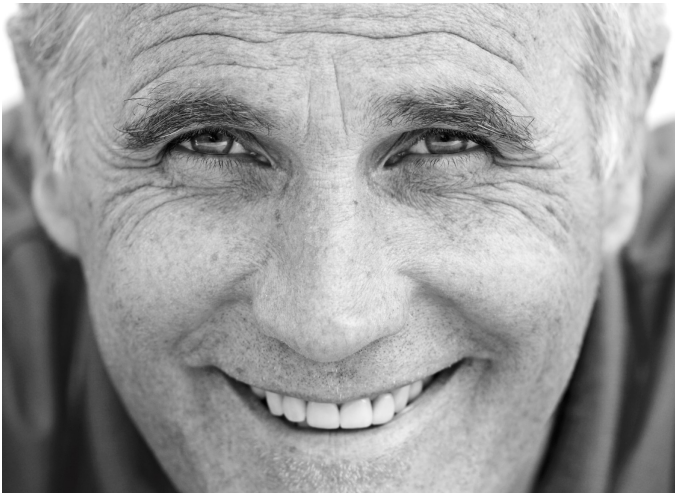
Combined Evidence of Coverage and Policy

SmartSmile℠ Individual Plans



Dental Health Services

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

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Table of contents

Your Personal Dental Plan

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

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

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

Recognizes receiving regular diagnostic and preventive care with low, or no copayments is the key to better health and long term savings.

Facilitates care by making all covered services available as soon as membership becomes effective.

Simplifies access by eliminating pre-authorization for treatment from the general dentist you've selected from our network.

Assures availability of care with high-quality, easy to find dental offices throughout Washington State and our network is continually expanding; please contact our office at 800-637-6453 or visit www.dentalhealthservices.com for the latest listing of our dentists.

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

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

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

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

- ToothTips[sm] oral health information sheets

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

About Dental Health Services

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

As employee owners, we have a vested interest in the well-being of our plan members. Part of our service focus includes, toll-free access to your knowledgeable Member Service Specialist, an automated member assistance and eligibility system, and www.dentalhealthservices.com to help answer questions about your plan and its benefits.

Your Participating Dentist

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

The ongoing care of each dental office is monitored regularly through our rigorous Quality Assurance standards.

Your First Dental Appointment

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

Your initial exam may require a copayment and you may need additional diagnostic services (e.g., periodontal charting and x-rays). You may also be

charged copayments for additional services as necessary. There is a copayment charged for each office visit regardless of the procedures performed.

After your initial visit, you may schedule an appointment for future care, such as cleanings, to complete your treatment plan. Reference your treatment plan with your enclosed Schedule of Covered Services and Copayments to determine the copayments for your scheduled procedures. Please note that crowns, bridges and dentures may require an extra charge for laboratory fees. Copayments are due in full at the time services are performed.

Your Member Service Specialist

Please feel free to call, fax, e-mail through our website, or write us anytime with questions or comments. We are ready to help you. Each of our Member Service Specialists have been specially trained and have experience working in a dental office. They can answer your plan and dental questions. Your Member Service Specialist can be reached through any of the following ways:

Phone:	206-633-2300 or 800-637-6453
Fax:	206-624-8755
Web:	www.dentalhealthservices.com
Mail:	Dental Health Services 100 W. Harrison St Suite S-440, South Tower Seattle, WA 98119

Eligibility

As the subscriber, you can enroll alone, with your spouse, domestic partner, and/or with children who are under 26 years of age.

Eligible children include a natural child, an adopted child, a child for whom the subscriber assumes legal obligation for total or partial support in anticipation of adoption, a stepchild, and a foster child for whom you or your spouse are the legal guardian. Children 26 years of age and older are only eligible for

coverage as a dependent while the child is and continues to be both:

1. incapable of sustaining employment by reason of developmental disability or physical handicap, and

2. is chiefly dependent upon the subscriber for support and maintenance.

Proof of incapacity and dependency must be furnished to Dental Health Services by the subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by Dental Health Services, but not more frequently than annually after the two-year period following the child's attainment of 26 years of age.

