

Delta Dental Premier®



**Washington Dental Service
Program No. 00496 (Buy-Up)
Union Employees & Their Families**

Effective January 1, 2009

Questions Regarding Your Program

If you have questions regarding your dental benefits program, you may call:

Washington Dental Service Customer Service

(206) 522-2300

(800) 554-1907

Written inquiries may be sent to:

Washington Dental Service
Customer Service Department
P.O. Box 75983
Seattle, WA 98175-0983

You can also reach us through Internet e-mail at info@DeltaDentalWA.com.

For the most current listing of Washington Dental Service participating dentists, visit our online directory at www.DeltaDentalWA.com.

Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

Communications with Washington Dental Service for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with Washington Dental Service through specially trained communications assistants.

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) or 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial Washington Dental Service Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the WDS customer service representative.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

MySmile[®] Personal Benefits Center

Washington Dental Service is proud to present the MySmile[®] personal benefits center, a unique online tool that provides personalized strategies for improving your oral health and that of your family members. Here are examples of what MySmile can do for you:

- Allows you to check your plan coverage and eligible benefits
- Lets you search for a dentist near your home or work place
- Lets you check the status of current claims and view previous payments
- Provides access to printable ID cards
- Provides personalized ways you can improve your oral health

For more about MySmile, visit our Web site at www.DeltaDentalWA.com/MySmile

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Summary of Benefits

Reimbursement Levels for Allowable Benefits

Class I	70%-100%
Class II	70%-100%
Class III - Restorative.....	Constant 80%
Class III - Prosthodontics	Constant 50%
Orthodontic procedures.....	Constant 50%

Plan Maximums

Annual Program Maximum per Person	\$2,000
Lifetime Orthodontic Benefits per Person	\$2,000

Benefit Period

Most dental benefits are calculated within a “benefit period,” which is typically for one year. For this program, the benefit period is the 12-month period starting January 1 and ending December 31.

All covered employees and covered dependents are eligible for Class I, Class II, Class III covered dental benefits, orthodontic benefits and dental accident benefits.

Introduction

Welcome to the Delta Dental Premier plan, which is administered by Washington Dental Service (WDS), the state’s largest and most experienced dental benefits carrier. WDS is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from Washington Dental Service, you join more than 50 million people across the nation who have discovered the value of our coverage.

This booklet sets forth in summary form an explanation of the coverage available under your dental program. The contract is on file with your employer.

How to Use Your Program

The best way to take full advantage of your dental plan is to understand its features. You can do this most easily by reading this benefits booklet *before* you go to the dentist. The booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this booklet does not answer all of your questions, or if you do not understand something, call a Washington Dental Service customer service representative at (206) 522-2300 or (800) 554-1907. *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

Choosing a Dentist

With Washington Dental Service, you may select any licensed dentist; however, your benefits may be paid at a higher level and your out-of-pocket expenses may be paid at a lower level if you choose a participating WDS dentist. Tell your dentist that you are covered by a Washington Dental Service dental plan and provide your member identification number, the program name and the group number — which is **00496 (Buy-Up)**.

Delta Dental Participating Dentists

If you select a dentist who is a Washington Dental Service participating provider, that dentist has agreed to provide treatment for eligible persons covered by WDS programs according to the provisions of his or her participating dentist contract. You will not have to hassle with sending in claim forms. Participating dentists complete claim forms and submit them directly to WDS. They receive payment directly from WDS. You will not be charged more than the participating dentist's approved fee or the fee that the WDS dentist has filed with us. You will be responsible only for stated coinsurances (see Coinsurance), deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered benefits.

Nonparticipating Dentists in Washington State

If you select a dentist who is not a Washington Dental Service participating dentist, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You can also download claim forms from our Web site at www.DeltaDentalWA.com. It is up to you to ensure that the claim is sent to WDS. Payment for services performed by a nonparticipating dentist will be based on actual charges or WDS's maximum allowable fees for nonparticipating dentists, whichever is less. You will be responsible for any balance remaining. Please be aware that Washington Dental Service has no control over nonparticipating dentists' charges or billing practices.

Out-of-State Dentists

If you receive treatment from a dentist outside Washington state, you are responsible for having the dentist complete and sign a claim form. It is also up to you to ensure that the claim is sent to Washington Dental Service. Payment will be based upon actual charges or WDS's maximum allowable fees for participating dentists, whichever is less.

Claim Forms

American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our Web site at www.DeltaDentalWA.com. Washington Dental Service/Delta Dental is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than six months after the date the treatment is provided. For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.

Predetermination of Benefits

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, sometimes called a "predetermination of benefits." This will allow you to know in advance what procedures may be covered, the amount Washington Dental Service may pay and your expected financial responsibility. A predetermination is not a guarantee of payment.

Reimbursement Levels

Your program is an incentive plan. It is designed to encourage prevention by increasing from one benefit period to the next the amount paid by Washington Dental Service for preventive care and regular visits. An incentive period covers 12 consecutive calendar months. The first incentive period starts on the first day of the month that an eligible person uses dental services. Subsequent incentive periods are based on that date.

