Dental Health Services

2019 Group Dental Plans

SuperChoice-EC sm · **SuperChoice- Plus-EC**sm · **SuperChoice Enhanced-EC**sm

Evidence of Coverage

Joshua Nace
Executive Vice President

Qualified Dental Plans that satisfy the pediatric dental Essential Health Benefit

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

Non-Discrimination Notice

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

Dental Health Services:

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

If you need these services, contact your Member Satisfaction Assurance Specialist, at 855-495-0907, 888-645-1257 (TDD/TTY).

If you believe that Dental Health Services has failed to provide these services or discriminated in in another way on the basis of race, color, national origin, age, disability, or gender, you can file a Grievance with the Member Satisfaction Assurance Specialist, 205 SE Spokane Street, Suite 334, Portland, OR 97202-6413, call 855-495-0907, 888-645-1257 (TDD/TTY), fax 503-968-0187, or email DHaggerty@dentalhealthservices.com. You can file a Grievance in person or by mail, fax, or email. If you need help filing a Grievance, the Member Satisfaction Assurance Specialist is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal Available at https//ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services (HHS), 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

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

English:

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

Spanish:

Este aviso tiene información importante. Este aviso tiene información importante acerca de su solicitud o cobertura por medio de Dental Health Services. Es posible que haya fechas clave en este aviso. Es posible que tenga que tomar medidas antes de ciertas fechas límite para mantener su

cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y ayuda en su idioma de forma gratuita. Llame al 1-866-756-4259.

Vietnamese:

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

Chinese:

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

Russian:

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

Korean:

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

Ukrainian:

Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через Dental Health Services. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1-866-756-4259.

Japanese:

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

Arabic:

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

Romanian:

Acest aviz conţine informaţii importante. Acest aviz conţine informaţii importante despre cererea dvs. sau despre acoperirea medicală asigurată prin intermediul Dental Health Services. În acest aviz pot exista date cheie. Este posibil să fie necesar să luaţi măsuri înainte de anumite date limită pentru a vă menţine acoperirea medicală sau pentru a acoperi anumite costuri. Aveţi dreptul să obţineţi gratuit aceste informaţii şi asistenţă în limba dvs. Apelaţi numărul de telefon 1-866-756-4259.

Cambodian:

ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗ។ ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗអំពីពាក្យសុំរបស់លោកអ្នក ឬការធានារ៉ាប់រងតាមរយៈ Dental Health Services។អាចមានកាលបរិច្ឆេទសំខាន់ៗនៅក្នុងការជូនដំណឹងនេះ។ លោកអ្នកអាចចាំបាច់ត្រូវចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ដើម្បីទុកការធានារ៉ាប់ រងសុខភាពរបស់លោកអ្នក ឬជួយខាងថ្លៃចំណាយ។ លោកអ្នក មានសិទ្ធិដើម្បីទទួល បានព័ត៌មាននេះ ហើយ ជួយជាភាសាលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅ 1-866-756-4259

Cushite:

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

German:

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Dental Health

Services Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-866-756-4259.

Persian:

ین اعلامیه حاوی اطلاعات مهمی است. این اعلامیه حاوی اطلاعات مهمی درباره درخواست شما و طرح پوشش بیمه Dental Health Services است. ممکن است تاریخ های مهمی در این اعلامیه عنوان شده باشد. ممکن است لازم باشد تا تاریخ خاصی اقداماتی را انجام دهید تا پوشش بیمه تان حفظ شود یا کمک مالی دریافت کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی ها را به زبان خودتان و به صورت رایگان دریافت کنید. با شماره-756-866-1.
4259.تماس بگیرید

French:

Cette notice contient d'importantes informations. Cette notice contient des informations importantes à propos de votre couverture ou de votre demande de couverture chez Dental Health Services. Cette notice peut contenir des dates clés. Il se peut que vous deviez entreprendre des démarches dans un délai imparti pour conserver votre couverture de santé ou pour l'aide financière. Ces informations et aides peuvent vous être fournies dans votre langue sans coût supplémentaire. Appelez-nous au : 1-866-756-4259

Thai:

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลสำคัญเกี่ยวกับการใช้งานหรือความคุ้มครองของ Dental Health Services อาจมีวันที่สำคัญในประกาศนี้

คุณอาจต้องดำเนินการภายในกำหนดเวลาเพื่อรักษาสภาพความคุ้มครองด้านสุขภาพของคุณหรือรับความช่วยเหลือด้านค่าใช้จ่าย

คุณมีสิทธิ์ได้รับข้อมูลนี้และความช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่าย โทร 1-866-756-4259

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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 your Designated Participating Primary Dentist from our network.
- Assures availability of care with high quality easy-to-find dental offices throughout our Oregon Service Area.
- 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.

