Dental Health Services

2020 Individual Dental Plans

SmartSmile-EC℠ · Super SmartSmile-EC℠ · SmartSmile Plus-EC℠

Combined Evidence of Coverage and Policy

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.

The Subscriber may return this Plan to Dental Health Services within ten (10) days of its delivery if, after examination of the Plan, they are not satisfied with it for any reason. Dental Health Services shall promptly return any fee paid for the Plan. Upon return of the Plan, it shall be void from the beginning and the parties shall be in the same position as if no Plan had been issued.

100 West Harrison Street, Suite S-440, South Tower
Seattle, Washington 98119

0319OM063

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 for 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 503.281.1771, 888.645.1257 (TDD/TTY).

If you believe that Dental Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a Grievance with the Member Satisfaction Assurance Specialist, 100 W. Harrison St., Ste. S-440, South Tower, Seattle, WA 98119, call 503.281.1771, 888.645.1257 (TDD/TTY), fax 503.968.0187, or email Membersatisfactionteam@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 (HHS), Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal Available at https//ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 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 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 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 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 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 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. 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 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。 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. معينة حتى تحتفظ بتغطيتك الصحية أو المساعدة في التكاليف. يحق لك الحصول على هذه المعلومات وكذلك المساعدة بأي لغة دون تكلفة. اتصل بالرقم 4259.756.866.

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 asistenţăîn limba dvs. Apelaţi numărul de telefon 866.756.4259.

Cambodian:

ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗ។ ការជូនដំណឹងនេះមានព័ត៌មានសំខាន់ៗអំពីពាក្យសុំរបស់លោកអ្នក ឬការធានារ៉ាប់រងតាមរយៈ Dental Health Services។អាចមានកាលបរិច្ឆេទសំខាន់ៗនៅក្នុងការជូនដំណឹងនេះ។ លោកអ្នកអាចចាំបាច់ត្រូវចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ដើម្បីទុកការធានារ៉ាប់ រងសុខភាពរបស់លោកអ្នក ឬជួយខាងថ្លៃចំណាយ។ លោកអ្នក មានសិទ្ធិដើម្បីទទួល បានព័ត៌មាននេះ ហើយ ជួយ ជ សូ មទូរស័ព្ទទៅ 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. 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 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 4259.756.866 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 : 866.756.4259.

Thai:

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลสำคัญเกี่ยวกับการใช้งานหรือความคุ้มครองของ Dental Health Services อาจมีวันที่สำคัญในประกาศนี้

คุณอาจต้องดำเนินการภายในกำหนดเวลางเพื่อรักษาสภาพความคุ้มครองด้านสุขภาพของคุณหรือรับความช่วยเหลือด้านค่าใช้จ่าย

คุณมีสิทธิ์ได้รับข้อมูลนี้ และความช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่าย โทร 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 while, 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 annual maximums for services performed by your Participating Primary Dentist.
- 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]

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 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 dentalhealthservices.com 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: 503.281.1771, 888.645.1257 (TDD/TTY)
Fax: 503.968.0187
Email: Membercare@dentalhealthservices.com
Web: dentalhealthservices.com
Mail: Dental Health Services
100 W. Harrison Street, Suite S-440, South Tower
Seattle, WA 98119

Eligibility

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

Subscribers must live within Dental Health Services' Service Area in order to enroll in a Dental Health Services Plan. Dependents may live outside Dental Health Services' Service Area but will only receive coverage at a Dental Health Services' Participating Dentist, 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 15th, 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.

As the Subscriber, you can enroll alone, or with:

1. a spouse or domestic partner,
2. Dependent Children under twenty-six (26) years of age.
3. Anyone you include on your federal income tax return (even if they do not live with you)

Eligible Dependent Children include:

1. a biological Child,
2. an adopted Child, or a Child for whom the Subscriber assumes legal obligation for total or partial support in anticipation of adoption; and
3. a Child for whom you or your spouse, domestic partner, or non-covered parent is the legal guardian.

