except when Delta Dental determines that there is such extensive change in the patient's dental condition (such as loss of a tooth or teeth) that the existing appliance cannot be made functional.
- u) Replacement of an occlusal guard or occlusal orthotic device not provided under a Delta Dental contract will be made only if it is unsatisfactory and cannot be made functional.
- v) Services for bruxism (grinding of teeth) unrelated to TMJ dysfunction are not covered.

- w) If your medical plan does not cover any particular claim for Dental Accident benefits, either in whole or in part, Delta Dental will pay based on your current plan design, subject to all limitations and annual maximum benefits. Your medical plan's customer service representatives will be able to confirm the coverage for Dental Accidents that your medical plan provides.

EXCLUSIONS/SERVICES WE DO NOT COVER

Delta Dental covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is important for you to know what these services are before you visit your dentist.

Delta Dental does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws, services which are provided by any federal or state government agency, or are provided without cost by any municipality, county or other political subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
2. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
3. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatments are equilibration and periodontal splinting.
4. Any Single Procedure, bridge, denture or other prosthodontic service, including implants, which was started before the Enrollee was covered by this program.
5. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.
6. Experimental procedures.
7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
8. Anesthesia, except for general anesthesia or I.V. sedation given by a dentist for covered oral surgery procedures and select Endodontic and Periodontic procedures and for disabled enrollees whose disability necessitates anesthesia in order for the dentist to provide treatment.
9. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").
10. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues, except those procedures listed in the Benefits provided by the Program.

11. Replacement of existing restoration for purposes other than active tooth decay. Replacement will not be made within two years, if done by the same dentist or by a dentist at the same dental office, unless due to external violent means, recurrent caries or radiation therapy.
12. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
13. Surgical procedures for correction of malalignment of teeth and/or jaws.
14. Gingival curettage.
15. Injection of antibiotic drugs.

AMOUNT OF BENEFITS PAYABLE

After you have satisfied the Deductible requirements stated below, the program provides payment of the indicated percentage of the remaining covered fees **up to the Maximum of \$1,700 for services provided by a Delta Dental PPO Dentist or \$1,500 for services provided by a non-Delta Dental PPO Dentist** (details below) for each Enrollee in each calendar year for the following Benefits:

Diagnostic & Preventive Benefits.....	100% PPO Dentist
.....	100% Premier Dentist
.....	100% Non-Delta Dental

Dentist

Other Preventive Benefits.....	100% PPO Dentist
.....	80% Premier Dentist
.....	80% Non-Delta Dental

Dentist
(Pit and Fissure Sealants)

Basic Benefits.....	80% PPO Dentist
.....	75% Premier Dentist
.....	75% Non-Delta Dental

Dentist
(Restorative, General anesthesia, Prosthetic Appliance Repair)

Other Basic Benefits.....	80% PPO Dentist
.....	80% Premier Dentist
.....	80% Non-Delta Dental

Dentist
(Oral Surgery, Endodontics, Periodontics)

Crowns, Inlays, Onlays, and Cast Restoration Benefits	50% PPO Dentist
.....	50% Premier Dentist
.....	50% Non-Delta Dental

Dentist

Prosthodontic & Implant Benefits.....	50% PPO Dentist
.....	50% Premier Dentist
.....	50% Non-Delta Dental
Dentist	

For a more complete description of Benefits, refer to Benefits Provided by the Program. The amount of Benefits payable is subject to Limitations and Exclusions.

Deductible: You will be responsible for the first \$50 of covered fees for each eligible member of your family in each calendar year. This Deductible does not apply to Diagnostic & Preventive Benefits (including Pit and Fissure Sealant Benefits) or Orthodontic Benefits.

Calendar Year Maximum: All Benefits listed above and Dental Accident Benefits are subject to a calendar year Maximum of \$1,700 for services provided by a PPO Dentist or \$1,500 for services provided by a Premier Dentist or a Non-Delta Dental Dentist per covered enrollee. TMJ and Orthodontic Benefits are not subject to the calendar year Maximum, however, are subject to a separate lifetime Maximum as listed below.

