Delta Dental PPO

Central Washington PUDs

Washington Dental Service, a Delta Dental Plan

Plan No. **00755**

Effective: **August 1, 2012**

Questions Regarding Your Plan

If you have questions regarding your dental benefits plan, 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 Washington Dental Service 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.

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Summary of Benefits

Reimbursement Levels for Allowable Benefits

Delta Dental/Washington Dental PPO Dentists

Class I	Constant 100%
Class II	Constant 90%
Class III	Constant 70%
Annual Deductible per Person	$50
Annual Deductible — Family Maximum	$50

Non-Delta Dental PPO Dentists

Class I	Constant 100%
Class II	Constant 80%
Class III	Constant 70%
Annual Deductible per Person	$50
Annual Deductible — Family Maximum	$50

Plan Maximum

Annual Plan Maximum per Person	$2,000

The payment level for covered dental expenses arising as a direct result of an accidental bodily injury is 100 percent, up to the unused plan maximum.

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

Introduction

Welcome to the Delta Dental PPO dental 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 WDS, 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 plan.

How to Use Your Plan

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 WDS 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 WDS, you may select any licensed dentist; however, your benefits may be paid at a higher level and your out-of-pocket expenses may be lower if you choose a participating WDS dentist. Tell your dentist that you are covered by a WDS dental plan and provide your identification number, the plan name and the group number.

Delta Dental/Washington Dental Service Participating Dentists

If you select a dentist who is a WDS participating provider, that dentist has agreed to provide treatment for eligible persons covered by WDS plans. 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 be responsible only for stated coinsurances, deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered dental benefits. You will not be charged more than the participating dentist's approved fee or the fee that the WDS dentist has filed with us.

Delta Dental/Washington Dental Service PPO Dentists

PPO dentists must be Delta Dental/Washington Dental Service Premier® dentists in order to participate in the PPO network. PPO dentists receive payment based on their PPO filed fees at the percentage levels listed on your plan for PPO dentists. Patients are responsible only for percentage coinsurance up to the PPO filed fees. PPO is a point-of-service plan, meaning that you can choose any dentist — in or out of the PPO network — at the time you need treatment. However, if you select a dentist who is a PPO dentist, your benefits will likely be paid at a higher level and your out-of-pocket expenses may be lower.

Delta Dental/Washington Dental Service Premier® Dentists (non-PPO)

Premier dentists also have contracts with WDS, but they are not part of the PPO network. Premier dentists will submit claim forms for you and receive payment directly from WDS.

Non-Participating Dentists

If you select a dentist who is not a WDS 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 WDS has no control over nonparticipating dentists' charges or billing practices.

Out-of-State Dentists

If you receive treatment from a dentist outside Washington state, other than a Delta Dental participating dentist, you may be responsible for having the dentist complete and sign a claim form. It may be up to you to ensure that the claim is sent to WDS. Payment will be based upon actual charges or the allowable fees, whichever is less, at the percentage levels listed for PPO network dentists.

Finding a Dentist

You can find the most current listing of participating dentists by going online to the Washington Dental Service Web site at www.DeltaDentalWA.com. Click on the Patients tab and then on the Find a Dentist tab to begin your search. Be sure to click on the Delta Dental PPO plan and follow the prompts.

Benefit Period

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

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.

WDS shall not be obligated to pay for treatment performed if claim forms are not submitted for payment in a timely manner after the date of such treatment. Written notice of claim for benefits must be received by WDS within six months after the date of treatment or as soon as medically possible. No claims will be accepted later than one year from the date of treatment unless the eligible person is legally incapacitated throughout the year.

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 WDS may pay and your expected financial responsibility.

A predetermination is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made and is not a guarantee of payment.

In the event your benefits are terminated and you are no longer eligible, the predetermination is voided. WDS will make payments based on your available benefits (maximum, deductible and other limitations as described in your benefits booklet) and the current plan provisions when the treatment is provided.

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 Plan”, “General Limitations” and “General Exclusions.” They warrant careful reading.

Reimbursement Levels

Your dental plan offers three classes of covered treatment. Each class also specifies limitations and exclusions. For a summary of reimbursement levels for your plan, see the Summary of Benefits section in the front of this booklet.

