Dental Health Services

Evidence of Coverage

General City of Seattle Employees, Fire Chiefs, Library, Seattle Housing Authority

1018WG033

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Non-Discrimination Notice

Dental Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.

Dental Health Services:

- Provides free services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact your Member Services Specialist, at 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TTY).

If you believe that Dental Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a Grievance with the Member Satisfaction Services Specialist, 100 West Harrison Street, Suite S-440, South Tower, Seattle, Washington 98119, call 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TTY), fax 206-624-8755, or email membercare@dentalhealthservices.com You can file a Grievance in person or by mail, fax, email or through the Plan's website at www.dentalhealthservices.com.. If you need help filing a Grievance, the Member Services Specialist is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal Available at https//ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English:

This notice has important information. This notice has important information about your application or coverage through Dental Health Services. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.
Call 1-866-756-4259.

Spanish:

Este aviso tiene información importante. Este aviso tiene información importante acerca de su solicitud o cobertura por medio de Dental Health Services. Es posible que haya fechas clave en este aviso. Es posible que tenga que tomar medidas antes de ciertas fechas límite para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y ayuda en su idioma de forma gratuita. Llame al 1-866-756-4259

Chinese:

本通知包含重要資訊。本通知包含關於您的Dental Health Services申請或保險的重要資訊。本通知中可能包含重要日期。您可能需要在特定截止日期之前採取行動，以維持您的健康保險或幫助解決費用相關問題。您有權免費獲取本資訊與以您母語進行的幫助。致電1-866-756-4259

Vietnamese:

Thông báo này có các thông tin quan trọng. Thông báo này có các thông tin quan trọng về đơn yêu cầu hay bảo hiểm của quý vị thông qua Dental Health Services. Có thể có những ngày quan trọng trong thông báo này. Quý vị có thể cần hành động chậm nhất vào một số thời hạn cuối cùng để duy trì bảo hiểm y tế của quý vị hoặc để được trợ giúp với các chi phí. Quý vị có quyền nhận thông tin này và được trợ giúp miễn phí bằng ngôn ngữ của quý vị. Gọi 1-866-756-4259

Korean:

본 안내문에는 중요 정보가 있습니다. 본 안내문에는 Dental Health Services를 통한 귀하의 보험 또는 신청서에 관한 중요 정보가 포함되어 있습니다. 본 안내문에 중요 날짜가 적혀 있을 수 있습니다. 본인의 건강 보험 또는 비용 보조를 유지하려면 특정 마감일까지 조치를 취하셔야 할 수도 있습니다. 관련 정보를 본인의 사용 언어로 무료로 받아볼 권리가 있습니다. 1-866-756-4259번으로 전화하십시오

Russian:

Данное извещение содержит важную информацию. Данное извещение содержит важную информацию о Вашем заявлении или страховом покрытии услуг стоматологии. Извещение может содержать ключевые даты. Возможно Вам необходимо будет предпринять соответствующие действия в определенных временных рамках. Вы имеете право на получение данной информации и помощи на своем родном языке. Позвоните по телефону 1-866-756-4259

Tagalog:

Ang paunawang ito ay nagtataglay ng mga mahahalagang impormasyon. Ang paunawang ito ay nagtataglay ng mga mahahalagang impormasyon tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Dental Health Services. Malamang na mayroong mga mahalagang petsa sa paunawang ito. Baka kailanganin ninyong magsagawa ng hakbang bago ang pagsapit ng mga partikular na deadline para mapanatili ang coverage ng inyong kalusugan o makatulong sa mga gastusin. Mayroon kayong karapatang makatanggap ng mga impormasyong ito at matulungan sa lengguahe nang walang bayad. Tumawag sa 1-866-756-4259

Ukranian:

Це сповіщення містить важливу інформацію. Це сповіщення містить важливу інформацію щодо вашого запиту або страхового покриття за планом Dental Health Services. Це сповіщення може містити ключові дати. Можливо вам знадобиться виконати певні дії до вказаних кінцевих дат, щоб зберегти медичне страхування або отримати допомогу із витратами. Ви маєте право на безкоштовне отримання цієї інформації і допомоги вашою мовою. Зателефонуйте за номером 1-866-756-4259

Cambodian:

ជូនដំណឹងនេះ នព័ត៌នសំន់ៗ។
ជូនដំណឹងនេះ នព័ត៌នសំន់ៗអំពី ស្ថាប័ន Dental Health Services ។ ច នលប ច សំន់ៗ ច
ជូនដំណឹងនេះ។
ច ក ច ំ ច ត ត ន ្រកីម លប ច ទ កំ កំ ដម្រ
ីទក ្រ ប
រដ្ឋាភិបាលច ក ជួយ ច ំ យ ច ក ក នសិទ ិ ដម្រីទទួល
នព័ត៌នេះ ហើយ ជួយ
ច ក ភាសាឥតគិតថ្ល។ សូ មទូរស័ព ច 1-866-756-4259

