



**THE BOEING COMPANY**

PREPAID PROVIDER PLAN – Non-union Employees

Washington Dental Service

Program No. 03850

January 1, 2008

### **Questions Regarding Your Program**

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

Washington Dental Service DeltaCare  
Customer Service  
(206) 517-6329  
(800) 650-1583

You can also reach us through Internet e-mail at  
[info@DeltaDentalWA.com](mailto:info@DeltaDentalWA.com).

Written inquiries may be sent to:  
DeltaCare Department  
Washington Dental Service  
P.O. Box 75983  
Seattle, WA 98175-0983

For the most current listing of Washington Dental Service participating dentists, visit our online directory at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) and select the Boeing 03850 option under DeltaCare.

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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.

### **Welcome to your Boeing Prepaid Dental Plan #03850**

**DeltaCare** is an innovative dental plan that provides you with comprehensive dental care at a significantly lower cost than the more traditional plans you may be accustomed to. It is unique in its emphasis on preventive care. Moreover, because there are no deductibles or annual maximums when you use a DeltaCare dentist, you can get the care you need when you need it.

**The health plan benefit description is incorporated as part of the Boeing Summary Plan Description.**

This summary plan description for this Plan is the combination of:

- The Boeing Company Health & Welfare Plans booklet for the eligible population
- Any applicable provider directory
- This coverage-specific brochure issued by Washington Dental Service

*No services will be covered unless obtained from an assigned primary care dentist or designated referral dentist.*

#### **Boeing Service Center for Health and Welfare Plans**

For detailed information concerning employee and dependent eligibility or enrollment, contributions, coverage terminations, leaves of absence provisions, eligibility reviews and appeal, Qualified Medical Child Support Orders (QMCSO), ERISA Special Disclosures and other general plan information, refer to The Boeing Health and Welfare Plans Summary Plan Description, (which supercedes any eligibility information contained in this document), or contact the plan administrator at:

Automated Phone System     Seven days a week, 24 hours a day

1-888-747-2016

1-800-855-8220 (hearing impaired)

847-883-0746 (if calling from overseas)

Boeing Service Center Representatives – Available through the above numbers, Monday through Friday

9 a.m. to 8 p.m. Eastern time,  
8 a.m. to 7 p.m. Central time,  
7 a.m. to 6 p.m. Mountain Time and  
6 a.m. to 5 p.m. Pacific Time

Your password is needed whenever you use the Boeing Service Center automated phone system.

**Eligible Employee Groups:**

**Active employees:** Non-union Salaried: BNA Nonunion Low Cost Subsidiary-Albuquerque, New Mexico, BNA Nonunion Low Cost Subsidiary-El Paso, Texas (Salaried employees), BNA Nonunion Low Cost Subsidiary, Heath Ohio and Corinth, Texas (Salaried employees), BNA Nonunion Low Cost Subsidiary-Shreveport, Louisiana, BNA Nonunion Low Cost Subsidiary-Duluth, Georgia, BNA Nonunion Low Cost Subsidiary-(various locations), BNA Nonunion Low Cost Subsidiary-Richardson, Texas, SVS, Jeppesen Sanderson Inc., Seabrook (Salaried exempt employees), San Antonio (Salaried employees), Seabrook (Salaried, nonexempt employees), San Antonio (Hourly employees), Nobletec Corporation, Jeppesen DataPlan Inc., Boeing Satellite Systems (BSS) Nonunion (effective April 1, 2003), Spectrolab Nonunion (effective April 1, 2003), SBS International (effective July 1, 2004), Boeing Advanced Information System - Maryland Operations (effective March 1, 2004) (formerly Conquest) and Alteon Training, LLC (effective January 1, 2003)

**New Enrollees & Late Enrollment**

Eligibility to participate in the plan is effective as determined by your employer. If you decline enrollment when first eligible and later wish to enroll yourself or dependents as a result of marriage, birth or adoption or other qualified change in status, your request for enrollment must be submitted to your employer within 30 days, or the timeframe established by your employer, if your employer allows more than 30 days for this type of change.

**An Excellent Network of Quality Providers**

As a DeltaCare member, you will choose a primary care dentist from the DeltaCare network. He or she will coordinate your dental care. DeltaCare dentists meet both the strict credentialing standards of the National Committee for Quality Assurance (NCQA) and Washington Dental Service's criteria for practice management.

**Low Out-of-pocket Costs**

The majority of required dental services are provided at no cost to you under the Boeing Prepaid Dental Plan. However, there are limitations and exclusions that will define your benefits. Specified dental services require copayments that you will pay directly to your dentist. Your out-of-pocket costs are completely predictable because they're based on a fixed copayment schedule. If you elect to upgrade your treatment, you will be responsible for the cost differential and will pay the difference directly to your dentist.