Refer to the “Benefits Covered by Your Plan” section of this booklet for specific covered dental benefits under this plan.

Coinsurance

WDS 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. It is paid even after a deductible is met, if applicable.

Plan Maximum

For your plan, the maximum amount payable by WDS/Delta Dental for Class I, II and III covered dental benefits (including dental accident 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 plan maximum based on the incurred date.

Plan Deductible

Your plan has a $50 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of $50 is made. Once each eligible person has satisfied the deductible during the period, no further deduction will apply to that eligible person until the next period. The maximum deductible per family each benefit period is $50. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be $50. Once a family has satisfied the maximum deductible amount during the period, no further deduction will apply to that family until the next succeeding period.

Employee Eligibility and Termination

Eligible employees are all full-time employees for whom employer contributions are made.

New employees are eligible on the date of hire.

You must complete an 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 WDS dental plan 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.

Dependent Eligibility and Termination

Eligible Dependents are your lawful spouse, or any person with whom you have a legal union validly formed in any jurisdiction, or state registered domestic partner and children from birth through age 25. Children include biological children, stepchildren, and adopted children. Spouses and children of married dependents are not eligible for coverage under this plan. Domestic partners are not eligible for coverage under COBRA.

Following termination of a domestic partnership a statement of termination must be filed with group's human resources department within 30 days of termination. Termination of domestic partnership includes death of a partner.

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. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see “Special Enrollment”).

Coverage may continue beyond the limiting age (shown under "Dependent Eligibility") for a dependent child who can't support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental or physical disability and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Disabled Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child’s 26th

birthday. Verification of continuing financial dependency must be provided to the group at least annually during the Open Enrollment.

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 at the end of the month in which the dependent ceases to be eligible, whichever occurs first.

You may terminate coverage of an eligible dependent only coincident with a qualifying event or subsequent open enrollment. Once an eligible employee terminates such eligible dependents coverage, the coverage cannot be reinstated outside of open enrollment, unless there is a subsequent change in family status.

A newborn shall be covered from and after the moment of birth, and an adopted child or child acquired through legal guardianship shall be covered from the date of assumption of a legal obligation for total or partial support. Any new dependent acquired through marriage or domestic partnership shall be covered as of the date of the marriage/registration. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Eligible employees who choose not to enroll an eligible dependent during the initial enrollment period of the dental plan may enroll the eligible dependent only during an open enrollment, except under special enrollment. If dependent children have not submitted an enrollment form within 30 days of becoming eligible, they must wait for the next open enrollment period to enroll.

Special Enrollment Periods

Special enrollments are allowed under the following conditions:

1. **Loss of Other Coverage**

   If you and/or your eligible dependents involuntarily lose coverage under another dental plan, you may apply for coverage under this Plan if the following applies:

   - You declined enrollment in this Plan.
   - You lose eligibility in another health plan or your coverage is terminated due to the following:
     - Legal separation or divorce
     - Cessation of dependent status
     - Death of Employee
     - Termination of employment or employer contributions
     - Reduction in hours
     - Loss of individual or group market coverage because of move from plan area or termination of benefit plan
     - Exhaustion of COBRA coverage
   - Your application to enroll in this Plan is received by WDS within 30 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

   If these conditions are not met, you must wait until the next Open Enrollment Period to apply for coverage.

Note: Eligible dependents may not enroll in this Plan unless the Employee is a Subscriber.

WDS or Group may require confirmation that when initially offered coverage the Eligible Person submitted a written statement declining because of other coverage. WDS requests that application for coverage under this Plan must be made within 30 days of the termination of previous coverage. If an additional Premium for coverage is required and enrollment and payment is not completed within the 30 days, such Eligible Dependent may be enrolled during the next Open Enrollment.

WDS or Group may require confirmation that when initially offered coverage the Eligible Person submitted a written statement declining because of other coverage. WDS requests that application for coverage under this Plan should be made within 30 days of the termination of previous coverage.

2. **Marriage, Birth or Adoption**

If you declined enrollment in this Plan, you may apply for coverage for yourself and your eligible dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support of a child(ren) in anticipation of adoption.

- Marriage or Domestic Partner Registration — WDS requests the application for coverage be made within 30 days of the date of marriage/registration. If enrollment and payment are not completed within the 30 days, the eligible dependent may be enrolled during the next open enrollment.

