Combined Evidence of Coverage and Policy

City of Seattle plan for Local 77

Dental Health Services

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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 saving you money. We are proud to offer you and your family excellent dental coverage that:

Encourages treatment by eliminating the burdens of deductibles and plan maximums.

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

Recognizes 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.

Simplifies access by not requiring pre-authorization for treatment from the general dentist you've selected from our network.

Assures availability of care with high-quality, easy to find dental offices throughout Washington State and our network is continually expanding; please contact our office at 206.788.3444 or 877.495.4455, or visit www.smartsmile.com/cityofseattle for the latest listing of our dentists.

Allows you to take an active role in your dental health and treatment by fully disclosing coverages and exact copayments prior to treatment.

Recognizes the importance of appearance and aesthetics by offering a discount for cosmetic dental procedures.

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

- ToothTips℠ oral health information sheets
- Member Service Specialists to assist you by telephone, fax, or e-mail
- Web access to valuable plan and oral health information at www.smartsmile.com/cityofseattle

About Dental Health Services

Dental Health Services has been a licensed limited healthcare service contractor since 1984. We are dedicated to assuring your satisfaction and to keeping your plan as simple and clear as possible.

Part of our service focus includes easy, toll-free access to your knowledgeable Member Service Specialist, an automated member assistance and eligibility system, and www.smartsmile.com/cityofseattle to help answer questions about your plan and its benefits.

Your participating dentist

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. The ongoing care of each dental office is monitored regularly through our rigorous Quality Assurance standards. You can rest assured that you are getting the quality care you deserve.

Membership cards

At approximately the time your coverage becomes effective, you will receive one membership card per family. Your participating 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 Service Specialist or request one online at www.smartsmile.com/cityofseattle.

Your first dental appointment

Your initial appointment is an opportunity for you to meet your selected participating dentist. Your dentist will complete an oral examination and formulate a treatment plan with you based on his or her assessment of your oral health.

Your initial exam may require additional diagnostic services such as periodontal charting and x-rays. You may also be charged copayments for additional services as necessary. There is also an office visit copayment that is charged for each office visit regardless of the procedures performed.

After your initial visit, you may schedule an appointment for future care, such as cleanings, to complete your treatment plan. You may reference your treatment plan with your Schedule of Covered Services and Copayments (starting on page 11) to determine the copayments for your scheduled procedures.

Please note that crowns and bridges may require an extra charge for metal upgrades or upgraded specialized porcelain. Copayments are due in full at the time services are performed.

Your Member Service Specialist

Please feel free to call, fax, e-mail through our website, or write us anytime with questions or comments. We are ready to help you. Your Member Service Specialist can be reached through any of the following ways:

Phone: 206.788.3444 or 877.495.4455
Fax: 206.624.8755
Web: www.smartsmile.com/cityofseattle
Mail: Dental Health Services
936 N 34th St., Ste. 208
Seattle, WA 98103

Eligibility

To be eligible for coverage, the Subscriber must be a regularly appointed full-time or part-time employee of Local 77 who is scheduled to work 80 hours per month. Regular employees who have met the initial eligibility rules and have eighty hours of paid time will be eligible for coverage for the current month. Regular employees with less than eighty 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 800 non-overtime hours in the previous 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 (page 40).

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):

- Lawful wife or husband (unless legally separated);

- Domestic partner who you have named in an Affidavit of Marriage/Domestic Partnership on file with your employer; and

- Children who are under 26 years of age.

- Disabled dependent children who are covered by the contract as a dependent child on the day before his or her 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 31 days of the request for that information by Dental Health Services or Group, but not more frequently than annually after the two year period following the child's attainment of 26 years of age.

Your children include:

- Your biological children
- Your adopted or legally placed for adoption children
- Your stepchildren for whom your home is their permanent residence
- Your domestic partner's children for whom your home is their permanent residence
- Children for whom you are a legal guardian and for whom your home is their permanent residence

Enrollment

An employee of the Group who is eligible for coverage on the effective date of the contract must become a Subscriber at that time or wait until the Group's next open enrollment period.

If a person becomes an employee of the Group after the effective date of the Contract, Dental Health Services must receive the enrollment application for coverage within 31 days after the employee first becomes eligible for coverage or the employee must wait until the Group's next open enrollment period.

Temporary employees must apply for coverage when first eligible in accordance with the terms established by the City or wait until the Group's next open enrollment period. If an employee of the Group had other health coverage at the time of initial eligibility under this Contract and declined enrollment under the Contract, in writing based upon such coverage, the employee may apply for

coverage under the Contract prior to the Group's open enrollment period if Dental Health Services receives the enrollment application within 31 days of exhaustion of COBRA continuation coverage, or loss of the prior health coverage.

Dependents must be added at the time of initial enrollment or at the one year renewal date unless one of the following apply:

1. Newborn children are covered from birth. If adding a newborn dependent increases your premium, Dental Health Services must receive a completed enrollment within 60 days to continue coverage for the newborn.

2. Adoptive children are covered from the date of placement for a period of 60 days. If the addition of an adoptive or foster child as a dependent increases your premium, Dental Health Services must receive a completed enrollment form within 60 days to continue coverage for the adoptive child;

3. New spouse or domestic partner may be enrolled within 31 days, and any additional children due to marriage or signed domestic partnership affidavit may be enrolled within 31 days of the event; or

4. Loss of other coverage.

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

Eligible employees, newly eligible employees, temporary eligible employees, or eligible dependents who fail to enroll during open enrollment are not able to enroll in the plan until

the following open enrollment period unless the following applies:

When the department of social and health services determines that it is cost-effective to enroll any person (subscriber or dependent) participating in a medical assistance program under chapter 74.09 RCW in an employer-sponsored dental plan, Dental Health Services shall permit the enrollment of the participicant who is otherwise eligible for coverage in the dental plan without regard to any open enrollment restrictions. The request for special enrollment shall be made by the department or participant within sixty days of the department's determination that the enrollment would be cost-effective.

It is recommended that Dental Health Services be notified in the event of a newborn or child received through adoption to notify the participating dentist of coverage and eligibility and to ensure they have access to member services. This allows Dental Health Services to provide preventive dental care and other services as necessary.

Coverage effective dates

Coverage for a Subscriber and for any dependent included on the Subscriber's initial enrollment application will begin on the first day of the month following date of hire, or concurrent with the date of hire if on paid status the first of the month, provided the application for coverage has been made and the premium has been paid.