Overaged Children Dependents:

Children 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.

Enrollment

This is a qualified dental plan. The Plan Year for qualified dental plans expire at the end of each calendar year. A Member's rate is determined by their age on the date of effectuation; and are valid for the Plan Year or until the Plan is terminated according to the provisions included in this certificate.

Subscribers and Dependents must be added at the time of initial enrollment or at the one-year renewal date, unless you experience a qualifying event.

If you experience a qualifying event, you may be eligible for a sixty (60) day Special Enrollment Period. You must report this event within sixty (60) days of the event to Dental Health Services at 503.281.1771, 888.645.1257 (TDD/TTY), or online through our website at dentalhealthservices.com for consideration of a sixty (60) day Special Enrollment Period.

You may be eligible for a sixty (60) day Special Enrollment Period if you experience one of the following events:

1. A qualified individual or Dependent loses minimum essential dental benefits.
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, erroneous, unintentional as a result of an error made by either HHS or HealthCare.gov.

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 agreement between the individual and the qualified dental plan.
5. New eligibility determination. A permanent move has given the individual access to a new qualified dental plan.

Coverage Effective Dates

Except for newborns, newly adopted Children, or Children placed for adoption, if your enrollment and Premium payment are received on or before the 20th of the current month, your coverage will begin on the first (1st) day of the following month. If either is received on or after the twenty-first (21st) day of the current month, your coverage will begin on the first (1st) day of the second month following your enrollment.

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 enroll your new Dependent within sixty (60) days from the date of birth, adoption, or placement for adoption. If enrollment is not completed according to the rules established by Dental Health Services, the new Dependent will not be eligible for coverage until the following year's renewal date, except according to the provisions in this certificate.

Upgrading Your Plan

If you are currently on the SmartSmile-EC℠ or Super SmartSmile-EC℠ plan and wish to transfer to the Super SmartSmile-EC℠ or SmartSmile Plus-EC℠ 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 twentieth (20th) of the month, your upgrade to the Super SmartSmile-EC℠ or SmartSmile Plus-EC℠ plan will be effective the first (1st) of the following month. If either is received on or after the twenty-first (21st) day of the current month, your upgrade to the Super SmartSmile-EC℠ or SmartSmile Plus-EC℠ Plan will begin on the first (1st) day of the second month following receipt of the upgrade form.

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 continue monthly automatic withdrawals, however the withdrawals will be in the amount of your new monthly Premium.

You must retain your upgrade for the remainder of the Plan Year. After this period, your new Plan Premium will remain in effect until we receive written notification indicating you would like to change or terminate your dental Plan. If you wish to terminate your membership, the standard termination 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 upgraded 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 chose to terminate your Plan prior to your first year's renewal period, our standard termination policy will apply.

Quality Assurance

We're confident about the care you'll receive because our Participating Primary Dentists meet and exceed the highest standards of care demanded by our Quality Assurance[sm] 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 Plan, you should designate a Participating Primary Dentist, from the SmartSmile-EC[sm] network of Quality Assured Participating Dentists to provide your dental care. Before you make an appointment with a Participating Primary Dentist, you will need to inform Dental Health Services of the Participating Primary Dentist you have designated to provide your dental care. Upon notification of the dentist you have selected as your Designated Participating Primary Dentist, Dental Health Service will swiftly notify the dentist of your eligibility.

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.

To search for Participating Primary Dentists online, visit Dental Health Services' website at dentalhealthservices.com.

If you prefer a printed directory, please call 503.281.1771, 888.645.1257 (TDD/TYY) and a directory will be mailed to you.

You are only eligible for services at Dental Health Services' Participating Primary Dentists, 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 cancelled with less than twenty-four (24) hours' notice. For your 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 included with this certificate 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 an emergency situation, 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 Designated Participating Primary Dentist 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 the 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 Primary Dentist.