  WDS considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefits booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. WDS and the group will follow all applicable state and federal requirements, including any applicable regulations.
- Birth/Adoption — A newborn shall be covered from and after the moment of birth. WDS requests the application for coverage be made within 60 days of the date of birth. If an additional premium for coverage is required and enrollment and payment is not completed within the 60 days, the eligible dependent may be enrolled during the next open enrollment. An adopted child shall be covered effective with the date of placement.

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.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the WDS 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:

- 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"

The "Continuation of Coverage" legislation passed into federal law (PL 99-272 and as amended by PL 104-191) requires that should certain qualifying events occur which would have previously terminated coverage, coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits up to 18 months, or until you are covered under another group dental plan, by self-paying the required premium in accordance with the COBRA administrative guidelines established by your employer.

If a dependent no longer meets the eligibility requirements due to the death or divorce of the employee, or does not meet the age requirement for children, coverage may continue up to three years, or until the dependent is covered under another group dental plan, by self-paying the required premium. Please note that registered domestic partners and their children are not eligible for COBRA coverage.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

MySmile® Personal Benefits Center

The MySmile® personal benefits center, available on Washington Dental Service's Web site at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your plan network, review your recent dental activity, check details of your plan coverage, view and print your ID card, check the status of current claims, and more.

For your convenience, your WDS dental benefits ID card can be found — and printed — directly from the middle of your MySmile personal benefits center portal page.

Health Insurance Portability and Accountability Act (HIPAA)

Washington Dental Service is committed to protecting the privacy of your dental health information.

The Health Insurance Portability and Accountability Act (HIPAA) requires WDS to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.DeltaDentalWA.com. You may also request a printed copy by calling the WDS privacy hotline at (206) 985-5963.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Employees called to military service have the right to continue dental coverage for up to 24 months by paying the monthly premiums, even if they are employed by groups that are too small to comply with COBRA. USERRA contains other employment-related requirements, including (but not limited to) the employer having to hold the employee's position until he/she returns from service. For further information on this act, please contact your legal counsel or insurance producer.

Children's Health Insurance Plan Reauthorization Act (CHIPRA)

CHIPRA allows special enrollment rights and allows states to subsidize premiums for employer-provided group health coverage for eligible children (excluding benefits provided under health FSA's and high-deductible health plans).

- Employees and dependents that are eligible but not enrolled for coverage may enroll under the following conditions:
- An employee or dependent loses Medicaid or CHIP coverage due to loss of eligibility, and the employee requests coverage within 60 days after the termination.
- An employee or dependent becomes eligible for a premium assistance subsidy under Medicaid of CHIP and the employee requests coverage within 60 days after the termination.

Contact your employer for further clarification and details of how they plan to implement this coverage for eligible persons.

Conversion Option

If your dental coverage stops because your employment or eligibility ends or the group policy ends, you may apply directly to WDS to convert your coverage to an individual policy. You must apply within 31 days after termination of your group coverage. The benefits and premium costs may be different from those available under your current plan. There may be a gap in coverage between the date your coverage under your current plan ends and the date that coverage begins under an individual policy.

You may apply for coverage under a WDS Individual Plan online at www.DeltaDentalWA.com/Individual or by calling (800) 286-1885 to have an application sent to you. Converted policies are subject to certain benefits and limits.

Necessary vs. Not Covered Treatment

You and your provider should discuss which services may not be covered dental benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your plan. However, there are certain treatments that remain the responsibility of the patient.

Benefits Covered By Your Plan

The following are the covered dental benefits under this plan and are subject to the limitations and exclusions (*refer also to General Limitations and General Exclusions*) contained in this booklet. Such benefits *(as defined)* are available only when provided by a licensed dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS.

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

The amounts payable by WDS for covered dental benefits are described on your Summary of Benefits section of this booklet.