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

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

About Dental Health Services

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

Dental Health Services has been offering dental plans along the West Coast to groups and individuals for over forty (40) years. We are dedicated to assuring your satisfaction and to keeping your Plan as simple and clear as possible.

As employee-owners, we have a vested interest in the well-being of our Plan Members. Part of our service focus includes, toll-free access to your knowledgeable Member Services Specialists, an

automated member assistance and eligibility system, and access to our website at www.dentalhealthservices.com/OR to help answer questions about your Plan and its Benefits.

Your Member Services Specialist

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

Phone: 855-495-0907, 888-645-1257 (TDD/TTY)
Fax: 503-968-0187
Email: Membercare@dentalhealthservices.com
Web: www.dentalhealthservices.com/OR
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 twenty-six (26) years of age.

Eligible Children include a biological child, an adopted Child, a Child placed for adoption, and a Child for whom the Subscriber assumes legal obligation for total or partial support in anticipation of adoption; and a Child for whom the Subscriber, Subscriber's spouse, domestic partner, or the non-covered parent is the legal guardian.

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

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 thirty-one (31) days of the Child's attainment of the limiting age and subsequently as may be required by Dental Health Services, but not more frequently than annually after the two-year period following the Child's attainment of twenty-six (26) years of age. Failure to do so may result in termination of the Child's eligibility.

Subscriber must live or work within Dental Health Services' Service Area in order to enroll in a SuperChoice -EC^{sm} plan. Dependents may live outside Dental Health Services' Service Area, but will only receive coverage at a Dental Health Services' Participating Primary Dentist (and Participating Specialists for Members eighteen (18) years of age and under, or adults enrolled in the

SuperChoice Enhanced-EC℠ Plan), except in the event of an emergency or when pre-authorized by Dental Health Services.

Members aged eighteen (18) and under are eligible for Pediatric Coverage under this Plan until their nineteenth (19th) birthday month. At the end of their nineteen (19th) birthday month, the Member will automatically be transferred to adult coverage. For example, if a Member's nineteenth (19th) birthday is July 15, on August 1st, the Member will automatically receive adult dental plan coverage. There is no lapse in coverage during this time.

Adult Members will be covered for Benefits included under the Adult Covered Services and Copayments section of the Schedule of Covered Services and Copayments included with this certificate. Once adult coverage is in effect, the pediatric Out-of-Pocket Maximum will no longer apply.

SuperChoice-EC℠ plans include specialty care for pediatric Members eighteen (18) years of age and under. For Members nineteen (19) years of age and older, refer to the Limitations & Exclusions in your Schedule of Covered Services and Copayments to determine if your Plan includes specialty coverage.

Enrollment

This is a qualified dental plan. Enrollment rates are valid for the Plan Year or until the Plan is terminated according to the procedures contained in this certificate. Subscribers and any eligible Dependents must enroll at the time of initial enrollment or at the Group's open enrollment period. There shall be a thirty (30) day open enrollment period prior to the Group Services Agreement renewal each year. All persons then eligible to enroll as a Subscriber or Dependent in the Plan may enroll during the open enrollment period. Any persons then eligible to enroll as a Subscriber or Dependent but who fails to enroll during this period shall not be entitled to enroll in the Plan until the next open enrollment period unless you experience a qualifying event.

If you experience one of the qualifying events listed below, you may be eligible for a thirty (30) day Special Enrollment Period. You must report this event within thirty (30) days of the event to HealthCare.gov for consideration of a thirty (30) day Special Enrollment Period.

HealthCare.gov may grant you a Special Enrollment Period due to one of the following circumstances:

1. A qualified individual or Dependent loses minimum essential dental benefits. (This excludes loss of coverage due to non-payment).

2. A qualified individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption.

3. Enrollment or non-enrollment through Healthcare.gov is unintentional or erroneous.

4. In the event an individual is able to adequately demonstrate to Healthcare.gov that the individual's current qualified dental plan substantially violated material provisions of the existing contract between the individual and the qualified dental plan.

