



Dental Health Services

# SmartSmile<sup>sm</sup>

## Individual Dental Plans

### Combined Evidence of Coverage and Policy

Joshua Nace  
Executive Vice President

Qualified Dental Plans that satisfy the pediatric dental Essential Health Benefit

The Subscriber to this agreement may return this contract to Dental Health Services within ten (10) days of its delivery to the Subscriber if, after examination of the contract, he or she is not satisfied with it for any reason and no services have been rendered. Dental Health Services shall promptly refund any fee paid for the contract. Upon return of the contract, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

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# Your Personal Dental Plan

Welcome to Dental Health Services!

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

- Encourages treatment by eliminating the burdens of deductibles 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 eliminating 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 office throughout Oregon State. Our network is continually expanding. Please visit [www.dentalhealthservices.com](http://www.dentalhealthservices.com) or contact our office at 503-281-1771 for the latest listing of our participating 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 hygiene and care, the following are available for plan members:

- ToothTips<sup>sm</sup> 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.dentalhealthservices.com](http://www.dentalhealthservices.com)

## **About Dental Health Services**

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

As employee owners, we have a vested interest in the well-being of our plan members. Part of our service focus includes toll-free access to your knowledgeable Member Service Specialist, an automated member assistance and eligibility system, and access to our website, [www.dentalhealthservices.com](http://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 member care of each dental office is monitored regularly through our rigorous Quality Assurance<sup>sm</sup> 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 for you based on his or her assessment of your oral health.

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 Schedule of Covered Services and Copayments to determine the copayments for your scheduled procedures. Copayments are due in full at the time services are performed.

## **Your Member Service Specialist**

Please feel free to call, fax, send an e-mail to [membercare@dentalhealthservices.com](mailto:membercare@dentalhealthservices.com), or write us anytime with questions or comments. We are ready to help you. Each of our Member Service Specialists are dental terminology trained and/or have been 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:** 503-281-1771  
**Fax:** 503-968-0187  
**Email:** membercare@dentalhealthservices.com  
**Web:** www.dentalhealthservices.com  
**Mail:** Dental Health Services  
205 SE Spokane Street, Suite 334  
Portland, OR 97202-6413

## Eligibility

As the subscriber, you can enroll alone, with your spouse, domestic partner, and/or with children who are under 26 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, domestic partner, or non-covered parent is the legal guardian. Children 26 years of age and older are only eligible for coverage as a dependent 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 26 years of age. Failure to do so may result in termination of the child's eligibility.

## Enrollment

Enrollment rates are valid for a year or until terminated according to procedures contained in this brochure.

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 form within 60 days to continue coverage for the newborn. If the enrollment information is not received within the first 60 days, the dependent coverage will lapse until the child's enrollment is received by Dental Health Services.

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. If the enrollment information is not received within the first 60 days, the dependent coverage will lapse until the child's enrollment is received by Dental Health Services.
3. A child dependent under the age of three (3) may be enrolled at any time during the plan year, upon your written request to Dental Health Services. Dental Health Services must receive the additional premium and a completed enrollment form before coverage will begin.
4. New spouse, domestic partner and any additional children due to marriage or new domestic partnership may be enrolled within 60 days of marriage or new domestic partnership. If the enrollment information is not received within the first 60 days, the dependents coverage will lapse until the dependent is enrolled during an open enrollment period. If the additional dependent is under the age of three (3), he/ she may be added according to section 3 above.
5. Loss of other coverage.

It is recommended that Dental Health Services be notified in the event of a newborn, foster 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.

## Upgrading Your Policy

### Upgrade Request Form

If you are currently on the SmartSmile or Super SmartSmile plan and wish to transfer to the Super SmartSmile or SmartSmile Plus plan and reduce your copayments for dental services, an upgrade form must be completed and returned to Dental Health Services. If your upgrade form is received by Dental Health Services by the 20th of the month, your upgrade to the Super SmartSmile or SmartSmile Plus plan will be effective the first of the following month.

### Monthly Premium Members

If you are currently paying for your dental plan through monthly automatic withdrawals from a checking, savings or credit card account, you will incur a one time charge to update your security deposit to make it equal to your new monthly premium.

You must retain your upgrade for one year of coverage. After this period, your new plan premium will remain in effect until we receive written notification indicating you would like to change or cancel your dental plan. If you wish to cancel your membership, the standard cancellation policy will apply.

## **Annual Premium Members**

If you are currently paying annually for your dental plan, you will be billed for the prorated difference in premium to cover your dental plan premium until your plan renewal.

