

Delta Dental PPO
National Coverage

Boeing BNA-UAW 887/1519

Washington Dental Service, a Delta Dental Plan
Program No. **04609**

Effective **January 1, 2010**

Questions Regarding Your Program

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

Washington Dental Service Customer Service

(206) 522-2300

(800) 554-1907

Written inquiries may be sent to:

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

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

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

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

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

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

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

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

The Summary Plan Description for this Plan is The Boeing Company Health and Welfare Plans booklet for the eligible population, any applicable provider directory and this coverage-specific brochure issued by Washington Dental Service.

For detailed information concerning employee and dependent eligibility, enrollment, contributions, coverage terminations, leave of absence provisions, eligibility review and appeals, Qualified Medical Child Support Order (QMCSO), ERISA Special Disclosures and other general plan information, refer to The Boeing Health and Welfare Plans Summary Plan Description, which supersedes any eligibility information contained in this document, or contact the plan administrator.

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

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Summary of Benefits

Reimbursement Levels for Allowable Benefits

Delta Dental PPO Dentists

*Class I	Constant 100%
Class II	Constant 80%
Class III Crowns	Constant 80%
Class III Denture and Bridges	Constant 60%
*Orthodontic procedures	Constant 50%

Delta Dental PPO Dentists Plan Deductible

*Annual Deductible per Person	\$50
*Annual Deductible — Family Maximum	\$150

*Annual deductible is waived for Class I and Orthodontic covered dental benefits.

Non-Delta Dental PPO Dentists

Class I	Constant 80%
Class II	Constant 50%
Class III	Constant 50%
*Orthodontic procedures	Constant 50%

Non-Delta Dental PPO Dentists Plan Deductible

*Annual Deductible per Person	\$75
*Annual Deductible — Family Maximum	\$225

*Annual deductible is waived for Orthodontic covered dental benefits.

Plan Maximum

Annual Program Maximum per Person	\$1,800
Lifetime Orthodontic Benefits per Person	\$1,800

Benefit Period

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

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

Introduction

Welcome to your Delta Dental PPO program from Washington Dental Service/Delta Dental. Washington Dental Service (WDS) is a member of the Delta Dental Plans Association (DDPA), the nation’s largest, most experienced dental benefits organization. It is made up of local, not-for-profit Delta Dental plans that provide a range of employee dental benefit programs. Delta Dental is unique in that its member plans contract with more than 124,000 dentists nationwide who provide dental care to subscribers and their dependents at previously agreed-upon fee levels. Washington Dental Service administers this Delta Dental PPO dental plan.

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

How to Use Your Program

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

Choosing a Dentist

With Washington Dental Service/Delta Dental, 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 Delta Dental dentist. Tell your dentist that you are covered by a Delta Dental plan and provide your member identification number, the program name and the group number — which is **04609**.

Delta Dental Participating Dentists

There are advantages to selecting a Delta Dental member dentist. First, you have a choice of more than 124,000 participating dentists nationwide. And, if you select a dentist who is a participant with Delta Dental, that dentist has agreed to provide treatment for eligible persons covered by Delta Dental programs according to the provisions of his or her member dentist contract. You will not have to hassle with claim forms or other paperwork. Participating dentists complete claim forms and submit them to Washington Dental Service/Delta Dental. Payment will be based on the pre-approved fees your dentist has filed with the local Delta Dental plan and will be sent directly to your dentist. You will be responsible only for stated coinsurance (see Coinsurance), deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered benefits.

You can find a participating dentist in your area by visiting the Washington Dental Service Web site at www.DeltaDentalWA.com. Go to Looking for a Dentist and click on Read More. This will bring up the WDS Dentist Directory and the Delta Dental Plans Association National Provider Directory.

Delta Dental PPO Dentists

Delta Dental PPO dentists must be Delta Dental member dentists in order to participate in the PPO network. More than 63,000 dentists participate in this network nationwide. 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 part of the Delta Dental PPO network, your benefits will likely be paid at a higher level and your out-of-pocket expenses may be lower. Delta Dental PPO dentists complete claim forms and submit them directly to Washington Dental Service/Delta Dental. PPO dentists receive payment based on their pre-approved PPO fees and they cannot charge you more than these fees. You will be responsible only for your stated deductibles, coinsurance and/or amounts in excess of the program maximums.

Delta Dental Premier® Dentists (non-PPO)

Delta Dental Premier® dentists also have contracts with Delta Dental, but they are not necessarily part of the PPO network. Delta Dental Premier dentists will still submit claims for you and receive payment directly from Washington Dental Service/Delta Dental. Their payments will be based on their pre-approved fees with Delta Dental. They also cannot charge you more than these fees. You will be responsible only for stated deductibles, coinsurance and/or amounts in excess of the program maximums.

Nonparticipating Dentists

You are not limited to visiting a Delta Dental dentist. However, if you choose a nonparticipating dentist, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Washington Dental Service/Delta Dental in Seattle, Washington. Claim payments will be based on actual charges or Washington Dental Service's maximum allowable fees for nonparticipating dentists in the state in which services are performed, whichever is less. You will be responsible for any balance remaining. Please be aware that Delta Dental has no control over nonparticipating dentists' charges or billing procedures.

Claim Forms

American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our Web site at www.DeltaDentalWA.com. Washington Dental Service/Delta Dental is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 12 months after the date the treatment is provided. For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.