Coverage for temporary employees will begin on the first of the month following the date the application has been made and the premium paid. An employee who is absent without pay on the

first of the month and returns by the 15th of the month will not have a lapse in coverage. Coverage for an employee who returns after the 15th of the month will begin the first of the following month.

In the case of a Subscriber's natural 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.

Receiving dental care

Upon enrolling in your plan, you should select your participating dentist. Directories are available by calling your Member Service Specialist at 206.788.3444 or 877.495.4455, or online through www.smartsmile.com/cityofseattle.

You may make an appointment with your dentist as soon as your eligibility has been confirmed. Simply call the telephone number as it appears below the dental office address in your Directory of Participating Dentists 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 weeks. You are only eligible for services at your participating dentist's office, except in an emergency situation.

Your relationship with your dentist

Dental Health Services values its members and participating dentists. Providing an environment that encourages healthy relationships between members and their dentists help to ensure the

stability and quality of your dental plan.

Participating dentists are responsible for providing dental advice or treatment independently, and without interference, from Dental Health Services or any affiliated agents. If a satisfactory relationship cannot be established between a member and their participating dentist, Dental Health Services, the member, or the dentist reserves the right to request the member's affiliation with the dental office be terminated.

Any request to terminate a specific member/dentist relationship should be submitted to Dental Health Services and shall be effective the first 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 dentist.

Changing dental offices

If you wish to change dentists you must notify Dental Health Services. This may be done by phone, in writing, by fax, or online. Requests can be made through 206.788.3444 or 877.495.4455, or by fax at 206.624.8755. Online changes can be done through www.smartsmile.com/cityofseattle.

Requests received by the 20th of the current month become effective the first day of the following month. Changes made after the 20th become effective the first day of the second 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 dentist. You should bring your x-rays to this consultation. If x-

rays are unnecessary, you will pay only your office visit and second opinion copayments.

After you receive your second opinion you may return to your initial participating dental office for treatment. If, however, you wish to select a new 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 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 uncovered services. All dental treatment copayments are to be paid at the time of service directly to your participating dental office.

As stated under the *Emergency care: out-of-area* section of this booklet, for services rendered by a non-contracted dentist, Dental Health Services will pay for the cost of emergency care beyond your applicable copayment. You are responsible for any other costs.

Schedule of Covered Services & Copayments

Services when performed by a participating Dental Health Services general dentist

Code	Service	Copayment
	Office visit charge - 0-3 years of service	5.00
	Office visit charge - 3+ years of service	None
	Failed (no show) appointment without 24-hour notice	10.00

Diagnostic

Code	Service	Copayment
D0120	Periodic oral evaluation	None
D0140	Limited oral evaluation - problem focused	None
D0150	Comprehesive oral evaluation - new or established patient	None
D0160	Detailed and extensive oral evaluation - problem focused, by report	None
D0170	Re-evaluation - limited, problem focused	None
D0180	Comprehensive periodontal evaluation - new or established patient	None
D0210	Intraoral - complete series of x-rays (including bitewings)	None
D0220	Intraoral - periapical first film	None
D0230	Intraoral - periapical each additional film	None
D0240	Intraoral - occlusal film	None
D0250	Extraoral - first film	None
D0260	Extraoral - each additional film	None
D0270	Bitewing - single film	None
D0272	Bitewings - two films	None
D0274	Bitewings - four films	None
D0330	Panoramic film	None
D0340	Cephalometric film	None
D0350	Oral/facial photographic images	None
D0415	Collection of microorganisms for culture and sensitivity	None
D0425	Caries susceptibility tests	None
D0460	Pulp vitality tests	None
D0470	Diagnostic casts	None

Preventive

Dental prophylaxis (teeth cleaning) includes shallow scaling and polishing - one per six months, two per contract year.

D1110	Prophylaxis - adult	None
D1120	Prophylaxis - child	None
D1203	Topical application of fluoride (propylaxis not included) - child	None
D1204	Topical application of fluoride (propylaxis not included) - adult	None
D1310	Nutritional counseling for control of dental disease	None
D1320	Tobacco counseling for control and prevention of oral disease	None
D1330	Oral hygiene instructions	None
D1351	Sealant - per tooth	None
D1510	Space maintainer - fixed - unilateral	None
D1515	Space maintainer - fixed - bilateral	None
D1520	Space maintainer - removable - unilateral	None
D1525	Space maintainer - removable - bilateral	None
D1550	Re-cementation of space maintainer	None

Amalgam restorations (fillings)

D2140	Amalgam - one surface, primary or permanent	None
D2150	Amalgam - two surfaces, primary or permanent	None
D2160	Amalgam - three surfaces, primary or permanent	None
D2161	Amalgam - four or more surfaces, primary or permanent	None

Resin-based composite restorations (fillings)

D2330	Resin-based composite - one surface, anterior	None
D2331	Resin-based composite - two surfaces, anterior	None
D2332	Resin-based composite - three surfaces, anterior	None
D2335	Resin-based composite - four or more surfaces, or involving incisal angle (anterior)	None
D2390	Resin-based composite crown, anterior	None
D2391	Resin-based composite - one surface, posterior	None
D2392	Resin-based composite - two surfaces, posterior	None
D2393	Resin-based composite - three surfaces, posterior	None
D2394	Resin-based composite - four or more surfaces, posterior	None

Inlay/onlay restorations

D2510	Inlay - metallic - one surface	*None
D2520	Inlay - metallic - two surfaces	*None
D2530	Inlay - metallic - three or more surfaces	*None
D2542	Onlay - metallic - two surfaces	*None
D2543	Onlay - metallic - three surfaces	*None
D2544	Onlay - metallic - four or more surfaces	*None
D2610	Inlay - porcelain/ceramic - one surface	*None
D2620	Inlay - porcelain/ceramic - two surfaces	*None
D2630	Inlay - porcelain/ceramic - three or more surfaces	*None
D2642	Onlay - porcelain/ceramic - two surfaces	*None
D2643	Onlay - porcelain/ceramic - three surfaces	*None
D2644	Onlay - porcelain/ceramic - four or more surfaces	*None
D2650	Inlay - resin-based composite - one surface	None
D2651	Inlay - resin-based composite - two surfaces	None
D2652	Inlay - resin-based composite - three or more surfaces	None
D2662	Onlay - resin-based composite - two surfaces	None
D2663	Onlay - resin-based composite - three surfaces	None
D2664	Onlay - resin-based composite - four or more surfaces	None