Class I

Diagnostic

Covered Dental Benefits

- Diagnostic evaluation for routine or emergency purposes
- X-rays

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- A complete series or a panoramic X-ray is covered once in a three-year period from the date of service.
  - Any number or combination of x-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.
- Supplementary bitewing X-rays are covered twice 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
- Study models

Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure sealants
- Topical application of fluoride including fluoridated varnishes
- Space maintainers
- Preventive resin restoration

Limitations

- Prophylaxis is limited to two covered procedures in a benefit period.
  - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Periodontal maintenance (periodontal prophylaxis) has no time limitation.
- Fissure sealants:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, sealants or preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
  - The application of a fissure sealant is a covered dental benefit once in a three-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth.
- Preventive resin restorations:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
  - The application of a preventive resin restoration is a covered dental benefit once in a three-year period per tooth from the date of service.
  - The application of preventive resin restoration is not a paid covered benefit for two years after a fissure sealant or preventive resin restoration on the same tooth from the date of service.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)

Class II

Sedation

Covered Dental Benefits

- General anesthesia when administered by a licensed Dentist or other 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.

- Intravenous sedation when administered by a licensed Dentist or other 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 WDS, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II and III covered dental benefits.
- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- General anesthesia or 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

- Restorations (fillings)
- Stainless steel crowns
- *Refer to Class III Restorative if teeth are restored with crowns, veneers or onlays.*

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- 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.

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 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
- Services covered include:
  - Periodontal scaling/root planing
  - Gingivectomy
  - Limited adjustments to occlusion (eight teeth or fewer)
  - Major (complete) occlusal adjustment
- *Refer to Class I Preventive for periodontal maintenance benefits.*
- *Refer to Class II Sedation for information.*
- *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 dental benefit. A predetermination is not a guarantee of payment.*

Limitations

- Limited occlusal adjustments are covered once in a 12-month period from the date of service.

Exclusions

- Occlusal guard (nightguard)

Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy
- *Refer to Class II Sedation for information.*
- *Refer to Class III Prosthodontics for root canals placed in conjunction with a prosthetic appliance.*

Limitations

- Root canal treatment on the same tooth is covered once per lifetime.
- Re-treatment of the same tooth is allowed when performed by a different dental office.

Exclusions

- Bleaching of teeth

Class III

Restorative

Covered Dental Benefits

- Crowns, veneers or onlays 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
- Post and core on endodontically treated teeth

Limitations

- A crown, veneer or onlay on the same tooth is covered once in a five-year period from the seat date.
- If a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the eligible person.
- Payment for a crown, veneer or onlay shall be paid based upon the seat date.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing and 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.
- A crown buildup or a post and core are covered once in a two-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within two years of a restoration 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.
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations without overt pathology is not a paid covered benefit.

Exclusions

- Copings

Prosthodontics

Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Inlays when used as a retainer for a fixed partial denture (fixed bridge)
- Removable partial dentures
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing prosthetic appliance is covered once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Payment for dentures, fixed partial dentures (fixed bridges); inlays (only when used as a retainer for a fixed bridge) and removable partial dentures shall be paid upon the seat/delivery date.
- Implants and superstructures are covered once every five-years.
- Implant maintenance procedures, including:
  - Removal of prosthesis
  - Cleansing of prosthesis and abutments
  - Reinsertion of prosthesis
- Crowns in conjunction with overdentures are not a paid covered benefit.
- **Full, immediate and overdentures** — WDS 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.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level.
- **Temporary/interim dentures** — WDS 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.
- **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 from the date of service.

Exclusions

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance or appliance, except for implant maintenance
- Copings

Well Baby Checkups

For your infant child, Washington Dental Service offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of services. When visiting a participating physician with your infant (age 0-3), WDS will reimburse the physician on your behalf for specific services performed, up to the amount listed below:

- Oral Evaluation: Reimbursed up to $43
- Topical application of fluoride: Reimbursed up to $36

Please see the “Benefits Covered by Your Plan” section of this booklet for any other limitations. Also, please be aware that Washington Dental Service has no control over the charges or billing practices of non-dentist providers which may affect the amount Washington Dental Service will pay and your financial responsibility.

Accidental Injury

WDS will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II and Class III covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused plan maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

Additional Procedures

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the plan. In such instances, the plan will pay the proper percentage of the lowest fee. The balance of treatment cost remains the eligible person's responsibility.

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.