Your incentive dental plan offers three classes of covered treatment. Each class has specific limitations and exclusions.

Reimbursement Levels for Class I and Class II Procedures

During the first incentive period, the payment level for covered and allowable Class I (diagnostic and preventive) and Class II (basic) procedures is 70 percent. This payment level increases 10 percentage points each successive incentive period in which an eligible person obtains dental treatment covered by this program. The payment level increases to a maximum of 100 percent.

You must visit the dentist at least once during each annual incentive period in order to increase — or maintain — your payment level. If an eligible person fails to utilize benefits during an incentive period, the payment level will not be decreased by 10 percentage points for each incentive period during which benefits are not used, but will remain constant until benefits are again utilized and the incentive period increases 10 percentage points up to a maximum of 100 percent.

Each eligible person establishes his or her own payment levels through utilization during incentive periods.

Reimbursement Levels for Class III Procedures

The payment level for covered and allowable Class III Restorative procedures is 80 percent. The payment level for covered and allowable Class III Prosthodontics procedures is 50 percent. The incentive provision described above does not apply to Class III procedures.

Reimbursement Levels for Orthodontic Procedures

The payment level for covered and allowable Orthodontic procedures is 50 percent. The incentive provision described above does not apply to Orthodontic procedures.

See "Benefits Covered by Your Program" for specific Class I, Class II and Class III covered dental benefits under this program.

Limitations and Exclusions

Dental plans typically include limitations and exclusions, meaning that the plans do not cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this booklet under the sections called "Benefits Covered by Your Program", "General Limitations" and "General Exclusions." They warrant careful reading.

Coinsurance

Washington Dental Service will pay a predetermined percentage of the cost of your treatment (see Reimbursement Levels for Allowable Benefits under the Summary of Benefits) and you are responsible for paying the balance. What you pay is called the coinsurance.

Program Maximum

For your program, the maximum amount payable by Washington Dental Service/Delta Dental for Class I, II and III covered dental benefits per eligible person is \$2,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

The lifetime maximum amount payable by Washington Dental Service/Delta Dental for orthodontic benefits is \$2,000 per eligible person.

Employee Eligibility and Termination

Eligible employees are all regular represented employees working a minimum of 20 hours per week for whom employer contributions are made.

- Any time the employee is off work but is compensated for any portion of the month. This would include full or partial paid leave.
- Up to six months if an employee is in an approved unpaid status if the City has elected to continue the benefit and this election is applied on a consistent basis to similar unpaid leaves. Unpaid FMLA leave and 'six months in an unpaid status' would not be combined to equal a period of greater than six months.

New employees are eligible on the first day of the calendar month following date of hire.

You must complete an enrollment form. WDS must receive a completed enrollment form within 31 days of employee's eligibility date. If the enrollment form is not received within 31 days, enrollment will not be accepted until the next open enrollment period. All of your eligible dependents must be listed on the enrollment form.

Coverage terminates at the end of the month in which you cease to be an eligible employee.

In the event of a suspension or termination of compensation directly or indirectly as a result of a strike, lockout, or other labor dispute, an eligible employee may pay the applicable premium directly to the employer for a period not to exceed six months. Payment of premiums must be made when due, or WDS may terminate the coverage.

The Federal Family and Medical Leave Act ("FMLA") became effective August 5, 1993. The benefits under your Washington Dental Service dental program may be continued provided you are eligible for FMLA and you are on a leave of absence that meets the FMLA criteria. For further information, contact your employer.

An employee shall continue to be eligible during the time this plan is in effect as long as the employee remains an Eligible Employee as defined above or as follows:

- The employee qualifies as an "active" employee of the City of Vancouver.; or
- The employee is on authorized leave under the Family and Medical Leave Act (FMLA). If the employee elects not to remain enrolled during the leave, they will be eligible to be reenrolled under the contract on the date they return from the FMLA leave.; or

- For a 12-month period beginning on the date that an employee no longer qualifies as “active” and continues to be on an approved leave-of-absence due to an on-the-job injury if the medical prognosis is for them to return to work in an active status within one year. The employee may continue coverage as an active employee for up to 12 months. If an employee remains covered as an active employee and is unable to return to work after 12 months, they can continue coverage under the “Continuation of Coverage” provision, however the last six months of leave of absence coverage will be counted toward the period of time allowed under COBRA continuation.; or
- Up to six months if an employee is on an approved leave of absence due to their own non-work related illness or injury if the intention is for the employee to return to work in an active status within that time period.

Dependent Eligibility and Termination

If dependent coverage is included in the program, eligible dependents are your lawful spouse or domestic partner for whom Group has received a Declaration of Domestic Partnership and unmarried children, including biological children, stepchildren, foster children and adopted children. Unmarried children of covered domestic partners must reside in your household and/or be dependent upon you for full or partial support.

Unmarried children are covered from birth to age 25.