** Additional charges of $70 for noble metal, $100 for high noble metal, $100 for titanium, and $125 for upgraded, specialized porcelain*

Crowns - single restoration only

D2710	Crown - resin-based composite (indirect)	None
D2712	Crown - 3/4 resin based composite (indirect)	None
D2740	Crown - porcelain/ceramic substrate	*None

D2750	Crown - porcelain fused to high noble metal	*None
D2751	Crown - porcelain fused to predominantly base metal	None
D2752	Crown - porcelain fused to noble metal	*None
D2780	Crown - 3/4 cast high noble metal	*None
D2781	Crown - 3/4 cast predominantaly base metal	None
D2782	Crown - 3/4 cast noble metal	*None
D2783	Crown - 3/4 porcelain/ceramic	*None
D2790	Crown - full cast high noble metal	*None
D2791	Crown - full cast predominantly base metal	None
D2792	Crown - full cast noble metal	*None
D2794	Crown - titanium	*None

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Other restorative services

D2910	Recement inlay, onlay, or partial coverage restoration	None
D2915	Recement cast or prefabricated post and core	None
D2920	Recement crown	None
D2930	Prefabricated stainless steel crown - primary tooth	None
D2931	Prefabricated stainless steel crown - permanent tooth	None
D2932	Prefabricated resin crown	None
D2933	Prefabricated stainless steel crown with resin window	None
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	None
D2940	Sedative filling	None
D2950	Core buildup, including any pins	None
D2951	Pin retention - per tooth, in addition to restoration	None
D2952	Cast post and core in addition to crown	None
D2954	Prefabricated post and core in addition to crown	None
D2955	Post removal (not in conjunction with endodontic therapy)	None
D2957	Each additional prefabricated post - same tooth	None
D2980	Crown repair, by report	None

Endodontics

D3110	Pulp cap - direct (excluding final restoration)	None
D3120	Pulp cap - indirect (excluding final restoration)	None
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	None
D3221	Pulpal debridement, primary and permanent teeth	None
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	None
D3240	Pulpal therapy (resorbable filling) - posterior,	

primary tooth (excluding final restoration) ..... None
D3310 Anterior root canal therapy (excluding final restoration) ..... None
D3320 Bicuspid root canal therapy (excluding final restoration) ..... None
D3330 Molar root canal therapy (excluding final restoration) ..... None
D3331 Treatment of root canal obstruction - non-surgical access ..... None
D3332 Incomplete endodontic therapy - inoperate, unrestorable or fractured tooth ..... None
D3333 Internal root repair of perforation defects ..... None
D3346 Retreatment of previous root canal therapy - anterior ..... None
D3347 Retreatment of previous root canal therapy - bicuspid ..... None
D3348 Retreatment of previous root canal therapy - molar ..... None
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) ..... None
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) ..... None
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) ..... None
D3410 Apicoectomy/periradicular surgery - anterior ..... None
D3421 Apicoectomy/periradicular surgery - bicuspid (first root) ..... None
D3425 Apicoectomy/periradicular surgery - molar (first root) ..... None
D3426 Apicoectomy/periradicular surgery - (each additional root) ..... None
D3430 Retrograde filling - per root ..... None
D3450 Root amputation - per root ..... None
D3920 Hemisection (including any root removal), not ..... including root canal therapy ..... None
D3950 Canal preparation and fitting of preformed dowel or post ..... None

Periodontics

D4210 Gingivectomy or gingivoplasty - four or more ..... contiguous teeth or bounded teeth spaces per quadrant ..... None
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant ..... None
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant ..... None
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth

	spaces per quadrant	None
D4249	Clinical crown lengthening - hard tissue	None
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	None
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	None
D4263	Bone replacement graft - first site in quadrant	None
D4264	Bone replacement graft - each additional site in quadrant	None
D4270	Pedicle soft tissue graft procedure	None
D4271	Free soft tissue graft procedure (including donor site surgery)	None
D4273	Subepithelial connective tissue graft procedures, per tooth	None
D4274	Distal or proximal wedge procedure	None
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	None
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	None
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	None
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	None
D4910	Periodontal maintenance	None

Dentures, denture adjustments, and repairs

Full or partial dentures - one per five year period. Replacement provided where casing is unsatisfactory and cannot be made satisfactory. Lost or stolen appliances are the responsibility of the patient. Unilateral partials (Nesbitt) are not a recommended treatment. Dentures and partials include four months' free adjustments. Add lab cost of any gold. Plastic teeth or dentures are a covered benefit. Patient is responsible for the cost of upgrades to teeth or dentures.

D5110	Complete denture - maxillary	None
D5120	Complete denture - mandibular	None
D5130	Immediate denture - maxillary	None
D5140	Immediate denture - mandibular	None
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	None
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	None
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	None
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including	

	any conventional clasps, rests and teeth)	None
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	None
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	None
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	None
D5410	Adjust complete denture - maxillary	None
D5411	Adjust complete denture - mandibular	None
D5421	Adjust partial denture - maxillary	None
D5422	Adjust partial denture - mandibular	None
D5510	Repair broken complete denture base	None
D5520	Replace missing or broken teeth - complete denture (each tooth)	None
D5610	Repair resin denture base	None
D5620	Repair cast framework	None
D5630	Repair or replace broken clasp	None
D5640	Replace broken teeth - per tooth	None
D5650	Add tooth to existing partial denture	None
D5660	Add clasp to existing partial denture	None
D5710	Rebase complete maxillary denture	None
D5711	Rebase complete mandibular denture	None
D5720	Rebase maxillary partial denture	None
D5721	Rebase mandibular partial denture	None
D5730	Reline complete maxillary denture (chairside)	None
D5731	Reline complete mandibular denture (chairside)	None
D5740	Reline maxillary partial denture (chairside)	None
D5741	Reline mandibular partial denture (chairside)	None
D5750	Reline complete maxillary denture (laboratory)	None
D5751	Reline complete mandibular denture (laboratory)	None
D5760	Reline maxillary partial denture (laboratory)	None
D5761	Reline mandibular partial denture (laboratory)	None
D5810	Interim complete denture (maxillary)	None
D5811	Interim complete denture (mandibular)	None
D5820	Interim partial denture (maxillary)	None
D5821	Interim partial denture (mandibular)	None
D5850	Tissue conditioning, maxillary	None
D5851	Tissue conditioning, mandibular	None
D5860	Overdenture - complete, by report	None
D5861	Overdenture - partial, by report	None
D5986	Fluoride gel carrier	None

