# Evidence of Coverage and Policy

SmartSmile[sm] Group Plans

This Evidence of Coverage is for your SmartSmile[sm] Group Plan provided by Dental Health Services, Inc. ("Dental Health Services")

Dental Health Services Inc.



0620WM360

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## Your Personal Dental Plan

Welcome to Dental Health Services! We want to keep you smiling by helping you protect your teeth, saving you time and money. We are proud to offer you and your family excellent dental Coverage that offers the following advantages:

*Encourages treatment* by eliminating the burdens of deductibles.

*Makes it easy to receive your dental care* without claim forms for most procedures.

*Recognizes that receiving regular diagnostic and preventive care with low, or no Copayments is the key* to better health and long-term savings.

*Facilitates care* by making all covered services available as soon as membership becomes effective.

*Your Plan provides availability* of covered services with dental offices within our network of Quality Assured Participating Dentists. Please visit our website at dentalhealthservices.com or call our Member Services Specialist at 800-637-6453, 888-645-1257 (TDD/TYY) for assistance in locating a Participating Dentist.

*Allows you to take an active role in your dental health and treatment* by fully disclosing Coverage and Copayments prior to receiving treatment.

In addition to your ongoing dental hygiene and care, the following are available for plan Members:

- ToothTips[sm] oral health information sheets
- Member Services Specialists to assist you by telephone, fax, or email
- Web access to valuable Plan and oral health information at www.dentalhealthservices.com

## About Dental Health Services

Dental Health Services is an employee-owned company founded by a pioneering dentist whose vision was to provide patient-focused, innovative, quality dental Coverage that emphasizes overall oral health and wellness. These core values continue to guide and set Dental Health Services apart in the dental health industry.

Dental Health Services has been offering dental plans along the West Coast to groups and individuals for over forty-five (45) years. We are dedicated to assuring your satisfaction and to keeping your plan as simple and clear as possible.

As employee owners, we have a vested interest in the well-being of our plan Members. Part of our service focus includes, toll-free access to your knowledgeable Member Services Specialist, an automated member assistance and eligibility system, and access to our website at www.dentalhealthservices.com to help answer questions about your Plan and its Benefits.

## Your Participating Dentist

Your network name for this Plan is Quality Assured Participating Dentists.

Service begins with the selection of local, independently owned, quality assured dental offices. Professional skill, commitment to prevention and wellness, convenience of location and flexibility in appointment scheduling are some of the most important criteria involved in approving a Participating Dentist.

Each dental office is monitored regularly through our rigorous quality assurance standards for ongoing member care.

You may find a Participating Dentist by going to our website www.dentalhealthservices.com or by calling Member Services Specialist at 800-637-6453.

## Your First Dental Appointment

Your initial office visit is an opportunity for you to meet your Selected Participating Dentist. Your dentist will complete an oral examination and formulate a treatment plan for you based on their clinical assessment of your oral health.

At your initial office visit you will be required to pay a Copayment and you may need additional diagnostic services (e.g. periodontal charting and x-rays). You may also be charged Copayments for any additional services received. There is a Copayment charged for each office visit regardless of the procedures performed.

After your initial office visit, you may schedule an appointment for future care, such as cleanings, to complete your treatment plan. Cross reference your treatment plan with your Plan's Schedule of Covered Services and Copayments to determine the Copayments for your scheduled procedures. Copayments are charged for each office visit and any additional covered services performed.

## Your Member Services Specialist

Please feel free to call, fax, send an email to membercare@dentalhealthservices.com, or write us anytime with questions or comments. We are ready to help you! Your Member Services Specialist can be reached through any of the following ways:

Phone: 800-637-6453
Fax: 206-624-8755
Email: Membercare@dentalhealthservices.com
Web: www.dentalhealthservices.com
Mail: Dental Health Services
100 W. Harrison St.
Suite S-440, South Tower
Seattle, WA 98119

## Eligibility

As the Subscriber, you can enroll alone, with your Spouse, and/or with children who are under twenty-six (26) years of age. As a Subscriber, you must meet the eligibility requirements established by Group. An eligible Dependents must meet the eligibility requirements established by Group.