Domestic Partner is defined as follows:

- 1 Share a common residence;
- 2 Are each 18 years of age or older;
- 3 Not married to another party and are each others sole domestic partner;
- 4 Are capable of consenting to this domestic partnership; and
- 5 Both of the following are true
 - Are not nearer of kin to each other than second cousins, whether of whole or half blood computing by the rules of civil law; and
 - Neither of is a sibling, child, grandchild, aunt, uncle nice, nephew to the other person.

Following termination of a domestic partnership a statement of termination must be filed with Group's Human Resources Department within 31 days of termination. Termination of domestic partnership includes:

- 1 Death of a partner
- 2 Death of the Eligible Employee, or
- 3 A change in one or more of the qualifying conditions as noted in the Eligibility section.

Coverage for an unmarried dependent child over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self sustaining employment by reasons of developmental disability or physical handicap and 2) chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity and dependency is furnished to WDS within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age.

A new family member, with the exception of newborns and adopted children, must be enrolled within 31 days following the date he or she qualifies as an eligible dependent.

A newborn shall be covered from and after the moment of birth, and an adopted child shall be covered from the date of placement for the purpose of adoption, provided that if this program requires payment of an additional monthly premium for coverage of such child, enrollment of the newborn or adopted child and payment to Washington Dental Service of all applicable premiums is completed within 90 days after the date of birth or placement to assure coverage.

Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of such infant children from the moment of birth. If no additional premium is required, Washington Dental Service requests completion of the enrollment process for the newborn or adopted child within 90 days after the date of birth or placement. Coverage will be provided in any event.

To enroll a newborn or adopted child, a parent must complete a new enrollment form provided by Washington Dental Service. If an additional premium for coverage is required and enrollment and payment is not completed for a newborn or adopted child within said 90 days, such child may be enrolled coincident with any renewal or extension of the Contract.

A child will be considered an eligible dependent as an adopted child if the following conditions are met: 1) the child has been placed with the eligible employee for the purpose of adoption under the laws of the state in which the employee resides; and 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. Notification of placement of a child for adoption and payment of any additional required monthly premiums must be furnished to Washington Dental Service within 90 days from the date of placement.

A newly acquired spouse or domestic partner and any additional children acquired by marriage or domestic partnership must be enrolled within 31 days following the date of marriage or domestic partnership. Coverage will begin the first of the month following the date of marriage or domestic partnership.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If parent is not enrolled in dental benefits, he/she must enroll for coverage for himself/herself and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. A custodial parent, a state agency or an alternate recipient may enroll a dependent child under the terms of a valid QMCSO. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Dependent coverage terminates at the end of the month in which the parent's coverage terminates, or the dependent ceases to be eligible, whichever occurs first.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, WDS shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this plan. Please call WDS customer service to see if your procedure qualifies for this extension.

Special Enrollment Periods

Special enrollments may occur when an eligible person with other dental coverage loses that coverage or if an eligible person becomes a new dependent through marriage, birth, adoption or placement for adoption, or a current plan's lifetime maximum benefits have been met. If a triggering event is a birth, adoption or placement for adoption, the child, the employee, and the employee's spouse are entitled to special enrollment — either individually or in any combination.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance broker, agent or individual may be committing insurance fraud, please contact the Washington Dental Service hotline for Fraud & Abuse at (800) 211-0359 or (206) 985-5927. You may also want to alert any of the appropriate law enforcement authorities listed below:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at 1 (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to www.insurance.wa.gov for more information.

Continuation of Coverage — “COBRA”

Federal Health Benefit Continuation Provision Applicable To The City Of Vancouver And Participating Agencies Group Dental Plan, (Part Of The Consolidated Omnibus Budget Reconciliation Act Of 1986 Known As “Cobra”. Public Law 99-272, And As Amended By Public Law 104-191) For Those Employees Not Represented By A Collective Bargaining Agreement, Cobra Is Effective As Of February 1, 1987. For Those Employees Represented By A Collective Bargaining Agreement, Cobra Is Effective January 1, 1989. In The Event Of Any Conflict Between This Continuation Of Health Care Provision And Cobra, Cobra Shall Govern.

An employee (and his/her family members) employed by an employer affected by the above law, should be aware of the following terms, conditions and limitations of this law as it applies to temporary continuation of group dental coverage upon the occurrence of certain qualifying events.

An employee of an employer covered by the City of Vancouver and Participating Agencies Group Dental Plan, has a right to choose this continuation coverage if group dental coverage is lost because of a reduction in hours of employment or the termination of employment for reasons other than gross misconduct on the part of the employee.

The spouse/domestic partner of an employee covered by the City of Vancouver and Participating Agencies Group Dental Plan, has the right to choose continuation coverage for himself or herself if group dental coverage under the City of Vancouver and Participating Agencies Group Dental Plan is lost for any of the following four reasons:

- (1) The death of his or her spouse/domestic partner;
- (2) A termination of the spouse/domestic partner's employment (for reasons other than gross misconduct) or reduction in the spouse/domestic partner's hours of employment;
- (3) Divorce or legal separation from the spouse; or termination of domestic partnership
- (4) The spouse/domestic partner becomes entitled to Medicare.