Dental Health Services requires proof of the above if a child is 26 years of age and older. The subscriber must furnish proof at the time of enrollment or within 31 days of such a request. Failure to do so may result in termination of the child's eligibility.

Enrollment

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

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

1. Newborn children are covered from birth. If adding a newborn dependent increases your premium, Dental Health Services must receive a completed enrollment within 60 days to continue coverage for the newborn. If the enrollment information is not received within the first 60 days, the dependent coverage will lapse until the child's enrollment is received by Dental Health Services.

2. Adoptive and foster children are covered from the date of placement for a period of 60 days. If the addition of an adoptive or foster child as a

dependent increases your premium, Dental Health Services must receive a completed enrollment form within 60 days to continue coverage for the adoptive or foster child. If the enrollment information is not received within the first 60 days, the dependent coverage will lapse until the child's enrollment is received by Dental Health Services.

3. A child dependent under the age of three (3) may be enrolled at any time during the plan year, upon your written request to Dental Health Services. If the addition of this dependent increases your premium, Dental Health Services must receive the additional premium and a completed enrollment form.

4. New spouse, domestic partner and any additional children due to marriage may be enrolled within 60 days of marriage. If the enrollment information is not received within the first 60 days, the dependent's coverage will lapse until the dependent is enrolled during an open enrollment period. If the additional dependent is under the age of three (3), he/she may be added according to section 3 above.

5. Loss of other coverage. If the premium will be affected due to the dependent addition, Dental Health Services must receive a completed enrollment form within the first 60 days of intended coverage of the dependent. If the enrollment information is not received within the first 60 days, the dependent coverage will lapse until the dependent is enrolled during an open enrollment period, unless the dependent is under the age of three (3).

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

If any of these circumstances apply to you, contact your Member Service Specialist to enroll dependents.

Upgrading Your Policy

Upgrade Request Form
If you are currently on the SmartSmile plan and wish to transfer to the Super SmartSmile 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 of the month, your upgrade to the Super SmartSmile plan will be effective the first of the following month.

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

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

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

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

Coverage Effective Dates

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

Receiving Dental Care

Upon enrolling in your plan, you should select your participating dentist. Directories are available by calling 800-637-6453 or through www.dentalhealthservices.com.

You may make an appointment with your dentist as soon as your eligibility has been confirmed. Simply call the telephone number as it appears below the dental office address in your Directory of Participating Dentists and request an appointment. Routine appointments will be scheduled within a reasonable time; in non-emergency cases, reasonable time shall not be more than three weeks. You are only eligible for services at your participating dentist's office, except in an emergency situation.

Working With Your Dentist

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

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

Any request to terminate a specific member/dentist relationship should be submitted to Dental Health Services and shall be effective the first day of the month following receipt of the request. Dental Health Services will always put forth its best effort to place the member with another dentist.

Changing Dental Offices

If you wish to change dentists you must notify Dental Health Services. This may be done by phone, in writing, by email, by fax, or online. Requests can be made through 800-637-6453 or by fax at 206-624-8755. Online changes can be done through www.dentalhealthservices.com.

Requests received by the 20th of the current month become effective the first day of the following month. Changes made after the 20th become effective the first day of the second month following receipt.

Obtaining a Second Opinion

If you believe you need a second opinion for any reason, Dental Health Services can arrange for you to be seen by another participating dentist. You should bring your x-rays to this consultation. If no x-rays are necessary, you will pay only your office visit and second opinion copayments.

After you receive your second opinion, you may return to your initial participating dental office for treatment. If, however, you wish to select a new dentist you must contact Dental Health Services directly, either by phone or in writing, before proceeding with your treatment plan.

Your Financial Responsibility

You are liable to your participating dentist for copayments and incidental broken appointment penalties or interest charges. Please be aware that you are also liable for any other amounts owed for uncovered services. All dental treatment copayments

are to be paid at the time of service directly to your participating dental office.

