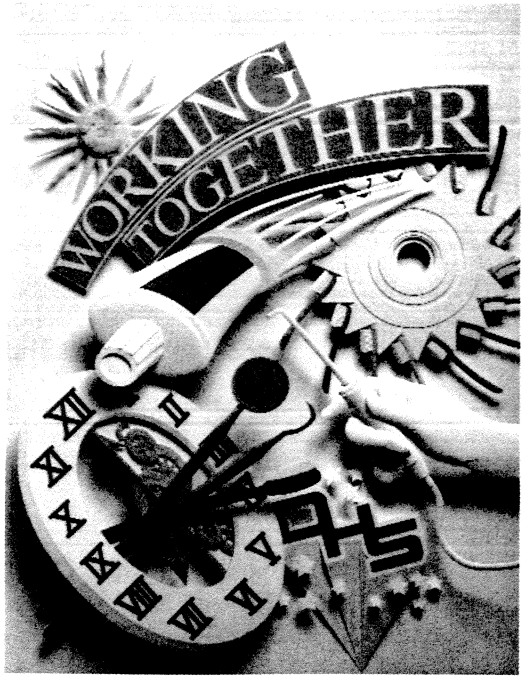
Your Personal Dental Plan



ILWU-PMA Welfare Plan Supplemental Summary Plan Description

For active and retired Longshormen, Ship Clerks, and Walking Bosses/Foremen, and their qualified survivors and dependents in the State of Washington

Dental Health Services

WA-195 5/03

Welcome to Dental Health Services!

Each participant of the ILWU-PMA Welfare Plan has been provided with a Supplemental Summary Plan Description, as required by ERISA (Employee Retirement Income Security Act). The Supplemental Summary Plan Description describes the Plan, its eligibility requirements and benefits. Additional Supplemental Summary Plan Descriptions are available from the Plan office upon request.

ILWU-PMA Welfare Plan
1188 Franklin Street, Suite 300
San Francisco, CA 94109
Phone: 415.673.8500
Area Welfare Director Phone:
206.938.6720 or 877.938.6720

IRS Employer Identification No. 94-6068578
Plan No. 501

What should I expect from my first dental appointment?

Your initial appointment is an opportunity for you and your selected dental provider to meet one another. Your new dentist will complete an oral examination and formulate a treatment plan with you based on his or her assessment of your oral health. At your initial exam, additional diagnostic services such as periodontal charting and x-rays may be required.

After your initial visit, you may schedule an appointment for future care including cleanings to complete your treatment plan. Please note that crowns and bridges may require an extra charge for metal upgrades.

If you have any questions regarding your plan coverage and benefits, please contact your Member Service Specialist at 800.63.SMILE (800.637.6453) or log on to www.dentalhealthservices.com.

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Your Personal Dental Plan:

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.

Simplifies access by not requiring pre-authorization for treatment from the provider you've selected from our network.

Assures availability of care with high-quality, easy to find dental offices throughout Puget Sound and selected areas. Our network continues to grow; please contact our office or visit www.dentalhealthservices.com for the latest listing of our dentists.

Allows you to take an active role in your dental health and treatment by fully disclosing coverages 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:

- Toll-free membership access
- ToothTips℠ dental 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 Your Dental Benefits

Dental Health Services

Dental Health Services has been a licensed Health Care Services Contractor since 1984. We are dedicated to assuring your satisfaction and are committed 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 dedication to serving you includes easy, toll-free access to your knowledgeable Membership Service Specialist, an Automated Member Assistance and Eligibility System, and our website, www.dentalhealthservices.com to help answer any of your questions about your plan and coverages.

Your Provider

Service begins with the selection of qualified dentists available in your area. Professional skill, commitment to prevention and wellness, convenience of location and flexibility in scheduling appointments are some of the important criteria involved in approving a Dental Health Services participating dentist. The ongoing care of each dental office is monitored regularly through our rigorous Quality Assurance standards. This way, we're always sure you are getting the quality care you deserve.

Your Summary Plan Description

This Summary Plan Description and Policy is a comprehensive brochure designed to enable you to more easily enjoy the benefits of your plan.

Your Member Services Representative

Please feel free to call, fax, e-mail or write to us anytime with any questions or comments you might have. We will do everything possible to help you. Your Member Service Specialist can be reached by:

Phone..... 800.63.SMILE (800.637.6453)
or 206.633.2300

Web..... www.dentalhealthservices.com

Fax..... 206.624.8755

Mail..... Dental Health Services
Northlake Plaza
936 N 34th St., Ste. 208
Seattle, WA 98103

Eligibility

You must be an eligible ILWU-PMA Welfare Plan participant in order to be entitled to dental benefits. You are eligible to enroll in the Dental Health Services Plan if you are a pensioner or survivor residing in Washington State or if you are assigned for Welfare Plan Coverage to one of the following Longshore Locals:

Locals: 7, 19, 21, 23, 24, 25, 27, 32, 47, 51, 52, 98

Eligible employees and pensioners and their dependants include:

1. Active Longshoremen, Ship Clerks, and Walking Bosses/Foremen;

2. Pensioners under the ILWU - PMA Pension Plan or the ILWU - PMA Watchmen Pension Plan;

3. Adult survivor pensioners;

4. Child survivor pensioners*;

5. Surviving dependant spouse or child*;

6. Dependants*;

7. Surviving ERISA spouse;

* Children over 19 years of age are eligible only if:

1. The child is unmarried, under 23 years of age and a full time student solely dependent upon subscriber for support; or
2. 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, they are eligible for coverage as a dependent. Proof of incapacity and dependency must be furnished to Benefit Plan Office by the subscriber 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 nineteen (19) years of age.