Japanese:

本通知には、重要な情報が含まれています。本通知には、Dental Health Servicesによる、お客様の申請または保障に関する重要な情報が含まれています。 本通知には、重要な日付が含まれる場合があります。 お客様の医療保障を維持するため、または、費用を節約するため、特定の期限までに行わなければならない項目がある場合があります。 お客様には、無料で、この情報を取得し、お客様の言語でサポートを受ける権利があります。1-866-756-4259にお電話をおかけください

Amharic:

ይህ ማስታወቂያ ወሳኝ መረጃ የያዘ ነው። ይህ ማስታወቂያ ማመልከቻዎ ወይንም በ Dental Health Services አማካኝነት የሚያገኙት ሽፋን በተመለከተ ወሳኝ መረጃ ይዟል። ማስታወቂያው ወሳኝ ቀናቶች ጭምር የያዘ ነው። የጤና ሽፋንዎ ወይንም የክፍያ እገዛዎችዎ ለማስጠበቅ የተቀመጡት ቀነገዶቦች ሳያልፉ ማድረግ ያለብዎ ተግባራት ማከናወን ይኖርብዎታል። ይሄንን መረጃ እና እገዛ ያለምንም ክፍያ በቋንቋዎ የማግኘት መብት አለዎት። በዚህ ስልክ ቁጥር ይደውሉ 1-866-756-4259

Cushite:

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisni kun waa’ee iyyannoo ykn haguuggii Dental Health Services keessan ilaalchisee odeeffannoo barbaachisaa qabatee jira. Beeksisa kana keessa guyyoon furtuun jiraachuu danda’u. Haguuggii fayyaa argachuu keessan itti fufuuf ykn baasii keessan hirrisuuf akka isin gargaaruuf daangaa guyyaa ta’een dura tarkaanfii fudhachuun isin barbaachisuu danda’a. Odeeffannoo kana fi gargaarsa afaan keessanii tola argachuuf mirga qabdu. 1-866-756-4259 irratti bilbilaa.

Arabic:

هذا الإخطار يضم معلومات مهمة. يشتمل هذا الإخطار على معلومات مهمة تتعلق بطلبك وتغطيتك التي تتلقاها عبر Dental Health Services. فقد ترد تواريخ مهمة في هذا الإشعار. وقد تحتاج إلى اتخاذ إجراءات قبل حلول مواعيد نهائية معينة حتى تحتفظ بتغطيتك الصحية أو المساعدة في التكاليف. يحق لك الحصول على هذه المعلومات وكذلك المساعدة بأي لغة دون تكلفة. اتصل بالرقم 1-866-756-4259

Panjabi:

ਇਸ ਸ਼ੰਦ ੇਸ਼ ਿਵਚ ਖਾਸ ਜ ਾਣਕ ਾਰ ੀ ਿਚੱਤ ੀ ਗਈ ਹੈ। ਇਸ ਨ ਿਟਸ ਿਵਚ ਤ ੁਹ ਾਡ ੀ ਅਰਜ਼ ੀ ਜ Dental Health Services ਬ ਾਰੇ ਜ ਾਣਕ ਾਰ ੀ
ਿਚੱਤ ੀ ਗਈ ਹ ੈ। ਇਸ ਸੂਚਨ ਾ ਿਵਚ ਿਵਸ਼ ੇਸ਼ ਿਮਤ ੀਆ ਂ ਿਦੱਤ ੀਆ ਂ ਹੋ ਸਕਦ ੀਆਂ ਹਨ। ਤ ੁਹਾਨ ੂੰ ਆਪਣ ੀ ਿਸਹਤ
ਕਵਰ ੇਜ ਅਤ ੇ ਕ ੀਮਤ ਿਵਚ ਮਦਦ ਲਈ ਕ ੁੱਝ ਸਮ ਸ ੀਮ ਾਵ ਅ ੰਦਰ ਕ ਾਰਵ ਾਈ ਕਰਨ ਦ ੀ ਲ ੋੜ ਪ ੈ ਸਕਦ ੀ ਹ ੈ।
ਤ ੁਹ ਾਨ ਇਸ ਸ ੂਚਨ ਾ ਨ ਪ ਾਪਤ ਕਰਨ ਅਤ ੇ ਆਪਣ ੀ ਭਾਸ਼ ਾ ਿਵਚ ਮ ੁਫਤ ਮਦਦ ਪ ਾਪਤ ਕਰਨ ਦ ਾ ਹ ੱਕ ਹ ਾ ਿਸਲ ਹ ੈ। 1-
866-756-4259 ‘ਤ ੇ ਕ ਾਲ ਕਰ ੋ।

German:

Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder Leistungen durch Dental Health Services. Diese Mitteilung kann wichtige Termine enthalten. Sie müssen möglicherweise innerhalb bestimmter Fristen handeln, um Ihre Leistungen oder

eine Kostenübernahme zu gewährleisten. Sie können diese Informationen und Hilfestellung kostenfrei in Ihrer Sprache anfordern. Rufen Sie an unter 1-866-756-4259