In the case of a child of an employee covered by the City of Vancouver and Participating Agencies Group Dental Plan, he or she has the right to choose continuation coverage if group dental coverage under the City of Vancouver and Participating Agencies Group Dental Plan is lost for any of the following five reasons:

- (1) The death of a parent;
- (2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with his or her employer;
- (3) Parent's divorce or legal separation or termination of domestic partnership;
- (4) A parent becomes entitled to Medicare, or
- (5) A child ceases to be an "eligible dependent" under the City of Vancouver and Participating Agencies Group Dental Plan.

Under the law, the employee or a family member has the responsibility to inform the plan administrator in writing of a divorce, legal separation, or a child losing dependent status under the City of Vancouver and Participating Agencies Group Dental Plan within 60 days of the qualifying event, or the date coverage would cease under the plan, whichever is later.

When the plan administrator is notified that one of these events has occurred, the plan administrator will in turn notify the employee or dependent of his or her right to choose continuation coverage. Under the law, the employee or dependent has up to 60 days from the date he or she would lose coverage because of one of the events described above or 60 days from the date the employee or dependent was notified of eligibility for continuation of coverage, whichever is later, to inform the plan administrator in writing that continuation coverage has been chosen.

If continuation coverage is not chosen, the group dental coverage will end as it normally would under the terms of the plan.

Covered employees are eligible to continue coverage for 18 months when coverage is lost due to termination of employment (other than for gross misconduct) or reduction in hours.

Dependents are eligible to continue coverage for 18 months when coverage is lost due to the employees termination of employment (other than for gross misconduct) or reduction of hours. Continuation of coverage is available to dependents for up to 36 months for other qualifying events.

If the covered employee has a child or adopts a child during the period of COBRA coverage, such employee may elect to cover that child.

Disabled beneficiaries, who are determined to be disabled by the Social Security Administration during his or her 18-month period of continuation or at the time of termination or reduction in hours and so notifies the plan administrator within 60 days of the determination and within the 18-month period, he or she may extend continuation for up to 29 months from the date continuation began or until it is determined there is no longer a disability.

In the case of multiple qualifying events (a qualifying event followed by one or more qualifying events) the dependent shall, upon proper notice to the plan administrator of the succeeding qualifying event, continue coverage for up to 36 months from the date the original continuation began. However, effective January 1, 1990, in the case of an active insured employee, with insured dependent(s), who becomes entitled to Medicare, the insured dependent(s) for any subsequent qualifying event such as the employee's termination of employment, death or divorce, may be eligible for continuation until the later of 36 months from the date of Medicare entitlement or 18 months from the date of termination of employment or reduction in hours.

You or your eligible dependents are responsible for the full cost of contribution. Premium for continuation coverage is due within 30 days of the group's premium due date. The only exception is the premium payment for the period preceding the election which may be up to 45 days from the date of the election and must include the retroactive premium amount from the COBRA effective date up through the current month of eligibility.

Continuation coverage may be ended according to the law for any of the following reasons:

- (1) The employer no longer provides group dental coverage to any of its employees;

- (2) The premium for continuation coverage is not paid, or not paid on time, as provided by law;
- (3) The employee/dependent becomes covered under another group dental plan; except as explained below regarding pre-existing conditions;
- (4) The person on COBRA becomes entitled to Medicare; or
- (5) The applicable period of continuation ends.

Generally, COBRA participants lose coverage when they become eligible under another group plan. However, if the new plan has pre-existing limitations or exclusions, affected individuals may continue coverage under the former plan until the pre-existing condition(s) is no longer limited or the continuation coverage period ends, whichever occurs first.

Coordination of Benefits

If an eligible person is entitled to benefits under two or more group dental plans, the amount payable under this plan will be coordinated with any other plan. The amount paid by WDS, together with amounts from other group programs, will not exceed the total of the highest allowable dental expenses incurred.

The following rules establish the order of benefit payments:

- a. The benefits of the plan that does not have a coordination of benefits (COB) provision will be primary (the plan whose benefits are determined first).
- b. The benefits of the plan that covers the person as an employee, member, policyholder, subscriber or retiree will be determined before the benefits of a plan that covers the person as a dependent.
- c. If the person is a child whose parents are not separated or divorced:

The benefits of the plan covering the parent whose month and day of birth occurs earlier in the calendar year will be determined before the benefits of the plan of the parent whose month and day of birth occurs later in the calendar year. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.
- d. If the person is a child of parents who are separated or divorced or not living together, whether or not they have ever been married, if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, then the benefits are determined in the following order:
 - 1) The plan covering the custodial parent, first;
 - 2) The plan covering the spouse of the custodial parent, second;
 - 3) The plan covering the non-custodial parent, third; and
 - 4) The plan covering the spouse of the non-custodial parent, last.
- e. If a court decrees that one parent has financial or health care expenses or health care coverage responsibility, that plan is primary.
- f. The plan covering the person as a retired or laid-off employee or dependent of such person will be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person. This provision will not apply if neither plan has a provision regarding laid-off or retired employees that results in each plan determining its benefits after the other.
- g. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan.

h. If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

If you are covered by more than one health plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

If payments that should have been made under this plan are made by another plan, WDS has the right, at its discretion, to remit to the other plan the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under this plan.