Enrollment

Eligible persons in the State of Washington may enroll when eligibility is first obtained, and each year in May for coverage effective July 1. In addition to the May open enrollment period, participants may change their dental plan coverage once at any time during the Plan Year (July 1 - June 30).

Membership Cards

At approximately the time your coverage becomes effective, you will receive one (1) membership card per family. Your provider receives an updated membership list each month, so it is not necessary to have your membership card to make an appointment or receive care.

How to Receive Dental Care

Upon enrolling in your plan, you should have selected a designated dental office (provider) as your personal dentist. If you have not yet selected a designated dental provider, Directories of Participating Dentists are available from your Membership Services Department at Dental Health Services, through www.dentalhealthservices.com, or from your ILWU Benefit Plan Office, Union Local and Area Director.

You may make an appointment with your provider as soon as your eligibility has been confirmed. Simply call the telephone number as it appears below the dental office address on your provider directory and request an appointment. Routine appointments will be scheduled within a reasonable time. In non-emergency cases, a reasonable time shall be not more than three weeks. You are only eligible for services at your designated dental office (provider), except in

an emergency situation. (Please see Out-of-Area Emergency Care, page 21.)

How to Change Dental Offices

If you wish to change to another provider you must notify Dental Health Services. This may be done in writing, by fax, online, or by phone. You may fax your request to 206.624.8755 or complete an online Provider Select/Change form at www.dentalhealthservices.com. You may also call your Member Service Specialist at 800.63.SMILE (800.637.6453) or 206.633.2300. If your request reaches our office by the 20th of the month, it will be effective the first day of the following month. If it arrives after the 20th, it will be effective the first day of the second month following receipt.

Obtaining a Second Opinion

If you believe you need a second dental opinion for any reason, Dental Health Services can arrange for you to be seen by another affiliated dentist. You should bring your x-rays if necessary.

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

ILWU - PMA Welfare Plan Schedule of Services and Copayments

ADA#	Service	Member Copayment
	Office visit charge (per visit)	**None**
	Failed (no show) appointment w/o 24 hr. notice (first missed appointment)	**$20.00**
	Failed (no show) appointment w/o 24 hr. notice (Each additional missed appointment)	**$40.00**

	Diagnostic and Preventive Services:	
D0120	Periodic oral evaluation	None
D0140	Limited oral evaluation - problem focused	None
D0150	Comprehensive oral evaluation- new or established patient	None
D0180	Comprehensive periodontal evaluation - new or established patient	None
D0210	Intraoral - complete series (including bitewings) Full-mouth x-rays– once every three years or as determined necessary by your dentist).	None
D0220	Intraoral - periapical first film	None
D0230	Intraoral - periapical each additional film	None
D0240	Intraoral-occlusal film	None
D0250	Extraoral - first film	None
D0260	Extraoral - each additional film	None
D0270	Bitewing - single film	None
D0272	Bitewings - two films	None
D0274	Bitewings - four films	None
D0330	Panoramic film	None
D0460	Pulp vitality tests	None
D0470	Diagnostic casts	None
	Dental Prophylaxis (cleaning) Maximum of two per contract year:	
D1110	Prophylaxis – adult Prophylaxis (cleaning) – maximum of two per contract year.	None
01120	Prophylaxis – child (up to age 14) Prophylaxis (cleaning) – maximum of two per contract year.	None
D1201	Topical application of fluoride (including prophylaxis)-Chld	None
D1203	Topical application of fluoride (prophylaxis not included)-Child	None
D1204	Topical application of fluoride (prophylaxis not included) - Adult	None
D1205	Topical application of fluoride (including prohylaxis) - Adult	None
D1330	Oral hygiene instructions	None
D1351	Sealant - per tooth	None
	Space Maintenance:	
D1510	Space maintainer, unilateral - fixed	None
D1515	Space maintainer, bilateral - fixed	None
D1520	Space maintainer, unilateral -removable	None
D1525	Space maintainer, bilateral-removable	None
	Basic/Restoration Services	
	Amalgam Restorations:	
D2140	Amalgam - one surface, primary or permanent	None
D2150	Amalgam - two surfaces, primary or permanent	None
D2160	Amalgam - three surfaces, primary or permanent	None
D2161	Amalgam - four or more surfaces, primary or permanent	None
	Resin-Based Composite Fillings Restorations:	
D2330	Resin-based composite - one surface, anterior	None
D2331	Resin-based composite - two surfaces, anterior	None
D2332	Resin-based composite - three surfaces, anterior	None
D2335	Resin-based composite - four or more surfaces, or involving incisal angle (anterior)	None
D2391	Resin-based composite - one surface, posterior	None
D2392	Resin-based composite - two surfaces, posterior	None
D2393	Resin-based composite - three surfaces, posterior	None
D2394	Resin-based composite - four or more surfaces, posterior	None

Crowns, Inlays, Onlays and Posts (there is an additional charge of $50 for noble/gold and $80 for high noble/gold

Inlay/Onlay Restorations:

D2510	Inlay - metallic - one surface	None
D2520	Inlay - metallic - two surfaces	None
D2530	Inlay - metallic - three or more surfaces	None
D2542	Onlay - metallic - two surfaces	None
D2543	Onlay - metallic - three surfaces	None
D2544	Onlay - metallic - four or more surfaces	None
D2610	Inlay - porcelain/ceramic - one surface	None
D2620	Inlay - porcelain/ceramic - two surfaces	None
D2630	Inlay - porcelain/ceramic - three or more surfaces	None
D2642	Onlay - porcelain/ceramic - two surfaces	None
D2643	Onlay - porcelain/ceramic - three surfaces	None
D2644	Onlay - porcelain/ceramic - four or more surfaces	None
D2650	Inlay - resin based composite - one surface	None
D2651	Inlay - resin based composite - two surfaces	None
D2652	Inlay - resin based composite - three or more surfaces	None
D2662	Onlay - resin based composite - two surfaces	None
D2663	Onlay - resin based composite - three or more surfaces	None
D2664	Onlay - resin based composite - four or more surfaces	None