Bridges

D6205	Pontic - indirect resin based composite	None
D6210	Pontic - cast high noble metal	*None
D6211	Pontic - cast predominantly base metal	None
D6212	Pontic - cast noble metal	*None
D6214	Pontic - titanium	*None
D6240	Pontic - porcelain fused to high noble metal	*None
D6241	Pontic - porcelain fused to predominantly base metal	*None
D6242	Pontic - porcelain fused to noble metal	*None

D6245	Pontic - porcelain/ceramic	*None
D6545	Retainer - cast metal for resin bonded fixed prosthesis	None
D6600	Inlay - porcelain/ceramic, two surfaces	*None
D6601	Inlay - porcelain/ceramic, three or more surfaces	*None
D6602	Inlay - cast high noble metal, two surfaces	*None
D6603	Inlay - cast high noble metal, three or more surfaces	*None
D6604	Inlay - cast predominantly base metal, two surfaces	None
D6605	Inlay - cast predominantly base metal, three or more surfaces	None
D6606	Inlay - cast noble metal, two surfaces	*None
D6607	Inlay - cast noble metal, three or more surfaces	*None
D6608	Onlay - porcelain/ceramic, two surfaces	*None
D6609	Onlay - porcelain/ceramic, three or more surfaces	*None
D6610	Onlay - cast high noble metal, two surfaces	*None
D6611	Onlay - cast high noble metal, three or more surfaces	*None
D6612	Onlay - cast predominantly base metal, two surfaces	None
D6613	Onlay - cast predominantly base metal, three or more surfaces	None
D6614	Onlay - cast noble metal, two surfaces	*None
D6615	Onlay - cast noble metal, three or more surfaces	*None
D6624	Inlay - titanium	*None
D6634	Onlay - titanium	*None
D6710	Crown - indirect resin based composite	None
D6740	Crown - porcelain/ceramic	*None
D6750	Crown - porcelain fused to high noble metal	*None
D6751	Crown - porcelain fused to predominantly base metal	*None
D6752	Crown - porcelain fused to noble metal	*None
D6780	Crown - 3/4 cast high noble metal	*None
D6781	Crown - 3/4 cast predominantly base metal	None
D6782	Crown - 3/4 cast noble metal	*None
D6783	Crown - 3/4 porcelain/ceramic	*None
D6790	Crown - full cast high noble metal	*None
D6791	Crown - full cast predominantly base metal	None
D6792	Crown - full cast noble metal	*None
D6794	Crown - titanium	*None
D6930	Recement fixed partial denture	None
D6972	Prefabricated post and core in addition to fixed partial denture retainer	None
D6973	Core build up for retainer, including any pins	None
D6975	Coping - metal	*None
D6980	Fixed partial denture repair, by report	None

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Oral surgery

D7111	Extraction, coronal remnants - deciduous tooth	None
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	None
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	None
D7220	Removal or impacted tooth - soft tissue	None
D7230	Removal of impacted tooth - partially bony	None
D7240	Removal of impacted tooth - completely bony	None
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	None
D7250	Surgical removal of residual tooth roots	None
D7260	Oroantral fistula closure	None
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	None
D7280	Surgical access of an unerupted tooth	None
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	None
D7310	Alveoloplasty in conjunction with extractions - per quadrant	None
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	None
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	None
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	None
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	None
D7471	Removal of lateral exostosis (maxilla or mandible)	None
D7510	Incision and drainage of abscess - intraoral soft tissue	None
D7520	Incision and drainage of abscess - extraoral soft tissue	None
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	None
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	None
D7670	Alveolus - closed reduction, may include stabilization of teeth	None
D7910	Suture of recent small wounds up to 5 cm	None
D7911	Complicated suture - up to 5 cm	None
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	None
D7970	Excision of hyperplastic tissue - per arch	None
D7971	Excision of pericoronal gingiva	None
D7980	Sialolithomy	None

Other services

*** General anesthesia is only covered solely for dependent children under the age of seven or the physically or developmentally disabled, only when medically necessary and in conjunction with a covered dental procedure performed at a participating dental office. May not be offered at all offices.*

D9110	Palliative (emergency) treatment of dental pain - minor procedure	None
D9215	Local anesthesia	None
D9220	Deep sedation / general anesthesia - first 30 minutes	**250.00
D9221	Deep sedation / general anesthesia - each additional 15 minutes	**None
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	None
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	None
D9440	Office visit - after regularly scheduled hours	25.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	None
D9940	Occlusal guard by report	350.00
D9951	Occlusal adjustment - limited	None
D9952	Occlusal adjustment - complete	None
D9970	Enamel microabrasion	None

Orthodontics

Copayment amount for the entire orthodontia treatment case will be determined by the subscribers' benefit at the time of banding. Copayments include retention appliances after orthodontic treatment and repairs of retention appliances. Copayments for limited and interceptive orthodontic services will be pro-rated based on the treatment rendered, as long as the copayment does not exceed the copayment for comprehensive services.

Initial orthodontic exam	25.00
Case presentation	None
Failed/no-show appointment without 24-hour notice	10.00
X-rays and models	125.00
Retention appliance - after treatment	None
Repair of orthodontic appliance	None
Comprehensive treatment up to 24 months - adolescent	400.00
Comprehensive treatment up to 24 months - transitional	400.00
Comprehensive treatment up to 24 months - adult	400.00

**Copayments for limited and interceptive orthodontic services will be pro-rated based on the treatment rendered, as long as the copayment does not exceed the copayment for comprehensive services.

Limited treatment - adolescent	pro-rated

Limited treatment - transitional ..... pro-rated
Limited treatment - adult ..... pro-rated
Interceptive treatment up to 24 months -
transitional ..... pro-rated

Cosmetic services

Non-covered cosmetic services, such as teeth whitening, bonding, and veneers are offered by a participating dentist at at 15% discounted fee. Discounted fees will not be waived because of secondary dental coverage provided by Dental Health Services through the City of Seattle.

Implants

Implant services are available at a discounted fee at Dental Health Services designated locations only. Please contact us at 877.495.4455 for additional information.

Discounted fees will not be waived because of secondary dental coverage provided by Dental Health Services through the City of Seattle.