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

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

Emergency Care: In-Area

Palliative care for emergency dental conditions in which acute pain, bleeding, or dental infection exist is a benefit according to your Schedule of Covered Services and Copayments.

If you have a dental emergency and need immediate care, first call your selected participating dental office. Dental offices maintain 24-hour emergency communication accessibility and are expected to see you within 24 hours of initial contact, or within a lesser period of time as may be medically necessary. If your dentist is not available, call your Member Service Specialist at 800-637-6453.

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

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

Emergency Care: Out-of-Area

All participating dental offices are expected to maintain 24-hour emergency communication

accessibility. Emergency (palliative) treatment can be obtained from any participating dentist. In case of an emergency dental condition, where no

participating dentist within a reasonable distance or time is available, no prior authorization is required to have emergency palliative treatment performed. Dental Health Services will be responsible for dental service fees beyond all applicable copayments in an emergency situation. Services for the treatment of emergency dental conditions are solely limited to procedures to stop bleeding, and to reduce swelling and pain. After emergency treatment is performed, the covered person must see their participating dentist to be covered by Dental Health Services.

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

If an enrollee receives services for the treatment of an emergency dental condition from a non-participating dentist, an additional $50 may be charged above the applicable copayments, unless the enrollee falls in one of the categories stated below. Dental Health Services will not charge an additional $50 copayment for services for the treatment of an emergency dental condition if:

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

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

After receiving treatment for an emergency dental condition, Dental Health Services requires pre-authorization for out-of-network post-emergency treatment. Dental Health Services shall provide access to an authorized representative 24 hours a day, seven days a week to facilitate reviews. To obtain access to an authorized representative, call 206-633-2300 or 800-637-6453 for instructions.

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

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

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

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

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

Dental Health Services
100 W. Harrison St
Suite S-440, South Tower
Seattle, WA 98119

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

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

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

If you wish to appeal the result of your emergency care claim, Dental Health Services will treat your appeal as a grievance. Dental Health Services' Dental Director and Service Review Committee will review your claim and make a determination. If your claim is denied and you appeal the decision, a reviewer other than the dentist providing the initial determination will review your appeal. If the decision is based on medical judgment, the consulting dentist will be different than the one

from the initial review process. Secondary appeals are referred to our Peer Review Committee, which is comprised of independent dentists.

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

Coordination of Benefits

This plan does not provide for coordination of benefits with other coverage.

Termination of Coverage

Upon canceling, denying, or refusing to renew any subscriber's dental benefit health plan, Dental Health Services shall notify the subscriber in writing of the reason(s) for canceling, denying or refusing renewal of the plan.

Coverage of an individual subscriber and/or his or her dependents may be terminated for any of the following reasons:

1. Failure of an enrollee to meet or maintain eligibility requirements.

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.

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

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

Termination Due to Nonpayment

Benefits under your plan depend on premium payments staying current. If payment is more than 10 days overdue, your eligibility may be terminated. If your coverage is terminated, the effective date of termination will be the same date in which your account became overdue. Any previously initiated service(s) then "in progress" must be completed within 30 days from the last appointment date occurring prior to the termination date. The subscriber will remain liable for the scheduled copayment, if any. If your coverage is terminated, you will be required to pay your participating dentist's usual fees for continuing the prescribed treatment.

Review of Termination

If you believe your membership was terminated by Dental Health Services solely because of ill health 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
100 W. Harrison St
Suite S-440, South Tower
Seattle, WA 98119

Cancellation Policy

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

Cancellation requests must be received in writing and must be signed by the primary subscriber. Cancellation requests received by the 15th of the current month will be effective the first of the following month.

Reinstatement Policy

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

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

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

Refund Provisions

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

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

An additional 10 percent penalty against Dental Health Services shall be included in any premium

refund due which is not paid within 30 days from the date Dental Health Services receives written notice of cancellation.

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 contract may be extended or renewed from year to year after its initial period. You will be able to obtain information about changes, if any, by contacting your Member Service Specialist.