In the event WDS makes payments in excess of the maximum amount, WDS shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

Benefits Covered By Your Program

The following are the Class I, Class II and Class III covered dental benefits under this program that are subject to the limitations and exclusions contained in this booklet. Such benefits (*as defined*) are available only when provided by a licensed dentist or other Washington Dental Service-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and Washington Dental Service.

The amounts payable by Washington Dental Service for Class I, II and III covered dental benefits are described elsewhere in this booklet.

Class I

Diagnostic

Covered Dental Benefits

- Routine examination (periodic oral evaluation).
- Comprehensive oral evaluation.
- X-rays.
- Emergency examination.
- Specialist examination performed by a specialist in an American Dental Association-recognized specialty.
- WDS-approved periodontal susceptibility/risk tests.

Limitations

- Routine examination is covered twice in a benefit period.
- Comprehensive oral evaluation is covered once in a three-year period as one of the two covered examinations in a benefit period per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a Delta Dental participating dentist.
- Complete series (any number or combination of intraoral X-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex X-rays are covered once in a five-year period from the date of service.
- Supplementary bitewing X-rays are covered once in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits.

Exclusions

- Consultations or elective second opinions.
- Caries susceptibility/risk tests.
- Study models.

Preventive

Covered Dental Benefits

- Prophylaxis (cleaning).
- Periodontal maintenance.
- Fissure sealants.
- Topical application of fluoride or preventive therapies, e.g. fluoridated varnishes
- Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations

- Prophylaxis and/or periodontal maintenance procedures will be limited to two procedures in a benefit period.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) may be covered up to a total of four times in a benefit period.

Note: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.*

- Topical application of fluoride or preventive therapies (*but not both*) is covered twice in a benefit period.
- Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once in a two-year period per tooth from the date of service.
- Replacement of a space maintainer previously paid for by Washington Dental Service is not a paid covered benefit.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits).
- Cleaning of a prosthetic appliance.

Periodontics

Covered Dental Benefits

- Prescription strength fluoride toothpaste.
- Antimicrobial mouth rinse.

Limitations

- Prescription strength fluoride toothpaste and antimicrobial mouth rinse are a covered benefit following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's Washington Dental Service history must show a periodontal procedure within the previous 180 days.
- Antimicrobial mouth rinse is covered once per periodontal treatment.
- Antimicrobial mouth rinse is available for women during pregnancy without any periodontal procedure.

****Refer also to General Limitations and General Exclusions****

Class II

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins*

General Anesthesia

Covered Dental Benefits

- General anesthesia when administered by a licensed dentist or other Washington Dental Service-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by Washington Dental Service, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III and Orthodontic covered dental procedures.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- General anesthesia for routine post-operative procedures is not a paid covered benefit.

Intravenous Sedation

Covered Dental Benefits

- Intravenous sedation when administered by a licensed dentist or other Washington Dental Service-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by Washington Dental Service.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- Intravenous sedation for routine post-operative procedures is not a paid covered benefit.

Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain.

Restorative

Covered Dental Benefits

- Amalgam restorations (fillings) and, in anterior teeth, resin-based composite or glass ionomer restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).
- Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspid.
- Stainless steel crowns.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspid as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Stainless steel crowns are covered once in a two-year period from the seat date.
- *Refer to Class III Restorative if teeth are restored with crowns, veneers, inlays or onlays.*

Exclusions

- Overhang removal, copings, re-contouring or polishing of restoration.

Oral Surgery

Covered Dental Benefits

- Removal of teeth.
- Preparation of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic injuries of the mouth.
- *Refer to Class II General Anesthesia or Intravenous Sedation for information.*

Exclusions

- Bone replacement graft for ridge preservation.
- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- Tooth transplants.
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth are a covered benefit. Services covered include periodontal scaling/root planing and periodontal surgery.
- Limited adjustments to occlusion (eight teeth or fewer).
- Washington Dental Service-approved localized delivery of antimicrobial agents.
- *Refer to Class I Preventive for periodontal maintenance benefits.*
- *Refer to Class III Periodontics for occlusal equilibration and occlusal guard.*

Note: *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.*

Limitations

- Periodontal scaling/root planing is covered once in a three-year period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
- Soft tissue grafts (per site) are covered once in a three-year period from the date of service.

- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Localized delivery of antimicrobial agents approved by Washington Dental Service is a covered benefit under certain conditions of oral health. Localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Localized delivery of antimicrobial agents is not a paid covered benefit when used for the purpose of maintaining non-covered dental procedures.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

- Periodontal splinting.
- Gingival curettage.

Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment.
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.
- *Refer to Class III Prosthodontics for root canals placed in conjunction with a prosthetic appliance.*

Exclusions

- Bleaching of teeth.

****Refer also to General Limitations and General Exclusions****

Class III

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins*

Periodontics

Covered Dental Benefits

- Under certain conditions of oral health, services covered are occlusal guard (nightguard), repair and relines of occlusal guard and complete occlusal equilibration.

Note: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.*

Limitations

- Occlusal guard (nightguard) is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Restorative

Covered Dental Benefits

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays (whether they are gold, porcelain, Washington Dental Service-approved gold substitute castings [except laboratory processed resin] or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin-based composites.
- Crown buildups, subject to limitations.
- Post and core, subject to limitations.

Limitations

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a seven-year period from the seat date.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspid as noted above), it will be considered as a cosmetic procedure, and an amalgam allowance will be made. Any difference in cost will be the responsibility of the patient.
- Washington Dental Service will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration – with limitations), onlay, veneer or crown.
- Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.
- Inlays (as a single tooth restoration) will be considered as a cosmetic procedure and an amalgam allowance will be made. Any difference in cost will be the responsibility of the patient.
- Crown buildups are a covered benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- Crown buildups are covered once in a seven-year period from the date of service.
- Crown buildups are not a paid covered benefit within two years from the date of service of a restoration on the same tooth.
- Crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a paid covered benefit.
- Post and core are covered once in a seven-year period on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.

- Crowns or onlays are not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a paid covered benefit.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

- Copings.

Prosthodontics

Covered Dental Benefits

- Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device.
- Surgical placement or removal of implants or attachments to implants.

Limitations

- Replacement of an existing prosthetic device is covered only once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered benefit on the same teeth once in a seven-year period from the delivery date only when used as an abutment for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Replacement of implants and superstructures is covered only after seven years from the delivery date have elapsed from any prior provision of the implant.
- Crowns in conjunction with overdentures are not a paid covered benefit.
- **Full, immediate and overdentures** — Washington Dental Service will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- **Temporary/interim dentures** — Washington Dental Service will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level.
- **Partial dentures** — If a more elaborate or precision device is used to restore the case, Washington Dental Service will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (*but not both*) will be covered once in a 12-month period.

Exclusions

- Duplicate dentures.
- Personalized dentures.
- Cleaning of prosthetic appliances.
- Copings.

****Refer also to General Limitations and General Exclusions****

Orthodontic Benefits for Adults and Eligible Children

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable by Washington Dental Service for orthodontic benefits provided to an eligible person shall be \$2,000. Not more than \$1,000 of the maximum, or one-half of Washington Dental Service's total responsibility shall be payable for treatment during the "construction phase". The final payment of Washington Dental Service's responsibility shall be made during the seventh month following the construction phase, providing the employee is eligible and the dependent is in compliance with the age limitation.

Washington Dental Service will pay a constant 50 percent of the lesser of the Maximum Allowable Fees or the fees actually charged for orthodontic benefits.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, Washington Dental Service prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the secondary payment of benefits, the secondary payment is not covered.

Covered Dental Benefits

- Treatment of malalignment of teeth and/or jaws. Orthodontic records: exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

- Payment is limited to:
 - Completion, or through limiting age (refer to Dependent Eligibility and Termination), whichever occurs first.
 - Treatment received after coverage begins, claims must be submitted to WDS within the time limitation (see Claim Forms section). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- Treatment that began prior to the start of coverage will be prorated:
 - Payment is made based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted.
 - WDS will issue payments based on our responsibility for the length of the treatment. The payments are issued providing the employee is eligible and the dependent is in compliance with the age limitation.
- In the event of termination of the treatment plan prior to completion of the case or termination of this program, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

- Charges for replacement or repair of an appliance.
- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by Washington Dental Service.

****Refer also to General Limitations and General Exclusions****

General Limitations

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.
3. General anesthesia/intravenous (deep) sedation is not a paid covered benefit, except as specified by Washington Dental Service for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a paid covered benefit except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

General Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
2. Application of desensitizing agents.
3. Experimental services or supplies, which include:
 - a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, Washington Dental Service, in conjunction with the American Dental Association, will consider them if:
 - i) The services are in general use in the dental community in the state of Washington;
 - ii) The services are under continued scientific testing and research;
 - iii) The services show a demonstrable benefit for a particular dental condition; and
 - iv) They are proven to be safe and effective.Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
 - b. Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental, may be appealed to Washington Dental Service. By law, Washington Dental Service must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual.
4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.
5. Prescription drugs.
6. In the event an eligible person fails to obtain a required examination from a Washington Dental Service-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
8. Broken appointments.

9. Patient management problems.
10. Completing claim forms.
11. Habit-breaking appliances.
12. TMJ services or supplies.
13. This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this program as covered dental benefits.

Washington Dental Service shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this Contract. Should there be a disagreement regarding the interpretation of such benefits; the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this contract and may seek judicial review of any denial of coverage of benefits.