Laotian:

ການແຈ້ ງການ ິນີ້ ແມ່ ນມ ໍຂໍ້ ມູ ນສາຄັ ນ. ການແຈ້ ງການ ິນີ້ ແມ່ ນມ ໍຂໍ້ ມູ ນສາຄັ ນກ່ ຽວກັ ບ ໍຄາຮ້ ອງຂອງທ່ ານ ຫລື

ການຄຸ້ ມຄອງ ັ ນໃນຂອງທ່ ານຜ່ ານ Dental Health Se rvices ອາດຈະ ິ ນວັ ນທ ໍ ສາຄັ ນໃນການແຈ້ ງການນີ້ [illegible]

ການຊ່ ວຍເ ືຫຼ ອດ້ ວຍຄ່ າໃຊ້ ຈ່ າຍ. ທ່ ານ ິມ ິສດໃນການຮັ ບ ໍຂມູ້ ນນ ້ ແລະ ການຊ່ ວຍເ ືຫ ອໃນພາສາຂອງທ່ ານໂດຍ ໍບເສັ ຽຄ່ າໃດໆໝົ ດ. ໂທ 1-866-756-4259

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.

Assures availability of care with high-quality, easy-to-find dental offices throughout our Washington service area.

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℠ 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.dentalhealthservice.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 Specialists, 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 Member Service 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: 206-788-3444 or 877-495-4455,
888-645-1257 (TDD/TTY)

Fax: 206-624-8755

Web: www.dentalhealthservices.com

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

Eligibility

To be eligible for coverage, the Subscriber must be a regularly appointed full-time or part-time employee of City of Seattle-Most City who is scheduled to work eighty (80) hours per month. Regular employees who have met the initial eligibility rules and have eighty (80) hours of paid time will be eligible for coverage for the current month. Regular employees with less than eighty (80) hours of paid time each month are not eligible for City-paid benefits.

Temporary employees who have worked at least 1,040 cumulative non-overtime hours and at least eight- hundred (800) non-overtime hours in the previous twelve (12) months, shall be eligible for enrollment on a self-paid basis. Employees, temporary and regular, losing eligibility due to a reduction of hours may continue coverage through the COBRA plan as described in the COBRA section.

Dependent eligibility

To be eligible for coverage as a Dependent, the Dependent must be one of the following (proof of dependency may periodically be required by Dental Health Services):

- Legal spouse (unless legally separated);
- Domestic partner; and
- Children who are under twenty-six (26) years of age.

All Dependents are subject to verification by the City of Seattle's third-party verification vendor.

Disabled Dependent Children who are covered by this Agreement as a Dependent Child on the day before their twenty-sixth (26th) birthday and continues to be both:

(a) incapable of self-sustaining employment by reason of developmental disability or physical challenge, and;

(b) chiefly dependent upon the Subscriber, spouse, domestic partner or non-covered legal parent for support and maintenance will be eligible for coverage during the uninterrupted continuance of the incapacity and dependency, provided proof of incapacity and dependency is furnished to Dental Health Services within thirty-one (31) days of the request for that information by Dental Health Services or Group, but not more frequently than annually after the two (2) year period following the Child's attainment of twenty-six (26) years of age.

Your Children include:

- Your biological Children
- Your adopted or legally placed for adoption Children
- Your stepchildren
- Your domestic partner's Children
- Children for whom you have a qualified court order to provide coverage, and Children for whom you are a legal guardian.

Enrollment

All employees and Dependents of Group who are eligible for coverage on the effective date of this Agreement must enroll as Subscribers and Dependent(s) at that time of Groups initial enrollment in the Plan, or wait until Group's next open enrollment period, unless the employee experiences a qualifying change in family status.

If a person becomes an employee of Group after the effective date of this Agreement, Dental Health Services must receive the enrollment form for coverage within thirty-one (31) days after the employee first becomes eligible for coverage, or the employee must wait until Group's next open enrollment period, unless the employee experiences a qualifying change in family status.

Temporary employees must apply for coverage when first eligible in accordance with the terms established by the City or wait until Group's next open enrollment period, unless the employee experiences a qualifying change in family status. If an employee of Group had other health coverage at the time of initial eligibility under this Agreement and declined enrollment under this Agreement, in writing

based upon such coverage, the employee may apply for coverage under the Agreement prior to Group's open enrollment period if Dental Health Services receives the enrollment form within thirty-one (31) days of exhaustion of COBRA continuation coverage, or loss of the prior health coverage.

There shall be a thirty (30) day open enrollment period prior to the Group Services Agreement renewal each year. All persons then eligible to enroll as a Subscriber or Dependent in the Plan may enroll during the open enrollment period. Any persons then eligible to enroll as a Subscriber or Dependent but who fails to enroll during Group's open enrollment period shall not be entitled to enroll in the Plan until the next open enrollment period, unless the employee experiences a qualifying change in family status.