Eligible children are children of the Subscriber and Subscriber's Spouse. Eligible children include a biological Child, a stepchild, an adopted Child, a Child for whom the Subscriber or the Subscriber's Spouse assumes legal obligation for total or partial support in anticipation of adoption, and a Child for whom the Subscriber or Subscriber's Spouse is the legal guardian.

Children twenty-six (26) years of age and older are only eligible for Coverage as a Dependent while the Child is and continues to be both:

- incapable of sustaining employment by reason of developmental disability or physical handicap, and

- is chiefly dependent upon the Subscriber for support and maintenance.

Proof of incapacity and dependency must be furnished to Dental Health Services by the Subscriber within thirty-one (31) days of the Child's attainment of the limiting age and subsequently as may be required by Dental Health Services, but not more frequently than annually after the two (2) year period following the Child's attainment of twenty-six (26) years of age.

## Enrollment

Enrollment rates are based on a term of one (1) year and continue until terminated according to procedures contained in the Group Services Agreement.

There shall be a thirty (30) day open enrollment period prior to the contract renewal each year. All persons then eligible to enroll as Subscribers in the Plan may enroll during the enrollment period. Any persons then eligible to enroll as a Subscriber but who fails to enroll during this period shall not be entitled to enroll in the Plan until the next enrollment period unless the following applies.

Dependents must be added at the time of the initial enrollment or at the one (1) year renewal date unless you experience a qualifying event.

Qualifying events include the following circumstances:

1. Gaining a Dependent through birth of a Child, adoption, foster care, or placement for adoption or foster care;
2. Child support order or other court order to cover Child;
3. Gaining a Dependent through marriage or domestic partnership;
4. Loss of Coverage due to the death of an employee, employment termination, reduction in hours, divorce or legal separation or end of domestic partnership, loss of Dependent status, or bankruptcy (retirees only);
5. Loss of eligibility under Medicaid or CHIP;

6. Loss of coverage because Member no longer lives in the Service Area;
7. Termination of employer contributions; or
8. Exhaustion of COBRA continuation Coverage.

If you experience a qualifying event, Dental Health Services must receive a completed enrollment form within sixty (60) days of the qualifying event in order to continue Coverage. If the addition of a newborn, newly adopted Child or foster Child does not affect the current Premium, Dental health Services does not require an enrollment form to obtain coverage for a newborn Child, foster Child, or Child received through adoption.

If any of these circumstances applies, please contact your group administrator to enroll Dependents. It is recommended that Dental Health Services be notified in the event of a newborn, foster or Child received through adoption to notify the Selected Participating Dentist of Coverage and eligibility, and to ensure they have access to Member Services Specialists.

## Coverage Effective Dates

Except for newborn, foster, or adoptive children, if your enrollment form is received before the twentieth (20th) of the month, your Coverage will begin on the first (1st) day of the following month. If either is received after the twentieth (20th) day of the month, your Coverage will begin on the first (1st) day of the second (2nd) month following your enrollment. Newborn, foster, or adoptive children are covered from the date of birth or placement.

## Copayment

The Copayments specified in the Schedule of Covered Services and Copayments will be separately charged and collected by the Participating Dentist or Participating Specialist or the provider who provides the services.

In the event Dental Health Services fails to pay the Participating Dentist or Participating Specialist, you will not be liable to the Participating Dentist or Participating Specialist for any sums owed by Dental Health Services.

## Receiving Dental Care

Your network name for this Plan is Quality Assured Participating Dentists.
Upon enrolling in your Plan, you should select a Participating Dentist from the network of Quality Assured Participating Dentists. Directories are available by calling 800-637-6453 or through www.dentalhealthservices.com.

You may make an appointment with your Selected Participating Dentist as soon as your eligibility has been confirmed. Simply phone the provider office at the number as it appears in the Directory of Quality Assured Participating Dentists that can be found online at www.dentalhealthservices.com. If you would like a provider directory mailed to you, contact Member Services at 800-637-6453. Routine appointments will be scheduled within a reasonable time; in non-emergency cases, reasonable time shall not be more than three (3) weeks. You are immediately eligible for services at your Selected Participating Dentist's office, even in an emergency situation.