Pre-natal Periodontal Benefit

In order to improve the overall health of our enrollees, your plan includes a pre-natal health improvement program.

Numerous studies indicate that women who have periodontal disease while pregnant are at much greater risk for having other health issues. While you are pregnant, your benefit includes a program to reimburse your copayments for necessary periodontic services when provided by a Dental Health Services' General Dentist.

This includes additional cleanings, scalings and periodontal irrigation/antimicrobials treatment determined by your dentist to be necessary.

You must submit an itemized receipt from the dental office that provided the services and an attestation of your pregnancy to Dental Health Services within 60 days of treatment.

Dental limitations

A. Authorized treatment is rendered only by your selected participating provider. Services provided by a dentist other than the enrollee's designated participating provider, except for emergency dental conditions, are not covered. (See item C. below)

B. Limitation on the frequency and appropriateness of services:

1. Prophylaxis (teeth cleaning, shallow scaling and polishing) – maximum one per six months, 2 per contract year.

2. Periodontal scaling and periodontal maintenance – limited to four quadrants per six months.

3. Periodontal surgery: Periodontal surgical procedures are limited to 4 quadrants in 2 years.

4. Full/partial dentures (upper and/or lower) – one per five year period. Replacement of appliances that are causing pain, bleeding, swelling or are required due to additional tooth loss which cannot be restored by modification of the appliance are covered. New dentures are covered only if the existing denture cannot be made satisfactory by either a reline or repair. Lost or stolen appliances are the responsibility of the patient.

5. Denture relines – one per year, per arch

6. Full-mouth x-rays – once every three years or as determined necessary by your dentist.

7. Partial dentures are appropriate treatment when dental spaces are bilateral and can be satisfactorily restored with removable dentures. Unilateral partials (Nesbitt) are not a recommended treatment.

8. Acid etched bridge (Maryland) is appropriate only on the anterior area.

9. Fixed bridges are optional and restricted for patients under the age of 16 when periodontal tissue is not supportive or in the presence of bilateral spaces.

10. Treatment by a pedodontist for baby bottle mouth syndrome is limited to a lifetime benefit of $500 per enrollee.

11. General anesthesia is only covered solely for dependent children under the age of seven (7) or the physically or developmentally disabled, only when medically necessary and in conjunction with a covered dental procedure performed at a participating provider. General anesthesia may not be offered at all participating provider offices.

C. Emergency dental condition – is the emergent and acute onset of a symptom or symptoms, including severe pain that would lead a prudent layperson acting reasonably to believe that dental condition exists that requires immediate, palliative care by a licensed dentist for the relief of pain, swelling or bleeding. This does not include routine, extensive or postponable treatment.

D. The additional cost to the enrollee for metal upgrades is $70 for noble metal and $100 for

high noble metal and titanium, and $125 for upgraded specialized porcelain.

E. Optional services (all cases in which the enrollee selects a plan of treatment that is considered unnecessary by the provider) are charged to the enrollee at fee-for-service rates.

F. Cosmetic dentistry – services for appearance only are at a discount off full fees. This includes the replacement of clinically acceptable amalgam fillings.

G. Implant services – implants are available at a discounted fee at Dental Health Services designated locations only. Discounted services include evaluations and x-rays specific to implants, surgical implant placement, abutments, and implant crowns. Not all services related to implants are available at a discount.

H. Unsatisfactory patient-doctor relationship: Dental Health Services providers reserve the right to limit or deny services to an enrollee who fails to follow the prescribed course of treatment, repeatedly fails to keep appointments, fails to pay applicable copayments, is abusive to the participating provider or their staff, or obtains services by fraud or deception.

I. Submit claims within 60 days. Dental Health Services shall not be liable to pay a claim for emergency care or for any Dental Health Services authorized treatment provided by a dentist other than a participating provider unless the enrollee submits the claim to Dental Health Services within 60 days after treatment.

J. Denturist benefit subject to existence and availability of a licensed denturist within a 30 mile radius. Enrollees may elect to travel to the nearest participating denturist for services.

K. Third molars (wisdom teeth) – complicated extractions of third molars are at the discretion of the general dentist and are often referred to oral surgeons (specialist).

L. Specialty services requiring any referral to a specialist must be pre-authorized by Dental Health Services.

M. Not all participating dentists can perform all dental procedures, please verify what services your selected provider can perform for you.

N. Services which are compensable under Worker's Compensation or employer liability laws.

O. All treatment of temporomandibular joint (TMJ) disorders must be pre-authorized before treatment begins. Benefits will be denied if treatment is not pre-authorized. Benefits are limited to a maximum of $1,000 per year, not to exceed a lifetime maximum of $5,000. No benefits will be provided for the repair or replacement of lost, stolen, or broken TMJ appliances. All covered services must be provided or ordered by a participating dentist and be:

    1. Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint;

    2. Effective for the control or elimination of one or more of the following, caused by a

disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing and swallowing food;

3. Recognized as effective, according to the professional standards of good dental practice;

4. Not investigational;

5. Not primarily for cosmetic purposes.

Dental exclusions

A. Services not specifically covered in the Schedule of Covered Services and Copayments.

B. Work in progress: Dental work in progress (non-emergency/temporary procedures started but not finished prior to the date of eligibility) is not covered. This includes crown preps prepared and temporized but not cemented, root canals in mid-treatment, prosthetic cases post final impression stage (sent to the lab), etc. This does not include teeth slated for root canal treatment and/or canals filled during an emergency visit.

C. Services that in the opinion of the attending dentist are not necessary for the patient's health. Extractions of non-pathologic, asymptomatic (healthy or non-symptomatic) teeth including extractions for orthodontic reasons.

D. Dispensing of drugs not normally supplied in a dental office.

E. Any dental procedure or service rendered while

a patient is hospitalized or not in the dental office.

F. Treatment for malignancies or neoplasms (tumors).

G. Procedures or charges for services prior to the date the enrollee became eligible for benefits under this plan, or re-treatment of these procedures within one (1) year of completion or charges incurred following termination of benefits under this plan.

H. Any dental procedure that cannot be performed in the dental office due to the general health of the enrollee.

I. Procedures, appliances or restorations other than fillings that are necessary to alter, restore or maintain occlusion, or are necessary for full-mouth rehabilitation, i.e., night guards, occlusal adjustments, etc.

J. Orthognathic treatment – surgical procedures and other treatment to correct the malposition of the maxilla and/or the mandible.