Maximums cross accumulate among in-network and out-of-network services. Members do not receive two separate Maximums between PPO and Non-Delta Dental PPO networks.

TMJ BENEFITS

The program provides payment of 50% of covered fees for occlusal guards and occlusal orthotic devices provided for the treatment of temporomandibular joint (TMJ) dysfunction. These services are subject to the \$50 annual calendar year Deductible. The Maximum amount payable under this program for all TMJ Benefits provided during an Enrollee’s lifetime is \$500. The TMJ lifetime Maximum is in addition to the \$1,700 or \$1,500 annual Maximum for other covered Benefits.

ORTHODONTIC BENEFITS

The program also provides payment of 50% of the covered fees for Orthodontic Benefits provided to Enrollees, up to the Maximum of \$1,500 for each eligible patient under age 26 and \$500 for each eligible patient age 26 and older. The Maximum amount is in addition to the \$1,700 or \$1,500 annual Maximum for other covered Benefits and is a lifetime Maximum. Orthodontic services are not subject to the Deductible, and amounts paid by an eligible patient for orthodontics will not be credited against the Deductible.

NOTE: If a plan member has orthodontic treatment initiated (bands placed) prior to their 26th birthday, and if the second installment is billed no later than one year after the 26th birthday, the member will receive the \$1,500 Maximum benefit.

DENTAL ACCIDENT BENEFITS

Services necessary as a result of a dental accident (a condition caused directly by external, violent or accidental means) may be covered as primary under your medical coverage. All

claims should first be submitted to your medical carrier for review and possible payment, prior to submitting them under your Delta Dental plan.

Questions regarding these fees should be directed to Delta Dental's Customer Service department at
1 (800) 777-5854.

Please refer to the section entitled Covered Fees for additional details.

COVERED FEES

Covered services are available from the Enrollee's eligibility date.

It is to your advantage to select a dentist who is a Delta Dental PPO Dentist, since a lower percentage of the Dentist's fees may be covered by this program if you select a Dentist who is not a Delta Dental PPO Dentist.

A list of Delta Dental Dentists (see DEFINITIONS) is available by calling 1-800-427-3237.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Dentist is the lesser of the Dentist's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Dentist is the lesser of the Dentist's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Dentist is the lesser of the Dentist's Submitted Fee or the Program Allowance.

Payment for Services — PPO Dentist

Payment for covered services performed for you by a PPO Dentist is calculated based on the Maximum Contract Allowance. PPO Dentists have agreed to accept the Delta Dental PPO Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Amount of Benefits Payable. Delta Dental's payment is sent directly to the PPO Dentist who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the Plan Year Maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Premier Dentist

Payment for covered services performed for you by a Premier Dentist is calculated based on the Maximum Contract Allowance. Premier Dentists have agreed to accept the Delta Dental Premier Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Amount of Benefits Payable. Delta Dental's payment is sent directly to the Premier Dentist who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the Plan Year Maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Delta Dental Dentist

Payment for services performed for you by a Non-Delta Dental Dentist is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Amount of Benefits Payable. Non-Delta Dental Dentists have no agreement with Delta Dental and are free to bill you for any difference between what Delta Dental pays and the Submitted Fee.

When dental services are received from a Non-Delta Dental Dentist, Delta Dental's payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Delta Dental Dentist's Submitted Fee. Non-Delta Dental Dentists will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Dentist yourself and then submit a claim to us for reimbursement. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Amount of Benefits Payable. Since our payment for services you receive may be less than the Non-Delta Dental Dentist's actual charges, your out-of-pocket cost may be significantly higher. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the Plan Year Maximum has been exceeded, and/or charges for non-covered services.

If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees or allowances reduced by the amount of such Patient Copayment or allowances that are discounted, waived, or rebated.