Crowns, Inlays, Onlays and Posts (there is an additional charge of $50 for noble/gold and $80 for high noble/gold

Crowns:

D2710	Crown - resin (indirect)	None
D2740	Crown - porcelain/ceramic substrate	None
D2750	Crown - porcelain fused to high noble metal	None*
D2751	Crown - porcelain fused to predominantly base metal	None
D2752	Crown - porcelain fused to noble metal	None*
D2780	Crown - 3/4 cast high noble metal	None*
D2781	Crown - 3/4 cast predominantly base metal	None
D2782	Crown - 3/4 cast noble metal	None*
D2783	Crown - 3/4 porcelain/ceramic	None
D2790	Crown - full cast high noble metal	None*
D2791	Crown - full cast predominantly base metal	None
D2792	Crown - full cast noble metal	None*

Crowns, Inlays, Onlays and Posts (there is an additional charge of $50 for noble/gold and $80 for high noble/gold

Other Restorative Services:

D2910	Recement Inlay	None
D2920	Recement crown	None
D2930	Prefabricated stainless steel crown - primary tooth	None
D2931	Prefabricated stainless steel crown - permanent tooth	None
D2932	Prefabricated resin crown	None
D2940	Sedative filling	None
D2950	Core buildup, including any pins	None
D2951	Pin retention - per tooth, in addition to restoration	None
D2952	Cast post and core in addition to crown	None
D2954	Prefabricated post and core in addition to crown	None

Crowns, Inlays, Onlays and Posts (there is an additional charge of $50 for noble/gold and $80 for high noble/gold

Endodontics:

D3110	Pulp cap - direct (excluding final restoration)	None
D3220	Therapeutic pulpotomy (excluding final restoration)	None
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	None
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	None

Endodontic Therapy (root canal therapy):

D3310	Anterior (excluding final restoration)	None
D3320	Bicuspid (excluding final restoration)	None
D3330	Molar (excluding final restoration)	None

Apexification/Recalcification Procedures:

D3351	Apexification/recalcificaton - initial visit	None
D3352	Apexification/recalcification - interim medication replacement	None
D3353	Apexification/recalcification - final visit	None

Apicectomy/Periradicular Services:

D3410	Apicoectomy/periradicular surgery-anterior	None
D3421	Apico/Periradicular surgery - bicuspid (first root)	None
D3425	Apico/Periradicular surgery - molar (first root)	None
D3426	Apico/Periradicular surgery - (each additional root)	None
D3430	Retrograde filling - per root	None
D3450	Root amputation - per root	None

Periodontics

Periodontal Surgery:

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	None
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	None
D4260	Osseous surgery (including flap entry and closure) four or more contiguous	None
D4261	Osseous surgery (including flap entry and closure) one to three teeth per quadrant	None
D4271	Free soft tissue graft procedure (including donor site surgery)	None

Non-Surgical Periodontal Services:

D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant (not 1110, limit 2 per visit)	None
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	None
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	None
D4910	Periodontal maintenance	None

Patient is responsible for the cost of upgrades to teeth or dentures.

Dentures: (When performed by your general dentist)

Full/partial dentures (upper and/or lower) - one per five year period. Replacement will be provided where casing is unsatisfactory and cannot be made satisfactory. Lost or stolen appliances are the responsibility of the patient. Unilateral partials (Nesbitt) are not a recommended treatment. Plastic teeth are a covered benefit. Patient is responsible for the cost of upgrades to teeth or dentures.

D5110	Complete upper denture	None*
D5120	Complete lower denture	None*
D5130/40	Immediate upper/lower (including 6 month adjustments)	None*
D5211	Upper partial denture - resin based (including any conventional clasps, rests, and teeth and 6 month adjustments)	None*
D5212	Lower partial denture - resin based (including any conventional clasps, rests, and teeth and 6 month adjustments)	None*
D5213	Partial upper denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	None*
D5214	Partial lower denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	None*

Patient is responsible for the cost of upgrades to teeth or dentures.

Adjustments/Repairs to Dentures:

D5410/11	Denture adjustments complete(after 6 months)	None
D5421/22	Adjust partial denture upper/lower	None
D5510	Repair broken complete denture base	None

D5520	Replace missing or broken teeth - complete denture, per tooth	None*
D5610	Repair broken denture -no tooth damaged	None
D5620	Repair cast framework	None
D5630	Replace/repair broken clasp	None
D5640	Replace broken teeth on denture, per tooth	None*
D5650	Add tooth to existing partial denture	None*
D5660	Add clasp to existing partial denture	None
D5710/11	Rebase complete denture upper/lower	None
D5720/21	Rebase partial denture upper/lower	None
D5730/31	Reline complete denture upper/lower (chairside) one per year	None
D5740/41	Office reline (chairside) - one per year	None
D5750/51	Reline denture complete or partial, upper or lower – lab processed Denture relines – one per year.	None
D5760/61	Reline upper/lower partial denture (laboratory) - one per year	None
D5810/11	Interim complete denture upper/lower	None
D5820/21	Denture - temporary partial	None
5850/1	Tissue conditioner	None
	Denture cleaning	None

Patient is responsible for the cost of upgrades to teeth or dentures.