Dental Health Services' wide range of in-network dentists and specialists are available to you for receiving your Covered Services. You must receive your care from your Selected Participating Dentist. Your Selected Participating Dentist will coordinate your care to a Participating Specialist or other healthcare professional such as RN, ARNP operating within the scope of their license. In some cases, you may need to receive your care outside of the Dental Health Services' network of participating providers. This may be due to an emergency situation or, in some instances, when your required care for Covered Services is not available within the network. If the treatment that you are needing is not within the scope of dental care within our network of providers and is a Covered service, contact our Member Services Specialists 800-637-6453 who will assist you in finding an out of network provider.

You are able to receive care directly from a network Denturist with no prior notification to Dental Health Services. Simply make an appointment directly with the Denturist.

In an emergency, when you are unable to receive emergency care from your Selected Participating Dentist, your Covered Services will be paid according to the applicable Copayment that is on your Schedule of Covered Services and Copayments.

Should you have any questions regarding this process, our Member Services Specialists can assist you at 800-637-6453.

## Working With Your Dentist

Dental Health Services values its Members and Participating Dentists. Providing an environment that encourages healthy relationships between Members and their dentists helps to ensure the stability and quality of your dental Plan. If a satisfactory relationship cannot be established between a Member and their Selected Participating Dentist, Dental Health Services, the Member, or the Selected Participating Dentist reserves the right to request the Member's affiliation with the dental office be terminated. Dental Health Services will always put forth its best effort to place the Member with another Participating Dentist.

Any request to terminate a specific Member/dentist relationship should be submitted to Dental Health Services and shall be effective the first (1st) day of the month following receipt of the request. Dental Health Services will always put forth its best effort to place the Member with another Participating Dentist.

## Changing Dental Offices

If you wish to change your Selected Participating Dentists, you must notify Dental Health Services. This may be done by phone, in writing, by email, by fax, or online. Requests can be made by calling 800-637-6453 or by fax at 206-624-8755. Online changes can be done through www.dentalhealthservices.com

Requests received by the twentieth (20th) of the current month become effective the first (1st) day of the following month. Changes made after the twentieth (20th) become effective the first (1st) day of the second (2nd) month following receipt.

## Obtaining a Second Opinion

If you believe you need a second opinion for any reason, Dental Health Services can arrange for you to be seen by another participating general dentist. You should bring your x-rays to this consultation. If no x-rays are necessary, you will pay only your office visit.

After you receive your second opinion, you may return to your Selected Participating Dentist for treatment. If, however, you wish to select a new Participating Dentist, you must contact Dental Health Services directly, either by phone or in writing, before proceeding with your treatment plan.

## Your Financial Responsibility

You are liable to your Selected Participating Dentist for Copayments and incidental broken appointment penalties or interest charges. Please be aware that you are also liable for any other amounts owed for non-covered services. All dental treatment Copayments are to be paid at the time of service directly to your Selected Participating Dentist or Specialist or the provider who provided the service.

As stated under the *Emergency Care* section of this Combined Evidence of Coverage and Policy, for services rendered by a non-participating dentist or a non-participating specialist, Dental Health Services will reimburse you for the cost of emergency care after you have paid your applicable Copayment(s) for the treatment of an Emergency Dental Condition.

Please reference your Schedule of Covered Services and Copayments for the Benefits specific to your dental Plan.

## Your Financial Responsibility for Non-Covered Services

You are free to contract for services outside of your Dental Health Services' Plan, including its network, on any terms or conditions you choose. You will be liable for the cost of all services performed. Experimental or Investigational Services as defined in the glossary section of this Evidence of Coverage and Policy are not covered services under this Plan. Supporting documentation upon which the criteria for Experimental or Investigational Services are established are made available upon request. For a complete list of the Exclusions and Limitations of this dental Plan, please refer to the Schedule of Covered Services and Copayments. You are not liable for any sums owed by Dental Health Services. IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, the dentist may charge you their usual fees for those services. Prior to providing you with dental services that are not a covered Benefit, you should be provided with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call your Member Services Specialist at 800-637-6453, 888-645-1257 (TDD/TTY).

## Emergency Care

You are covered for Emergency Dental Condition at all times, both inside and outside of Dental Health Services' service area.