Changing Dental Offices

If you wish to change your Designated Participating Primary Dentist, you must notify Dental Health Services. Requests can be made by calling 503.281.1771, 888.645.1257 (TDD/TTY),or sending a fax to 503-968-0187. Online requests can be done through our website at dentalhealthservices.com.

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 (1st) day of the second month following receipt of the request. For example, if you request to change your Designated Participating Primary Dentist on or before August 20th, your new dentist selection will become effective September 1st. If you make your Designated Participating Primary Dentist change request on or after August 21st, your 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, 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 must return to your Participating Dentist for treatment. However, if you wish to select a new Participating 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-Network 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 Dentist, 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 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.

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 [503-281-1771], [888-645-1257 (TDD/TTY)].

Out-of-Pocket Maximum (OOPM)

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

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

Essential Health Benefit Copayments for covered services received accumulate through the Plan Year towards the 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 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 the out-of-pocket payments over the course of the Plan Year. When the Pediatric Age Member's payments reach the Out-of-Pocket Maximum for their Plan, we will send a letter to both the Subscriber and their Designated Participating Primary Dentist, to ensure that the Pediatric Age Member is not responsible for Essential Health Benefit Copayments for future services, for the remainder of the Plan Year.

You are encouraged to track your out-of-pocket expenses by retaining receipts for all of the covered services you receive 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

Dental Health Services does not facilitate the coordination of benefits with other coverage. During coordination of benefits facilitated by either the Member or another 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 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 503.281.1771, 888.645.1257 (TDD/TTY).

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

3. If there are no Participating Dentists available to provide treatment for an Emergency Dental Condition or you are out of Dental Health Services' Service Area, seek emergency palliative treatment from 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, an additional $50 may be charged above the applicable Copayments. Dental Health Services will not charge an additional $50 for services for the treatment of an Emergency Dental Condition if, due to uncontrollable circumstances the Member is unable to go to a Participating Dentist 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 Dentist.
5. When services are provided by an Out-of-Network Dentist, you will be responsible for paying the entire bill to the Out-of-Network Dentist 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 additional $50 for services rendered by an Out-of- Network Dentist, 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
   100 W Harrison Street, Suite S-440, South Tower
   Seattle, WA 98119
   If you do not submit this information within one hundred-eighty (180) days, Dental Health Services reserves the right to refuse payment.

Grievance Procedure

If a Member has a Grievance regarding service delivery issues, dissatisfaction with dental care, waiting time for dental services, dentist or staff attitude or demeanour, or dissatisfaction with services provided by Dental Health Services, the Member may submit a Grievance to Dental Health Services.

A. Grievances may be made in writing, over the telephone, fax or through Dental Health Services' website at [www.dentalhealthservices.com].

Written Grievances must include:

1. The Subscriber's name, address and telephone number,
2. Member's name receiving dental care services, and
3. Dentist's name, location and contact information.

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

B. Within three (3) 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 the dentist involved. If a clinical examination is required, you may be referred to another Participating Dentist for a second opinion. When all information has been collected and reviewed, a decision will be made by the appropriate Dental Health Services administrator.

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 number below:
Oregon 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 is 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

Specialty Care Referral

All SmartSmile-EC℠ plans include specialty care coverage.

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 your 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 pre-authorization, and notify you, the Participating Primary Dentist, and Specialist of the pre-authorized referral.

Adult Members (Members 19 years of age & over) have a $1000 calendar year maximum for services provided by a Specialist. Once Dental Health Services has paid $1000 in a calendar year towards covered services provided by a Specialist, the Adult Member will be responsible for all costs for services provided by a Specialist for the remainder of the calendar year. This plan maximum does not apply to Pediatric Aged Members.

Pre-Authorization Submission

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

Claims

Claim forms are your 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.