Payment to a dentist located in another state or outside the United States will be based on the applicable percentage of the lesser of the Submitted Fee, or the fee which the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees under this plan. For a dentist who is not a Delta Dental Dentist, payment will be based on the applicable percentage of the lesser of the Submitted Fee or the Program Allowance.

EXTENSION OF BENEFITS

All Benefits cease on the date coverage terminates except that Delta Dental will pay for Single Procedures, other than orthodontic procedures, which were commenced while eligible.

If an Enrollee is totally disabled when coverage ceases, dental expense benefits will continue to be available during the disability for up to 12 months, but only if expenses incurred represent the charges for covered services which have been rendered and received, including delivered and installed, if applicable, prior to the end of the 12-month period.

However, dental expense Benefits will cease immediately when the individual becomes covered under any group plan with similar benefits, if the coverage terminates for any reason other than discontinuance of the Benefit section as to the eligible class of which the Enrollee is a member.

CONTINUITY OF CARE

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this Contract with your terminated Delta Dental Provider for certain specified dental conditions. If you are a new Enrollee, you may have the right to completion of care under this Contract with your Non-Delta Dental Provider for certain specified dental conditions. You must make a specific request for this completion of care benefit. To make a request, contact our Customer Service Center at 800-765-6003. You may also contact us to request a copy of Delta Dental's Continuity of Care Policy. Delta Dental is not required to continue care with the Provider if you are not eligible under this Contract or if Delta Dental cannot reach agreement with the Non-Delta Dental Provider or the terminated Delta Dental Provider on the terms regarding Enrollee care in accordance with California law.

IDENTIFICATION

During your first appointment, be sure to give your dentist the following information:

1. Your Delta Dental group number:

18066 (Employees, Retirees, and dependents)
18067 (COBRA enrollees)
2. The employer's name:

University of California
3. Campus/Lab Name.
4. Primary Enrollee's or Retiree's member identification number (which must also be used by Dependents).

You can print an I.D. card with this information by visiting our website at <https://www1.deltadentalins.com/group-sites/uc.html>.

REIMBURSEMENT PROVISIONS

Delta Dental is entitled to receive to lawful extents information and records about examinations and treatment provided to you from an attending or examining Dentist, or from hospitals in which a Dentist's care is provided, as may be required in the administration of your claims, or to require that a patient be examined by a dental consultant retained by Delta Dental in or near the patient's community or residence. Delta Dental agrees in every case to hold such information and records as confidential.

Delta Dental will pay Delta Dental Dentists directly. Delta Dental of California's agreement with our Delta Dental Dentists makes sure that you will not be responsible to the dentist for any money we owe. However, if for any reason we fail to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dental Dentist, Delta Dental will pay you. Payments made to you are not assignable (in other words, we will not grant requests to pay non-Delta Dental Dentists directly).

Payment for claims exceeding \$500 for services provided by dentists located outside the United States may, at Delta Dental's option, be conditioned upon a clinical evaluation at Delta Dental's request (see Second Opinions). Delta Dental will not pay Benefits for such services if they are found to be unsatisfactory.

Delta Dental does not pay Delta Dental Dentists any incentive as an inducement to deny, reduce, limit, or delay any appropriate service. If you wish to know more about the method of reimbursement to Delta Dental Dentists, you may call Delta Dental's Customer Service department for more information.

Payment for any Single Procedure which is a Covered Service will only be made upon completion of that procedure. Delta Dental does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any Deductible (and determines when a charge is made against any Maximum) under your program.

If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental's Customer Service department. We may be able to help you resolve the situation.

Delta Dental may deny payment of any claim form for services submitted more than six months after the date the services were provided. If a claim is denied due to a Delta Dental Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta Dental (unless you failed to advise the dentist of your eligibility at the time of treatment).

The process Delta Dental uses to determine or deny payment for services are distributed to all Delta Dental Dentists. They describe in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the program. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Delta Dental's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service department for more information regarding Delta Dental's processing policies.