	Bridges:	
D6210	Pontic, cast high noble metal	None*
D6211	Pontic cast predominantly base metal	None
D6212	Pontic cast to noble metal	None*
D6240	Pontic porcelain fused to high noble metal	None*
D6241	Pontic porcelain fused to predominantly base metal	None
D6242	Pontic porcelain fused to noble metal	None*
D6245	Maryland Bridge (Acid etched bridge (Maryland) is appropriate only on the anterior area.)	None
D6600	Inlay - porcelain/ceramic, two surfaces	None
D6601	Inlay - porcelain/ceramic, three or more surfaces	None
D6602	Inlay - cast high noble metal, two surfaces	None*
D6603	Inlay - cast high noble metal, three or more surfaces	None*
D6604	Inlay - cast predominantly base metal, two surfaces	None
D6605	Inlay - cast predominantly base metal, three or more surfaces	None
D6606	Inlay - cast noble metal, two surfaces	None*
D6607	Inlay - cast noble metal, three or more surfaces	None*
D6608	Onlay - porcelain/ceramic, two surfaces	None
D6609	Onlay - porcelain/ceramic, three or more surfaces	None
D6610	Onlay - cast high noble metal, two surfaces	None*
D6611	Onlay - cast high noble metal, three or more surfaces	None*
D6612	Onlay - cast predominantly base metal, two surfaces	None
D6613	Onlay - cast predominantly base metal, three or more surfaces	None
D6614	Onlay - cast noble metal, two surfaces	None*
D6615	Onlay - cast noble metal, three or more surfaces	None*
D6750	Crown-porcelain fused to high noble metal	None*
D6751	Crown-porcelain fused to predominantly base metal	None
D6752	Crown-porcelain fused to noble metal	None*
D6780	Crown - 3/4 cast high noble metal	None*
D6781	Crown - 3/4 cast predominantly base metal	None
D6782	Crown - 3/4 cast noble metal	None*
D6783	Crown- 3/4 porcelain/ceramic	None
D6790	Crown-full cast high noble metal	None*
D6791	Crown-full cast predominantly base metal	None
D6792	Crown-full cast noble metal	None*
D6930	Recement fixed partial denture	None

Crowns, Inlays, Onlays and Posts (there is an additional charge of $50 for noble/gold and $80 for high noble/gold

	Oral Surgery:	
D7140	Extraction, erupted tooth or exposed root	None
D7210	Surgical removal of erupted tooth	None
D7220	Removal of impacted tooth - soft tissue	None
D7230	Removal of impacted tooth - partially bony	None
D7240	Removal of impacted tooth - completely bony	None
D7280	Surgical access of erupted tooth	None
D7310	Alveoloplasty, per quadrant, with extractions	None
D7320	Alveoloplasty, per quadrant, not in conjunction with extractions	None
	Other Services:	
D9110	Emergency treatment during office hours	10.00
D9215	Local anesthesia	None
D9220/21	Deep sedation/ general anesthesia	50% up to $200*
D9310	Second Opinion	None
D9440	Emergency treatment after office hours	20.00
D9940	Occlusal guard, by report	175.00

**General Anesthesia is covered at 50% up to $200 reinbursement per person per year for IV sedation or general anesthesia only when medically necessary and in conjunction with a covered dental procedure performed only at a participating provider or participating specialty office. General Anesthesia may not be offered at all participating offices.*

Cosmetic Services: All Cosmetic Services offered at a 15% discount

Limitations:

A. Authorized treatment is rendered only by your selected participating provider. Services provided by a dentist other than your designated participating provider, are not covered except for emergency (palliative) care. (See item C below). You may choose to change your dentist, to another participating Dental Health Services provider, at any time, but you must notify Dental Health Services.

B. Limitation on the frequency and appropriateness of services:

1. Prophylaxis (cleaning) – maximum of two per contract year. Your contract year is the 12 months following the effective date of your coverage.
2. Periodontal scaling and periodontal maintenance limited to four quadrants per six months. (Your mouth is divided into 4 sections called quadrants).
3. Periodontal surgery: Periodontal Surgical procedures are limited to four quadrants in two years.
4. Full/partial dentures (upper and/or lower) –one per five year period unless there has been such an extensive loss of remaining teeth or change in support structure that the existing appliance cannot be made satisfactory by either a reline or repair. Lost or stolen appliances are the responsibility of the patient.

5. Plastic teeth or dentures are a covered benefit. Patient is responsible for the cost of any upgrades to teeth or dentures.
6. Denture relines – one per year per arch.
7. Full-mouth x-rays - once every three years or as determined necessary by your dentist.
8. Partial dentures are appropriate treatment when dental spaces are bilateral and can be satisfactorily restored with removable dentures. Unilateral partials (Nesbitt) are not a recommended treatment.
9. Acid etched bridge (Maryland) is appropriate only on the anterior area.
10. Fixed bridges are optional and restricted for patients under the age of 16 when periodontal tissue is not supportive or in the presence of bilateral spaces.
11. General Anesthesia is only covered at participating provider and specialist offices. General Anesthesia or IV sedation is covered at 50% up to $200 per person per year only when medically necessary and in conjunction with a covered dental procedure. General Anesthesia may not be offered at all participating provider offices.

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

D. The additional cost to the enrollee for metal upgrades is $50 for noble metal/gold, and $80 for high noble metal/gold.

E. Optional service (all cases in which the enrollee selects a plan of treatment that is considered unnecessary by the provider) is charged to the enrollee at fee-for-service rates.

F. Cosmetic dentistry - services for appearance only are at a 15% discount off of full fees. This includes replacement of clinically acceptable amalgam filings.