**No Annual Maximums or Network Deductibles**

Unlike most traditional dental plans, there are no annual maximums or deductibles when you receive care from your selected DeltaCare dentist.

### **DeltaCare Is Easy to Use**

Simply contact your DeltaCare dentist and receive treatment. Your primary care dentist will collect any applicable copayments. There are never any claim forms for you to complete when you visit your DeltaCare dentist or a specialist to whom your primary care dentist refers you.

## **Plan information**

### **Provider Selection**

The employee must select a participating provider at the time of enrollment or during the open-enrollment period. Thereafter, all covered dental services except orthodontia will be provided to the employee and each of his or her eligible dependents by the selected provider. If you are a new enrollee, we have made every attempt to assign you to your dentist of choice. If the dentist/dental office on your card is not the dentist you have selected, you may contact the DeltaCare unit at 1(800) 650-1583 to verify that we received the original information or discuss additional options.

### **Identification Cards**

Each newly eligible member receives an identification card that lists the subscriber's name and group number, as well as the DeltaCare dentist's name, address and telephone number.

The patient should show this card upon arrival for an appointment. However, please note that eligibility is not based exclusively on the presentation or lack of an identification card. Your dental office should check its most recent list to verify eligibility. If a member's name does not appear on your most recent eligibility list, the dental office may contact the DeltaCare unit for eligibility confirmation.

New identification cards will be issued when the eligible member contacts DeltaCare and selects a new dentist. You may also contact DeltaCare at 1 (800) 650-1583 for replacement of lost ID cards.

### **Changing Dentists**

To obtain a list of current providers, please contact the DeltaCare unit at 1-(800)-650-1583. The subscriber may elect to transfer to another participating dentist by contacting Washington Dental Service. If the selection is made prior to the 25<sup>th</sup> of the month, it will be effective the first of the following month. The DeltaCare customer service representative will confirm the effective date.

### **Dentist Deletion**

Washington Dental Service contracts with private dental offices to participate in the DeltaCare program. For various reasons, these contracts are sometimes terminated. In that event, DeltaCare will attempt to contract with another dentist in the same area. You will be notified of the change in dentists, along with an effective date and current list of open providers. You will have the option to contact DeltaCare with an alternative selection.

### **Patient Copayments**

The patient copay schedule shows what you will pay when you receive treatment from your DeltaCare office. There will be a \$10 per visit copayment for all visits that contain non-diagnostic/non-preventive visits.

### **Necessary vs. Not Covered Treatment**

The provider will inform the patient of services that are covered benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are provided at no cost to the patient under the DeltaCare Plan. However, there are certain treatments that, according to the contract between The Boeing Company and Washington Dental Service, remain the responsibility of the patient. Patients can also contact the DeltaCare unit at Washington Dental Service at (206) 517-6329 or call toll free at 1 (800) 650-1583 with questions.

### **Referral Process**

Specific procedures may be referred to a plan specialist. Your primary care dentist will determine the need for the referral and refer you to a plan specialist in your area. Specialty services are listed in the patient copay schedule.

### **Urgent Care**

The Panel Dentist shall provide urgent dental care for a covered procedure that is required if an enrollee is within 35 miles of the office of the Panel Dentist. If an enrollee requires urgent dental care and is more than 35 miles from the office of the Panel Dentist, the Plan shall reimburse the enrollee for the cost of such urgent dental care up to \$100 maximum per 12 month calendar year. Urgent dental care shall be limited to listed procedures, and/or as described, "Palliative (emergency) treatment of dental pain under the conditions of which the enrollee can be screened and adequately stabilized to allow for further treatment from the enrollee's assigned dentist. Any further treatment of the cause of such urgent dental care would require pre-authorization from the Plan provided it is practical according to a prudent layperson if the care is to be performed by a non-panel dentist. In cases which require immediate additional care beyond stabilization and palliative treatment, the Plan will carefully review and consider additional reimbursable coverage beyond the \$100 maximum and according to the standard list of covered benefits under the plan.

### **Emergency Care**

DeltaCare Dental Plan primary dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, 365 days a year. Treatment of emergency dental care, those rare dental health instances that may be life threatening or cause severe bodily injury, shall not require pre-authorization if a prudent layperson acting reasonably would believe that such an emergency condition exists. The Plan would encourage the enrollee to seek a pre-authorization from the Plan for such emergency care if at all practical, but would not require pre-authorization if the treatment is a listed procedure under the terms of coverage. The Enrollee should notify DeltaCare after receiving emergency dental care within 15 days, or when practical, as to the extent of such emergency dental treatment.