Once you have completed the upgrade process, your plan will remain in effect until your renewal date. If you choose to cancel your plan prior to your first year's renewal period, our standard cancellation policy will apply.

## **Coverage Effective Dates**

Complete and signed applications and premium must be submitted for individuals to be enrolled in Dental Health Services' SmartSmile plans.

Except for newborn, foster or adoptive children, if your application and 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 SmartSmile, a participating dentist should be selected to provide dental care. You can find a list of Participating Dentists online at [www.dentalhealthservices.com](http://www.dentalhealthservices.com). For a printed directory, call 503-281-1771 or email us at [membercare@dentalhealthservices.com](mailto:membercare@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 online with the dental office address or in the Directory of Participating Dentists and request an appointment. Routine appointments will be scheduled within a reasonable time; in non-emergency cases, reasonable time shall not be more than three weeks.

*You are eligible for services only 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 independently, and without interference, from Dental Health Services or any affiliated

agents. If a satisfactory relationship cannot be established between members 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 email, by fax, or online. Requests can be made through 503-281-1771 or by fax at 503-968-0187. Online changes can be done through [www.dentalhealthservices.com](http://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, in writing, by email, by fax, or online 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 non-covered 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 reimburse you up to \$150 per occurrence 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.

## Exclusions and Limitations

In addition to the limitations already described in your Schedule of Covered Services and Copayments, please reference your Exclusions and Limitations of benefits. Procedures described in the Exclusions portion of this booklet are considered non-covered services even if they are medically necessary and/or recommended by a dentist.

Pediatric dental services apply to enrollees 18 and under. Enrollees will lose pediatric benefits at the end of the month of the enrollees 19th birthday. Adult benefits will begin immediately up the enrollees loss of pediatric benefits.

**This Evidence of Coverage describes your dental plan benefits. It is the responsibility of the members to review this booklet carefully and to be aware of its exclusions and limitations of benefits.**

## 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.

Pediatric dental services apply to enrollees 18 and under. Enrollees will lose pediatric benefits at the end of the month of the enrollees 19th birthday. Adult benefits will begin immediately up the enrollees loss of pediatric benefits.

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 a lesser period of time as may be medically necessary. If your dentist is not available, call your Member Service Specialist at 503-281-1771 for assistance scheduling an emergency dental appointment with another Dental Health Services participating dentist in your area.

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 up to \$150.00 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, prior authorization is not required to have emergency palliative treatment performed by any licensed dentist practicing within the scope of their license. Dental Health Services will reimburse you up to \$150 per occurrence 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.

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 enrollee 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 enrollee would have been unable to arrive at a participating dental office in a timely fashion without serious impairment to the enrollee's health.

Dental Health Services requires 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.

If services for the treatment of an emergency dental condition are authorized by any service staff member of Dental Health Services, we may not deny the responsibility of enrollee reimbursement up to \$150 per occurrence beyond all applicable copayments, unless approval was based on misrepresentation about the covered enrollee's condition made by the dentist performing the emergency treatment.

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 the itemized dental bill and a Dental Health Services' Post-Service Emergency Dental Care Claim Form to Dental Health Services. Dental Health

Services only reimburses for the amount over the copayment up to \$150 for dental work done to eliminate pain, swelling or bleeding. Dental Health Services' Post-Service Emergency Dental Care Claim Forms may be requested directly from your Member Service Specialist. Within 60 days of the occurrence, send the Post-Service Emergency Dental Care Claim Form and itemized bill to:

Dental Health Services  
Attn: Claims Department  
205 SE Spokane Street, Suite 334,  
Portland, Oregon 97202-6413

If you do not submit this information within 60 days, Dental Health Services reserves the right to refuse payment. Determinations and payment for all completed post-service emergency dental care claims are decided and paid within 30 working days. You have 180 days to appeal any denied claim.

If you wish to appeal the result of your post-service emergency dental 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 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.

## Specialty Care, Claims and Appeals

**All plans include Specialty Care coverage for enrollees 18 and under. Enrollees will lose pediatric benefits the last day of the month following the child's 19th birthday. Adult benefits will begin immediately upon the enrollee's loss of pediatric benefits.**

**Refer to the Limitations and 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.**

### **Pediatric Specialty Care Claims and Appeals**

All treatment received from participating specialists must be pre-authorized. All claims must be submitted within 60 days of the date services were rendered. If the claim form is not submitted within 60 days, Dental Health Services reserves the right to refuse payment. Covered services provided by participating specialists are provided for children aged 18 and under only. Children will lose pediatric benefits at the end of the month of their 19th birthday. **Adult benefits will begin immediately upon the enrollee's loss of pediatric benefits.**

### **Pre-Authorization for Specialty Care**

All treatments received from a participating specialist must be pre-authorized by Dental Health Services.

