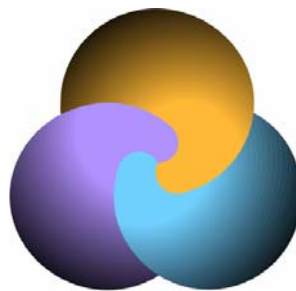


SmartSmilesm

Your Personal Dental Plan



Dental
Health
Services

936 N. 34th St. · Ste. 208 · Seattle · WA · 98103
206.633.2300 · www.dentalhealthservices.com · 800.63.SMILE
FAX 206.624.8755

Questions & Answers

Your SmartSmileSM plan features:

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

How does SmartSmileSM work?

The independent SmartSmileSM dental plan provides 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 dentist. During your first appointment, he or she will assess your oral health and outline your treatment plan. Your care then proceeds according to your plan. Most procedures require a copayment. (Please see your “*Schedule of Covered Services and Copayments*” on pages 4 and 5.)

What is a copayment?

A copayment is the exact amount listed in your “*Schedule of Covered Services and Copayments*” that you pay directly to your participating dentist at the time of service. A \$10.00 office visit copayment is paid each time you visit your dentist.

How do I select a dentist?

SmartSmileSM members may choose any of the conveniently located dental offices. Dental care is rendered by your selected dentist, except for an out-of-area emergency. You may also change your dentist by contacting Dental Health Services.

How do I receive dental care?

Simply telephone your selected dental office and introduce yourself. Tell them you are a member of Dental Health Services’ SmartSmileSM plan and ask for a convenient appointment time. Your dentist receives a membership eligibility list each month so it is not necessary to have your membership card to make an appointment or receive care.

When does my coverage become effective?

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 you enroll after the 20th day of the current month, your coverage will begin on the first day of the second month following your enrollment.

Dental Glossary

Amalgam: a metal alloy used to fill and impede an area of decay on the surface of a tooth.

Bridge: a fixed or removable appliance constructed to replace missing teeth by attachment to other teeth.

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

Crown: a cap secured on a tooth to restore its natural shape. This procedure is used when the enamel of a tooth is damaged by decay or fractured to the point that it cannot be restored successfully with a filling or onlay.

Prophylaxis: cleaning & surface scaling of teeth to remove stains, calculus, and plaque deposits.

Root Canal: a procedure used to remove an infected nerve or pulp tissue within a tooth and fill the chamber with an inert material to stop pain and sustain the life of the tooth. A crown is often needed after a root canal is performed.

Membership Dues

	Monthly	Annually
Subscriber	\$17.75	\$213.00
Subscriber + 1 dependant	\$33.75	\$405.00
Subscriber + 2 dependants	\$43.50	\$522.00
Subscriber + 3 or more dependants	\$53.25	\$639.00

The convenient monthly payment option is available when you pre-authorize a monthly withdrawal from your checking account or credit card. Monthly checking account withdrawals require an initial enrollment payment of two (2) month's premium. The authorization information is on the enrollment form on page 7.

You have ten days after you submit payment to be sure you are completely satisfied. If, within these ten days, you decide to cancel, you may request a full refund. If you later decide to cancel your membership within the first year, you will be subject to a \$50.00 cancellation fee and will receive a pro-rated refund.

Your SmartSmileSM Dental Plan

Schedule of Covered Services and Copayments

SmartSmileSM covers more than 120 services including periodontal, orthodontic, denture and prosthodontic care. The most popular procedures are listed here for your convenience. A complete list including relevant *Limitations and Exclusions* is available upon request. The following procedures and those included on the complete list of Covered Services are available to you when performed by a participating general dentist.