Frequently Asked Questions about Your Dental Benefits

What is a Washington Dental Service “participating dentist”?

A Washington Dental Service participating dentist is a dentist who has signed an agreement with Washington Dental Service stipulating that he or she will provide dental treatment to subscribers and their dependents covered by Washington Dental Service's group dental care programs. WDS participating dentists submit claims directly to Washington Dental Service for their patients.

Can I choose my own dentist?

See “Choosing a Dentist” under the “How to Use Your Program” section in the front of this booklet.

How can I obtain a list of Washington Dental Service participating dentists?

You can obtain a current list of WDS dentists by going to our Web site at www.DeltaDentalWa.com. Go to Looking for a Dentist and click on Read More. This will bring up the WDS Find a Dentist directory.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your dentist. You can also obtain a copy of the approved claim forms from our Web site at www.DeltaDentalWa.com. **Note:** If your dentist is a Washington Dental Service participating provider, he or she will complete and submit claim forms for you.

What is the mailing address for Washington Dental Service claim forms?

If you see a Washington Dental Service participating dentist, the dental office will submit your claims for you. If your dentist is not a participating dentist, it will be up to you to ensure that the dental office submits your claims to Washington Dental Service at P.O. Box 75983, Seattle, WA 98175-0983.

Who do I call if I have questions about my dental plan benefits?

If you have questions about your dental benefits, call Washington Dental Service's customer service department at (206) 522-2300 or call toll-free at (800) 554-1907. Questions can also be addressed via e-mail at cservice@DeltaDentalWa.com.

Do I have to get an “estimate” before having dental treatment done?

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a “predetermination of benefits.” The estimates provided do not represent a guarantee of payment, but they provide you with estimated costs and benefits for your procedure.

Why does Washington Dental Service pay less for tooth-colored fillings on my back teeth?

Tooth-colored fillings, or fillings made of resin-based composite, are considered to be cosmetic. Dental amalgams, or what we normally think of as silver fillings, are less expensive and clinically equivalent to resin-based composite. Because of this, your plan reimburses your dentist for the least costly clinically equivalent fillings in back (posterior) teeth. If you have questions about this, feel free to discuss them with your dentist.

I am divorced. If my former spouse and I both have dental coverage, whose plan covers the children first?

It usually depends on who has financial responsibility for the children. If the parents have joint custody, then the parent with the birthday earliest in the calendar year has primary coverage. If the custodial parent does not have financial responsibility, the parent who does has primary coverage. For more information, see the *Coordination of Benefits* section in this book.

My former spouse and I are divorced. What kind of documentation do I need to provide to Washington Dental Service to maintain the children’s dental coverage?

A parenting plan or statement of financial responsibility is required to verify which parent has primary coverage and which has secondary coverage for children in a divorce situation.

What is Delta Dental?

Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide employer groups with dental benefits coverage. Washington Dental Service is a member of the Delta Dental Plans Association.

Glossary

ALVEOLAR — Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

AMALGAM — A mostly silver filling often used to restore decayed teeth.

APICOECTOMY — Surgery on the root of a tooth.

APPEAL — An oral or written communication by a subscriber requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits.

BITEWING X-RAY — An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

BRIDGE — A replacement for a missing tooth or teeth. The bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

CARIES — Decay. A disease process initiated by bacterially produced acids on the tooth surface.

CARIES SUSCEPTIBILITY TEST — A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

COMPLAINT — An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

COMPREHENSIVE ORAL EVALUATION — Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

COPING — A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridgework, if the tooth is lost.

COVERED DENTAL BENEFITS — Those dental services that are covered under this Contract, subject to the limitations set forth in Benefits Covered by Your Program.

CROWN — A restoration that replaces the entire surface of the visible portion of tooth.

DELIVERY DATE — The date a prosthetic appliance is permanently cemented into place.

DENTURE — A removable prosthesis that replaces missing teeth. A complete (or “full”) denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

ENDODONTICS — The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

EXCLUSIONS — Those dental services that are not contract benefits set forth in Benefits Covered by Your Program and all other services not specifically included as a Covered Dental Benefit set forth in Benefits Covered by Your Program.

FILED FEES — Approved fees that participating Washington Dental Service participating dentists have agreed to accept as the total fees for the specific services performed.

FILLED RESIN — Tooth-colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

FLUORIDE — A chemical agent used to strengthen teeth to prevent cavities.

FLUORIDE VARNISH — A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

GENERAL ANESTHESIA — A drug or gas that produces unconsciousness and insensibility to pain.

IMPLANT — A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

INLAY — A dental filling shaped to the form of a cavity and then inserted and secured with cement.

INTRAORAL X-RAYS COMPLETE SERIES (INCLUDING BITEWINGS) — A series of radiographs which display the root and coronal portions of all the teeth in the mouth.

INTRAVENOUS (I.V.) SEDATION — A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

LICENSED PROFESSIONAL — An individual legally authorized to perform services as defined in his or her license. Licensed professional includes, but is not limited to, dentist, hygienist and radiology technician.