Employees who experience a qualifying change in family status may be eligible for a Special Enrollment Period. Within sixty (60) days from the date of the change in family status, the employee must notify Dental Health Services of the event, in order to be eligible for a Special Enrollment Period.

Qualifying changes in family status includes the following circumstances:

1. Birth, adoption, or placement for adoption or legal guardianship
2. Marriage or formation of a domestic partnership
3. Loss of a Child, spouse or domestic partner eligibility under another health plan.
4. Divorce, termination of domestic partnership, or legal separation.

If any of these circumstances apply, please contact your group administrator to enroll Dependents.

Coverage Effective Dates

Coverage for a Subscriber and for any Dependent included on the Subscriber's initial enrollment form will begin on the first (1st) day of the month following date of hire, or concurrent with the date of hire if on paid status the first (1st) of the month, provided the enrollment form for coverage has been made and the Premium has been paid.

Coverage for temporary employees will begin on the first (1st) of the month following the date the enrollment form has been submitted and the Premium paid. An employee who is absent without pay on the first (1st) of the month and returns by the fifteenth (15th) of the month will not have a lapse in coverage. Coverage for an employee who returns after the fifteenth (15th) of the month will begin the first (1st) of the following month.

In the case of a Subscriber's biological newborn Child, coverage will be retroactive to the date of birth if the Subscriber applies for coverage as specified in this Section. Coverage for the Subscriber's adoptive Child will be retroactive to the date of placement for adoption, or the date the Subscriber assumed a total or partial legal obligation for support of a Child in anticipation of adoption.

Services shall be furnished irrespective of whether or not the inception of the dental defect requiring such services occurred prior to or after the effective date of coverage.

Quality Assurance

We're confident about the care you'll receive because our Participating Primary Dentists meet and exceed the highest standards of care demanded by our quality assurance program. Before we contract with any dentists, we visit their offices to make sure your needs will be met. Dental Health Services' Professional Services Specialists regularly meet and work with our Participating Primary Dentists to maintain excellence in dental care.

Your Participating Primary Dentist

Service begins with the selection of local, independently owned, quality assurance 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 Primary Dentist.

The ongoing care of each dental office is monitored regularly through our rigorous quality assurance standards.

Receiving Dental Care

Upon enrolling in a Dental Health Services' Plan, a Participating Primary Dentist should be selected from the network of Quality Assured Participating Dentists. To search for Participating Primary Dentist online, visit Dental Health Services' website at www.dentalhealthservices.com.

If you prefer a printed directory, please call 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TYY) and a directory will be mailed to you.

You may make an appointment with your Designated Participating Primary Dentist as soon as your eligibility has been confirmed. Simply call your Designated Participating Primary Dentist and request an appointment. Routine appointments will be scheduled within a reasonable time; in non-emergency cases a reasonable time shall not be more than three (3) weeks. You are immediately eligible for services at your Designated Participating Primary Dentist 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 Designated Participating Primary 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 or Orthodontist with no prior notification to Dental Health Services. Simply make an appointment directly with the Denturist or Orthodontist.

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.

Each dental office is independently owned and establishes its own policies, procedures, and hours. If you need to cancel your appointment, please call your dental office at least twenty-four (24) hours prior to your scheduled appointment time. A penalty may be assessed if your dental appointment is canceled with less than twenty-four (24) hours' notice. For your dentist's appointment and cancellation policy and procedures, please contact the dentist office directly.

Membership Cards

At approximately the time your coverage becomes effective, you will receive one membership card per family. Your Designated Participating Primary Dentist receives an updated membership list each month, so it is not necessary to have your membership card

to make an appointment or receive care. If you would like an additional card, please contact your Member Services Specialist at 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TYY)or request one online at www.dentalhealthservices.com.

Your First Dental Appointment

Your initial appointment is an opportunity for you to meet your Designated Participating Primary Dentist. Your dentist will complete an oral examination and formulate a treatment plan for you based on their 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 such as periodontal charting or 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 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.

Working With Your Designated Participating Primary Dentist

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

Dental Health Services values its Members and Participating Primary Dentists. Providing an environment that encourages healthy relationships between Members and their dentist helps to ensure the stability and quality of your dental Plan. If a satisfactory relationship cannot be established between a Member and their Designated Participating Primary Dentist, Dental Health Services, the Member, or the Designated Participating Primary 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. Dental Health Services will limit, deny or terminate a Member's coverage, only when legally permissible.

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 Primary Dentist.

Changing Dental Offices

If you wish to change dentist, you must notify Dental Health Services. Requests can be done by calling 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TTY) or sending a fax to 206-624-8755. Online requests can be done through our website at 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) of the month become effective the first (1st) day of the second month following receipt of your request. For example, if you request to change your dentist on or before August 20th, your new dentist selection will become effective September 1st. If you make your dentist change request on or after August 21st, your new dentist change request will become effective October 1st.