5. A permanent move has given the individual access to a new qualified dental plan.

6. An American Indian, as defined by the Indian Health Care Improvement, may enroll in or change qualified dental plans one time each month.

7. An individual demonstrates to Healthcare.gov that in accordance with guidelines provided by HHS the individual meets other exceptional circumstances as Healthcare.gov may provide.

If you experience one of the qualifying events below, you may be eligible for a sixty (60) day Special Enrollment Period. You have sixty (60) days to report the event to Healthcare.gov through their web portal. Healthcare.gov may grant a Special Enrollment Period due to one of the following circumstances:

1. Newly eligible for premium assistance under Medicaid or CHIP
2. Loss of eligibility for coverage due to the circumstance below:
    a. Loss of minimum essential coverage (coverage is not COBRA continuation coverage);
    b. Loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
    c. Loss of coverage because no longer in Service Area;
    d. Loss of coverage because plan no longer offers any benefits to the class of similarly situated individuals;
    e. Termination of employer contributions;
    f. Exhaustion of COBRA continuation coverage.
    g. Loss of minimum essential coverage does not include failure to pay Premiums on a timely basis, including a failure to pay COBRA premiums, or situations allowing for a rescission.

For complete detailed enrollment provisions set forth by HealthCare.gov in accordance with the guidelines provided by HHS, please go to HealthCare.gov.

Coverage Effective Dates

Coverage effective dates are determined during your application and enrollment with HealthCare.gov and can be affected by any medical policy you purchased. Your Dental Health Services coverage will begin once the enrollment process is complete, Premium payment is received and the effective date is communicated to Dental Health Services by HealthCare.gov. Your Dental Health Services Member Services Specialists are ready to assist you with communicating to

HealthCare.gov. Please contact us at 855-495-0907 or connect with us at www.dentalhealthservices.com/OR.

New Dependent Additions

New Dependent enrollments are subject to the rules established by HealthCare.gov. Enrollment request for newly acquired Dependents must be submitted to HealthCare.gov within thirty (30) days of the new Dependent addition, according to their policies and procedures. HealthCare.gov will determine the effective date of the Dependents Plan according to the Effective Date the enrollment request was submitted.

Newborn and Adoptive Children

A newborn, newly adopted Child, or a Child placed for adoption is eligible from the moment of birth, adoption, or placement for adoption. You must apply through HealthCare.gov to enroll your new Dependent within thirty (30) days from the date of birth, adoption, or placement for adoption. If enrollment is not completed according to the rules established by HealthCare.gov, the new Dependent will be effective according to the open enrollment rules established by HealthCare.gov.

Dependent additions due to Marriage

The effective date for Dependents acquired through marriage will be effective the first (1st) of the month following the date of marriage. You must apply through HealthCare.gov within thirty (30) days to enroll your new Dependent. If enrollment is not completed according to the rules established by HealthCare.gov, the new Dependent will be effective according to the open enrollment rules established by HealthCare.gov.

Children Covered by Child Support Orders

Dependent additions required by child support orders will be effective the date of the order, unless the application was not submitted to HealthCare.gov in a timely manner. An application must be submitted to HealthCare.gov within thirty (30) days from the date of the order, along with a copy of the child support order. The application may be submitted by the Subscriber, the Child's custodial parent, or a state agency administering Medicaid. If enrollment is not completed according to the rules established by HealthCare.gov, the new Dependent will be effective according to the open enrollment rules established by HealthCare.gov.

Quality Assurance

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

Your Participating Primary Dentist

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

The ongoing Member care at each dental office is monitored regularly through our rigorous Quality Assurance[sm] standards.

Receiving Dental Care

Upon enrolling in a SuperChoice-EC[sm] plan, a Participating Primary Dentist should be selected from the SuperChoice –EC network of Quality Assured Participating Dentists. To search for Participating Primary Dentist online, visit Dental Health Services' website at www.dentalhealthservices.com/OR.)

If you prefer a printed directory, please call 855-495-0907, 888-645-1257 (TDD/TYY) and a directory will be mailed to you.

You may make an appointment with your Designated Participating Primary Dentist as soon as your eligibility has been confirmed. Simply call your Designated Participating Primary Dentist and request an appointment. Routine, non-emergency appointments will be scheduled within a reasonable time period.

You are only eligible for services at Dental Health Services' Participating Primary Dentist (and Participating Specialist for Members eighteen (18) years old and under, and adult Members on SuperChoice Enhanced-EC[sm] Plan. Pre-authorization from Dental Health Services is required for services provided by a Participating Specialist), except in an emergency situation, or when pre-authorized by Dental Health Services.