G. Unsatisfactory patient-doctor relationship: Dental Health Services providers reserve the right to limit or deny services to an enrollee who fails to follow the prescribed course of treatment, repeatedly fails to keep appointments, fails to pay applicable copayments, is abusive to the participating provider or their staff, or obtains services by fraud or deception.

H. Submit claims within 60 days. Dental Health Services shall not be liable to pay a claim for emergency care or for any Dental Health Services authorized treatment provided by a dentist other than a participating provider unless the enrollee submits the claim to Dental Health Services within 60 days after treatment.

I. Denturist benefit subject to existence and availability of a licensed denturist within a 30 mile radius. Enrollees may elect to travel to the nearest participating denturist provider for services.

J. Third Molars (wisdom teeth) - complicated extractions of third molars are at the discretion of the general dentist and are often referred to oral surgeons (specialist).

K. Not all participating dentists can perform all dental procedures, please verify what services your selected provider can perform for you.

Exclusions:

The following are not covered by your dental plan.

A. Services not specifically covered in the ILWU-PMA Welfare Plan "Supplemental Summary Plan Description".

B. Work in progress: Dental work in progress (non-

emergency/temporary procedures started but not finished prior to the date of eligibility) is not covered. This includes crown preps prepared and temporized but not cemented, root canals in mid-treatment, prosthetic cases post final impression stage (sent to the lab), etc.

C. Services that in the opinion of the attending dentist are not necessary for the patient's health. Extractions of non-pathologic, asymptomatic teeth (healthy or non-symptomatic) teeth including extractions for orthodontic reasons.

D. Implants: Services for or attachments to implants..

E. Dispensing of drugs not normally supplied in a dental office.

f. Any dental procedure or service rendered while a patient is hospitalized or not in the dental office.

G. Temporomandibular joint (TMJ) disorders and related disease including myofunctional therapy. Procedures for training, treating or developing muscles in and around the jaw of the mouth (unless provided by a separate, supplemental Dental Health Services program).

H. Treatment for malignancies or neoplasms (tumors).

I. Procedures or charges for services prior to the date the enrollee became eligible for benefits under this plan, or re-treatment of these procedures within one (1) year of completion or charges incurred following termination of benefits under this plan.

J. Any dental procedure that cannot be performed in the dental office due to the general health of the enrollee.

K. Procedures, appliances or restorations other than fillings that are necessary to alter, restore or maintain occlusion, or are necessary for full-mouth rehabilitation,

i.e., night guards, occlusal adjustments.

L. Orthognathic treatment- surgical procedures and other treatment to correct the malposition of the maxilla and/or the mandible.

M. Congenital/developmental malformations: Procedures, appliances or restorations for correction of developmental conditions are not covered. This includes, but is not limited to : congenitally missing teeth, cleft palate, adverse growth patterns, facial deformities or skeletal abnormalties.

N. Full Mouth Rehabilitation is not covered. Procedures requiring extensive restorative treatment involving more than 10 crowns and/or an increase or decrease of the horizontal or vertical dimension, gnathological recordings, full mouth equilibration, periodontal splinting, temporary processed functional crowns/appliances and realignment of teeth are not covered.

Denturist Benefits

Denturists are licensed specialists who make, fit, repair and directly provide denture (prosthodontic) services. Coverage for the following prosthodontic services are available through a network of participating denturists.

Please contact your Member Service Specialist to request a directory of Participating Denturists. Services listed under "Dentures" on your Schedule of Covered Services and Copayments are always available from your selected participating general dentist.

Covered Denturist Services & Copayments

When services are received from a licensed Dental Health Services' Denturist:

Plastic teeth are a covered benefit. Patient is responsible for the cost

of upgrades to teeth or dentures.

D5110	Complete upper denture	None*
D5120	Complete lower denture	None*
D5130/40	Immediate upper/lower (including 6 month adjustments)	None*
D5213	Partial upper denture - cast metal framework with resin denture bases with resin denture (including any conventional clasps, rests and teeth)	None*
D5214	Partial lower denture - cast metal framework with resin denture bases with resin denture (including any conventional clasps, rests and teeth)	None*
D5410/11	Denture adjustments complete (after 6 months)	None
D5421/22	Adjust partial denture upper/lower	None
D5510	Repair broken complete denture base	None
D5520	Replace missing or broken teeth - complete denture, per tooth	None*
D5610	Repair broken denture -no teeth damaged	None
D5620	Repair cast framework	None
D5630	Replace/repair broken clasp	None
D5640	Replace broken teeth on denture, per tooth	None*
D5650	Add tooth to existing partial denture	None*
D5660	Add clasp to existing partial denture	None
D5710/11	Rebase complete denture upper/lower	None
D5720/21	Rebase partial denture lower/upper	None

****Patient is responsible for the cost of upgrades to teeth or dentures.***

D5730/31	Reline complete denture upper/lower	None
D5740/41	Office reline	None
D5750/51	Reline denture complete or partial, upper or lower – lab processed Denture relines – one per year.	None
D5760/61	Reline upper/lower partial denture	None
D5810/11	Interim complete denture upper/lower	None*
D5820/21	Denture - temporary partial	None*
D5850/1	Tissue Conditioning	None
	Denture Cleaning	None

****Patient is responsible for the cost of upgrades to teeth or dentures.***

Orthodontic Benefits

ILWU-PMA Welfare Plan members and dependants (up to the age of 19) are entitled to Orthodontic treatment at a participating Orthodontist. Orthodontic benefits are not available to any Plan member or dependant over the age of 19.

Making an Orthodontic Appointment:

Before making an appointment, you must contact Dental Health Services' Membership Services Department at 800.63.SMILE (800.637.6453) or through www.dentalhealthservices.com, for a referral. You will only receive a referral to a participating Dental Health Services Orthodonitst.