### **Orthodontic Care**

Orthodontic care may be obtained from any licensed dentist. The lifetime maximum is \$2,000 and will be paid on a fee-for-service basis at the 50% level. You must return to your DeltaCare dentist for any additional treatment your orthodontist recommends.

### **Grievance Resolution**

We urge you to communicate directly with your DeltaCare dentist if you are dissatisfied with the service provided. We are confident that your DeltaCare dentist will welcome the opportunity to address your questions and concerns. If you are still dissatisfied, please contact DeltaCare Customer Service at 1 (800) 650-1583. A Customer Service representative will be available to assist you.

## **Member Rights and Responsibilities**

### **As a DeltaCare member, you have the right to:**

- Be provided with appropriate information about DeltaCare and its benefits, providers and policies
- Be informed of your diagnosis, the proposed treatment and prognosis by your dentist
- Give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment
- Obtain a copy of your dental record, in accordance with the law
- Be treated with respect and have your dignity and need for privacy recognized

### **You have the responsibility to:**

- Ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers
- Provide dentists with the information necessary to care for you
- Be familiar with DeltaCare benefits, policies and procedures by reading DeltaCare's written materials or calling the DeltaCare Unit at Washington Dental Service
- Understand and follow dental office policy on late cancellations, broken appointments and scheduling

## **Coordination of Benefits**

This contract shall always be considered primary for all covered dental benefits except orthodontics, which will be processed according to the order of benefit payment indicated below. Except that if both this contract and the other plan have provisions stating they are primary, then the following rules shall establish the order of benefit payment under this contract and the other Plan:

- The benefits of the plan that does not have a coordination of benefits provision shall be primary (the plan whose benefits are determined first).
- The benefits of the plan that covers the person as an active employee shall be determined before the benefits of a plan which covers the person as a dependent.
- If the person is a child whose parents are not separated or divorced, the plan covering the parent whose month and day of birth occurs earlier in the calendar year.
- If the child has parents who are separated or divorced, then the order of benefits are as follows:
  - The plan of the parent with custody
  - The plan of the new spouse of the parent with custody
  - The plan of the parent without custody
  - The plan of the new spouse of the parent without custody
- However, if the court decrees financial responsibility for the child's health care, the plan of the parent with the financial responsibility is the primary plan.
- Benefits under this plan will not be coordinated with benefits paid under any other group plan offered by The Boeing Company.

## **Subrogation**

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

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

What this means is that if an eligible person receives this program's benefits for an injury or condition possibly caused by another person, he or she must include in his or her insurance claim or liability claim the amount of these benefits. After he or she has been fully compensated for his or her loss, any money recovered in excess of that loss must be used to reimburse Participating Plan.

Participating Plan shall prorate any attorneys' fees against the amount owed to Participating Plan.

### **Accidental Injury Rider**

The Participating Plan shall pay or reimburse 100% of the local state's allowable fees, less any applicable patient copayment(s), for the following Dental Accident Benefits:

Services described in the Covered Dental Benefits, Limitations and Exclusions and Payment Schedule, as well as the following services when provided for conditions caused directly and indirectly by external, violent and accidental means.

Additional Dental Accident Benefits:

- Intra-oral grafting
- Reimplantation
- Splinting
- Stayplate

All dental Accident Benefits are subject to the maximum, limitations and exclusions of this plan.

### **Maximum**

- The program shall provide the Dental Accident Benefits for an eligible person up to a maximum of \$1,600 per patient per any 12-month period.

### **Limitations**

- Dental Accident Benefits shall be limited to services provided to an eligible person within 180 days following the date of the accident, and shall not include any services for conditions caused by an accident occurring prior to the patient's eligibility date.

### **Exclusions**

- Services covered under Worker's Compensation or Employers' Liability laws
- Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons
- Service for restoring or stabilizing tooth structures lost from wear
- Any services started prior to the date of eligibility
- Prescribed drugs, pre-medication or analgesia

- Experimental procedures
- Prophylaxis
- All hospital costs and any additional fees charged by the dentist for hospital treatment
- Charges for general anesthesia
- Extra-oral grafts
- Implants, the removal of implants or procedures related to the placement or removal of implants
- Diagnosis or treatment by any method or condition related to temporomandibular joint or associated musculature, nerves and other tissues
- Replacement of existing restorations due to carious lesions
- Orthodontic services

**Initial Claims/Predeterminations**

Initial claim determination will be performed on all properly submitted claims within 30 days of receipt (predeterminations will be 15 days). A 15-day extension is available if the claim determination is delayed for reasons beyond our control. In that case we will notify the subscriber.