K. Full mouth rehabilitation is not covered. Procedures requiring extensive restorative treatment involving more than 10 crowns in a one year period and/or an increase or decrease of the horizontal or vertical dimension, gnathological recordings, full mouth equilibration, periodontal splinting, temporary processed functional crowns/appliances and realignment of teeth are not covered.

L. Services and supplies incurred before your effective date under the plan or after your termination under the plan except as may be

provided under the other continuation options administered through your employer.

M. Any dental expense that is covered by a third party, such as automobile insurance, other liability insurance, etc.

N. Services and supplies for treatment of illness or injury for which a third party is or may be responsible.

O. Expenses for services and supplies incurred as a result of any work related injury or illness, including claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law

Orthodontic limitations

A. Replacement of lost or broken appliances

B. Changes in treatment necessitated by accident of any kind.

C. Services which are compensable under Worker's Compensation or employer liability laws.

D. Malocclusions too severe or mutilated which are not amenable to ideal orthodontic therapy.

Orthodontic exclusions

A. Retreatment of orthodontic cases.

B. Treatment of a case in progress at inception of eligibility, unless authorized by Dental Health Services.

C. Surgical procedures (including extraction of teeth) incidental to orthodontic treatment.

D. Treatment and/or surgical procedures related to cleft palate, micrognathia or microdontia.

E. Treatment related to temporomandibular joint disturbances and/or hormonal imbalances.

F. Any dental procedures considered to be within the field of general dentistry, including but not limited to:

1. Myofunctional therapy.

2. General anesthetics including intravenous and inhalation sedation.

3. Dental services of any nature performed in a hospital.

4. Services which are compensable under Worker's Compensation or employer liability laws.

G. Payment by Dental Health Services for treatment rendered or required after enrollee is no longer eligible for coverage. The cost of treatment will be pro-rated and converted by a UCR (fee-for-service) amount.

Emergency care: in-area

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.

If you have a dental emergency and need

immediate care, first call your selected participating dental office. Dental offices maintain 24-hour emergency communication accessibility and are expected to see you within 24 hours of initial contact, or within such lesser time as may be medically necessary. If your dentist is not available, call your Member Service Specialist at 206.788.3444 or 877.495.4455.

If both your dental office and Dental Health Services cannot be reached, you are covered for emergency care from another participating dental office, or from any licensed dentist. You will be reimbursed for the cost of emergency palliative treatment less any copayments that apply. Contact your selected participating dentist for follow-up care as soon as possible.

If you have a medical emergency, receive care immediately by calling 911 or by going to the nearest hospital emergency room.

Emergency care: out-of-area

All participating dental offices are expected to maintain 24-hour emergency communication accessibility. Emergency (palliative) treatment can be obtained from any participating dentist. In case of an emergency dental condition, where no participating dentist within a reasonable distance or time is available, no prior authorization is required to have emergency palliative treatment performed. Dental Health Services will be responsible for dental service fees beyond all applicable copayments in an emergency situation. Services for the treatment of emergency dental conditions are solely limited to procedures to stop bleeding, and to reduce swelling and pain. After emergency treatment is performed the covered

person must see their participating dentist to be covered by Dental Health Services.

If services for the treatment of an emergency dental condition are authorized by any service staff member of Dental Health Services, Dental Health Services may not deny the responsibility of fees beyond all applicable copayments, unless approval was based on misrepresentation about the covered person's condition made by the dentist performing the emergency treatment.

If an enrollee receives services for the treatment of an emergency dental condition from a non-participating dentist, an additional $50.00 may be charged above the applicable copayments, unless the enrollee falls in one of the categories stated below. Dental Health Services will not charge an additional $50.00 copayment for services for the treatment of an emergency dental condition if:

1. Due to uncontrollable circumstances the covered person is unable to go to a participating dentist in a timely fashion without serious detriment to their health.

2. A prudent layperson possessing average knowledge of health and medicine would have reasonably believed that the covered person would have been unable to arrive at a participating dental office in a timely fashion without serious impairment to the covered person's health.

After receiving treatment for an emergency dental condition, Dental Health Services requires pre-authorization for out-of-network post-emergency treatment. Dental Health Services shall provide access to an authorized representative 24 hours a

day, seven days a week to facilitate reviews. To obtain access to an authorized representative, call 206.788.3444 or 877.495.4455 for instructions.

In order for services for the treatment of post-emergency dental condition(s) to be covered, the non-participating dentist or facility must make a documented good faith effort to contact Dental Health Services within 30 minutes of stabilization.

Dental Health Services will respond within 30 minutes. Failure to do so authorizes immediately required medically necessary services for the treatment of post-emergency dental condition(s) unless Dental Health Services makes a good faith effort to contact the non-participating dentist within 30 minutes. Dental Health Services shall immediately arrange for an alternate plan of treatment for the covered person if Dental Health Services and the non-participating dentist cannot reach an agreement regarding necessary services beyond those needed for the treatment of the emergency dental condition.

Dental Health Services may require that after services for the treatment of an emergency dental condition are performed, the covered person be transferred to a participating dental office for post-emergency dental condition treatment. Follow-up care that is a direct result of the emergency must be obtained within Dental Health Services' usual terms and conditions of coverage.

For an emergency handled by an out-of-network dentist, enrollees are responsible for the entire bill. To be reimbursed for any amount over the emergency copayment, plan members must submit a Dental Health Services claim form, along with the itemized dental bill. Dental Health Services

only reimburses for the amount over your copayment for dental work done to eliminate pain, swelling or bleeding. Dental Health Services claim forms may be requested directly from your Member Service Specialist. Within 60 days of the occurrence, send the claim form & itemized bill to:

Dental Health Services
936 N 34th St., Suite 208
Seattle, WA 98103

If you do not submit this information within 60 days, Dental Health Services reserves the right to refuse payment.

All approved post-service emergency dental claims are paid within 30 working days. If you submit a completed claim appeal, a decision regarding your appeal will be decided within 30 working days of the receipt of your appeal. You will be also notified of this decision within these 30 working days. If any additional information is needed by Dental Health Services in order to reach a decision regarding your claims appeal, you will be notified within 14 working days of your appeal's receipt.

If you submit a claim involving urgent care, Dental Health Services will notify you within 72 hours after receiving your claim. If information to complete the claim is insufficient, we will notify you of any additional information needed or procedures that must be followed within 24 hours. Dental Health Services' notification may be oral or written. Once we receive the needed information to complete your claim, you will be notified within 48 hours of your claim's approval or denial.