If you are experiencing Emergency Dental Condition and need immediate care, please follow the steps below:

1. Call your Selected Participating Dentist. Dental offices maintain twenty-four (24) hour emergency communication accessibility and are expected to see you within twenty-four (24) hours of initial contact, or within such lesser time as may be Medically Necessary.

2. If your Selected Participating Dentist is not available, call your Member Services Specialist at 800-637-6453, 888-645-1257 (TDD/TTY). Your Member Services Specialist will assist you in scheduling an emergency dental appointment with another Participating Dentist in your area.

3. If there are no Participating Dentists available to provide treatment for an Emergency Dental Condition, or you are out of Dental Health Services' service area, or it is after business hours and there are no Participating Dentists available to provide treatment for an Emergency Dental Condition, seek Emergency Dental treatment from any dentist or healthcare provider practicing within the scope of their license.

4. When services are provided by a non-participating dentist or non-participating specialist, you may be responsible for paying the entire bill to the non-participating dentist or non-participating specialist at the time of service. Dental Health Services will reimburse you for the amount over your Copayment for dental services provided to treat Emergency Dental Condition.
   To be reimbursed for any amount over the emergency Copayment, the Members or the dentist or the healthcare provider must submit the itemized dental bill from the dental office, to Dental Health Services. Dental Health Services will reimburse you for the amount over your Copayment for dental services provided to treat Emergency Dental Condition.

   Within one hundred-eighty (180) days of the occurrence, send the itemized bill to:

   Dental Health Services
   100 W. Harrison Street
   Suite S-440, South Tower
   Seattle, WA 98119

## Claims, Adverse Benefit Determinations & Appeals

**Claims Payment**
Your Selected Participating Dentist will determine whether a chosen service or treatment is Medically Necessary. Any Experimental or Investigational Service is subject to review by Dental Health Services' Dental Director. In all cases, the treatment or service must be in accordance with the American Dental Association (ADA) guidelines and standards. For information regarding Medically Necessary standards, please visit our website at
https://www.dentalhealthservicesportal.com/#!/12

Claim forms are the dentist's formal request for reimbursement, which includes an accounting of dental procedures rendered to you.

Claim forms are submitted directly to Dental Health Services by the treating dentist.

All claims must be submitted within one hundred-eighty (180) days of the date services were rendered, or as soon as reasonably possible. Claims are generally paid or denied within thirty (30) days of receipt unless Dental Health Services needs additional time. Dental Health Services will process ninety-five percent (95%) of clean claims within thirty (30) days of Dental Health Services' receipt of the claim, electronically or by US Mail. Clean claims are claims that have no defects or lack any required information or language. If your claim is denied, and as a result services are not covered, this is considered an adverse benefit determination.

**Adverse Benefit Determination means:**

- a denial, reduction, or termination of, or a failure to provide or make full or partial payment for a Benefit under our Plan that does not meet our requirements for dental necessity, appropriateness, level of care, or effectiveness;
- a denial, termination, or failure to provide or make full or partial payment based upon a person's eligibility to enroll in our Plan, and
- a denial, termination, or failure to provide or make full or partial payment for a benefit that is determined to be experimental or investigational.

If all or part of your claim is denied in whole or in part, or is modified, Dental Health Services will notify you and the dentist in writing of the adverse benefit determination. The adverse benefit determination will include the following:

1. Actual reason(s) for the determination.
2. Reference to specific Plan provisions from which the determination was based.
3. Instructions for Appealing of the decision through Dental Health Services.
4. If you have any questions, you may call our Member Services Specialist at 800-637-6453.

**Appeals**

***Initial/Internal Review Process:***

If any part of your claim was denied in whole or in part, or is modified, you have the right to submit an appeal for a full and fair review through Dental Health Services' Initial/Internal Review Process. Requests to file an appeal through the Initial/Internal Review Process may be submitted orally, electronically, and by US mail.

All appeals must be submitted within one hundred-eighty (180) days from the date of the adverse benefit determination letter. Dental Health Services will notify the appellant within seventy-two (72) hours to confirm receipt of the appeal.

All standard appeals are investigated and resolved, if possible, within fourteen (14) days of receipt of appeal. If more time is needed, you and the dentist will be notified that an extension of sixteen (16) days is needed for a resolution.

