Questions & Answers

Dental Health Services

A Great Reason to Smile[sm]

Mission Statement

Consistently deliver high quality, affordable, value-driven dental service through a caring staff and an accountable provider network committed to member satisfaction.

Welcome to Dental Health Services

You are eligible for membership in a Dental Health Services Plan with your group. You now have an affordable, quality alternative to high dental costs and traditional insurance policies.

The following pages contain answers to your most commonly asked questions and specific benefit information for your Dental Health Services group plan. To help you get the most of your coverage, we provided a glossary of dental health and insurance terms, and other information related to your plan. This is just one of many resources available to you from Dental Health Services.

Dental Health Services looks forward to serving you for many years to come!

Your group dental plan features:

- Low copayments
- Quality network of independent dental offices
- Fully disclosed coverages and exact copayments
- Pre-existing condition coverage
- No deductibles, claim forms, or waiting periods
- Orthodontic coverage

It's easy to join today!

1. Select a participating dentist from our *Directory of Participating Dentists,* and indicate your choice on your Enrollment Form.
2. Complete the Enrollment Form and submit to your benefits administrator.
3. Upon your eligibility date, schedule an appointment with your selected dentist and protect your smile.

We encourage you to see your dentist on a regular basis. The broad range of services covered - emphasizing preventive care and long-term dental health - will protect the dental and financial health of you and your family.

We're here to serve you!

The more you know about your dental coverage, the healthier you and your family will be! Visit us online at www.dentalhealthservices.com for ToothTips, an expanded glossary, dentist directory profiles, and Questions & Answers.

Call your Member Services Specialist at 800-637-6453 for valuable plan and oral health information. We are always happy to assist you and answer your questions!

Questions & Answers

What should I know about my group's Dental Health Services dental plan?

Dental Health Services dental plans include independent, privately owned neighborhood dental offices that deliver high quality dental care to you and your family. You select a conveniently located participating dentist who will assess your oral health and outline your treatment plan. Your care will proceed according to your plan. Most procedures require a copayment as outlined in your Schedule of Benefits & Copayments.

What is a copayment?

A copayment is the amount listed in your Schedule of Benefits & Copayments that you pay directly to your participating dentist for specific procedures at the time of service. Services not listed and those specifically excluded are your responsibility. You should discuss all payments and costs with your dental office when making an appointment or prior to starting treatment.

How do I select or change my dentist?

You can choose any of the conveniently located dental offices from your Dental Health Services Directory of Participating Dentists. All dental care must be rendered by your selected dentist, except in the case of an out-of-area emergency. You may change your dentist by contacting your Member Service Specialist at 800-637-6453.

Can I still go to my dentist if I don't have my Membership Card?

Yes, although you and your eligible dependents may use your Membership Card, you are not required to have it when you go to the dentist. Dental Health Services dentists have a current roster of eligible members.

Are pre-existing dental conditions covered?

Yes, your plan covers routine pre-existing dental conditions including: dental decay, periodontal conditions, root canals and missing teeth. However, treatment already in progress is not a covered benefit.

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

If you have a serious emergency, please call 911. Otherwise, call your participating dentist at their regular or after-hours phone number.

Does my plan give me emergency coverage while I'm out of town?

Yes, you're always covered with your group's dental plan. You can visit any Dental Health Services dentist and pay a $25 copayment (in addition to any office visit or other charge) for an emergency visit to relieve pain, swelling and/or bleeding (palliative care). If you cannot find a participating dentist in an emergency, you may go to any dentist, and you will be reimbursed up to $50 less your copayment. Send the itemized receipt from the dental office that provided the urgent service with a brief explanation and your subscriber ID number to Dental Health Services within 180 days. You will be reimbursed for the relief of pain and/or bleeding within 30 days following receipt of verification of services ($100 annual maximum benefit).

What if I need to see a specialist?

You must see your selected general dentist first. If your dentist feels a specialist is necessary, and your plan provides specialist coverage, he or she will issue a referral request to Dental Health Services. All referrals for covered specialist services must be pre-authorized. You are responsible for the specialty copayment listed in your Schedule of Covered Services and Copayments. Unlisted services are not covered.

What if I need to see an orthodontist?

Your dentist will help you determine if a referral is appropriate. If you need orthodontic treatment, please contact your Member Service Specialist at 800-637-6453 to receive an orthodontic consultation referral.

What if I have questions or need assistance?

Dental Health Services is committed to helping you and your family get the most out of your dental plan. If you have questions or need assistance, please contact your Member Service Specialist by calling 800-637-6453 or visit our website at www.dentalhealthservices.com.

Glossary

Benefit or Coverage: the specific services that members are entitled to use according to the plan contract

Copayment: the member's treatment cost which is paid directly to the dentist at the time of service

Exclusion: specific treatment for which this policy will not provide benefits

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

Member: any person enrolled on the plan, sometimes referred to as an "enrollee." Members include subscribers and their eligible, enrolled dependents

Prepaid plan: in contrast to indemnity plans and PPOs, prepaid plans pay for a significant part of a member's treatment cost in advance via monthly capitation payments to network dentists, prior to the member receiving care

Preventive treatment: the management and care of a patient to prevent the occurrence of a disease or undesirable condition

Dentist Provider: a licensed professional who provides dental care services to members covered under the plan

Subscriber: a person whose relationship as the primary enrollee is the basis for coverage under the plan

Usual, Customary and Reasonable (UCR) fee: the regular fee charged in a community or area for a specific service

Dental Treatment Plan: These are the procedures recommended by your dental provider. It can range from regular cleanings to fillings, crowns and bridges.

Dental Health Services

A Great Reason to Smile℠

3833 Atlantic Avenue
Long Beach, CA 90807

Member Services: 800-637-6453
www.dentalhealthservices.com