Grievance Procedure

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

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

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

C. Dental Health Services will collect and review all relevant information from the complainant and participating dentists involved, and the complainant is invited to present his or her issues in person. If the Dental Director feels a clinical examination

is required, the complainant may be referred to another participating dentist or specialist for a second opinion. When all information has been collected and reviewed, a decision will be made by the appropriate Dental Health Services administrator.

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

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

F. Once a decision is made, Dental Health Services will promptly notify the complainant in writing of the disposition of his or her complaint. The notification will include the actual reason(s) for the determination, the instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

G. If the complainant is not satisfied with the disposition of his or her complaint, the

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

Privacy Notice

Dental Health Services is committed to protecting your privacy and the confidentiality of your dental, medical, and Protected Health Information (PHI) that we may obtain or to which we have access. We do not sell our client information. Your personal information will not be disclosed to non-affiliated third parties unless permitted or required by law, or authorized in writing by you.

Throughout this Notice, unless otherwise stated, your medical and dental health information refers to only health information created or received by Dental Health Services and identified in this Notice as Protected Health Information (PHI). Please note that your dentist maintains your dental records, including payments and charges. Dental Health Services will have a record of this portion of your PHI only in special or exceptional cases.

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

Under what circumstances must Dental Health Services share my PHI?

Dental Health Services is required to disclose your PHI to you and to the U.S. Department of Health and Human Services (HHS) when it is conducting an investigation of compliance with legal requirements. Dental Health Services is also required to disclose

your PHI, subject to certain requirements and limitations, if the disclosure is compelled by (any of the following):

A. A court order.

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

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

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

E. A search warrant.

F. A coroner in the course of an investigation.

G. By other law.

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

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

A. Payment purposes include activities to collect premiums and to determine or maintain coverage. These include using PHI in billing and collecting premiums, and related data processing including how your dentist obtains pre-authorization for certain dental services. For example, Dental Health Services periodically conducts quality assurance inspections of your dentist's office and during such visits may review your dental records as part of this audit.

B. Health Care Administration means basic activities essential to Dental Health Services function as a licensed limited healthcare service contractor, and includes reviewing the qualifications and competence of your dentist;

evaluating the quality of his/her services; providing subscriber services and information, including answering enrollee inquiries without disclosing PHI. Dental Health Services may, for example, review your dentist's records to determine if the copayments being charged by the office comply with the contract under which you receive dental coverage.

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

1. Public health activities.
2. Concerning victims of abuse, neglect or domestic violence.
3. Health oversight agency.
4. Judicial and administrative proceedings including the defense by Dental Health Services of a legal action or proceeding brought by you.
5. Law enforcement purposes, subject to subpoena of law.
6. Workers' Compensation purposes.
7. Parents or guardians of a minor.
8. Persons or entities who perform services on behalf of Dental Health Services and from whom Dental Health Services has received contractual assurances to protect the privacy of your PHI.

Is Dental Health Services ever required to get my permission before sharing my PHI?

Uses and disclosures of PHI other than those required or permitted by law will be made by Dental Health Services only with your written authorization. You may revoke any authorization given to Dental Health Services at any time by written notice of

revocation to Dental Health Services, except to the extent that Dental Health Services has relied on the authorization before receiving your written revocation. Uses and disclosures beyond those required or permitted by law, or authorized by you, are prohibited.

Does my employer have the right to access my PHI?

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

A. You sign an authorization for release of your medical/dental information.

B. Health care services were provided with specific prior written request and expense of the employer; and are relevant in a grievance, arbitration or lawsuit; or describe limitations entitling you to leave from work or limit work performance.

Any such disclosure is subject to Dental Health Services' minimum necessary disclosure policy.

What is Dental Health Services' minimum necessary disclosure policy?

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

A. Your dentist for treatment purposes.

B. You.

C. Disclosures covered by an authorization you provided to another entity.

What are my rights regarding the privacy of my PHI?

Your rights respecting your PHI, and how you may

exercise these rights are summarized here.