Member ADA#	Service	Copayment
	Office visit charge (per visit)	10.00
DIAGNOSTIC AND PREVENTIVE SERVICES		
150	Comprehensive oral examination	5.00
210	Complete series x-rays Full-mouth x-rays— once every three years or as determined necessary by your dentist.	25.00
1201	Prophylaxis including fluoride - <i>child</i> Prophylaxis (cleaning) — maximum of two per contract year.	20.00
1205	Prophylaxis including fluoride - <i>adult</i> Prophylaxis (cleaning) — maximum of two per contract year.	25.00
1351	Sealant - per tooth	10.00
BASIC/RESTORATION SERVICES		
Amalgam restorations, permanent teeth:		
2140	Cavities involving one tooth surface	42.00
2161	Cavities involving four or more tooth surfaces	72.00
Composite fillings, (anterior):		
2330	Composite resin - one tooth surface	62.00
2335	Composite resin - four tooth surfaces including incisal angle	95.00
Root canals:		
3310	Anterior (excluding final restoration)	300.00
3320	Bicuspid (excluding final restoration)	355.00
3330	Molar (excluding final restoration)	590.00
Periodontics:		
4341	Perio scaling - per quadrant	85.00
Extractions:		
7140	Extraction, erupted tooth or exposed root	60.00
7210	Surgical extraction	135.00

MAJOR PROCEDURES

Inlays/Onlays:

**Patient is responsible for the cost of any laboratory charges*

2630	*Inlay - porcelain - three or more surfaces	390.00
2644	*Onlay - porcelain - four or more surfaces	390.00

Crowns:

**Patient is responsible for the cost of any laboratory charges*

2740	*Porcelain crown	400.00
2750	*Porcelain with precious metal	400.00
2751	*Porcelain with non-precious metal	400.00
2752	*Porcelain with semi-precious metal	400.00

Periodontal Surgery

4210	Gingivectomy or gingivoplasty, per quad	225.00
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Dentures:

(When performed by your general dentist)

5110	*Complete upper denture	425.00
5120	*Complete lower denture	425.00
5213	*Partial upper denture with chrome clasps	500.00
5214	*Partial lower denture with chrome clasps	500.00
5740/41	Office reline	125.00

Bridges:

**Patient is responsible for the cost of any laboratory charges*

6240	*Pontic porcelain fused to high noble metal	400.00
6750	*Crown-porcelain fused to high noble metal	400.00
6790	*Crown-full cast high noble metal	400.00

Oral surgery:

7220	Removal of impacted tooth - soft tissue	150.00
7230	Removal of impacted tooth - partially bony	180.00
7240	Removal of impacted tooth - completely bony	215.00

***Orthodontics:**

**Orthodontia is available only in those areas where Dental Health Services has contracted with an orthodontist.*

Consultation	40.00
(paid by enrollee and credited to banding if treatment commences)	
Child/Adult Conventional comprehensive treatment* (excluding x-rays and models)	3377.00
Retention-functional applicant (after orthodontic treatment)	315.00
<i>*Additional charges apply for more extensive treatment</i>	

Others:

No show appointment without 24 hour advance notice	40.00
9310 Second Opinion	20.00
9440 Emergency treatment after office hours	40.00
9940 *Occlusal guard, by report	175.00

**Patient is responsible for the cost of any laboratory charges*

Cosmetic services (e.g. veneers, bonding) will be offered at a 15% discount.

See Your Savings with SmartSmileSM

Examples of savings from six services.

ADA Code	Procedure	Regular Fee*	Your Copayment*	Your Savings*
I20	Periodic Oral Evaluation	\$42.00	\$2.00	\$40.00
I110	Prophylaxis (Cleaning)	\$106.00	\$20.00	\$86.00
210	Complete Series X-rays	\$131.00	\$25.00	\$106.00
2150	2-Surface Amalgam Filling	\$206.00	\$47.00	\$159.00
3310	Root Canal - Anterior Tooth	\$469.00	\$300.00	\$169.00
2750**	Porcelain Crown	\$1011.00	\$400.00	\$611.00
Total:		\$1965.00	\$794.00	\$1171.00

PLUS, Cosmetic Services (e.g. veneers, bonding) will be offered at a 15% discount.

