

Combined Evidence of Coverage and Policy

SmartSmileSM Group Plans



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, and save your time and 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, conveniently located dental offices throughout Washington State and our network is continually expanding. Please contact our office at 800.63.SMILE or visit www.dentalhealthservices.com for the latest listing of our dentists.

Sets no age limits or enrollment restrictions because dental maintenance is always important.

Allows you to take an active role in your dental health and treatment by fully disclosing coverage 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 care, the following features are available for plan members:

- ToothTipsSM oral health information
- Member Service Specialists to assist you by telephone, fax, or e-mail
- Web access to valuable plan and oral health information at www.dentalhealthservices.com

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.

As Employee Owners, we have a vested interest in the wellbeing of our plan members. 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.dentalhealthservices.com 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.

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 have a copayment and you may require additional diagnostic services such as periodontal charting and x-rays. You may be charged copayments for additional services as necessary. There is an office visit copayment 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. Reference your treatment plan with your enclosed Schedule of Covered Services and Copayments brochure to determine the copayments for your scheduled procedures. Please note that crowns, bridges and dentures may require an extra charge for laboratory fees. 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. Each of our Member Service Specialists are specially trained and have experience working in a dental office. They can answer your plan and dental questions.

Your Member Service Specialist can be reached through any of the following ways:

Phone: 206.633.2300 or 800.63.SMILE

Fax: 206.624.8755

Web: www.dentalhealthservices.com

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

Eligibility

As the subscriber, you can enroll alone, with your spouse, domestic partner, and/or with unmarried children who are under 25 years of age.

Eligible children include a natural child, an adopted child, a child for whom the subscriber assumes legal obligation for total or partial support in anticipation of adoption, a stepchild, and a foster child for whom you or your spouse are the legal guardian. Children 25 years of age and older are only eligible while the child is and continues to be both:

1. incapable of sustaining employment by reason of developmental disability or physical handicap, and
2. is chiefly dependent upon the subscriber for support and maintenance.

Proof of incapacity and dependency must be furnished to Dental Health Services by the subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by Dental Health Services, but not more frequently than annually after the two-year period following the child's attainment of 25 years of age.

Enrollment

Enrollment rates are based on a term of one year and continue until terminated according to procedures contained in this brochure.

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

When the Department of Social and Health Services determines that it is cost-effective to enroll an eligible employee 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 participant 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.

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

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 and foster 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 or foster child;
3. New spouse, domestic partner and any additional children due to marriage may be enrolled within 60 days of marriage; or
4. Loss of other coverage. (Must notify within 60 days of loss).
5. When the Department of Social and Health Services determines that it is cost-effective to enroll a child or adult 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 participant 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.

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

A newborn child shall be covered from the moment of birth for a period of 60 days. A child physically placed with the subscriber for the purpose of adoption or foster care shall be covered from the date of placement for a period of 60 days if the subscriber has full financial responsibility for the dental expenses of the child. Dental Health Services does not require an enrollment form if the added dependent does not affect the current premium.

If the premium will be affected due to the dependent addition, Dental Health Services must receive a completed enrollment form within the first 60 days of intended coverage of the dependant. If the enrollment information is not received within the first 60 days, the dependent coverage will lapse until the child is enrolled during an open enrollment period.

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

Coverage effective dates

Except for newborns, foster or adoptive children, if your application and the group's payment are received before the 20th of the current month, your coverage will begin on the first day of the following month. If either is received after the 20th day of the current month, your coverage will begin on the first day of the second month following

your enrollment.

Receiving dental care

Upon enrolling in your plan, you should select your participating dentist. The most current *Directory of Participating Dentists* is available by calling 800.63.SMILE or at www.dentalhealthservices.com.

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.

Working with your dentist

Dental Health Services values its members and participating dentists. Providing an environment that encourages healthy relationships between members and their dentists helps to ensure the stability and quality of your dental plan.

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

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, mail, email, fax, or through our website. Requests may be made through 800.63.SMILE or by fax at 206.624.8755. Online changes can be done through www.dentalhealthservices.com.

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 no x-rays are necessary, 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 liable for any other costs.

Please reference your Schedule of Covered Services and Copayments for the benefits specific to your dental plan.

Emergency care: in-area

Palliative care for emergency dental conditions in which acute pain, bleeding, or dental infection exist 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 800.63.SMILE.

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 his or her 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 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 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 206.633.2300 or 800.63.SMILE 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 and itemized bill to:

Dental Health Services
936 N 34th St., Ste. 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 necessary 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

Not all plans include specialty coverage. Refer to the Limitations & Exclusions in your *Schedule of Covered Services and Copayments* to determine if your plan includes specialty coverage. 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., Ste. 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, you will be notified whether your

claim is approved or denied within 15 days of receiving your claim. 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 the 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, you will be notified of the failure and the proper procedures to be followed in submitting your claim within 5 days following Dental Health Services' discovery of any procedural error. 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 necessary 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.

Coordination of benefits

This plan does not coordinate benefits with any other coverage.

Termination of coverage

Coverage of an individual subscriber and/or his or her 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 (15 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 15 days overdue, your eligibility may be terminated. Any previously initiated service(s) than "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.

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.

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 800.63.SMILE.

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, participating dentist, or authorized representative. Complaints in writing may be made 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 grievance 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 will be 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 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 one year.

Supplemental coverage

If you have additional coverage for TMJ disorder or orthodontia through your group agreement, your membership card 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 (PHI) 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 Personal 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?

Usage 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. Usage 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. Healthcare 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.

Whom 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 800.63.SMILE during regular

office hours or at www.dentalhealthservices.com.

Glossary

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

Benefits/coverage: The specific covered services that plan members and their dependents are entitled to use with their dental plan.

Child: Eligible children include a natural child; adopted child; a child for whom the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; a stepchild; or a child for whom the subscriber or the subscriber's spouse is the legal guardian.

Composite filling: A restoration or filling composed of a 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 fees charged by a participating dentist according to the plan's Schedule of Covered Services and Copayments. Copayments for services covered by your plan are listed on this Schedule. These fees are paid directly to the participating dentist at the time of service. An office visit copayment is paid during each dental office visit.

Dependents: Eligible dependents include a legal spouse, domestic partner, and children of the covered individual or partner.

Emergency: 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 palliative care by a licensed dentist for the relief of pain, swelling, or bleeding only. This does not include routine, extensive, or postponable treatment.

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

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

Exclusion: Treatment or coverage not included as a benefit.

Limitation: A provision other than an exclusion that restricts coverage available under the plan.

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

Oral surgery: The branch of dentistry concerned with the extraction of teeth and maxillofacial,

reconstructive, or plastic surgery for the treatment of fractures to the jaw, cleft palates, and damaged oral-facial structures.

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

Participating dental office: 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 dentist agrees that the subscribers shall be held liable only for their copayment and related lab and metal costs, and no additional amount.

Periodontal exam: An evaluation of periodontal conditions, including probing and charting for patients showing signs or symptoms of gum disease.

Periodontics: The branch of dentistry concerned with the treatment of periodontal (gum) disease.

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

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

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