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

Your First Dental Appointment

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

Your initial exam may require an office visit Copayment and you may need additional diagnostic services such as periodontal charting or x-rays. You may also be charged Copayments for additional services as necessary.

After your initial visit, you may schedule an appointment for future care, such as cleanings, to complete your treatment plan. Cross-reference your treatment plan with your Schedule of Covered Services and Copayments to determine the Copayments for your scheduled procedures.

Working with Your Dentist

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

Covered services must be provided by your Designated Participating Primary Dentist, except in emergency situations or when pre-authorized by Dental Health Services.

Dental Health Services values its Members and Participating Primary Dentists. Providing an environment that encourages healthy relationships between Members and their Participating Primary Dentists helps to ensure the stability and quality of your dental Plan.

Participating Primary Dentists are responsible for providing dental advice or treatment independently, and without interference, from Dental Health Services or any affiliated producers. If a satisfactory relationship cannot be established between Members and their Designated Participating Primary Dentist, Dental Health Services, the Member, or Designated Participating Primary 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 (1st) day of the month following receipt of the request. Dental Health Services will always put forth its best effort to swiftly place the Member with another Participating Dentist.

Changing Dental Offices

If you wish to change dentists, you must notify Dental Health Services. Requests can be done by calling 855-495-0907, 888-645-1257 (TDD/TTY), or sending a fax to 503-968-0187. Online requests can be done through our website at www.dentalhealthservices.com/OR.

Requests made by the twentieth (20th) of the current month become effective the first (1st) day of the following month. Changes made after the twentieth (20th) of the month become effective the first day of the second month following receipt of your request. For example, if you request to change your dentist on or before August 20th, your new dentist selection will become effective September 1st. If you make your dentist change request on or after August 21st, your new dentist change request will become effective October 1st.

Obtaining a Second Opinion

If you believe you need a second opinion for any reason, Dental Health Services can arrange for you to be seen by another Participating Dentist (or Participating Specialist for Members eighteen (18) years of age and under) if necessary. You should bring your x-rays to this consultation. If x-rays are not necessary, you will pay only your office visit and second opinion copayments.

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

Your Financial Responsibility

You are liable to your 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 the dentist office.

As stated under the Emergency Care section of this certificate, for services rendered by an Out-of-Dentist, Dental Health Services will reimburse you up to $150 per occurrence for the cost of emergency care after you have paid your applicable Copayments (this includes the additional $50 fee for services rendered by an Out-of-Network, if applicable). You are responsible for any other costs.

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

Exclusions and Limitations

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

Please reference the Exclusions and Limitations of Benefits described in your Schedule of Covered Services and Copayments included with this certificate. Procedures described in the Exclusions and Limitations of Benefits section are considered non-covered services even if they are Medically Necessary or are recommended by a licensed dentist.

Your Financial Responsibility for Non-Covered Services

You are free to contract for services outside of your Dental Health Services' Plan, including its network, on any terms or conditions you choose. You will be liable for the cost of all services performed. You are not liable for any sums owed by Dental Health Services.

IMPORTANT: If you opt to receive dental services that are not covered services under this Plan, the dentist may charge you their usual fees for those services. Prior to providing you with dental services that are not a covered Benefit, you should be provided with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call your Member Services Specialist at 855-495-0907, 888-645-1257 (TDD/TTY).

Out-of-Pocket Maximum (OOPM)

OOPM applies only to the Essential Health Benefits for Pediatric Age Members (18 years old and under).

Out-of-Pocket Maximum (OOPM) is the total amount of Copayments you'll need to pay on your own before your Plan Benefits are paid in full for the Plan Year. Once you've met the Out-of-Pocket Maximum for a Plan Year, you will not be required to pay further Essential Health Benefit Copayments for covered dental services under your Dental Health Services Plan for the remainder of the Plan Year.

Essential Health Benefit Copayments for covered services received accumulate through the Plan Year toward your Out-of-Pocket Maximum. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes Premium, prescriptions, or dental care your dental Plan doesn't cover. After the Pediatric Age Member meets their OOPM, they will have no further Copayments for Essential Health Benefits services for the remainder of the Plan Year.