If a claim is denied, in whole or part, the eligible person will be given a written notice of an adverse benefit determination that will include:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information necessary to process the claim
- The appropriate information as to the steps to be taken for an appeal

**Member Appeal Rights**

Should a claim/predetermination be denied, in whole or in part, the eligible person has a right to a full and fair review. The request to have a denied claim reviewed may be submitted orally or in writing and within 180 days from the date the claim was denied. Further consideration will not be allowed after 180 days. A final benefit determination will be made within 30 days (predeterminations will be 15 days) following receipt of an appeal. In the case of an urgent claim, Washington Dental Service will notify you of its decision within 72 hours. An appeal must include name, identification number, group number, claim number, and dentist’s name as shown on the Explanation of Benefits.

Send your appeal to:

Washington Dental Service  
DeltaCare  
Appeals/Customer Service  
Post Office Box 75983  
Seattle, WA 98175-0983

Written comments, documents or other information may be submitted in support of an appeal.

**Legal Action**

If you do not agree with the determination of the service representative (Washington Dental Service) Boeing Service Center, or Employee Benefit Plans Committee, you have the right to initiate a lawsuit under ERISA Section 502 (a). However, you first must exhaust the claim and appeal procedures described above, and must bring any legal action within two years after the rendering of the services on which the claim is based, or within two years of the date you or your dependent initially is denied participation in the plan.

## **Boeing Group 03850 DeltaCare Prepaid Custom Dental Exclusions and Limitations**

**LIMITATIONS:** *The following limitations apply to custom Boeing DeltaCare Plan Group 03850 Custom plan limitations are specific and unique for each custom plan.*

### **Diagnostic**

- Examination is covered once in a 6 month period;
- Comprehensive oral evaluation.
- Full mouth or panorex x-rays limited to one set every 36 consecutive months;
- Bitewing x-rays limited to not more than one series of 4 films in any 6 month period;

### • **Preventive**

- Prophylaxis limited to one treatment in a 4 month period (includes periodontal maintenance following active therapy),
- Topical application of fluoride or preventive therapies (e.g., fluoridated varnishes) is covered twice in a calendar year through the age of 18. Children through the age 18 are eligible for either topical application of fluoride or preventive therapies, but not both, as described above;
- Fissure sealants are limited to non-carious, non-restored permanent first and second molars through the age of 14. The application of pit and fissure sealants is a covered benefit only once in a 3 year period;

### • **Restorative**

- Restorations on the same surface(s) of the same tooth are covered once in a 2 year period;
- Crowns are covered once in a 5 year period;
- Stainless steel crowns on primary teeth are covered once in a 2 year period;

### • **Periodontics**

- Root planing/subgingival curettage is covered once in a 12 month period;
- Limited occlusal adjustments are covered once in a 12 month period;
- Localized delivery of antimicrobial agents approved by the Plan are a covered benefit when performed at the suggested regimen for that therapy;
- Periodontal surgery is covered once in a 3 year period;
- Soft tissue grafts are covered once in a 3 year period;
- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment;
- Localized delivery of antimicrobial agents is limited to two teeth per quadrant and covered up to two times (per tooth) in a benefit period.
- One periodontal maintenance therapy treatment, specifically periodontal prophylaxis, is covered once in a 4 month period and is to be charged at the applicable copayment level. Periodontal prophylaxis treatments over one in a four month period are patient responsibility;
- Full mouth debridement is covered once in a 3 year period;

### • **Endodontics**

- Root canal treatment on the same tooth is covered only once in a 2 year period;

- **Prosthodontics**
- Full upper and/or lower dentures are not to exceed one each in any 5 year period and only then if it is unserviceable and cannot be made serviceable;
- Partial dentures are not to be replaced within any 5 year period from initial placement unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
- Denture relines are limited to one per denture during any twelve consecutive months except in the case of an immediate denture then a reline is a benefit six months after initial placement.
- **EXCLUSIONS:**
- General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist. General anesthesia except when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.
- Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;
- Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the Eligible Person by any federal or state or provincial government agency or provided without cost the Eligible Person by a 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:
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth;
- Application of desensitizing agents;
- Experimental services or supplies.  
 Experimental 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, shall consider: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective.  
 Any individual whose claim is denied due to this experimental exclusion clause shall be notified of the denial within 20 working days of receipt of fully documented request. Any denial of benefits by Washington Dental Service on the grounds that a given procedure is deemed experimental, may be appealed to WDS;
- Dental services performed in a hospital and related hospital fees;
- Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);
- Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;
- Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility;
- Cysts and malignancies;
- Laboratory examination of tissue specimen;

- Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;
- Accidental injury. 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;
- Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
- Prophylactic removal of impactions (asymptomatic, nonpathological);
- Specialist consultations for non-covered benefits;
- Implant placement or removal, appliance placed on or services associated with implants;
- Orthodontic treatment which involves therapy for myofunctional problems, TMJ, dysfunctions, micrognathia, macroglossia, cleft palate, or hormonal imbalances causing growth and developmental abnormalities;
- All other services not specifically included on the patient's copayment schedule as a covered dental benefit;
- Treatment of fractures and dislocations to the jaw;
- Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Care".
- Materials placed in extraction sockets for the purpose of generating osseous filling.

### **DeltaCare Governing Administrative Policies**

Unlike medical care, where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The patient must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional treatment plus any copayment for covered benefits.

Failure to pay a scheduled copayment at the time of service may prevent future dental services from being rendered. Emergency services that are required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability and death, are exempt.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five (5) year limitation for replacements.

### **Preventative Control Programs**

Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed copayments, if any. Irrigation, infusion, special toothbrush, etc., are considered optional treatment. If performed, the patient is responsible for the cost.

Follow-up examinations for re-evaluation, particularly periodontal re-evaluation, are considered to be part of the general serviced rendered.

### **Fillings and Crowns**

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

Predominately base metal crowns are considered the covered benefit. The request for noble or high noble metal is considered optional and the cost difference is the patient's responsibility.

Porcelain or porcelain fused to metal crowns on all 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> molars is considered optional treatment; base metal crowns are considered adequate restorations. If performed, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

The DeltaCare program provides amalgam and resin restorations for the treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional and, if provided, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes, including but not limited to, cosmetics, abrasion, erosion, restoring or altering vertical dimension, or the anticipation of future fractures, are not covered benefits.

Composite resin restorations in posterior teeth are considered optional treatments. If provided, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Anterior porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a five (5) year period from initial placement.

A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required.

### **Partial Dentures**

A removable cast metal partial denture is considered an adequate restoration of a case when more than one tooth is missing in a dental arch. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

If a cast metal partial denture will restore the case, the panel dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance that the patient and dentist may choose to use. The patient must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional treatment plus any copayment for the covered benefit.

An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. The patient shall pay the applicable copayment for a cast metal partial denture.

The replacement of a single posterior tooth is not a covered benefit.

### **Complete Dentures**

If, in the construction of a denture, the patient and the Panel Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Full upper and/or lower dentures are not to exceed one each in any five year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either relining or repair.

### **Fixed Bridges**

A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years or older. Such treatment will be covered if the patient's oral health and general condition permits.

Fixed bridges used to replace missing posterior teeth are considered optional. The patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement and shall be covered only when the replacement duplicates the original bridge.

Fixed bridges are not a benefit for patients under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

## **Reconstruction**

The DeltaCare program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare program. Benefits only for emergency care will be available until the patient is able to transfer to the #4400 plan during open enrollment.

## **Specialized Techniques**

Precious metal (noble or high noble metal) for removable appliances, precision abutments for partials, crowns or bridges (overlays, implants, and appliances associated therewith), personalization and characterization are all considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's usual fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

## **Stayplates**

Stayplates in conjunction with fixed or removable appliances are only a benefit to replace recently extracted anterior permanent teeth during a healing period.

## **Frenectomy**

The frenum can be excised when the tongue has limited mobility or has a large diastema between teeth or when the frenum interferes with a prosthetic appliance.

## **Pedodontia**

Pedodontic referrals must be preauthorized by DeltaCare. Benefits for dependent children through age 3 and disabled dependents, are covered at 100% of the agreed upon fee less any applicable copayments for covered benefits, and children 4 years and older are covered at 50% of agreed-upon fee less any applicable copayments for covered services.

## **Treatment Planning**

The objective of this program is to see that all patients are brought to a good level of oral health and that this level of oral health is maintained. To achieve those objectives takes treatment planning. Priorities have been established on the following basis:

1. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the patient's overall oral health.
2. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the patient's oral health.
3. Priority is given to replacement of missing teeth causing a gross lack of function.
4. Exceptions are made to this treatment-planning concept based on individual

### Boeing Non-Union Employees Patient Copayment Schedule

The patient copay schedule shows what the patient will pay when he/she receives treatment from his/her DeltaCare provider. There will be a \$10 per visit copayment for all non diagnostic/preventative visits.