Appeals pertaining to Experimental or Investigational Service are researched and resolved, if possible, within twenty (20) days of receipt of the appeal. If more time is needed, written consent

will be obtained from the Member or their authorized representative.

If you appeal the result of an urgent care claim, a decision regarding the appeal will be made within seventy-two (72) hours of Dental Health Services receipt of the appeal and communicated to you or your authorized person and dentist. An urgent appeal is one for which you are currently receiving or is prescribed treatment or Benefits that would end because of the adverse benefit determination; or where the treating dentist believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or when the claim determination is related to an issue related to admission, availability of care, continued stay, or emergency health care services when you have not been discharged from the emergency room or transport service.

For standard appeals, you will be notified of the Initial/Internal Review Process determination by US mail. All notifications for urgent appeals are by phone and US mail. Notifications will include your rights if you disagree with the final Initial/Internal Review Process determination. You have thirty (30) days from the date of the Initial/Internal Review Process determination letter to file for a Second Level Review of the confirmed adverse benefit determination.

***Second Level Review Process***

All requests to file an appeal through the Second Level Review Process must be received within thirty (30) days from the date of the Initial/Internal Review Process determination letter and may be submitted orally, electronically, and by US mail by you, your authorized person, or dentist.

Dental Health Services Service Review Committee or the Dental Director will review your appeal. In all cases, the reviewer will be someone other than the person who upheld the Initial/Internal appeal. The reviewer will not give deference to the initial denied claim or the Initial/Internal upheld appeal. If the decision is based on medical judgement, the consulting dentist will be different from the dentist involved in the Initial/Internal Review Process. If the decision does not require medical judgement, the Management Committee excluding the Dental Director will do the Second Level Review.

The Second Level Review decision is final and is not intended to limit your care. Your treatment choices are between you and your provider. US mail of the final determination will notify the Member and the dentist. Please contact us at 800-637-6453 or 888-645-1257 (TDD/TTY) if you have any questions about your Benefits.

***Concurrent Expedited Appeal***

Under certain circumstances, you may be eligible to request a concurrent expedited review. A concurrent expedited review means initiating both Initial/Internal and Second Level Review simultaneously to:

1. Review a decision made under the provisions of this Plan; or
2. Review conducted during your course of treatment in a facility, dental professional's office, or any inpatient/outpatient health care setting so the final adverse benefit determination is reach expeditiously.

For assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If you have questions or concerns about the actions of your insurance company or agent, or would like information on your rights to file an appeal, contact the Washington state Office of the

Insurance Commissioner's consumer protection hotline at 1-800-562-6900 or visit www.insurance.wa.gov. The insurance commissioner protects and educates insurance consumers, advances the public interest, and provides fair and efficient regulation of the insurance industry.

During review of your appeal, Dental Health Services will continue to provide Coverage for the disputed Benefit pending outcome of the review if you are currently receiving services or supplies under the disputed Benefit. If Dental Health Services prevails in the appeal, you may be responsible for the cost of Coverage received during the review period. The decision at the Second Level Review is binding unless other remedies are available under state or federal law.

## Grievance Procedure

If a Member has a Grievance regarding service delivery issues, dissatisfaction with dental care, waiting time for dental services, dentist or staff attitude or demeanor, or dissatisfaction with services provided by Dental Health Services, the Member may submit a Grievance to Dental Health Services.

A. Grievances may be made in writing, over the telephone, fax or through the Plan's website at www.dentalhealthservices.com. To request for help in submitting a Grievance, please call our toll- free number at 800-637-6453 or 888-645-1257 (TDD/TTY).

   Written Grievances must include:
   1. The Subscriber's name, address, and telephone number,
   2. Member's name receiving dental care services, and
   3. Dentist's name, location and contact information.

   Although grievance forms are not required to submit a Grievance, confidential grievance forms are available through Dental Health Services' website at www.dentalhealthservices.com, in the Participating Dentist offices, and upon request. You may also provide a brief written explanation of the facts and issue(s). Personnel at Participating Dentist offices are requested to be available to provide assistance in the preparation and submission of any Grievance.