If you wish to appeal the result of your emergency care claim, Dental Health Services will treat your appeal as a grievance. Dental Health Services'

Dental Director and Service Review Committee will review your claim and make a determination. If your claim is denied and you appeal the decision, a reviewer other than the dentist providing the initial determination will review your appeal. If the decision is based on medical judgment, the consulting dentist will be different than the one from the initial review process. Secondary appeals are referred to our Peer Review Committee, which is comprised of independent dentists.

All urgent or emergency care appeals are decided within 72 hours. If you appeal a claim decision made after you received the dental care upon which the claim is based, your appeal will be decided within 30 days. You have 180 days to appeal any denied claim.

Specialty care claims and appeals

All treatment received from participating specialists must be pre-authorized.

Dental Health Services claim forms may be requested directly from your Member Service Specialist. Within 60 days of the occurrence, send the claim form and itemized bill to:

Dental Health Services
936 N 34th St., Suite 208
Seattle, WA 98103

If you do not submit the invoice within 60 days, Dental Health Services reserves the right to refuse payment.

If you submit a pre-service claim for authorization, within 15 days of receiving your claim you will be

notified if your claim is approved or denied. This 15 day period may be extended one time, for up to an additional 15 days, provided such an extension is necessary due to circumstances beyond Dental Health Services' control. In the event an extension is necessary, we will notify you of these circumstances requiring this extension within 5 days of receiving your claim.

If you fail to submit your pre-service claim for authorization according to the procedures outlined in this brochure, within 5 days following Dental Health Services' discovery of any procedural error, you will be notified of the failure and the proper procedures to be followed in submitting your claim. Notification may be oral or written.

All approved dental claims are paid within 30 working days. If you submit a completed claim appeal, a decision regarding your appeal will be decided within 30 working days of the receipt of your appeal. You will be also notified of this decision within these 30 working days. If any additional information is needed by Dental Health Services in order to reach a decision regarding your claims appeal, you will be notified within 14 working days of the receipt of your appeal.

If you submit a claim involving urgent care, Dental Health Services will notify you within 72 hours after receiving your claim. If information to complete the claim is insufficient, we will notify you of any additional information needed or procedures that must be followed within 24 hours. Dental Health Services' notification may be oral or written. Once we receive the needed information to complete your claim, you will be notified within 48 hours of your claim's approval or denial.

If you wish to appeal the result of your claim,

Dental Health Services will treat your appeal as a grievance. Dental Health Services' Dental Director and Service Review Committee will then review your claim and make a determination. If your claim is denied and you appeal the decision, a reviewer other than the dentist providing the initial determination will review your appeal. If the decision is based on medical judgment, the consulting dentist will be different than the one from the initial review process. Secondary appeals are referred to our Peer Review Committee, which is comprised of independent dentists.

All urgent or emergency care appeals are decided within 72 hours. If you appeal a claim decision made after you received the dental care upon which the claim is based, your appeal will be decided within 30 days. You have 180 days to appeal any denied claim.

Coordination of benefits provision

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 waived for all covered services.

Cosmetic services and implant services are at a discounted fee and fees for these services will not be waived.

Member is responsible to inform Dental Health Services if they have dual coverage (both City of Seattle employees and their spouse or domestic partner have both elected Dental Health Services for their primary dental plan). Member is to pay all applicable copayments to the dental office at the time of service (except for orthodontic treatment

copayments, as these cases are pre-authorized). Member is to sumbit receipts for copayments (within 60 days of service) to Dental Health Services and they will be reimbursed directly.

Termination of coverage

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 30 days before annual anniversary date.

2. Failure of an enrollee 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 the group to pay premium in a timely manner (30 days after payment is due.)

Termination due to non-payment

Benefits under your plan depend on the group's premium payments staying current. If payment is more than 30 days overdue, your eligibility may be terminated. Any previously initiated service(s) then "in progress" must be completed within 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 participating dentist's usual fees for continuing the prescribed treatment.

Renewal provisions

The group contract may be extended or 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 Service Specialist at 206.788.3444 or 877.495.4455.

Grievance procedure

Complaints by subscribers and enrollees shall be handled in the following manner:

A. Complaints may be made by phone or in writing by a subscriber, enrollee, a participating dentist, or an authorized representative. Complaints in writing may be made on forms provided by Dental Health Services or simply by providing a brief written explanation of the facts and issue(s). Personnel at participating dental offices are requested to be available to provide assistance in the preparation and submission of any complaints.

B. Within 3 days of receiving a complaint, Dental Health Services will acknowledge its receipt in writing, including the name and telephone number of the contact person assigned to handle the complaint.

C. Dental Health Services will collect and review

all relevant information from the complainant and participating dentists involved, and the complainant is invited to present his or her issues in person. If the Dental Director feels a clinical examination is required, the complainant may be referred to another participating dentist or specialist for a second opinion. When all information has been collected and reviewed, a decision is made by the appropriate Dental Health Services administrator.

D. Every effort will be made by Dental Health Services to provide a disposition of the complaint within 14 days of its receipt. However, Dental Health Services may notify the complainant that an extension is necessary to complete the review. This extension will not exceed 30 days from the receipt of the complaint without the written consent of the complainant.

E. When the complaint involves an adverse decision by Dental Health Services and a delay in its review would jeopardize the complainant's life or materially jeopardize the complainant's health, Dental Health Services will expedite and process a complaint in no later than 72 hours after receipt of the complaint. If the treating participating dentist determines that a delay in review would jeopardize the complainant's life or materially jeopardize the person's health, Dental Health Services shall presume the need for expeditious review.

F. Once a decision is made, Dental Health Services will promptly notify the complainant in writing of the disposition of his or her

complaint. The notification will include the actual reason(s) for the determination, the instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

G. If the complainant is not satisfied with the disposition of his or her complaint, the complainant may appeal the decision by requesting non-binding mediation. If Dental Health Services is not able to provide a disposition to a complaint within 30 days of its receipt by Dental Health Services or within the time frame agreed to in writing by the complainant, the complainant may proceed as if the complaint had been rejected and request nonbinding mediation.

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 otherwise have paid Dental Health Services. Coverage may be continued on this self-payment basis for up to six months.

Supplemental coverage and services

If you have additional coverage for TMJ disorder or orthodontia through your group agreement, your Schedule of Covered Services and Copayments will indicate your coverage for either or both of these additional benefits.