NB = Not a benefit on this plan

OP = Optional treatment

<b>Code</b>	<b>Procedure</b>	<b>Co-pay.</b>
<b>I. Diagnostic 00100 - 00999</b>		
D0120	Periodic oral evaluation – established patient	\$00.00
D0140	Limited oral evaluation-problem focused - GP	\$00.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$00.00
D0150	Comprehensive oral evaluation - GP	\$00.00
D0160	Detailed and extensive oral evaluation - problem focused GP	\$00.00
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit) GP	\$00.00
D0190	Specialist Exam (To referred specialist)	\$00.00
D0210	Intraoral - complete series, including bitewings	\$00.00
D0220	Intraoral - periapical, first film	\$00.00
D0230	Intraoral - periapical, each additional film	\$00.00
D0272	Bitewings - two films	\$00.00
D0273	Bitewings - three films	\$00.00
D0274	Bitewings - four films	\$00.00
D0277	Bitewings - four films	\$00.00
D0330	Panoramic film	\$00.00
D0460	Pulp vitality tests	\$00.00
<b>II. Preventive 01000 - 01999</b>		
D1110	Prophylaxis - adult	\$00.00
D1120	Prophylaxis - child	\$00.00
D1203	Fluoride excluding prophylaxis - child	\$00.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients – <i>child to age 19; 1 per 6 month period</i>	\$00.00
D1330	Oral hygiene instruction	\$00.00
D1351	Sealant - per tooth	\$00.00
D1510	Space maintainer - fixed, unilateral	\$00.00
D1515	Space maintainer - fixed, bilateral	\$00.00
D1520	Space maintainer - removable, unilateral	\$00.00
D1525	Space maintainer - removable, bilateral	\$00.00
D1550	Recementation of space maintainer	\$00.00
D1555	Removal of fixed space maintainer	\$00.00
<b>III. Minor Restorative 02000 - 02335</b>		
D2140	Amalgam - one surface, primary or permanent	\$00.00
D2150	Amalgam - two surfaces, primary or permanent	\$00.00
D2160	Amalgam - three surfaces, primary or permanent	\$00.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$00.00
D2330	Resin - one surface, anterior	\$00.00
D2331	Resin - two surfaces, anterior	\$00.00
D2332	Resin - three surfaces, anterior	\$00.00
D2335	Resin - four or more surfaces, anterior	\$00.00
<b>IV. Major Restorative 02510-02999</b>		
D2710	Crown - resin (indirect)	\$00.00
D2750	Crown - porcelain fused to high noble metal	\$194.00
D2751	Crown - porcelain fused to predominantly base metal	\$159.00
D2752	Crown - porcelain fused to noble metal	\$195.00

<b>Code</b>	<b>Procedure</b>	<b>Co-pay.</b>
D2780	Crown – 3/4 cast high noble metal	NB
D2781	Crown – 3/4 cast predominantly base metal	NB
D2782	Crown – 3/4 cast noble metal	NB
D2790	Crown - full cast high noble metal	\$190.00
D2791	Crown - full cast predominantly base metal	\$150.00
D2792	Crown - full cast noble metal	\$176.00
D2810	Crown - 3/4 cast metallic	\$180.00
D2910	Recement inlay	\$00.00
D2920	Recement crown	\$00.00
D2930	Prefabricated stainless steel crown - primary tooth	\$00.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$00.00
D2932	Prefabricated resin crown anterior teeth only	\$00.00
D2933	Prefabricated stainless steel resin crown w/ resin window	NB
D2940	Sedative filling	\$00.00
D2950	Crown build-up (substructure) including any pins	\$00.00
D2951	Pin retention - per tooth, in addition to restoration	\$00.00
D2952	Post and core in addition to crown, indirectly fabricated	\$00.00
D2953	Each additional indirectly fabricated post – same tooth	\$00.00
D2954	Prefabricated post and core in addition to crown	\$00.00
D2957	Each additional prefabricated post same tooth	NB
D2970	Temporary crown (fractured tooth)	\$00.00
D2980	Crown repair	NB

#### **V. Endodontics 03000 - 03999**

D3110	Pulp cap-direct (excluding final restoration)	\$00.00
D3120	Pulp cap-indirect (excluding final restoration)	\$00.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament	\$00.00
D3230	Pulpal therapy anterior, primary tooth	NB
D3240	Pulpal therapy posterior, primary tooth	NB
D3310	Root canal therapy - anterior	\$00.00
D3320	Root canal therapy - bicuspid	\$00.00
D3330	Root canal therapy - molar	\$00.00
D3346	Root canal - four canal	\$00.00
D3347	Retreatment of previous root canal therapy - anterior	\$00.00
D3348	Retreatment of previous root canal therapy - bicuspid	\$00.00
D3350	Apexification/recalcification per visit	\$00.00
D3351	Retreatment of previous root canal therapy - molar	\$00.00
D3410	Apexification/recalcification-final visit	\$00.00
D3421	Apicoectomy/periradicular surgery - anterior	\$00.00
D3425	Apicoectomy/periradicular surgery - bicuspid	\$00.00
D3426	Apicoectomy/periradicular surgery - molar (first root)	\$00.00
D3430	Apicoectomy/periradicular surgery - (additional root)	\$00.00
D3450	Retrograde filling - per root	\$00.00
D3920	Root amputation - per root	\$00.00