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 Dentist or Participating Specialist if necessary.

You should bring your x- rays to this consultation, if possible. If x-rays are not necessary, you will pay only your office visit Copayment.

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

Your Financial Responsibility

You are liable to your Designated Participating Primary 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 Designated Participating Primary Dentist or specialist or the provider who provided the service. As stated under the *Emergency Care* section of this certificate, for services rendered by an Out-of-Network Dentist or Out-of-Network 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 the Emergency Dental Condition.

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

Exclusions and Limitations

This Evidence of Coverage describes your dental Plan Benefits. It is the responsibility of the Members to review this certificate carefully and to be aware of its Exclusions and Limitations of Benefits.

Please reference the Exclusions and Limitations of Benefits described in your Schedule of Covered Services and Copayments included with this certificate.
If you have any questions about Schedule of the Covered Services and Copayments including Exclusions and Limitations of Benefits, please contact Member Services at 877-495-4455 206-788-3444 or 877-495-4455,

888-645-1257 (TDD/TTY).

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 Combined 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 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 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TTY).

Coordination of Benefits (COB)

This Plan does not provide for coordination of benefits with other coverage. However, if your secondary dental coverage is provided by Dental Health Services through the City of Seattle, all Copayments will be reimbursed for all covered services.

Cosmetic services and all services related to an

Implant are not eligible for this benefit. Member is responsible to inform Dental Health Services if they have dual coverage (both City of Seattle employee and their spouse or domestic partner have both elected Dental Health Services for their primary dental plan). To request reimbursement of Copayments, Member is to submit receipts for Copayments (within one hundred and eighty (180) of service) to Dental Health Services and they will be reimbursed directly. Requests for reimbursement should be sent to:

Dental Health Services
Attn: Claims
100 West Harrison Street
Suite S-440, South Tower
Seattle, Washington 98119

Emergency Care:

You are covered for dental emergencies at all times, both inside and outside of Dental Health Services' service areas.

Palliative care for Emergency Dental Conditions in which acute pain, bleeding, or dental infection exists is a Benefit according to your Schedule of Covered Services and Copayments. Palliative care is treatment to relieve pain or alleviate a symptom without dealing with the underlying cause.

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

1. Call your selected Designated Participating Primary 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 a lesser period of time as may be Medically Necessary.
2. If your Designated Participating Primary Dentist is not available, call your Member Services Specialist at 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TTY).

   Your Member Services Specialist will assist you in scheduling an emergency dental appointment with another Participating Primary Dentist in your area.

   If there are no Participating Primary 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 Primary Dentist seek emergency palliative treatment from any dentist practicing in the scope of their license.
3. When services are provided by an Out-of-Network Dentist or Out-of-Network Specialist, you will be responsible for paying the entire bill to the Out-of-Network Dentist or Out-of-Network Specialist at the time of service. 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.

To be reimbursed for any amount over the applicable emergency Copayments, you must submit the itemized dental bill from the dental office to Dental Health Services. Dental Health Services only reimburses for the amount over your Copayment for dental work done to eliminate pain, swelling or bleeding.

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

Dental Health Services
Attn: Claims Department
100 West Harrison Street
Suite S-440, South Tower
Seattle, Washington 98119

If you do not submit this information within one hundred-eighty (180) days, Dental Health Services reserves the right to refuse payment.

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,
3. Group name, and
4. 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 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 you grievance was not handled properly, you may contact the Office of Insurance 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.

For questions about your rights, this notice, or for assistance, you can contact: Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Dental Health Services' grievance system 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 system. 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.

Claims, Adverse Benefit Determinations & Appeals

Your Designated Participating Primary 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.

Claims Payment

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 Determinations

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 the decision through Dental Health Services.
4. Dental Health Services' contact information for inquiries about the denial prior to filing an Internal Review Process request.

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 representative 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 representative, 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. The Member and the dentist will be notified of the final determination through US Mail. 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 a r course of treatment in a facility, dental professional's office, or any inpatient/outpatient health care setting so the final Adverse Benefit Determination is reached expeditiously.

For assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You may also contact the 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.

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.

Termination of Coverage

Upon terminating, denying, or refusing to renew any Member's dental Plan, Dental Health Services will notify the Subscriber and Group Administrator in writing of the reason(s) for terminating, denying, or refusing renewal of the Plan. Coverage of a subscriber and/or their Dependents may be terminated for any of the following reasons:

1. Termination of the Group Dental Care Services Agreement by written notice one-hundred-eighty (180) days before Groups annual renewal.
2. Failure of a Member to meet or maintain eligibility requirements.
3. Material misrepresentation (fraud) in obtaining coverage.
4. 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.
5. Failure of Group to pay Premium in a timely manner (thirty (30) days after payment is due.)
6. Dependent reaches limiting age.
7. 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 Non-Payment

Your Plan's Benefits depend on Premium payments staying current. If Group Premium payment is more than thirty (30) days overdue, your eligibility may be terminated.