Once you receive a referral to an Orthodontist, you must make your appointment directly with the orthodontic office.

Orthodontic Services:

Your first appointment will consist of a consultation, including an examination, and your treatment needs will be discussed. After your consultation, all recommended and needed treatment must be pre-authorized by Dental Health Services prior to starting treatment. Your Orthodontist will send a pre-treatment estimate to Dental Health Services for pre-authorization.

As a member of Dental Health Services' ILWU-PMA Welfare Plan, you are responsible for paying 10% of all covered services (see below). You are responsible for paying full fees for any treatments performed that are not covered services, such as x-rays and study models. Your total out of pocket cost is determined by the type and length of orthodontic treatment required.

Below is a list of covered orthodontic services:

Consultation Fee - Child up to age 19 years
Full-Banded /Full Treatment (child) - not including x-rays or models)
Retreatment-Functional Appliances (after orthodontic treatment)

Orthodontic Limitations/Exclusions

Limitations:

(The following are subject to additional charges)

A. Cephalometric x-rays, dental x-rays.
B. Tracings and photographs

C. Study Models.

D. Replacement of lost or broken appliances.

E. Changes in treatment necessitated by accident of any kind.

F. Services which are compensable under Worker's Compensation or employer liability laws.

G. Malocclusions too severe or mutilated which are not amenable to ideal orthodontic therapy.

Exclusions:

(The following are not covered by your dental plan)

A. Retreatment of orthodontic cases.

B. Treatment of a case in progress at inception of eligibility.

C. Surgical procedures (including extraction of teeth) incidental to orthodontic treatment.
(The following are not covered by your dental plan)

D. Treatment and/or Surgical procedures related to cleft palate, micrognathia or microdontia.

E. Treatment related to Temporomandibular joint disturbances and/or hormonal imbalances.

F. Any dental procedures considered to be within the field of general dentistry, including but not limited to:

1. Myofunctional therapy.
2. General anesthetics including intravenous and inhalation sedation.
3. Dental services of any nature performed in a hospital.
4. Services which are compensable under Worker's Compensation or employer liability laws.

G. Payment by Dental Health Services or any special discounted orthodontic copayment for treatment rendered or required after enrollee is no longer eligible for coverage (i.e. current premium unpaid). The cost of treatment in progress will be pro-rated and converted to the Orthodontists actual fee-for-service amount.

Emergency Care: In-Area

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

If you have a dental emergency and need to seek immediate care, first call your Dental Health Services' dentist. Participating dental offices maintain 24-hour emergency communication accessibility and are expected to see you within 24 hours of contacting the dental office or within such lesser time as may be medically indicated. If your dentist is not available, call your Dental Health Services' Member Service Specialist. If both your dental office and Dental Health Services cannot be reached, you are covered for emergency care at another Dental Health Services' provider or from any dentist. You will be reimbursed for the cost of emergency palliative treatment less any copayments that apply. Contact your assigned provider for follow-up care as soon as possible. If you have a medical emergency, you should get care immediately by calling 9-1-1 or going to the nearest hospital emergency room.

Reimbursement for Out-of-Area Emergency Care

Dental emergencies can often be reduced or eliminated by maintaining proper oral health and by contacting your provider at the first sign of pain, swelling or bleeding.

All provider offices are expected to maintain 24-hour emergency communication accessibility. Emergency (palliative) treatment can be obtained from any participating provider. In case of an emergency dental condition, and no participating provider 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 reduce swelling and pain. After emergency treatment is performed the covered person must see their designated participating provider to be covered by Dental Health Services.
If services for the treatment of an emergency dental condition are authorized by any service staff member of Dental Health Services, Dental Health Services may not deny the responsibility of fees beyond all applicable copayments, unless approval was based on misrepresentation about the covered persons condition made by the provider of emergency treatment.

After receiving treatment for an emergency dental condition, Dental Health Services requires pre-authorization for out of network post-emergency dental condition 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 800.248.8108 for instructions.

In order for services for the treatment of post-emergency dental condition(s) to be covered, the non-participating provider 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 made a good faith effort to contact the non-participating provider within 30 minutes.

Dental Health Services shall immediately arrange for an alternate plan of treatment for the covered person if Dental Health Services and the non-participating provider 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 is transferred to a participating provider's 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, you are responsible for the entire bill. To be reimbursed for any amount over your emergency copayment you must submit a Dental Health Services claim form, along with the itemized dental bill. Dental Health Services will only reimburse you for the amount over your copayment for dental work done to eliminate pain, swelling and/or bleeding. Dental Health Services claim forms are available from your provider, or may be requested directly from your Membership Service Specialist. Send the claim form and itemized bill to our Administrative Office: Northlake Plaza, 936 North 34th Street, Suite 208, Seattle, WA 98103, within 60 days following the occurrence. If you do not submit the invoice 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. Dental Health Services will notify you within this 30 day period if any part of your claim is being denied. This period may be extended one time, for up to 15 days, provided such an extension is necessary due to circumstances beyond Dental Health Services' control. In the event

an extension is necessary, we will notify you of these circumstances prior to the expiration of the initial 30 day period.

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 to be followed within 24 hours. Dental Health Services' notification may be oral or written. Once we receive the needed information to complete your claim, you will be notified within 48 hours if your claim is approved or denied.

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 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 60 days. You have 180 days to appeal any denied claim.

Specialty Care Claims and Appeals

Dental Health Services claim forms are available from your provider, or may be requested directly from your Membership Service Specialist. Send the claim form and itemized bill to our Administrative Office: Northlake Plaza, 936 North 34th Street, Suite 208, Seattle, WA 98103, within 60 days following the occurrence. If you do not submit the invoice within

60 days, Dental Health Services reserves the right to refuse payment.