Delta Dental uses a method called "first-in/first-out" to begin processing your claims. The date we receive your claim determines the order in which processing begins. For example, if you receive dental services in January and February, but we receive the February claim first, processing begins on the February claim first.

Incomplete or missing data can affect the date the claim is paid. If you or your dentist has not provided Delta Dental with all information necessary to complete claim processing, payment could be delayed until any missing or incomplete data is received by Delta Dental.

Unless the services are exempt, you are required to pay the Deductible on the first claim for which processing is completed in a calendar year. Your Deductible is normally paid on the first service subject to a deductible listed on a claim with multiple services.

The order in which your claims are processed and paid by Delta Dental may also impact your annual Maximum. For example, if a claim with a later date of service is paid and your annual Maximum for the year has been reached then a claim with an earlier date of service in the same calendar year will not be paid.

Maximums can also be affected when the amount paid for services provided by Delta Dental PPO Dentists is higher than the maximum paid for services provided by non-PPO dentists. For example, if the Delta Dental PPO Plan's annual Maximum is \$1,700 and the maximum for services provided by non-PPO dentists is \$1,500 and Delta Dental has paid \$1,500 or more dollars for covered dental services, you do not qualify for any further payments for services provided by non-PPO dentists. But, if any other covered services are provided by a Delta Dental PPO Dentist, you qualify for an additional \$200.

PREDETERMINATIONS

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than \$300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send a claim form to us listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your Dentist and decide to go ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to Delta Dental.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

University of California Healthcare Plan Notice of Privacy Practices - Self-Funded Plans – Effective January 1, 2025

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 Healthcare Notification of Privacy Practices applies to the University of California Self-Funded Plans, including UC Care, UC Health Savings, CORE, UC High Option Supplement to Medicare, UC Medicare PPO, UC Medicare PPO without Prescription Drugs and the Dental PPO.

UC'S COMMITMENT

The University is committed to protecting the privacy of your protected health information or PHI. PHI refers to health information that a Self-Funded Plan creates or receives that relates to your physical or mental health, your healthcare, or payment for your healthcare. In most cases, your PHI is maintained by the business associate that serves as the third party administrator for the Self-Funded Plan in which you participate, but the University, as a group health plan sponsor, may also hold health-related information. Generally, the University-held information is limited to enrollment data, but in limited instances, it may include information you provide to designated UC staff to help with coordination of benefits, or resolving complaints.

The privacy protections described in this notice reflect the requirements of federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). They require the Self-Funded Plans to:

- Comply with HIPAA privacy standards and other federal laws;
- Make sure that your PHI is protected;
- Give you this notice of the Self-Funded Plans' legal duties and privacy practices with respect to your PHI; and
- Follow the legal duties and privacy practices described in this notice ("Notice").

How We May Use and Disclose Your Health Information

We typically use and disclose your health information in the following ways.

- **Treatment.** A Self-Funded Plan may use and disclose your PHI to doctors, nurses, technicians, and other personnel who are involved in providing you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may then tell the dietitian if you have diabetes so the dietitian can meet any special menu needs. Different departments may share your PHI so they can coordinate services you need, such as lab work, x-rays, and prescriptions.
- **Payment.** A Self-Funded Plan may use and disclose your PHI in the course of activities that involve reimbursement for healthcare, such as determination of eligibility for coverage, claims processing, billing, obtaining, and payment of premium, utilization review, medical necessity determinations, and pre-certifications.
- **Healthcare Operations for a Self-Funded Plan.** Self-Funded Plans may use and disclose your PHI to carry out business operations and to assure that all enrollees receive quality care. For example, a Self-Funded Plan may disclose your PHI to a business associate who handles claims processing or administration, data analysis, utilization review, quality assurance, benefit management, practice management or referrals to specialists, or provides legal, actuarial, accounting, consulting, data aggregation, management, or financial services.
- **Plan Sponsor.** A Self-Funded Plan may disclose summary health information (that is claims data that is stripped of most individual identifiers) to the University in its role as plan sponsor in order to obtain bids for health insurance coverage or to facilitate, modifying, amending, or terminating a plan. A Self-Funded Plan may also provide the University with enrollment or disenrollment information. In addition, if you request help from the University in coordinating your benefits or resolving a complaint (i.e., benefits administration), a Self-Funded Plan may disclose your PHI to designated University staff, but no PHI may be disclosed to facilitate employment-related actions or decisions or for matters involving other benefits or benefit plan. The University may not further disclose any PHI that is disclosed to it in these limited instances.
- **As Required By Law.** A Self-Funded Plan will disclose your PHI if required to do so by federal, state, or local law, or regulation.
- **To Avert a Serious Threat to Health or Safety.** A Self-Funded Plan may disclose your PHI when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Disaster Relief Efforts.** A Self-Funded Plan may share your health information to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.
- **Military and Veterans.** If you are or were a member of the armed forces, a Self-Funded Plan may release your PHI to military command authorities as authorized or required by law. A Self-Funded