For families with more than one Pediatric Age Member, Copayments made by each individual Child for Essential Health Benefits services contribute to the family Out-of-Pocket Maximum. Once the Copayments paid by all Pediatric Age Members for Essential Health Benefits services meets the family Out-of-Pocket Maximum, no further Copayments for Essential Health Benefits services will be required by any of the Pediatric Age Member for the remainder of the Plan Year.

Dental Health Services monitors your out-of-pocket payments over the course of your Plan Year. When your payments reach the Out-of-Pocket Maximum for your Plan, we will send a letter to both you and your Designated Participating Primary Dentist to ensure that you are not responsible for Essential Health Benefit Copayments for future services.

You are encouraged to track your out-of-pocket expenses by retaining receipts for all the covered services you received under your Dental Health Services Plan through the Plan Year. Never hesitate to ask your dentist for an itemized receipt for services provided during your visit.

Coordination of Benefits

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

Emergency Care

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

Pre-authorization is not required to receive treatment for an Emergency Dental Condition.

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. Palliative care is treatment to relieve pain or alleviate a symptom without dealing with the underlying cause.

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

1. Call your selected Designated Participating Primary Dentist.

   Dental offices maintain twenty-four (24) hour emergency communication accessibility and are expected to see you within twenty-four (24) hours of initial contact, or within a lesser period of time as may be Medically Necessary.

2. If your Designated Participating Primary Dentist is not available, call your Member Services Specialist at 855-495-0907, 888-645-1257 (TDD/TTY).

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

3. If there are no Participating Primary Dentists available to provide treatment for an Emergency Dental Condition, or you are out of Dental Health Services' Service Area, seek emergency palliative treatment form any dentist practicing in the scope of their license.

   If you receive services for the treatment of an Emergency Dental Condition from an Out-of-Network Dentist or Out-of-Network Specialist, an additional $50 may be charged above the applicable Copayments, unless the member falls in one of the categories stated below.

   Dental Health Services will not charge an additional $50 for services for the treatment of an Emergency Dental Condition if:

   a. Due to uncontrollable circumstances, the member is unable to go to a Participating Dentist or Participating Specialist in a timely fashion without serious impairment to their health.

4. You will only be responsible for the applicable Copayments for emergency treatment when services are provided by a Participating Primary Dentist or Participating Specialist.

5. When services are provided by an Out-of-Network Dentist or Out-of-Network Specialist, you will be responsible for paying the entire bill to the Out-of-Network Dentist or Out-of-Network Specialist at the time of service. Dental Health Services will reimburse you up to $150 per occurrence for the cost of emergency care after you have paid your applicable copayment(s) for the treatment of an Emergency Dental Condition (this includes the $50 fee for services rendered by an Out-of-Network Dentist or Out-of-Network Specialist, if applicable)

   To be reimbursed for any amount over the applicable emergency Copayments, you must submit the itemized dental bill from the dental office to Dental Health Services.

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

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

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

Grievance Procedure

Grievances for Members shall be handled in the following manner:

A. Grievances may be made in writing, over the telephone, fax or through the Plan's website at www.dentalhealthservices.com.

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

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

C. Dental Health Services will collect and review all relevant information from you and dentist involved. If you prefer, you are welcome to present your Grievance in person. If a clinical examination is required, you may be referred to another Participating Primary Dentist for a second opinion. When all information has been collected and reviewed, a decision will be made by the appropriate Dental Health Services administrator.

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

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

F. Dental Health Services does not have an Appeals process for Member Grievances. Members may contact the Division of Financial Regulation for assistance at the contact address and phone numbers below:

   For questions about your rights, this notice, or for assistance, you can contact: If group health plan coverage: The Employee Benefits Security Administration at 1-866-444-EBSA (3272). Group or Individual coverage you may also contact. The Division of Financial

Regulation, Consumer Advocacy Unit at Phone: 888-877-4894, Fax: 503-378-4351 Email: cp.ins@oregon.gov.

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

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

Specialty Care Referral & Pre-Authorization for Specialty Care

All SuperChoice-EC[sm] plans include specialty coverage for Members eighteen (18) years of age and under, and adult Members enrolled in the SuperChoice Enhanced-EC[sm] Plan.

All treatment received from Participating Specialists (Specialist) or Out-of-Network Specialists (Specialist) must be pre-authorized by Dental Health Services.

When pre-authorized by Dental Health Services, you will never be required to pay more than your Copayment amount. You will be referred to a Participating Specialist if one is available in their area. In cases where there is no Participating Specialist in your area, Dental Health Services will arrange for care with an Out-of-Network Specialist at no additional cost to you.