#### **VI. Periodontics - 04000 - 04999**

D4210	Gingivectomy or gingivoplasty - Four or more contiguous teeth or bounded teeth spaces per quadrant	\$00.00
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<b>Code</b>	<b>Procedure</b>	<b>Co-pay.</b>
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	\$00.00
D4220	Gingival curettage surgical per quadrant	\$00.00
D4240	Gingival flap procedure including root planing per quadrant	NB
D4245	Apically position	\$00.00
D4249	Crown lengthening - hard/soft tissue	\$00.00
D4260	Osseous surgery - Four or more contiguous teeth or bounded teeth spaces per quadrant	\$00.00
D4261	Osseous graft – single site	\$00.00
D4262	Osseous graft – multi site	\$00.00
D4270	Pedicle soft tissue graft procedure	\$00.00
D4271	Free soft tissue graft and donor site	\$00.00
D4341	Periodontal root planing - Four or more contiguous teeth or bounded teeth spaces per quadrant	\$00.00
D4355	Full Mouth debridement to enable comprehensive evaluation and diagnosis	\$00.00
D4381	Localized delivery of chemotherapeutic agents	\$00.00
D4910	Periodontal maintenance following active therapy	\$00.00

#### **VII. Prosthodontics, removable 05000 - 05899**

D5110	Complete denture, upper**	\$243.00
D5120	Complete denture, lower**	\$243.00
D5130	Immediate denture, upper**	\$428.00
D5140	Immediate denture, lower**	\$428.00
D5211	Upper partial denture, resin base**	NB
D5212	Lower partial denture, resin base**	NB
D5213	Upper partial denture - metal base with resin saddles**	\$264.00
D5214	Lower partial denture - metal base with resin saddles**	\$264.00
D5281	Unilateral partial denture	NB
D5410	Adjust complete denture - upper	\$00.00
D5411	Adjust complete denture - lower	\$00.00
D5421	Adjust partial denture - upper	\$00.00
D5422	Adjust partial denture – lower	\$00.00
D5510	Repair broken complete denture base	\$00.00
D5520	Replace missing or broken teeth - complete denture	\$00.00
D5610	Repair resin saddle or base	\$00.00
D5620	Repair cast framework	\$00.00
D5630	Repair or replace broken clasp	\$00.00
D5640	Replace broken teeth - per tooth	\$00.00
D5650	Add tooth to existing partial denture	\$00.00
D5660	Add clasp to existing partial denture	\$00.00
D5710	Rebase denture - complete, upper	\$00.00
D5711	Rebase denture - complete, lower	\$00.00
D5720	Rebase denture - partial, upper	\$00.00
D5721	Rebase denture - partial, lower	\$00.00
D5730	Reline denture - complete upper (chairside)	\$00.00
D5731	Reline denture - complete lower (chairside)	\$00.00
D5740	Reline denture - partial upper (chairside)	\$00.00
D5741	Reline denture - partial lower (chairside)	\$00.00
D5750	Reline denture - complete upper (laboratory)	\$00.00
D5751	Reline denture - complete lower (laboratory)	\$00.00

<b>Code</b>	<b>Procedure</b>	<b>Co-pay.</b>
D5760	Reline denture - partial upper (laboratory)	\$00.00
D5761	Reline denture - partial lower (laboratory)	\$00.00
D5820	Temp partial stay plate, upper	NB
D5821	Temp partial stay plate, lower	NB
D5850	Tissue conditioning, upper - denture	\$00.00
D5851	Tissue conditioning, lower - denture	\$00.00
D5860	Overdenture - complete by report	NB
D5861	Overdenture - partial by report	NB