Privacy notice

Dental Health Services is committed to protecting your privacy and the confidentiality of your dental, medical, and personal health information that we may obtain or to which we have access. We do not sell our client 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 to only health information created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). Please note that your dentist maintains your dental records, including payments and charges. Dental Health Services will have a record of this portion of your PHI only in special or exceptional cases.

Dental Health Services' privacy policies describe who has access to your PHI, how it will be used, when your PHI may be disclosed, safeguards to protect the privacy of your PHI and the training we provide our employees regarding maintaining and protecting your privacy.

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.

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

C. A party to a proceeding pursuant to a subpoena, subpoena duces tecum, or other authorized discovery in a proceeding before a court or an administrative agency.

D. An arbitrator or panel of arbitrators in a law fully-requested arbitration.

E. A search warrant.

F. A coroner in the course of an investigation.

G. 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 payment and health care administration.

A. Payment purposes include activities to collect premiums and to determine or maintain coverage. These include using PHI in billing

and collecting premiums, and related data processing including how your dentist obtains pre-authorization for certain dental services. For example, Dental Health Services periodically conducts quality assurance inspections of your dentist's office and during such visits may review your dental records as part of this audit.

B. Health Care Administration means basic activities essential to Dental Health Services' function as a licensed limited healthcare service contractor, and includes reviewing the qualifications and competence of your dentist; evaluating the quality of his/her services; providing subscriber services and information including answering enrollee inquiries but without disclosing PHI. Dental Health Services may, for example, review your dentist's records to determine if the copayments being charged by the office comply with the contract under which you receive dental coverage.

C. In addition, Dental Health Services is permitted to use and disclose your PHI, without your authorization, in a variety of other situations, each subject to limitations imposed by law. These situations include, but are not limited to, the following uses and disclosures:

1. Public health activities.

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.

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 given to Dental Health Services at any time by written notice of revocation to Dental Health Services, 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 an enrollee 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.

B. 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 is Dental Health Services' minimum necessary disclosure 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?

Your rights respecting your PHI, and how you may exercise these rights are summarized here.

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 the 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 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 30 days of receipt of request.

D. 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 60 days of receipt of the request and, in certain circumstances may extend this period for up to an additional 30 days.

E. You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to 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 purposes.

2. Disclosures occurring prior to February 26, 2002.

Your request must be made in writing. Dental Health Services will provide the accounting within 60 days of your request but may extend the period for up to an additional 30 days. The first accounting requested during any 12-month period will be made without charge. There is a $25 charge for each additional accounting requested during such 12-month period. You may withdraw or modify any additional requests within 30 days of the initial request in order to avoid or reduce the fee.

F. You have the right to receive a copy of this Notice, and any amended Notice, upon written or telephone request made to Dental Health Services.

G. All written requests for the purposes described in this section, and all other written communications to Dental Health Services desired or required by this Notice, must be delivered to:

Dental Health Services
936 N 34th St., Ste. 208
Seattle, WA 98103

by any of the following means:

1. Personal delivery.

2. E-mail delivery to

customercare@dentalhealthservices.com.

3. First class or certified U.S. Mail.

4. Overnight or courier delivery, charges prepaid.

What duties does Dental Health Services agree to perform?

A. 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.

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 Services makes a revised Notice, it shall 1) post it on its website, and 2) distribute a written copy personally by first class U.S. mail to each of its subscribers who are enrolled with Dental Health Services during the period that such revised Notice remains effective.

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:

Dental Health Services
Attn: Privacy Officer
936 N 34th St., Ste. 208
Seattle, WA 98103

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 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.

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 by contacting your Member Service Specialist at 206.788.3422 or 877.495.4455 during regular office hours or at www.smartsmile.com/cityofseattle.

Glossary

Benefits mean services performed by a dentist that are covered under this contract and any payments made by Dental Health Services for an enrollee for services or supplies covered under this contract.

Calendar year means January 1 through December 31.

Child includes a natural child, an adopted child, a child for whom the subscriber assumes a legal obligation for total or partial support in

anticipation of adoption, a stepchild and a child for whom the subscriber or the subscriber's spouse is the legal guardian.

Copay and copayments means the dollar amount that will be the patient's responsibility to pay for certain services received under the Contract. Copayments for each service covered under your plan are listed in your Schedule of Covered Services and Copayments.

Dependent means a person listed on the subscriber's enrollment application as a dependent of the subscriber, who is eligible for dependent coverage under the terms of the contract, and whose enrollment application for coverage has been accepted by Dental Health Services, and for whom the applicable premium for coverage has been paid.

Dental emergency means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson, acting reasonably, to believe that a dental condition exists that requires immediate care by a licensed dentist to relieve pain, swelling or bleeding only. This does not include routine, extensive or postponable treatment.

Enrollee or member means a person who is entitled to receive dental services under this agreement. The term includes both subscribers and those family members (and dependents) enrolled by subscribers for whom a premium has been paid.

Exclusion means treatment or coverage not included as a benefit.

Family unit means 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.

Group means the employer (including approved affiliates and subsidiaries) that has entered into an agreement with Dental Health Services for dental care coverage.

Group representative means the employer or a person who has been designated by the group to act as its agent to remit the premium to Dental Health Services and to give and receive any notices under this contract.

Licensed dentist means a licensed doctor of dental surgery (D.D.S) or a licensed doctor of medical dentistry (D.M.D).

Limitation means a provision other than an exclusion which restricts coverage available under the plan.

Optional treatment means any treatment other than covered services which, 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 to pay the cost on a fee-for-service basis.

Participating dentist means a licensed dental professional who has entered into a written agreement with Dental Health Services to provide dental care services to subscribers and their dependents covered under the plan. The contract includes provisions in which the participating dentist agrees that the subscriber shall be held

liable only for their copayment (and related lab and metal costs) and no additional amount.

Participating specialist means a participating licensed dentist who has completed additional training in one or more areas of dental treatment and who provides services to an enrollee upon referral by a participating dentist.

Plan means dental benefits or coverages available to the subscriber and any eligible dependents in exchange for the payment of membership dues (premium).

Premium means the total money to be paid to Dental Health Services each month as specified in Article 6 of this contract, as consideration for the benefits offered by this contract.

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 application for coverage has been accepted by Dental Health Services, and for whom applicable premium has been paid.

Temporomandibular joint syndrome means a disorder that has 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.

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