In order to see a Specialist, you must first be referred by a Participating Primary Dentist. Dental Health Services will review the request for referral and notify you, your Participating Primary Dentist and Participating Specialist of the pre-authorized referral.

Pre-Authorization Submission

The Participating Primary Dentist or Participating Specialist will submit a pre-authorization request for your services. You, your Participating Primary Dentist, and Participating Specialist will be notified whether the pre-authorization is approved or denied within five (5) business days for all clean standard pre-authorizations. Clean standard pre-authorizations are pre-authorizations that have no defects or lack any required information or language. For clean expedited pre-authorization requests, you, your Participating Primary Dentist, and Participating Specialist will be notified by Dental Health Services whether your pre-authorization request is approved or denied within seventy-two (72) hours of Dental Health Services receipt of the request.

Claims, Adverse Benefit Determinations & Appeals

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

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

Claims Payment

All claims must be submitted within one hundred-eighty (180) days of the date services were rendered. If the claim form is not submitted within one hundred-eighty (180) days, Dental Health Services reserves the right to refuse payment.

All approved clean claims are paid within thirty (30) days of Dental Health Services' receipt of the claim, electronically or by US Mail. Clean claims are claims that have no defects or lack any required information or language.

Adverse Benefit Determinations

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

1.Actual reason(s) for the determination.

2. Reference to specific Plan provisions from which the determination was based.

3. Instructions for obtaining an Appeal of the decision through Dental Health Services' Internal Review Process.

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

Appeals

Internal Review Process:

If any part of your claim was denied in whole or in part, or is modified, you have the right to submit an Appeal for a full and fair review through Dental Health Services' Internal Review Process.

Requests to file an Appeal through the Internal Review Process may be submitted orally, electronically, and by US mail.

All Appeals must be submitted within one hundred-eighty (180) days from the date the claim was denied in whole or in part or is modified.

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

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

For standard Appeals, you will be notified of the Internal Review Process determination by US mail. All notifications for urgent Appeals are by phone and US mail. Notifications will include your rights if you disagree with the final Internal Review Process determination. You have one hundred-eighty (180) days to file for an external review of the confirmed Adverse Benefit Determination.

External Review Process

You have one hundred-eighty (180) days of the receipt of the Internal Review Process determination to file a request for an external review of the denial from the Internal Review Process.

All requests to file an Appeal through the External Review Process may be submitted orally, electronically, and by US mail by you, your authorized person, or dentist.

Dental Health Services will select an Independent Review Organization (IRO) for review of the Plan's final internal review determination. All documents from the original Internal Review file are forwarded to the IRO.

The IRO will make a final determination of the request for external review. The Member, dentist, and Dental Health Services will be notified by US mail of their final determination.

If Dental Health Services does not comply with the final determination provided by the IRO, you may sue Dental Health Services under ORS 743B.258.

Concurrent Expedited Appeal

Under certain circumstances, you may be eligible to request a concurrent expedited review. A Concurrent Expedited Review means initiating both internal and external expedited review simultaneously to:

1. Review a decision made under the provisions of this Plan; or

2. Review conducted during your course of treatment in a facility, dental professional's office, or any inpatient/outpatient health care setting so the final Adverse Benefit Determination is reach expeditiously.

At any time during the Internal and External Review Process, you may request assistance for the Division of Financial Regulation.

For assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You may also contact The Oregon Division of Financial Regulation, Consumer Advocacy Unit at Phone: 888-877-4894, Fax: 503-378-4351 Email: cp.ins@oregon.gov.

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

Termination of Coverage

Upon terminating, denying, or refusing to renew any Member's dental Plan, Dental Health Services will notify the Subscriber and Group Administrator in writing of the reason(s) for terminating, denying, or refusing renewal of the Plan.

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

1. Termination of the Group Dental Care Service Agreement by written notice thirty (30) days before Group's annual renewal.

2. Failure of a Member to meet or maintain eligibility requirements.

3. Material misrepresentation (fraud) in obtaining coverage.

4. Permitting the use of a Dental Health Services membership card by another person or using another person's membership card or identification to obtain care other than that to which one is entitled.

5. Failure of the Group to pay Premium in a timely manner (fifteen (15) days after payment is due).

6. Dependent reaches limiting age.

Any previously initiated services then "in progress" must be completed within thirty (30) days from the last appointment date occurring prior to the termination date. The Subscriber will remain liable for any scheduled Copayments. If your coverage is terminated, you will be required to pay your participating dentist's usual fees for continuing the prescribed treatment.