In order to see a Dental Health Services' participating specialist, you must first be referred by your participating general dentist. Dental Health Services will review the participating general dentist's request for pre-authorization and your treatment plan, and notify the specialist of the authorized services.

### **Pre-Service (Before Treatment) Claim Submission**

Your participating specialist will submit a pre-service claim for authorization for your services. You and your specialist will be notified whether your pre-services claim is approved or denied within 15 days of receiving the 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 and your specialist of the circumstances requiring this extension within 5 days of receiving your claim.

If your pre-service claim for authorization is not submitted according to the procedures outlined in this booklet, you and your specialist 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, written or electronic.

### **Urgent Care Claim Submission**

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

*All approved clean claims are paid within 30 working days of the receipt of the claim.*

### **Adverse Determination**

If all or part of your claim is denied, Dental Health Services will notify you in writing of this adverse determination. The adverse determination will include the actual reason(s) for the determination, the instructions for obtaining an appeal of the decision, a written statement on the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

*All claim appeals must be submitted within 180 days from the date the claim was in whole or part denied.*

## **Member Appeals**

If any part of your claim was denied, you have a right to submit an appeal for a full and fair review.

If you submit a completed claim appeal, a determination regarding your appeal will be decided within 30 working days of the receipt of your appeal. If any additional information is needed by Dental Health Services in order to reach a determination regarding your appeal, you will be notified within 14 working days of the receipt of your appeal. You will be notified of the appeal determination within 30 working days from the date your appeal was received by Dental Health Services.

If you wish to appeal the result of your urgent care claim, a decision regarding your appeal will be decided within 72 hours. 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. 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 facilitate the coordination of benefits with other coverage. During coordination of benefits facilitated by either the enrollee or other dental plan, Dental Health Services' plan will always be defined as the primary plan.

## **Termination of Coverage**

Upon canceling any member's dental benefits plan, Dental Health Services shall notify the subscriber in writing of the reason(s) for canceling, the plan.

Coverage of a subscriber's dependents may be terminated for any of the following reasons:

1. Failure of subscriber to make premium payments in a timely manner. (See Termination Due to Nonpayment).
2. Material misrepresentation (fraud) in obtaining coverage.
3. 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.

4. The enrollee relocates outside of the state of Oregon, and is outside of Dental Health Services' service area.

In the event coverage is terminated, no premium for the current term shall be returned or refunded, and the member shall become liable for all charges resulting from treatment initiated after termination. Refer to your plan's exclusions and limitations for more related information.

In the event that an enrollee ceases to be qualified as a dependent of a subscriber for reasons of termination of marriage or death of the subscriber, the dependents shall have the right to continue coverage under their current plan.

## **Termination Due to Nonpayment**

Benefits under your plan depend on premium payments staying current. If payment is more than 10 days overdue, your eligibility may be terminated. If your coverage is terminated, the effective date of termination will be the same date in which your account became overdue. 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.

## **Review of Termination**

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

Dental Health Services  
Attn: Dental Director  
205 SE Spokane Street, Suite 334  
Portland, Oregon 97202-6413

## **Cancellation Policy**

If subscribers wish to cancel their plan after the 10-day free look period, and prior to their first year's renewal period, they will be subject to a \$50 cancellation fee to cover the administrative and healthcare costs of the cancellation process.

Cancellation requests must be received in writing and must be signed by the primary subscriber. Additionally, cancellation requests must be received by the 15th of the current month in order to take effect the first of the following month.

## Reinstatement Policy

If you wish to reinstate your coverage and you have previously completed a minimum of one year's continuous dental enrollment, you may reinstate your coverage at any time by submitting your request in writing (including the signature of the subscriber) to Dental Health Services. In order for you to maintain continuous coverage, Dental Health Services must receive your request for reinstatement within 30 days after your coverage has been terminated.

In the event your plan is terminated prior to completing one year of dental plan membership (enrollment), you may reinstate coverage according to the policy above only if you have paid applicable cancellation fees.

If it is determined that you are responsible for any unpaid premium or other obligations to Dental Health Services, the unpaid balance must be received prior to reinstating your coverage.

If reinstatement premiums are not paid within the 30 day period and subsequent premiums are accepted by Dental Health Services, the member's dental coverage shall be considered for reinstatement. Dental Health Services will approve or disapprove this reinstatement request within 45 days from the date that subsequent premiums were accepted, unless Dental Health Services previously notified the Subscriber in writing of its disapproval of such request for reinstatement.