B. Dental Health Services will collect and review all relevant information from you and the dentist involved. If a clinical examination is required, you may be referred to another Participating Dentist for a second opinion. When all information has been collected and reviewed, a decision will be made by the appropriate Dental Health Services administrator.

C. Every effort will be made by Dental Health Services to provide a determination of the Grievance within fourteen (14) days of its receipt. However, Dental Health Services may notify you that an extension is necessary to complete the review. This extension will not exceed thirty (30) days from the receipt of the Grievance.

D. Once a decision is made, Dental Health Services will promptly notify you in writing of the determination of your Grievance.

E. If you believe your grievance was not handled properly, you may contact the Office of Insurance the Commissioner at:

Washington State Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 Phone: 1-800-562-6900 or (360) 725-7080 Fax: (360) 586-2018 or website at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status.

Dental Health Services' grievance process addresses the linguistic and cultural needs of Members with disabilities including but not limited to visually, speech and hearing impaired. Dental Health Services ensures all Members have access to and fully participate in the grievance process. This assistance is at no charge to the Member. This assistance includes, but not limited to, translations of grievance procedures, forms, and Dental Health Services' responses to Grievances. In addition, Dental Health Services provides access to oral interpreters and translation of documents; telephone relays systems and other devices that aid disabled individuals and LEP (Limited English Proficiency) Members to communicate.

There shall be no discrimination against a Member solely on the ground that such person filed a Grievance or Appeal.

## Coordination of Benefits

This Plan does not facilitate the coordination of Benefits with other coverage. During coordination of Benefits facilitated by either the Member or other dental plan, Dental Health Services' dental Plan will always be defined as the primary Plan.

## Termination of Coverage

Coverage of an individual Subscriber and/or their Dependents may be terminated for any of the following reasons:

- Termination of the Group Services Agreement by written notice sixty (60) days before annual renewal date.
- Failure of a Member to meet or maintain eligibility requirements.
- Material misrepresentation (fraud) in obtaining Coverage.
- Permitting the use of a Dental Health Services membership card by another person or using another person's membership card or identification to obtain care other than that to which one is entitled.
- Failure of the group to pay premium in a timely manner (fifteen (15) days after payment is due).

All procedures started prior to the Member's termination date shall be completed without further charge (except the applicable Copayments) within thirty (30) days from the termination date. This applies only to those procedures started but unfinished including, but not limited to, prosthetic appliances which require multiple stages to complete. It shall not include dental defects which may have been diagnosed, but on which treatment or operative work had not begun prior to termination. It shall also not include serial or repetitive-type treatments such as periodontal or oral treatments where the same can be reasonably interrupted.

## Termination Due to Nonpayment

Benefits under your Plan depend on the group's premium payments staying current. If payment is more than fifteen (15) days overdue, your eligibility may be terminated. Any previously initiated

service(s) then "in progress" must be completed within thirty (30) days from the last appointment date occurring prior to the termination date. The Subscriber will remain liable for the scheduled Copayment, if any. If your Coverage is terminated, you will be required to pay your Selected Participating Dentist's usual fees for continuing the prescribed treatment.

## Renewal Provisions

The group contract may be renewed from year to year after its initial period. Renewal may change the Copayment and/or premium fees paid by the group and/or the Subscriber. You may obtain information about these changes, if any, from a Dental Health Services representative during the open enrollment period or by calling your Member Services Specialist at 800-637-6453.

## COBRA

If you qualify for continuing coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act), Dental Health Services will gladly provide benefits through your employer. Please contact your benefits administrator.

## Labor Disputes

In the event of suspension or termination of employee compensation due to a strike, lockout, or other labor dispute, a Subscriber may continue uninterrupted Coverage for the family unit by paying to the group the monthly premium charge that the group would pay to Dental Health Services. Coverage may be continued on this self-payment basis for up to six months (6) months. The Subscriber may elect to enroll in Dental Health Services individual plan when termination of their group coverage occurs by contacting Dental Health Services Member Specialist at 800-637-6453. Termination of coverage may occur during this six-month (6) period or at the end of the coverage period, whichever the Subscriber may choose.

## Supplemental Coverage

If your group has selected TMJ Supplemental Coverage, you will receive an additional Schedule of Covered Services describing those benefits including details about limitations and exclusions.