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) business 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

Adverse Benefit Determination means:

• a denial, reduction, or termination of, or a failure to provide or make full or partial payment for a benefit under our Plan that does not meet our requirements for dental necessity, appropriateness, level of care, or effectiveness;

• a denial, termination, or failure to provide or make full or partial payment based upon a person's eligibility to enroll in our Plan, and

• a denial, termination, or failure to provide or make full or partial payment for a benefit that is determined to be experimental or investigational.

If all or part of your claim is denied in whole or part, or is modified, Dental Health Services will notify you and the dentist in writing of this 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 is denied in whole or 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 part, or is modified.

All standard Appeals are investigated and resolved within fourteen (14) days of receipt of the Appeal, if possible. If more time is needed, the Member 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 have been prescribed treatment which would end because of the Adverse Benefit Determination; or where the treating dentist believes that a delay in treatment based on the time needed to complete a standard review 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 made 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 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. You or your authorized person have five business days to provide any additional information in writing to the IRO that you wish considered in the review.

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 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 healthcare setting so the final Adverse Benefit Determination is reach expeditiously.

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

For assistance, you may contact the Oregon Division of Financial Regulation at Phone: 888.877.4894, Fax: 503.378.4351 Email: cp.ins@oregon.gov.

During the review of your Appeal, Dental Health Services will continue to provide coverage for the disputed Benefit pending the 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 Benefits Plan, Dental Health Services shall notify the Subscriber 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. Failure of the 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 Member relocates outside of Dental Health Services' Service Area.

5. Loss of Dependent status due to limiting age.

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 of Benefits for more related information.

Coverage for the Member and their Dependents will terminate at the end of the month during which the Subscriber or Member ceases to be eligible for coverage. Dental Health Services will issue a notice of termination to the Subscriber by mail at least thirty (30) days prior to terminating coverage.

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. You will be required to pay your dentist's usual fees for continuing treatment beyond completion of the previously initiated "in progress" services.

Termination of Coverage Due to Non-Payment

Your Plan's Benefits depend on Premium payments staying current. If Premium payment is more than ten (10) days overdue, your eligibility may be terminated. If your coverage is terminated, the effective date of the termination will be the same date in which the Premium became overdue.

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
100 West Harrison Street, Suite S-440, South Tower
Seattle, WA 98119

Termination of Coverage by Subscriber

If Subscribers wish to terminate their Plan after the ten (10) day free look period, and prior to their first year's renewal period, they will be subject to a $50 termination fee to cover the administrative and healthcare costs of the termination process.

Termination requests must be received in writing (signed by the Subscriber) or sent via email from the Subscriber's email address on file with Dental Health Services to membercare@dentalhealthservices.com. Termination requests must be received on or before the

fifteenth (15th) of the current month in order to take effect the first (1st) of the following month. Termination requests received on or after the sixteenth (16th) of the month will take effect the first (1st) of the second month following the request for termination.

The $50 termination fee does not apply under the following circumstances:

1. Member obtains other Essential Health Benefits through another qualified dental plan during an open enrollment or Special Enrollment Period.
2. Death of the Member.

Refund Provisions

Coverage for the Subscriber and their Dependents will terminate when the Subscriber gives advance notice according to the procedures included in this certificate to Dental Health Services in writing (signed by the Subscriber) or sent via email from the Subscriber's email address on file with Dental Health Services to membercare@dentalhealthservices.com. All unearned Premiums will be refunded within thirty (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.

Reinstatement Policy

If you wish to reinstate your coverage and you have previously completed a minimum of one year's continuous enrollment, you may reinstate your coverage at any time by submitting your request in writing (signed by the Subscriber) or sent via email from the subscriber's email address on file with Dental Health Services to membercare@dentalhealthservices.com. In order for you to maintain continuous coverage, Dental Health Services must receive your request for reinstatement within thirty (30) days from the date your coverage was terminated.

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

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 thirty (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 per Subscriber.