If you submit a pre-service claim for authorization, within 15 days of receiving your claim, you will be notified if your claim is approved or denied. This 15 day period may be extended one time, for up to an additional 15 days, provided such an extension is necessary due to circumstances beyond Dental Health Services' control. In the event an extension is necessary, we will notify you of these circumstances requiring this extension within 5 days of receiving your claim.

If you fail to submit your pre-service claim for authorization according to the procedures and guidelines described within this Summary Plan Description brochure, within 5 days following Dental Health Services' discovery of any procedural error, you will be notified of the failure and the proper procedures to be followed in submitting your claim. Notification may be oral or written.
All approved post-service dental claims are paid within 30 working days. Dental Health Services will notify you within this 30 day period if any part of your claim is being denied. This period may be extended one time, for up to 15 days, provided such an extension is necessary due to circumstances beyond Dental Health Services' control. In the event an extension is necessary, we will notify you of these circumstances prior to the expiration of the initial 30 day period.

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 to be followed within 24 hours. Dental Health Services' notification may be oral or written. Once we receive the needed information to complete your claim, you will be notified within 48 hours if your claim is approved or denied.

If you wish to appeal the result of your claim, Dental Health Services will treat your appeal as a grievance. Dental Health Services' Dental Director, or designated dentist, and Service Review Committee review all claims and make a determination. A reviewer other than the dentist providing the initial determination decides appeals. 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 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 60 days. You have 180 days to appeal any denied claim.

Coordination of Benefits Provision

This plan does not provide for reduction of benefits because of other coverage.

Termination of Coverage

Coverage of an individual subscriber and/or their dependants may be terminated for any of the following reasons:

1. Termination of the Group Dental Care Services agreement by written notice 30 days before annual anniversary date.
2. Failure of an enrollee to meet or maintain eligibility requirements.
3. Material misrepresentation (fraud) in obtaining coverage.
4. Permitting the use of a Dental Health Services membership card by another person, or using another person's membership card or identification to obtain care other than that to which one is entitled.
5. Failure of the group to pay premium in a timely manner (15 days after payment is due.)

Termination due to Nonpayment

Benefits under your plan depend on premium payments staying current. If payment is more than 10 days in arrears, your eligibility may be terminated. 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 provider's usual fees for continuing the prescribed treatment.

Review of Termination

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

Renewal Provisions

The group contract may be extended or renewed from year to year after its initial period. Renewal may change the copayment and/or premium fees paid by the subscriber. You may be able to obtain information about these changes, if any, from a Dental Health Services representative during the open enrollment period or from the Dental Health Services Member Services Department.

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 provider 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 each of the dental centers are requested to be available to provide assistance in the preparation and submission of any complaints.

B. Within three (3) days of receiving a complaint, Dental Health Services will acknowledge its receipt in writing including the name and telephone number of a contact person assigned to handle the complaint.
C. Dental Health Services will collect and review all relevant information from the complainant and providers 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 provider or specialist for a second opinion. When all information has been collected and reviewed, a decision is 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 fourteen (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 thirty (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 in no later than seventy-two (72) hours after receipt of the complaint. If the treating dental care provider determines that a delay in its 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 non-binding mediation.)

COBRA (Consolidated Omnibus Budget Reconcilation Act)

If you qualify for continuing coverage through COBRA, Dental Health Services will gladly provide ongoing benefits through your employer. Please contact your employee benefits manager.

Labor Disputes

In the event of suspension or termination of employee compensation due to a strike, lockout, or other labor dispute, a subscriber may continue uninterrupted coverage for the family unit by paying to the Group the monthly premium charge that the Group would otherwise have paid Dental Health Services. Coverage may be continued on this self-payment basis for up to one year.

Privacy Notice

Dental Health Services is devoted 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 nonaffiliated 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 recieved by Dental Health Services and identified in this Notice as

Protected Health Information (PHI). Please note that your dentist maintains your dental records, including payments and charges. Dental Health Services will have a record of this portion of your PHI only in special or exceptional circumstances.

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

Under what circumstances must Dental Health Services share my PHI?

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

A. 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 lawfully-requested arbitration;
E. a search warrant;
F. a coroner in the course of an investigation; or
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 Administation means basic activities essential to Dental Health Services' function as a licensed Health Care Service Plan, and includes reviewing the qualifications and competence of your dentist; evaluating the quality of his/her services; providing subscriber services and information including answering enrollee inquiries but without disclosing PHI. Dental Health Services may, for example, review your dentist's records to determine if the copayments being charged by the office comply 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. judical 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; and
8. persons or entities who perform services on behalf of Dental Health Services and from whom Dental Health Services has recieved 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 athorization for release of your medical/dental information, or
B. health care services were provided with specific prior written request and expense of the Plan, 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" Policy?

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

A. your dentist for treatment purposes;
B. you; or
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 excercise 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 recieve communications of your PHI by alternative means or at alternative locations. Such requests must be made to Dental Health Services in writing.
C. You have a right, subject to certain limitations, to inspect and copy your PHI. Your request must be made in writing. Dental Health Services will act on such request within 30 days of receipt of request.
D. You have the right to amend your PHI. The request to amend must be made in writing, and must contain the reason you wish to amend your PHI. Dental Health Services has the right to deny such requests under certain conditions provided by law. Dental Health Services will respond to your request within 60 days of receipt of the request and, in certain circumstances may extend this period for up to an additional 30 days.
E. You have the right to receive an accounting of disclosures of your PHI made by Dental Health Services for up to 6 years preceding such request subject to certain exceptions provided by law. These exceptions include, but are not limited to:

1. disclosures made for payment or health care operations purposes, and
2. disclosures occurring prior to February 26, 2002

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

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

G. All written requests for the purposes described in this section, and all other written communications to Dental Health Services desired or required by this Notice, must be delivered to Dental Health Services, 936 N. 34th St., Suite 208, Seattle, WA 98103 by any of the following means:

1. personal delivery;
2. email delivery to customer-care@dentalhealthservices.com;
3. first class or certified U.S. Mail; or
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, www. dentalhealthservices.com and 2) distribute a written copy personally by First Class U.S. Mail to each of its subscribers who are enrolled with Dental Health Services during the period that such revised Notice remains effective.