Termination of Coverage Due to Non-Payment

Your Plan's Benefits depend on Premium payments staying current. If Group Premium payment is more than fifteen (15) days overdue, your eligibility may be terminated. Your coverage will terminate at the expiration of the fifteen (15) day grace period provided to the group for Premium payment.

Review of Termination

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

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

Renewal Provisions

The Group Services Agreement may be extended or renewed from year to year after its initial period. Renewal may change the Copayment and/or Premium fees paid by Group and/or Subscriber. You may obtain information about these or any changes from a Dental Health Services' Representative during the open enrollment period or by calling your Member Services Specialist at 855-495-0907, 888-645-1257 (TDD/TTY).

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 on this self-payment basis for up to six (6) months.

Provision Conflicts

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

Your Privacy and Confidentiality 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 access and control your information. Please review it carefully. This notice is updated effective March 1, 2018.

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

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

Under what circumstances must Dental Health Services share my PHI?

Dental Health Services is required to disclose your PHI to you, and to the U.S. Department of Health and Human Services (HHS) when it is conducting an investigation of compliance with legal requirements. Dental Health Services is also required to disclose your PHI, subject to certain requirements and limitations, if the disclosure is compelled by any of the following:

- A 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 treatment, payment, and health care administration.

- Treatment purposes include disclosures related to facilitating your dental care.
- Payment purposes include activities to collect Premiums and determine and maintain coverage, and related data processing, including pre-authorization for certain dental services.
- Health Care Administration means basic activities essential to Dental Health Services' function as a Limited Health Care Services Contractor and includes reviewing the qualifications, competence, and service quality of your Participating Dentist; and providing referrals for specialists.
- In some situations, Dental Health Services is permitted to use and disclose your PHI, without our authorization, subject to limitations imposed by law. These situations include, but are not limited to:

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

Does my employer have the right to access my PHI?

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

- you sign an authorization for release of your medical/dental information; or
- health care services were provided with specific prior written request and expense of the employer, and are relevant in a grievance, arbitration or lawsuit, or describe limitations entitling

you to leave from work or limit work performance.

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

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 amount necessary to accomplish the purpose of the use or disclosure. This restriction includes requests for PHI form another entity, and to requests made by Dental Health Services to other entities. This restriction does not apply to the requests by:

- Your dentist for treatment purposes;
- You;
- 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 our top priority and Dental Health Services is not required to agree to your requested restriction. If Dental Health Services agrees to your 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 to receive communications of your PHI by alternative means or at alternative locations. Such request 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 confirm the assigned person has this authority and can act for you before we take any action.
- You have the right, subject to certain limitations, to inspect and copy your PHI. Your request must be made in writing. Dental Health Services will act within thirty (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 within sixty (60) days of receipt of the request and, in certain circumstances may extend this period up to an additional thirty (30) days.
- You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to six (6) years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to:

- Disclosures made for payment or health care operations

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

You have the right to receive a copy of this Privacy Notice by contacting Dental Health Services at 855-495-0907, 888-645-1257 (TDD/TTY) or membercare@dentalhealthservices.com. This notice is always available at www.dentalhealthservices.com/privacy.

All written requests desired or required by this Notice, must be delivered to Dental Health Services, 205 SE Spokane Street, Suite 334, Portland, OR 97202-6413 by any of the following means:

- Personal delivers;
- Email deliver to: membercare@dentalhealthservices.com
- Fax: 503-968-0187
- 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 revises this Notice, it will promptly post the notice on its website and distribute a new version within 60 days of revision.

What if I am dissatisfied with Dental Health Services' compliance with HIPAA (Health Insurance Portability and Accountability Act) privacy regulations?

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

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

You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Suite 515F, HHH Building, Washington DC, 20201, calling 800- 368-1019, 800- 537-7697(TDD), or by visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

You may express dissatisfaction about Dental Health Services' privacy policy in writing to Dental Health Services, 205 SE Spokane Street, Suite 334, Portland, OR 97202, Attn: Member Satisfaction Assurance Specialist.

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

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

Glossary

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

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

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

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

Child(ren): Eligible Children includes a biological Child, an adopted Child, a Child for whom the Subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or a

Child for whom the Subscriber, Subscriber's spouse, domestic partner, or the non-covered parent is the legal guardian.