## Glossary

Amalgam: A metallic alloy formed mostly of silver and tin, mixed with mercury into a soft plastic material that sets hard in a few hours after placement inside a tooth cavity.

Benefits/Coverage: The specific covered services that Plan Members and their Dependents are entitled to use with their dental Plan.

Child: Eligible children include a biological Child; a stepchild, an adopted Child; a Child for whom the Subscriber or the Subscriber's Spouse assumes a legal obligation for total or partial support in anticipation of adoption; and a Child for whom the Subscriber or the Subscriber's Spouse is the legal guardian.

Comprehensive exam: A thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. Typically includes the evaluation of dental caries (cavities), missing or unerupted teeth, restorations, and occlusal relationships.

Composite filling: A restoration or filling composed of a plastic resin material that resembles the natural tooth.

Copayment: The amount that you owe at the time covered Benefits under this Plan are received. Copayment amounts for covered Benefits are listed on the Schedule of Covered Services and Copayments document. Copayments are paid directly to the provider at the time services are rendered.

Dependents: Eligible Dependents include a Spouse and children of the Subscriber and Spouse.

Emergency Dental Condition: a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:

- Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; and
- Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part

Endodontics: The branch of dentistry concerned with the treatment of disease or inflammation of the dental pulp or nerve of the tooth.

Enrollee/Member: A person who is entitled to receive dental services under this Policy. The term includes both Subscribers and those family Members (and Dependents) enrolled by the Subscriber for whom a premium has been paid.

Exclusion: Treatment or Coverage not specifically included as a Benefit.

Experimental or Investigational Services: Any medications, dental treatments for specific conditions or devices still under investigation or observation as determined by the American Dental Association. Dental Health Services Dental Director in determining whether services are experimental or investigational, will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

Grievance: A complaint submitted by or on behalf of a covered person or participating dentist regarding service delivery issues, dissatisfaction with dental care, waiting time for dental services, dentist or staff attitude or demeanor, or dissatisfaction with services provided by Dental Health Services.

Limitation: Any provision other than an Exclusion, which limits or restricts Coverage available under the Plan.

Licensed Dentist: Means a licensed Doctor of Dental Surgery (D.D.S), a licensed Doctor of Medical Dentistry (D.M.D), or a licensed Denturist.

Medically Necessary: Means a determination by your Selected Participating Dentist that a Covered Service is appropriate for the evaluation and treatment of disease, condition, illness, injury, is

necessary for your health, and is consistent with the applicable standards of care. This does not include any service that is cosmetic or elective in nature.

Optional treatment: Any treatment other than covered services that, in the opinion of the attending dentist, is not necessary for the patient's dental health. If an Enrollee chooses an Optional Treatment, the Enrollee is responsible for paying the cost on a fee-for-service basis.

Palliative: An action that relieves pain, swelling, or bleeding. This does not include routine, extensive, or postponeable treatment.

Participating Dentist: A licensed dental professional who has entered into a written agreement with Dental Health Services or other Licensed Dentist or specialist that Dental Health Services designate as a Participating Dentist or Participating Specialist to provide dental care services to Subscribers and their Dependents covered under the Plan. The agreement includes provisions in which the dentist agrees that the Subscribers shall be held liable only for their Copayment amount according to the services received and for any non-covered service according to the Schedule of Covered Services and Copayments. The Participating Dentist or Participating Specialist joins our network of Quality Assured Participating Dentists to provide dental care services to Subscribers and their Dependents covered under this Plan.

Participating Specialist: A participating licensed dentist who has completed additional training in one or more areas of dental treatment, is board certified or is board eligible and provides specialty services to an Enrollee.

Plan: The dental benefits or coverage provided for the Subscriber and dependents in exchange for the payment of membership dues.

Spouse: The person to whom you are legally married under applicable law. Spouse includes state registered domestic partnerships recognized by the state of Washington.

Subscriber: A person whose relationship as the primary Member is the basis for coverage under this agreement.

Selected Participating Dentist: The Participating Dentist you have selected to provide your dental care.

100 W. Harrison St.
Suite S-440, South Tower
Seattle, WA 98119

800-637-6453

www.dentalhealthservices.com



AN EMPLOYEE-OWNED COMPANY