Your coverage will terminate at the expiration of the thirty (30) day grace period provided to Group for Premium payment.

Review of Termination

If you believe your membership was terminated by Dental Health Services solely because of ill health or your need for care, you may request a review of the termination by writing to the Dental Health Services Dental Director:

Dental Health Services
Attn: Dental Director Dental Health Services
100 West Harrison Street
Suite S-440, South Tower
Seattle, Washington 98119

Renewal Provisions

The Group Services Agreement may be extended or renewed from year to year after its initial period. Renewal may change the Copayment and/or Premium fees paid by Group and/or the Subscriber. You may obtain information about these or any changes from a Dental Health Services' Representative during the open enrollment period or by calling your Member Services Specialist at 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TYY).

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. Termination of coverage may occur during this six (6) month period or at the end of the coverage period, whichever the Subscriber may choose.

Conflicts

Any conflicts between the provisions included in the Group Services Agreement for this Plan and this Evidence of Coverage certificate, the conflict shall be resolved according to the Evidence of Coverage provided to Members.

Governing Law

This Evidence of Coverage is issued and delivered in the state of Washington, is governed by the laws thereof, and subject to the terms and conditions recited in this certificate.

Privacy Notice

Dental Health Services is required by law to maintain the privacy and security of your Protected Health Information (PHI). This notice describes how your medical and dental information may be used and disclosed, and how you access control of your information. Please review it carefully. This notice is updated effective March 1, 2018.

Dental Health Services is devoted to protecting your privacy and the confidentiality of your dental, medical, and personal health information. We do not sell our Member information. Your personal information will not be disclosed to non-affiliated third parties, unless permitted or required by law, or authorized in writing by you.

Throughout this Notice, unless otherwise stated, your medical and dental health information refers only to information created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). Examples of PHI include your name, address, phone number, email address, birthdate, treatment dates and records, enrollment and claims information. Dental Health Services will have a record of this portion of your PHI only in special or exceptional circumstances.

Under what circumstances must Dental Health Services share my PHI?

Dental Health Services is required to disclose your PHI to you, and to the U.S. Department of Health and Human Services (HHS) when it is conducting an investigation of compliance with legal requirements.

Dental Health Services is also required to disclose your PHI, subject to certain requirements and limitations, if the disclosure is compelled by any of the following:

A. A court order or subpoena.

B. A board, commission or administrative agency, pursuant to its lawful authority.

C. An arbitrator or panel of arbitrators in a lawfully requested arbitration.

D. A search warrants.

E. A coroner in the course of an investigation; or by other law.

When may Dental Health Services disclose my PHI without my authorization?

Dental Health Services is permitted by law to use and disclose your PHI, without your authorization, for purposes of treatment, payment, and health care administration.

A. Treatment purposes include disclosures related to facilitating your dental care.

B. Payment purposes include activities to collect Premiums and to determine or maintain coverage.

C. Health Care Administration means basic activities essential to Dental Health Services' function as a licensed Limited Healthcare Service Contractor, and includes reviewing the qualifications, competence and service quality of your Participating Dentist; and providing referrals for Specialists.

D. In some situations, Dental Health Services is permitted to use and disclose your PHI, without your authorization, subject to limitations imposed by law. These situations include, but are not limited to:

1. Preventing or reducing a serious threat to the public's health or safety;
2. Concerning victims of abuse, neglect or domestic violence;
3. Health oversight agency;
4. Judicial and administrative proceedings including the defense by Dental Health Services of a legal action or proceeding brought by you;
5. Law enforcement purposes, subject to subpoena of law;
6. Workers' Compensation purposes;
7. Parents or guardians of a minor; and
8. Persons or entities who perform services on behalf of Dental Health Services and from whom Dental Health Services has received contractual assurances to protect the privacy of your PHI.

Is Dental Health Services ever required to get my permission before sharing my PHI?

Uses and disclosures of PHI other than those required or permitted by law will be made by Dental Health Services only with your written authorization. You may revoke any authorization by written notice, except to the extent that Dental Health Services has relied on the authorization before receiving your written revocation. Uses and disclosures beyond those required or permitted by law, or authorized by you, are prohibited.

Does my employer have the right to access my PHI?

If you are a Member under a plan sponsored by your employer, Dental Health Services will not disclose PHI to your employer except under the following conditions:

A. You sign an authorization for release of your medical/dental information; or Health care services were provided with specific prior written request and expense of the employer, and are relevant in a grievance, arbitration or lawsuit, or describe limitations entitling you to leave from work or limit work performance.

Any such disclosure is subject to Dental Health Services' "minimum necessary" disclosure policy.

What are Dental Health Services' "Minimum Necessary" Policy?