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

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

Copayments: The fees paid by the Subscriber or Member, directly to the dentist or specialist at the time of service. The fees charged shall be according to your Plan's Schedule of Covered Services and Copayments.

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

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

Emergency Dental Condition: A dental condition that manifests itself by acute symptoms of sufficient severity requiring immediate treatment. This includes, acute infection, acute abscesses, severe tooth pain, unusual swelling of the face or gums, or a tooth that has been avulsed (knocked out).

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

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

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

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

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

Licensed Dentist: A doctor licensed with the Oregon Board of Dentistry as a Doctor of Dental Surgery (D.D.S) or a licensed Doctor of Medical dentistry (D.M.D).

Licensed Denturist: A denturist licensed with the Oregon Board of Dentistry as a denturist.

Limitation: A provision that restricts coverage under this Plan.

Medically Necessary: Dental services and supplies provided by a 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.

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

Out-of-Network Dentist: A dentist for whom Dental Health Services has pre-authorized to provide Benefits to Members under this Plan. An Out-of-Network Dentist includes an Out-of-Network Primary Dentist, Out-of-Network Denturist and an Out-of-Network Orthodontist (for the treatment of non-medically necessary orthodontia when covered under the Plan).

Out-of-Network Orthodontist: A dentist who specializes in orthodontics for whom Dental Health Services has pre-authorized to provide dental services to Members covered under this Plan.

Out-of-Network Primary Dentist – A dentist for whom Dental Health Services has pre-authorized to provide general dental services to Members covered under this Plan

Out-of-Network Specialist: A dentist for whom Dental Health Services has pre-authorized to provide Specialty Services to Members cover under this Plan.

Out-of-Pocket Maximum (OOPM): The maximum amount of money that a Pediatric Age Member must pay for Benefits during a Plan Year. OOPM applies only to the Essential Health Benefits for Pediatric Aged Members. Copayments for covered services received from your dentist accumulate through the Plan Year toward your Out-of-Pocket Maximum. Please consult your Schedule of Covered Services and Copayments for complete information on covered services. OOPM never includes Premium, prescriptions, or dental care your dental Plan doesn't cover. After the Pediatric Age Member meets their OOPM, they will have no further Essential Health Benefits Copayments for the remainder of the Plan Year. For families with more than one Pediatric Age Member, Essential Health Benefit Copayments made by each individual Child for Essential Health Benefits contribute to the family Out-of-Pocket Maximum. Once the Essential Health Benefits Copayments paid by all Pediatric Age Members meets the family Out-of-Pocket Maximum, no further Essential Health Benefits Copayments will be required by any of the Pediatric Age Members for the remainder of the Plan Year.

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

Participating Dentist – A Licensed Dentist in the state of Oregon who has signed an agreement with Dental Health Services to provide Benefits to Members under this Plan. A Participating Dentist includes a Participating Primary Dentist, a Participating Denturist and a Participating Orthodontist (for the treatment of non-medically necessary orthodontia when covered under the plan).

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

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

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

Participating Specialist: A Licensed Dentist who provides Specialty Services to Members under this Plan, upon referral by a Participating Primary Dentist.

Pediatric Age Member: Members aged eighteen (18) and under.

Pediatric Dental Benefits: One of the ten Essential Health Benefits required under the Affordable Care Act (ACA). Pediatric dental benefits cover dental care and services such as cleanings, x-rays, and fillings for those eighteen (18) years of age and under.

Plan: Dental Benefits or coverages available to the Subscriber and any eligible Dependents for the payment of Premium.

Plan Year: A twelve (12) month period of Benefits coverage under a dental plan.

Qualified Dental Plan: An insurance plan that is certified by a health benefit exchange which provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and Out-of-Pocket Maximum amounts) and meets other requirements. All Healthcare.gov dental plans are qualified dental plans.

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

Service Area: Dental Health Services proudly services the following counties: Benton, Clackamas, Columbia, Douglas, Hood River, Josephine, Lane, Linn, Marion, Multnomah, Polk, Wasco, Washington, and Yamhill.

Specialty Services: Dental services provided by a Dental Health Services Participating Specialist (endodontist, periodontist, pediatric dentist, oral surgeon, or orthodontist). All referrals for covered Specialty Services must be pre-authorized by Dental Health Services, except non-medically necessary orthodontia.

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

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

Dental Health Services

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