Any reinstatement premium payments accepted due to lack of timely premium payments will be applied to the unpaid balance prior to reinstating your coverage. Reinstatement premiums shall not be applied to a period of more than 30 days prior to the date of reinstatement.

Subscribers are only eligible for review of reinstatement requests due to lack of timely premium payments two (2) times for any Subscriber.

## Refund Provisions

Coverage for the subscriber and his or her enrolled dependents will terminate when the subscriber gives 31 days advance notice to Dental Health Services in writing, with the subscriber's signature. All unearned premiums (after any applicable cancellation fees are deducted) will be refunded within 30 days.

All premiums are prorated from the termination date. Annualized premium will be multiplied by the number of remaining months of prepaid coverage to generate a total refund amount due.

## 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 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 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 non-binding mediation.

## Privacy Notice

Dental Health Services is required by law to maintain the privacy and security of your protected health information. This notice describes how your medical and dental information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is updated effective April 1, 2014.

Dental Health Services is devoted 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 nonaffiliated third parties, unless permitted or required by law, or authorized in writing by you. Additionally, Dental Health Services will not use your member information for marketing purposes.

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 circumstances.

Dental Health Services' privacy policies describe who has access to your PHI within the organization, 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 court order or subpoena;
- a board, commission or administrative agency pursuant to its lawful authority;
- an arbitrator or panel of arbitrators in a lawfully-requested arbitration;
- a search warrant;
- a coroner in the course of an investigation; or by other law.

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

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

- 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.
- Health Care Administration means basic activities essential to Dental Health Services' function as a Limited Health Care Service Contractor, and includes reviewing the qualifications and competence of your dentist; evaluating the quality of his/her services; providing subscriber services such as referrals for specialists, 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.
- 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:
  - preventing or reducing a serious threat to the public's health or safety;
  - concerning victims of abuse, neglect or domestic violence;
  - health oversight agency;
  - judicial and administrative proceedings including the defense by Dental Health Services of a legal action or proceeding brought by you;
  - law enforcement purposes, subject to subpoena or law;
  - Workers' Compensation purposes;
  - parents or guardians of a minor; and
  - 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.

### ***What is Dental Health Services' "Minimum Necessary" Policy?***

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

- your dentist for treatment purposes;
- you; or
- disclosures covered by an authorization you provided to another entity.

### ***What are my rights regarding the privacy of my PHI?***

- 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.
- Dental Health Services will comply with your reasonable requests 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.
- You have the right to have the person you've assigned medical power of attorney, or your legal guardian, exercise your rights and make choices about your health information. We will ensure the person has this authority and can act for you before we take any action.
- 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 the request.
- 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.
- 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:
  - disclosures made for payment or health care operations

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.

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

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, 205 SE Spokane Street, Suite 334, Portland, OR 97202-6413 by any of the following means:

- personal delivery;
- email delivery to: [membercare@dentalhealthservices.com](mailto:membercare@dentalhealthservices.com);
- first class or certified U.S. Mail; or
- overnight or courier delivery, charges prepaid

#### ***What duties does Dental Health Services agree to perform?***

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

- Dental Health Services will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Dental Health Services will abide by the terms of this Notice and any revised Notice, during the period that it is in effect.
- 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, [www.dentalhealthservices.com](http://www.dentalhealthservices.com) 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  
205 SE Spokane Street, Suite 334  
Portland, OR 97202-6413

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 503-281-1771, Monday through Friday, 8:00 am to 5:00 pm or at [www.dentalhealthservices.com](http://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. Pediatric benefits apply to children aged 18 and under. Children will lose pediatric benefits at the end of the month of their 19th birthday. **Adult benefits will begin immediately upon the loss of pediatric benefits.**

**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 each services covered by your plan are listed on this schedule. These fees are paid directly by you, 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

failure to receive immediate palliative treatment by a licensed dentist in order to relieve pain, swelling, or bleeding may place the health of a person or fetus, in the case of a pregnant woman in serious jeopardy. 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.

**Medical Necessity:** Dental services and supplies provided by a participating dentist appropriate to the evaluation and treatment of disease, condition, illness or injury and consistent with the applicable standard of care. This does not include any service that is cosmetic in nature.

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

**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 subscriber shall be held liable only for their copayment and related lab and metal costs, and no additional amount.

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

# Dental Health Services

205 SE Spokane Street, Suite 334,  
Portland, Oregon 97202-6413  
503-281-1771  
[www.dentalhealthservices.com](http://www.dentalhealthservices.com)

*An Employee-Owned Company*

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