A. You may request Dental Health Services to restrict uses and disclosures of your PHI in the performance of its payment or health care operations. However, a written request is required. Your health is the top priority and Dental Health Services is not required to agree to your requested restriction. If Dental Health Services agrees to your requested restriction, the restriction will not apply in situations involving emergency treatment by a health care provider.

B. Dental Health Services will comply with your reasonable request that you wish to receive communications of your PHI by alternative means or at alternative locations. Such requests must be made to Dental Health Services in writing.

C. You have a right, subject to certain limitations, to inspect and copy your PHI. Your request must be made in writing. Dental Health Services will act on such request within 30 days of receipt of request.

D. You have the right to amend your PHI. The request to amend must be made in writing, and must contain the reason you wish to amend your PHI. Dental Health Services has the right to deny such requests under certain conditions provided by law. Dental Health Services will respond to your request within 60 days of receipt of the request and, in certain circumstances, may extend this period for up to an additional 30 days.

E. You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to six years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to:

1. Disclosures made for payment or healthcare operations purposes.

2. Disclosures occurring prior to February 26, 2002.

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

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

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

Dental Health Services
100 W. Harrison St
Suite S-440, South Tower
Seattle, WA 98119

by any of the following means:

1. Personal delivery.

2. E-mail delivery to customercare@dentalhealthservices.com.

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

4. Overnight or courier delivery, charges prepaid.

What duties does Dental Health Services agree to perform?

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

B. Dental Health Services will abide by the terms of this Notice and any revised Notice, during the period that it is in effect.

C. Dental Health Services reserves the right to change the terms of this Notice or any revised Notice. Any new terms shall be effective for all PHI that it maintains including PHI created or received by Dental Health Services prior to the effective date of the new terms.

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

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

You have the right to express your dissatisfaction or objection to:

Dental Health Services
Attn: Privacy Officer
100 W. Harrison St.
Suite S-440, South Tower
Seattle, WA 98119

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

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

You may obtain further information regarding your PHI privacy rights by contacting your Member Service Specialist at 800-637-6453 during regular office hours or at www.dentalhealthservices.com.

Glossary

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

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

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

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

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

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

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

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

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

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

Exclusion: Treatment or coverage not included as a benefit.

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

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

Oral surgery: The branch of dentistry concerned with the extraction of teeth and maxillofacial, reconstructive, or plastic surgery for the treatment of fractures to the jaw, cleft palates, and damaged oral-facial structures.

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

Participating dental office: A licensed dental professional who has entered into a written agreement with Dental Health Services to provide dental care services to subscribers and their dependents covered under the plan. The contract includes provisions in which the dentist agrees that the subscriber shall be held liable only for their copayment and related lab and metal costs, and no additional amount.

Dental Health Services

100 W. Harrison St
Suite S-440, South Tower
Seattle, WA 98119
800-637-6453
www.dentalhealthservices.com

An Employee-Owned Company

Dental Health Services

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

Combined Evidence of Coverage and Policy Amendment

Effective August 12, 2012, this Amendment entirely replaces any and all grievance, claims, and appeals language in the Combined Evidence of Coverage and Policy of 08.12WA193.

Notwithstanding any provision to the contrary, the following language will control:

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 demeanor, 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 the Plan's 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. However, 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 Washington State Office of the Insurance Commissioner for assistance at the contact address and phone numbers below:

   Washington State Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 Phone: 1-800-562-6900 or (360) 725-7080 Fax: (360) 586-2018 or website at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status.

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.

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

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 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. 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.

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 a 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.

You may also contact the Washington State Office of the Insurance Commissioner
P.O. Box 40255 Olympia, WA 98504-0255 Phone: 1-800-562-6900 or (360) 725-7080
Fax: (360) 586-2018 or website at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status.

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.

Dental Health Services

Combined Evidence of Coverage & Policy
Address Amendment

This Amendment entirely replaces any and all addresses for Dental Health Services in the Combined Evidence of Coverage & Policy:

08.12WA193 effective August 12, 2012

Notwithstanding any provision to the contrary, the following language will control:

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