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, WDS, 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 WDS. WDS will 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 eligible person.
   c. Whenever WDS makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, WDS shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).
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 WDS-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. Behavior management
10. Completing claim forms

11. Habit-breaking appliances
12. Orthodontic services or supplies
13. TMJ services or supplies
14. This plan 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.
15. All other services not specifically included in this plan as covered dental benefits.

WDS shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this benefits booklet. 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 benefits booklet and may seek judicial review of any denial of coverage of benefits.

Frequently Asked Questions about Your Dental Benefits

What is a WDS "participating dentist"?

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

Can I choose my own dentist?

See "Choosing a Dentist" under the "How to Use Your Plan" section in the front of this booklet.

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 WDS participating provider, he or she will complete and submit claim forms for you.

What is the mailing address for WDS claim forms?

If you see a WDS 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 WDS'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.

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. WDS 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 Plan.

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.

Emergency Dental Condition — The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Emergency Examination — Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

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 Plan and all other services not specifically included as a Covered Dental Benefit set forth in Benefits Covered by Your Plan.

Filed Fees — Approved fees that participating WDS 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, denturist, hygienist and radiology technician.

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

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 Plan.

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.

Open Enrollment Period — The annual period in which subscribers can select benefits plans and add or delete eligible dependents.

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.

Panoramic 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.

Specialist — A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

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 WDS 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 is 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, WDS 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, WDS 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 WDS 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.

WDS 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, WDS 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 WDS 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 sends 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 this 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 WDS 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.

Coordination of Benefits

Coordination of this Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plan*s do not exceed 100 percent of the total *Allowable Expense*.

Definitions: For the purpose of this section, the following definitions shall apply:

A "***Plan***" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plan*s or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.

- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *plan* or other nongovernmental *plan*; automobile insurance policies required by statute to provide medical benefits; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plan*s, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

"***This Plan***" means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plan*s. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

"**Allowable Expense**", except as outlined below, means any health care expense including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering you. When coordinating benefits as the secondary plan, Washington Dental Service must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will WDS be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the *plan*s is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by two or more *Plan*s that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan's negotiated fee is not an *Allowable Expense*.

"***Closed Panel Plan***" is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"***Custodial Parent***" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by two or more *Plan*s, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plan*s state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

"***Non-Dependent or Dependent***:" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the two *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

"***Dependent Child Covered Under More Than One Plan:***" Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
   a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
   b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
   b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
   c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;

d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or

e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:

I. The *Plan* covering the *Custodial Parent*, first;
II. The *Plan* covering the spouse of the *Custodial Parent*, second;
III. The *Plan* covering the non*custodial Parent*, third; and then
IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

"***Active Employee or Retired or Laid-off Employee:***" The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***COBRA or State Continuation Coverage:***" If your 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 you as an employee, member, subscriber or retiree or covering you 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*. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***Longer or Shorter Length of Coverage:***" The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expense*s must be shared equally between the *Plan*s meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of *This Plan*: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plan*s during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. Total *Allowable Expense* is the *Allowable Expense* of the *Primary Plan* or the *Secondary Plan up to this plan's allowable expense*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

How We Pay Claims When We Are Secondary: When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each *plan* involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

Right to Receive and Release Needed Information: Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plan*s. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plan*s covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

Right of Recovery: The Company has the right to recover excess payment whenever it has paid *Allowable Expense*s in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plan*s.

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*.

Notice to covered persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plan*s to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plan*s have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan*'s claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plan*s any changes in your coverage.

Subrogation

Based on the following legal criteria, subrogation means that if you receive this plan'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 WDS. WDS will prorate any attorneys' fees against the amount owed.

To the extent of any amounts paid by WDS for an eligible person on account of services made necessary by an injury to or condition of his or her person, WDS shall be subrogated to his or her rights against any third party liable for the injury or condition. WDS 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 WDS 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 WDS in asserting its rights under the contract, to supply WDS with any and all information and execute any and all instruments WDS reasonably needs for that purpose.

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

Your Rights and Responsibilities

At WDS 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 WDS, our subscribers and our participating member 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 (WDS member/nonmember), 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 WDS customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our Web site at 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 WDS to assist with the processing of claims, predeterminations or appeals.
- If applicable, pay the dental office the appropriate co-payments 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 WDS and your benefits, visit our Web site at www.DeltaDentalWA.com.