\*\*Includes any adjustments for 6 months

### **VIII. Prosthodontics, Fixed 06200 - 06999**

D6210	Pontic - cast high noble metal	\$186.00
D6211	Pontic - cast predominantly base metal	\$150.00
D6212	Pontic - cast noble metal	\$173.00
D6240	Pontic - porcelain fused to high noble metal	\$188.00
D6241	Pontic - porcelain fused to predominantly base metal	\$156.00
D6242	Pontic - porcelain fused to noble metal	\$180.00
D6520	Inlay Metallic 2 surface	NB
D6530	Inlay Metallic 3 or more surface	NB
D6540	Onlay 3 surface base metal onlay	NB
D6544	Onlay 4 or more surfaces base metal onlay	NB
D6722	Crown - resin with noble metal	NB
D6750	Crown - porcelain fused to high noble metal	\$190.00
D6751	Crown - porcelain fused to predominantly base metal	\$162.00
D6752	Crown - porcelain fused to noble metal	\$182.00
D6780	Crown - 3/4 cast high noble metal	NB
D6781	Crown - 3/4 cast predominantly base metal	NB
D6782	Crown - cast high noble metal	NB
D6790	Crown - full cast high noble metal	NB
D6791	Crown - full cast predominantly base metal	NB
D6792	Crown - full cast noble metal	NB
D6930	Recement bridge	\$00.00
D6940	Stress breaker	\$00.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	\$00.00
D6972	Prefabricated post and core buildup	\$00.00
D6973	Core buildup for retainer, including any pins	\$00.00
D6976	Each additional indirectly fabricated post – same tooth	NB
D6977	Each additional prefab post	NB
D6980	Bridge repair	NB

### **IX. Oral Surgery 07000 - 07999**

D7110	Single tooth	\$00.00
D7120	Each additional tooth	\$00.00
D7130	Root removal - exposed root	\$00.00
D7210	Surgical removal of erupted tooth	\$00.00
D7220	Removal of impacted tooth - soft tissue	\$00.00
D7230	Removal of impacted tooth - partially bony	\$00.00
D7240	Removal of impacted tooth - completely bony	\$00.00
D7241	Removal of impacted tooth - completely bony	\$00.00

<b>Code</b>	<b>Procedure</b>	<b>Co-pay.</b>
D7250	Surgical removal of residual tooth roots	\$00.00
D7280	Surgical exposure impacted/unerupted tooth - ortho	\$00.00
D7281	Surgical exposure impacted/unerupted tooth - aid eruption	\$00.00
D7286	Biopsy of oral tissue, soft	\$00.00
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces - per quadrant	\$00.00
D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces - per quadrant	\$00.00
D7340	Vestibuloplasty	\$00.00
D7350	Vestibuloplasty - ridge extension	\$00.00
D7470	Removal of exostosis maxilla or mandible	\$00.00
D7510	Incision and drainage of abscess	\$00.00
D7520	Incision and drainage of abscess extra oral	NB
D7960	Frenulectomy (frenectomy or frenotomy)	\$00.00
D7970	Exc of hyperplastic tissue - per arch	\$00.00

**X. Additional Procedures 09000 - 09999**

D9110	Palliative treatment	\$00.00
D9211	Regional block anesthesia	\$00.00
D9212	Trigeminal division block anesthesia	\$00.00
D9215	Local anesthesia	\$00.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$00.00
D9430	Office visit for observation, regular hours, no other tx	NB
D9440	Office visit - after regularly scheduled hours	\$00.00
D9951	Occlusal adjustment - limited	\$00.00
D9952	Occlusal adjustment - complete	\$00.00

**Specialty Services**

<b>Code</b>	<b>Procedure</b>	<b>Co-pay.</b>
D0190	Specialist examination	\$00.00
D3330	Molar root canal (excluding final restoration)	\$00.00
D3410	Apicoectomy/Perriradicular surgery-anterior	\$00.00
D4260	Osseous surgery (including flap entry and closure)-per quadrant	\$00.00
D4261	Osseous graft-single site (including flap entry, closure and donor site)	\$00.00
D4262	Osseous graft-multiple sites (including flap entry, closure and donor site)	\$00.00
D4270	Pedicle soft tissue graft procedure	\$00.00
D4271	Free soft tissue graft procedure (including donor site)	\$00.00
D7220	Removal of impacted tooth-soft tissue	\$00.00
D7230	Removal of impacted tooth-partially bony	\$00.00
D7240	Removal of impacted tooth-completely bony	\$00.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$00.00
D7285	Biopsy of oral tissue-hard	\$00.00
D7286	Biopsy of oral tissue-soft	\$00.00
D7510	Incision and drainage of abscess-intraoral soft tissue	\$00.00
D7520	Incision and drainage of abscess-extraoral soft tissue	\$00.00



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, as part of the nation's largest dental benefits provider, we serve approximately 1.5 million people 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 member 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. Healthy teeth for a wonderful smile – that is what we are all about!

To learn more about Washington Dental Service and your benefits, visit our Internet Web site at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com).