Plan may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

– **Research.** In limited circumstances, a Self-Funded Plan may use and disclose PHI for research purposes, subject to the confidentiality provisions of state and federal law. Your PHI may be important to further research efforts and the development of new knowledge. All research projects conducted by the University of California must be approved through a special review process to protect member safety, welfare, and confidentiality.

– **Workers' Compensation.** A Self-Funded Plan may release PHI for workers' compensation or similar programs as permitted or required by law. These programs provide benefits for work-related injuries or illness.

– **Health Oversight Activities.** A Self-Funded Plan may disclose PHI to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

– **Legal Proceedings.** A Self-Funded Plan may disclose PHI to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

– **Lawsuits and Disputes.** If you are involved in a lawsuit or other legal proceeding, a Self-Funded Plan may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process.

– **Law Enforcement.** If authorized or required by law, a Self-Funded Plan may disclose your PHI under limited circumstances to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, or to provide information about the victim of a crime.

– **Department of Health and Human Services.** A Self-Funded Plan may be required to disclose your PHI to the Department of Health and Human Services if the Secretary is conducting a compliance audit.

– **National Security and Intelligence Activities.** If authorized or required by law, a Self-Funded Plan may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.

– **Protective Services for the United States President and Others.** A Self-Funded Plan may disclose your PHI to authorized federal and state officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or conduct special investigations as authorized or required by law.

– **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, a Self-Funded Plan may release your PHI to the correctional institution or law enforcement official, as authorized or required by law. This release would be necessary for the

institution to provide you with healthcare; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

– **Marketing or Sale of Health information.** Most uses and sharing of your health information for marketing purposes or any sale of your health Information are strictly limited and require your written authorization.

– **Separation Between Covered Functions and Non-Covered Functions.** To comply with the requirements of HIPAA, the University must maintain separation between covered functions (including the University's Group Health Plans), and non-covered functions (such as employer-related functions not associated with the University's Group Health Plans). The University prohibits the use or disclosure of member PHI for employment-related actions or decisions; nor may it be used or disclosed in connection with any other benefit or employee benefit plan of the University. Workforce members engaged in multiple roles, some part of which involves use and disclosure of PHI, must take special care to keep those roles separate. A disclosure of PHI from the SPHC to a non-covered function or unit may require written authorization.

– **Disclosures to Subcontractors.** A Self-Funded Plan shall ensure that any agents (including any subcontractor) to whom the Plan provides PHI agree to the same restrictions and conditions that apply to the Plan with respect to such information.

– **Other Uses and Disclosures of Health Information.** Other ways we share and use your health information not covered by this Notice will be made only with your written authorization. If you authorize us to use or disclose your health information, you may cancel that authorization, in writing, at any time. However, the cancellation will not apply to information we have already used and disclosed based on the earlier authorization.

Special laws apply to certain kinds of health information considered particularly private or sensitive to a patient. This sensitive information includes psychotherapy notes, sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will not share this type of information without your written permission. In certain circumstances, a minor's health information may receive additional protections.