Dental Health Services uses reasonable efforts to limit the use and disclosure of your PHI to the minimum necessary to accomplish the purpose of the use or disclosure. This restriction includes requests for PHI from another entity, and to requests made by Dental Health Services to other entities. This restriction does not apply to requests by:

A. Your dentist for treatment purposes;

B. You;

C. Disclosures covered by an authorization you provided to another entity.

What are my rights regarding the privacy of my PHI?

A. You may request Dental Health Services to restrict uses and disclosures of your PHI in the performance of its payment or health care operations. However, a written request is required. Your health is our top priority and Dental Health Services is not required to agree to your requested restriction. If Dental Health Services agrees to your

requested restriction, the restriction will not apply in situations involving emergency treatment by a health care provider.

B. Dental Health Services will comply with your reasonable request that you wish to receive communications of your PHI by alternative means or at alternative locations. Such requests must be made to Dental Health Services in writing.

C. You have the right to have the person you've assigned medical power of attorney, or your legal guardian, exercise your rights

and make choices about your health information. We will confirm the assigned person has this authority and can act for you before we take any action.

D. You have a right, subject to certain limitations, to inspect and copy your PHI. Your request must be made in writing. Dental Health Services will act on such request within thirty (30) days of receipt of request.

E. You have the right to amend your PHI. The request to amend must be made in writing and must contain the reason you wish to amend your PHI. Dental Health Services has the right to deny such requests under certain conditions provided by law. Dental Health Services will respond to your request within sixty (60) days of receipt of the request and, in certain circumstances may extend this period for up to an additional thirty (30) days.

F. You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to six (6) years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to:

1. Disclosures made for payment or healthcare operations. Your request must be made in writing. Dental Health Services will provide the accounting within sixty (60) days of your request but may extend the period for up to an additional thirty (30) days. The first accounting requested during any twelve (12)-month period will be made without charge. There is a $25 charge for each additional accounting requested during such twelve (12) month period. You may withdraw or modify any additional requests within thirty (30) days of the initial request in order to avoid or reduce the fee. You have the right to receive a copy of this Privacy Notice by contacting Dental Health Services at 206-788-3444 or 877-495-4455, 888-645-1257 (TDD/TTY) or membercare@dentalhealthservices.com. This notice is always available at www.dentalhealthservices.com/privacy.

All written requests desired or required by this Notice, must be delivered to Dental Health Services, 100 West Harrison Street, Suite S-440, South Tower Seattle, Washington 98119 by any of the following means:

1. Personal delivery;
2. Email delivery to membercare@dentalhealthservices.com
3. Fax: 206-624-8755
4. First class or certified U.S. Mail; or.
5. Overnight or courier delivery, charges prepaid.

What duties does Dental Health Services agree to perform?

Dental Health Services will maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices with respect to PHI.

A. Dental Health Services will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

B. Dental Health Services will abide by the terms of this Notice and any revised Notice, during the period that it is in effect.

C. Dental Health Services reserves the right to change the terms of this Notice or any revised Notice. Any new terms shall be effective for all PHI that it maintains including PHI created or received by Dental Health Services prior to the effective date of the new terms.

Each time Dental Health Service revises this Notice, it will promptly post the notice on its website and distribute a new version within sixty (60) days of revision. What if I am dissatisfied with Dental Health Services' compliance with HIPAA (Health Insurance Portability and Accountability Act) privacy regulations?

You have the right to express your dissatisfaction or objection to the Secretary of HHS and/or Dental Health Services if you believe your privacy rights have been violated.

Your written dissatisfaction must describe the acts or omissions you believe to be in violation of the provisions of this Notice or applicable laws. Your written objection to HHS or Dental Health Services must be filed within one hundred-eighty (180) days of when you knew or should have known of the act or omission. You will not be penalized or retaliated against for communicating your dissatisfaction.

You can file a complaint with the US Department of Health and Human Services, Office for Civil Rights, by sending a letter to 200 Independence Avenue, SW, Washington DC, 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You may express dissatisfaction about Dental Health Services' privacy policy in writing to Dental Health Services, 100 West Harrison Street, Suite S-440, South Tower, Seattle, Washington 98119, Attn: Member Satisfaction Assurance Specialist.

Who should I contact if I have any questions regarding my privacy rights with Dental Health Services?

You may obtain further information regarding your PHI privacy rights during regular business hours, by email at membercare@dentalhealthservices.com, or any time through www.dentalhealthservices.com. We are eager to assist you!

Glossary

Adverse Benefit Determination: A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Benefit, including a denial, reduction, termination or failure to provide or make a payment that is based on determination of a Member's or Subscriber's eligibility to participate in a Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or part, for a Benefit resulting from application of any utilization review, as well as failure to cover an item or service for which Benefits are otherwise provided because it is determined to be not medically necessary or appropriate.

Amalgam Filling/Restoration: A restoration or filing composed of metallic alloy formed mostly of silver, tin and copper, mixed with mercury, into a soft malleable material that sets hard after placement inside a tooth cavity.