* Regular fees are the averages of the 80th percentile of usual and customary fees charged for each service, based on a 2005 dental fee analysis by Ingenix. Savings may vary based on actual dental services needed. We encourage you to contact your current dentist for a fee comparison. ** Patient is responsible for the cost of any laboratory charges.

It's easy to join SmartSmileSM today!

1. Select a participating dentist from the Directory of Participating Dentists and indicate your choice on the enrollment form. Contact us at 800.248.8108 for the most current Directory of Participating Dentists or search for a dentist online at www.dentalhealthservices.com.
2. Complete the enrollment form on page 7.
3. Select ONE of the four methods of payment listed on your enrollment form and include your check, money order, or credit card number.
4. Mail the enrollment form and your payment to 936 N. 34th Street, Suite 208, Seattle, WA 98103. If paying by credit card you may choose to fax the form to 206.624.8755.

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.

SmartSmileSM Enrollment Form

First Name	Last	M.I.	Social Security Number
Address	City	State	Zip Code
Home Phone #	Work Phone #	E-mail Address	Birthdate

Dentist # - Found to the left of the dentist's name on the enclosed directory **Requested Effective Date** - Enroll by the 20th of one month to be eligible for the first of the following month.

Sex	Why did you decide to enroll?	Where did you hear of us?
<input type="checkbox"/> Male	<input type="checkbox"/> Need immediate care	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Female	<input type="checkbox"/> Cost effectiveness	<input type="checkbox"/> Insurance Commissioner
Marital Status	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Friend or relative
<input type="checkbox"/> Single	<input type="checkbox"/> No employer benefits	<input type="checkbox"/> Broker or agent
<input type="checkbox"/> Married	<input type="checkbox"/> Retired	<input type="checkbox"/> Dentist
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

For Office Use Only		
	A M	IDP
Effective Date	Cycle	Group #
I	SCHD2i	
P/S #	Plan	I.A. #
Agent Name	Agent#	

Dependants to be covered*:

Last Name (if different)	First Name	M.I.	Sex M F	Child or Spouse	Birthdate
1					
2					
3					
4					
5					
6					

I authorize my dentist to release any information regarding my patient history to Dental Health Services, consulting professional or other entity designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am over 18 years of age.

* Dependants include your spouse, domestic partner, and /or unmarried children who are under 19 years of age. 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 development disability or physical handicap, and (2) is chiefly dependent upon the subscriber for support and maintenance.

Please select ONE of the four following payment options:

- 1. Check or money order - annual payment
- 2. Automatic checking withdrawal - monthly payments
- 3. Credit card - annual payment
- 4. Credit Card - automatic monthly payments
 - Visa MasterCard Discover Card

_____ _____
Credit card number Expiration date

_____ _____
\$ amount (annual or monthly) 3 digit security code

_____ _____
Signature Date

Annual payments (option 1 or option 3): Your account will be charged the full annual amount. You will receive written notification before your policy expires, allowing you to renew for another year.

Monthly payments (option 2 or option 4): You authorize Dental Health Services to withdraw the monthly premium from your account on a recurring basis. This authorization will remain in effect for a minimum of one year and will renew automatically unless written notice is received by Dental Health Services.

The first monthly deduction will include a security deposit in the amount of one month's premium, to be used for your last month's coverage in the event you decide to cancel, or in the event that automatic withdrawal is unavailable for any reason. Your account will be charged the first week of every month, beginning with the first month you are eligible for services.

Annual Premium	
Subscriber	\$213.00
Subscriber + 1 dependant	\$405.00
Subscriber + 2 dependants	\$522.00
Subscriber + 3 or more dependants	\$639.00

Monthly Premium	
(Requires an initial 2-month payment)	
Subscriber	\$17.75
Subscriber + 1 dependant	\$33.75
Subscriber + 2 dependants	\$43.50
Subscriber + 3 or more dependants	\$53.25