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

You have the right to express your dissatisfaction or objection to Dental Health Services, 936 N. 34th St., Suite 208, Seattle, WA 98103. Attn: Privacy Officer. 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. We are eager to assist you.

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 Dental Health Services' Member Service Specialist at 800.637.6453 (800.63.SMILE) during regular office hours or at www.dentalhealthservices.com.

Your Personal Dental Plan: Questions & Answers

How do the SmartSmile plans work?

The independent SmartSmile dental plans use a network of privately owned, neighborhood dental offices to deliver high quality dental care to you and your family. You select a conveniently located participating provider who will assess your oral health and outline your treatment plan. Your care then proceeds according to your plan.

How do I select a provider?

Plan members may choose any of the conveniently located dental offices by calling your Membership Service Specialist at 800.63.SMILE (800.637.6453) or visiting www.dentalhealthservices.com. Dental care is rendered by your selected provider, except for an out-of-area emergency.

May I change dental offices?

Yes. Simply call your Member Service Specialist at 800.63.SMILE (800.637.6453) or visit www.dentalhealthservices.com to select a new provider. You may also mail or fax your provider change request. Your provider selection should be effective the first of the following month.

How do I receive dental care?

Simply telephone your selected dental office to verify the hours they are open. Tell them you are a member of Dental Health Services' family of SmartSmile plan members and ask for a convenient appointment time. Your provider receives a membership list each month so it is not necessary to have your membership card to make an appointment or receive care.

What if I have an emergency dental condition on a weekend or after hours?

Call your participating provider office at their regular after-hours number. Your participating provider has procedures for handling after hours emergencies.

What if I have an emergency and my dentist is unavailable?

The dental office should have a replacement dentist if the regular dentist is on vacation. You should try to see this dentist first. If this dentist is unavailable, you should try to see another participating provider, or you may see any licensed dentist practicing within the scope of their license to be reimbursed for palliative care only.

How is an emergency dental condition out of my area covered?

First, attempt to contact your selected participating provider. If that is not realistic, please contact any available dentist and receive palliative care (to relieve pain, swelling or bleeding). Dental Health Services will reimburse you for palliative care only. Any costs over and above palliative care will be your full responsibility. Send the itemized bill to Dental Health Services with an explanation of what happened. You will be reimbursed minus your copayment within 30 days following receipt of verification of service. For a complete explanation, please see "Reimbursement of Out-of-Area Emergency Care", (see page 21).

What if I encounter a problem or have a question?

Call your Dental Health Services Member Service Specialist at 800.63.SMILE (800.637.6453). Your specialist welcomes your call and can provide you with valuable information about your dental care, participating providers, available services, copayments and any of your coverage or dental questions. Dental Health Services wants to help you maintain excellent, long-term dental health. Please don't hesitate to call.

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 or coverages: Are the specific services the members (subscribers and their dependents) are entitled to use in their dental plan (i.e., covered services).

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. May typically include the evaluation and recording of dental caries (cavities), missing or unerupted teeth, restorations, and occulsal relationships.

Copayments: Copayment is the fee charged to an enrollee by the provider according to the schedule in this brochure. Copayments for each service covered under your plan are listed in your "Schedule of Covered Services and Copayments" (see page 8) that you pay directly to your participating provider at the time of service.

Dependants: The legal spouse and children of the covered individual.

Designated dental office: The specific dental office selected by the subscriber (and/or dependants) that provides covered services.

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 for disease or inflammation of the dental pulp or nerve of the tooth.

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

Exclusion: Treatment or coverage not included as a benefit.

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

Limited (problem focused) exam: An evaluation limited to a specific oral health problem.

Optional treatment: Any treatment other than covered services which, 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 to pay 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: Action that relieves pain, bleeding, and swelling, but is not curative.

Periodontal Exam: An evaluation of periodontal conditions including probling and charting for patients showing signs or symptoms of gum disease.

Periodontal Scaling/Root Planing: The removal of plaque and calculus from below the gum line.

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

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

Provider: A licensed dental professional who has entered into 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 provider agrees that the subscriber shall be held liable only for their copayment (and related lab and metal costs) and no additional amount.

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

Maintaining Your Dental Health

Your dental coverage and benefits are an important part of your overall well-being. In addition to the dental care you receive from your provider and the services available from Dental Health Services, you are the most important part of your dental health. Although it sounds simple, proper brushing and flossing and good nutrition are still the most important factors for a lifetime of healthy teeth.

About Dental Health Services

Dental Health Services of America was founded by Dr. Godfrey Pernell in 1974 under the guiding principles of Quality Service, Prevention and Savings. These three principles make it possible for Dental Health Services to offer a unique combination of quality and affordable dental care through a coordinated network of independent dentists. Your Dental Health Services plan is committed to low cost, high quality preventive dental care in order to maintain optimal health and avoid painful and major dental problems in the future.

A Great Reason to Smile™

Dental Health Services
936 N. 34th St., Ste. 208
Seattle, WA 98103
800.63.SMILE (800.637.6453)
206.633.2300
www.dentalhealthservices.com

WA-192