Appeal: A request for reconsideration of a dental claim due to an Adverse Benefit Determination rendered by Dental Health Services.

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

Child(ren): Your Children or your spouse's Children under the age of twenty-six (26); includes biological Children, adopted Children, stepchildren, Children of your domestic partner, children for whom you have a qualified court order to provide coverage, and Children for whom you are the legal guardian.

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

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.

Copayments: 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.

Cosmetic Dentistry: Those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory, and no pathologic conditions exist.

Dependent: An individual for whom coverage is obtained by a parent, relative, or other person. Eligible Dependents may include a legal spouse (unless you are legally separated), domestic partner, and/or Children of the Subscriber, Subscriber's spouse or domestic partner.

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

Emergency Dental Condition: The treatment of an emergency 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:

(i) 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;

(ii) Serious impairment to bodily functions; or

(iii) 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.

Exclusion: Treatment or coverage not included as a Benefit under this Plan.

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.

Family Unit: A unit composed of a Subscriber and each person whose eligibility for Benefits is based upon such person's relationship with, or dependency upon such Subscriber.

Grievance: A complaint submitted by or on behalf of a covered person or Participating Dentist or Participating Specialist regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, dentist or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Group: A firm, corporation, employer, or association of employers that has entered into an agreement with Dental Health Services for dental care coverage.

Licensed dentist means a licensed Doctor of Dental Surgery (D.D.S) or a Doctor of Medical Dentistry (D.M.D) or a licensed Denturist.

Licensed Denturist: A denturist licensed with the Washington Department of Health as a denturist.

Limitation: A provision that restricts coverage under this Plan.

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.

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

Out-of-Network Dentist: A dentist who does not have a contract with Dental Health Services. An Out-of-Network Dentist includes an Out-of-Network Primary Dentist, Out-of-Network Denturist and an Out-of-Network Orthodontist.

Out-of-Network Orthodontist: A dentist who specializes in orthodontics and does not have a contract with Dental Health Services.

Out-of-Network Primary Dentist: A dentist who provides general dental services and does not have a contract with Dental Health Services.

Out-of-Network Specialist: A dentist who provides Specialty Services and does not have a contract with Dental Health Services.

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

Participating Dentist: A Licensed Dentist who has signed an agreement with Dental Health Services to provide Benefits to Members covered under this Plan. A Participating Dentist includes a Participating Primary Dentist, a Participating Denturist and a Participating Orthodontist.

Participating Denturist: A licensed denturist who has signed an agreement with Dental Health Services to provide Benefits to Members under this Plan.

Participating Orthodontist: A Licensed Dentist who specializes in orthodontics and has signed an agreement with Dental Health Services to provide Benefits to Members under this Plan.

Participating Primary Dentist: A Licensed Dentist who has signed an agreement with Dental Health Services to provide general dental services to Members covered under this Plan. A Participating Dentist includes a Participating Primary Dentist, a Participating Denturist and a Participating Orthodontist

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: Dental Benefits or coverages available to the Subscriber and any eligible Dependents in exchange for the payment of Premium. **Plan Year:** A twelve (12) month period of Benefits coverage under a dental plan.

Special Enrollment Period: A time outside the yearly open enrollment period when consumers can sign up for dental benefits coverage. Consumers qualify for a Special Enrollment Period if they've experienced certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child

Specialty Services: Dental services provided by a Dental Health Services' Participating Specialist (endodontist, periodontist, pediatric dentist, oral surgeon, or orthodontist).

Subscriber: means a person whose employment, or other relationship to or membership in Group is the basis for eligibility for participation in the Plan and whose enrollment form for coverage has been accepted by Dental Health Services, and for whom applicable Premium has been paid.

Temporomandibular Joint Syndrome (TMJ): Includes those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal

derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of the temporomandibular joint.

Usual, Customary & Reasonable (UCR):
The base amount that is treated as the standard or most common charge for a particular dental service.

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COVID 19 Health Plan Endorsement

THIS ENDORSEMENT MODIFIES YOUR PLAN AGREEMENT[i]. PLEASE READ IT CAREFULLY.

These changes are in response to the extraordinary circumstances surrounding the COVID-19 pandemic, in compliance with Washington Emergency Order 20-01 through Emergency Order 20-04 and the Governor's Proclamation 20-29.

This endorsement changes your:

1. GRACE PERIOD: Your Grace Period for premium payment is changed from thirty (30) days to sixty (60) days.

2. TELEMEDICINE: Your Dentist will provide covered dental services consistent with state and local emergency directives related to the Coronavirus. Consult with your dentist to determine if your routine or emergency dental care can be provided using appropriate dentistry methods.

Except as provided in this endorsement, all terms and conditions of your Plan remain unchanged. For assistance in understanding your plan please contact Member Services at 1800-637-6453.

[i] Includes all Group Services Agreements and Group and Individual Plan Evidence of Coverage.