– **Genetic Information is Protected Health Information.** In accordance with the Genetic Information Nondiscrimination Act (GINA), a Self-Funded Plan will not use or disclose genetic information for underwriting purposes, which includes eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Your Rights

You have the following rights regarding the PHI that a Self-Funded Plan maintains about you:

– Right to Inspect and Copy. With certain exceptions you have the right to inspect and obtain a copy of your PHI that is maintained by or for a Self-Funded Plan. To inspect and obtain a copy of the PHI you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request.

A Self-Funded Plan may deny your request to inspect and/or obtain a copy in certain limited circumstances. For example, HIPAA does not permit you to access or obtain copies of psychotherapy notes. If your request is denied, you will be informed in writing, and you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. The plan will comply with the outcome of the review.

– Right to Request an Amendment. If you believe that the PHI maintained by a Self-Funded Plan is incorrect or incomplete, you may request that the plan amend the information. You have the right to request an amendment for as long as the information is kept by or for the plan. A request for an amendment should be made in writing and submitted to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. In addition, you must provide a reason that supports your request.

A Self-Funded Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the plan may deny your request if you ask to amend information that was not created by the plan; is not part of the PHI maintained by or for the plan; is not part of the information that you would be permitted to inspect and copy under the law; or if the information is accurate and complete. If the request is granted, the plan will forward your request to other entities that you identify that you want to receive the corrected information. For example, if your PHI has been disclosed to the UC staff so that it may help to coordinate benefits or resolve a complaint, you may direct the plan to share the correction with the designated staff members.

– Right to an Accounting of Disclosures. You have the right to receive an “accounting of disclosures,” which is a list of disclosures such as those that were made of PHI about you, with the exception of certain documents, including those relating to treatment, payment, and healthcare operations and disclosures made to you or consistent with your authorization. To request an accounting of disclosures, you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

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. For additional lists, the plan may charge you for the costs of providing the list. You will be notified of any costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

– **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use and disclosure of your PHI for treatment, payment or healthcare operations, or to request a restriction on the PHI that the plan may disclose about you to someone who is involved in your care, or the payment for your care such as a family member or friend. The plan is not required to agree to your request. If the plan agrees to your request, it will comply with the requested restriction unless the information is needed to provide you emergency treatment or to assist in disaster relief efforts.

To request a restriction you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. Your request should state the information you want to limit; whether you want to limit the plan's use or disclosure or both; and to whom you want the limits to apply for example disclosures to your spouse.

– **Right to Request Confidential Communications.** You have the right to request that a Self-Funded Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the plan only contact you at work or by mail to a specific address. To request confidential communications, you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. The plan will accommodate all reasonable requests and will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

– **Right to a Paper Copy of This Notice.** You may ask the University to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer.

– **Breach.** You have the right to be notified, and your Self-Funded Plan has the duty to notify you, of the discovery of a breach of unsecured PHI.

– **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. The plan will make sure the person has this authority and can act for you before the plan takes any action.

Changes to this Notice

The Self-Funded Plans are required to abide by the terms of the Notice of Privacy Practices currently in effect. However, the Self-Funded Plans reserve the right to change this notice and to

make the revised or changed notice effective for PHI your plan already maintains on you as well as any information the plan receives or creates in the future.

A copy of the current notice will be posted at the UC website at <https://ucnet.universityofcalifornia.edu/forms/pdf/uc-healthcare-plan-notice-of-privacy-practices-self-funded-plans.pdf>. The notice will contain the effective date on the first page in the top right-hand corner. In addition, a copy of the notice that is currently in effect will be given to new health plan members and thereafter, available upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

- the Secretary of the Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201,
- UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94612, Attention: Privacy Officer. Email will not be accepted; all complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Questions

If you have questions or for further information regarding this privacy notice, contact the UC Healthcare Plan Privacy Officer at 1-800-888-8267, press 1.