Renewal Provisions

Renewal is automatic for monthly Subscribers. If you pay on an annual basis, you will receive a renewal notice for the next year's Premium. Renewal may change the Copayment(s) and/or Premium fees paid by the subscriber.

The individual Plan may be renewed from year to year after its initial period. You will be able to obtain information about changes, if any, by contacting your Member Services Specialist.

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 get access to this 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, to determine or 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 and competence of your dental provider; and providing referrals for specialists.

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

    - 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 form another entity, and to requests made by Dental Health Services to other entities. This restriction does not apply to the requests by:

- Your Participating 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 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 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 ensure the 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 on such request 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 to your request within sixty (60) days of receipt of the request and, in certain circumstances may extend this period for up to an additional thirty (30) days.
- 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 for up to an additional thirty (30) days. The first accounting requested during any twelve (12) month period will be made without charge. There is a $25 charge for each additional accounting requested during such twelve (12) month period. You may withdraw or modify any additional requests within thirty (30) days of the initial request in order to avoid or reduce the fee.

You have the right to receive a copy of this Privacy Notice by contacting Dental Health Services at 503.281.1771, 888.645.1257 (TDD/TTY) or by emailing membercare@dentalhealthservices.com. This Notice is always available at dentalhealthservices.com/privacy.

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

- Personal delivery;
- Email delivery 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 shall promptly post the Notice on its website and distribute a new version within sixty (60) days of revision.

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

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

Your written dissatisfaction must describe the acts or omissions you believe to be in violation of the provisions of this Notice or applicable laws. Your written objection to HHS or Dental Health Services must be filed within 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 Ave., S.W., Suite 515F, HHH Building, Washington DC, 20201, calling 800.368.1019, 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, 100 West Harrison Street, Suite S-440, South Tower, Seattle, WA 98119, Attn: Member Satisfaction Assurance Specialist.

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

You may obtain further information regarding your PHI privacy rights by contacting your Member Services Specialist at 503.281.1771, 888.645.1257 (TDD/TTY) Monday through Friday, 8:00 am to 5:00 pm or at dentalhealthservices.com. We are eager to assist you!

Glossary

Adverse Benefit Determination: A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Benefit, including a denial, reduction, termination or failure to provide or make 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.

Annual Maximum: An annual maximum is the maximum dollar amount the Plan will pay toward the cost of dental care within a calendar year. If your Plan's annual maximum is $1,0 00, Dental Health Services will pay its portion of your bill up to that amount for any covered dental services received in that year.

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 extra-oral 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 designated 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 the Subscriber.

Grievance: A complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for dental services, dissatisfaction with dental care, waiting time for dental services, provider or staff attitude or demeanor, or dissatisfaction with service provided by Dental Health Services.

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 who does not belong to Dental Health Services' network of Quality Assured Participating Dentists. Services performed by an Out-of-Network Dentist are not

covered unless pre-authorized by Dental Health Services due to emergency situations or other exceptional circumstances.

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 Essential Health Benefit 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 Dentistwho 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, Participating Orthodontist and Participating Specialist.

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 Members: 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: The Plan Year for Qualified Dental Plans corresponds to the calendar year. Your coverage ends December 31st even if your coverage started after January 1st. Any changes to your Qualified Dental Plan's Benefits or rates are made at the beginning of the calendar year.

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.

Special Enrollment Period: A time outside the yearly open enrollment 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.

Specialist: A licensed dentist who provides Specialty Services to Members under this Plan, upon referral by a Participating Primary Dentist. Specialist includes Participating Specialists and Out-of-Network Specialists.

Specialty Services: Dental services provided by a 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 who is responsible for the account, whose name is on the enrollment form, resides in Dental Health Services' Service Area and meets Plan eligibility requirements.

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

100 West Harrison Street, Suite S-440, South Tower, Seattle, Washington 98119

503.281.1771
888.645.1257 (TDD/TTY)

dentalhealthservices.com

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