LIMITATIONS — Those dental services that are subject to restricting conditions set forth in Benefits Covered by Your Program.

LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS — Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

MAXIMUM ALLOWABLE FEES — The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

NIGHTGUARD — See “Occlusal Guard”.

NOT A PAID COVERED BENEFIT — Any dental procedure that, under some circumstances, would be covered by WDS, but is not covered under other conditions. Examples are listed in Benefits Covered by Your Program.

OCCLUSAL ADJUSTMENT — Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

OCCLUSAL GUARD — A removable dental appliance — sometimes called a nightguard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (nightguard) is typically used at night.

ONLAY — A restoration of the contact surface of the tooth that covers the entire surface.

ORTHODONTICS — Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

OVERDENTURE — A removable denture constructed over existing natural teeth or implanted studs.

PALLIATIVE TREATMENT — Services provided for emergency relief of dental pain.

PANOREX X-RAY — An X-ray, taken from outside the mouth, that shows the upper and lower teeth and the associated structures in a single picture.

PERIODIC ORAL EVALUATION (Routine Examination) — An evaluation performed on a patient of record to determine any changes in the patient’s dental and medical health status following a previous comprehensive or periodic evaluation.

PERIODONTICS — The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

PROPHYLAXIS — Cleaning and polishing of teeth.

PROSTHODONTICS — The replacement of missing teeth by artificial means such as bridges and dentures.

PULPOTOMY — The removal of nerve tissue from the crown portion of a tooth.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) — An order issued by a court under which an employee must provide medical coverage for a dependent child. QMCSO’s are often issued, for example, following a divorce or legal separation.

RESIN-BASED COMPOSITE — A tooth colored filling, made of a combination of materials, used to restore teeth.

RESTORATIVE — Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

ROOT PLANING — A procedure done to smooth roughened root surfaces.

SEALANTS — A material applied to teeth to seal surface irregularities and prevent tooth decay.

SEAT DATE — The date a crown, veneer, inlay or onlay is permanently cemented into place on the tooth.

TEMPOROMANDIBULAR JOINT — The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

VENEER — A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

Claim Review and Appeal

Predetermination of Benefits

A predetermination is a request made by your dentist to Washington Dental Service to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but strictly an estimate for services. Payment for services is determined when the claim is submitted (please refer to the Initial Benefits Determination section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, Washington Dental Service may request additional information, request an extension of 15 days and pend the predetermination until all of the information is received. Once all of the information is received a determination will be made within 15 days of receipt. If no information is received at the end of 45 days, the predetermination will be denied.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, Washington Dental Service will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to Washington Dental Service for payment, modification, or denial of services. In accordance with regulatory requirements, WDS processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

Informal Review

If your claim for dental benefits has been completely or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see below), must submit your request for a review within 180 days from the date your claim was denied (please see your explanation of benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your explanation of benefits form)
- The name of the dentist

Please submit your request for a review to:

Washington Dental Service
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

For oral appeals, please refer to the phone numbers listed on the inside front cover of your benefit booklet.

You may include any written comments, documents or other information that you believe supports your claim.

Washington Dental Service will review your claim and make a determination within 30 days of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, Washington Dental Service will consult with a dental professional advisor.

Appeals Committee

If you are dissatisfied with the outcome of the informal review, you may request that your claim be reviewed formally by the Washington Dental Service Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedures appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

Authorized Representative

You may authorize another person to represent you and to whom Washington Dental Service can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.

Subrogation

Based on the following legal criteria, subrogation means that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss any money recovered in excess of full compensation must be used to reimburse Washington Dental Service. Washington Dental Service will prorate any attorneys' fees against the amount owed.

To the extent of any amounts paid by Washington Dental Service for an eligible person on account of services made necessary by an injury to or condition of his or her person, Washington Dental Service shall be subrogated to his or her rights against any third party liable for the injury or condition. Washington Dental Service shall, however, not be obligated to pay for such services unless and until the eligible person, or someone legally qualified and authorized to act for him or her, agrees to:

- include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
- repay Washington Dental Service those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;
- cooperate fully with Washington Dental Service in asserting its rights under the contract, to supply WDS with any and all information and execute any and all instruments Washington Dental Service reasonably needs for that purpose.

Provided the injured party is in compliance with the above, Washington Dental Service will prorate any attorneys' fees incurred in the recovery.

Subscriber Rights and Responsibilities

At Washington Dental Service our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between Washington Dental Service, our subscribers and our participating members' dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have The Right To:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta member/non-member), but you can receive care from any dentist you choose.

- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact Washington Dental Service customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at www.deltadentalwa.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To Receive The Best Oral Health Care Possible, It Is Your Responsibility To:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to Washington Dental Service to assist with the processing of claims.
- If applicable, pay the dental office the appropriate co-insurance amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.

Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

Washington Dental Service, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today we cover more than 50 million people nationwide through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Advancing better oral health — that is what we are all about!

To learn more about Washington Dental Service and your benefits, visit our Web site at www.DeltaDentalWA.com.