Predetermination of Benefits

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

Reimbursement Levels

Your dental plan offers three classes of covered treatment, and your reimbursement level will depend on whether or not you seek care from a Delta Dental PPO dentist. 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.

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

Limitations and Exclusions

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

Coinsurance

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

Program Maximum

For your program, the maximum amount payable by Washington Dental Service/Delta Dental for Class I, II and III covered dental benefits per eligible person is \$1,800 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

The lifetime maximum amount payable by Washington Dental Service/Delta Dental for orthodontic benefits is \$1,800 per eligible person.

Delta Dental PPO Dentists Program Deductible

Your program 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 \$150. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be \$150. 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. The deductible does not apply to Class I covered dental benefits, or orthodontic benefits.

Non-Delta Dental PPO Dentists Program Deductible

Your program has a \$75 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of \$75 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 \$225. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be \$225. 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. The deductible does not apply to orthodontic benefits.

New Hire Eligibility

If you are a newly hired employee, coverage will become effective on the first day of the month following your first day of employment.

Dependent Eligibility

Coverage for unmarried dependent children under age 25. Tax free health care coverage for dependent children will be modified to conform to IRS rules for dependent children, as described below.

Overview of Changes

If the following requirements are not met, benefits are taxable. A new definition of dependent child will apply to match the IRS definition. The IRS requires that you, your spouse, and/or your former spouse provide more than half of the child's support. Also, if the child is not your natural child, adopted child, stepchild, or otherwise related by blood or marriage, the child must live with you. If the child is living at home, the value of room and board is included as support provided by the parents. The purpose of the change is to avoid imputed income on the value of health care coverage for dependent children.

Employee Eligibility and Termination

Eligible Employee Groups are shown as follows for California only:

- 501 – International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local No. 887
- 505 – International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local No. 1519
- 513 – International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local No. 952
- 514 – International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local No. 1558
- 556 – International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local No. 864
- 561 – International Brotherhood of Carpenters & Joiners of America—Local No. 721
- 562 – International Brotherhood of Electrical Workers AFL-CIO—Local No. 2295
- 564 – International Union of Operating Engineers—Local No. 501
- 565 - International Brotherhood of Painters & Allied Trades of America, District Council 36
- 567 – Sheet Metal Workers International Association—Local No. 461
- 568 – International Brotherhood of Teamsters, Local No. 952
- 569 – International Brotherhood of Teamsters, Local No. 578

Eligible employees are all full-time employees for whom employer contributions are made. In cases where both husband and wife are employees of the group both must be enrolled in this program either as an employee or as a dependent. No person may be enrolled as both an employee and as a dependent.

You must complete an enrollment form. WDS must receive a completed enrollment form within 60 days of employee's eligibility date. If the enrollment form is not received within 60 days, enrollment will not be accepted until the next open enrollment period. Open enrollment occurs annually as determined by your employer. All of your eligible dependents must be listed on the enrollment form.

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

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

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

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 that would have previously terminated coverage, employee 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.

Contact your employer for further clarification and details of how it plans to implement this continuation of coverage for eligible persons. The Employer determines the Employee and Dependent eligibility for benefits. Please refer to the Boeing Health and Welfare Summary Plan Description for details.

Dependent Eligibility and Termination

Dependents eligible for the dental plan will include your legal spouse and children (natural children, adopted children, children legally placed with you for adoption, and stepchildren) who are under age 25 and unmarried.

You also may request coverage for the following dependents:

- State registered Domestic Partner.
- A common-law spouse if the relationship meets the common-law requirements for the state in which you entered into the common-law relationship.
- A same-gender domestic partner of an active employee under the medical and dental plans if you and your same-gender domestic partner meet all of the following requirements. You and your partner are
 - Of the same gender.
 - Eighteen years of age or older.
 - Financially interdependent and share the same residence.
 - Not married to or legally separated from another person or involved in another same-gender domestic partner relationship.
 - Not blood relatives of a degree of closeness that would prohibit marriage.
 - A same-gender domestic partner of an active employee is considered a spouse for the purpose of the medical and dental plans. You must complete an Affidavit of Domestic Partnership to cover a same-gender domestic partner under the plans.
- Unmarried children of the active employee’s same-gender domestic partner who are under age 25. These children are considered stepchildren for the purpose of the dental plan. The Affidavit of
- Domestic Partnership requirement applies.
- Other children, as follows, who are under age 25 unmarried:
 - Children who are related to you either directly or through marriage (such as grandchildren, nieces, nephews).
 - Children for whom you have legal custody or guardianship, or a pending application for legal custody or guardianship, or foster children, who are living with you.

In accordance with Federal law, the Company also will provide medical and dental coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Documentation will be required to request coverage for a child named in a QMCSO, for a child for whom you have been given legal custody or guardianship, or for a same-gender domestic partner or his or her children.

A new family member, with the exception of newborns and adopted children, must be enrolled on the first day of the month following the date he or she qualifies as an eligible dependent.

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

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

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

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

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

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, dependent coverage may continue for a period of time on a self-pay basis.

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.

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

Incapacitated Children

A disabled child age 25 or older may continue to be eligible (or enrolled if the child of a newly eligible employee) if he or she is incapable of self-support due to any mental or physical condition that began before age 25. The child must be unmarried and dependent on you for principal support. Coverage may continue under the dental plan for the duration of the incapacity as long as you continue to be eligible under the plans and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 25 or older.

Principal Support

Principal support means you, your spouse, and/or your former spouse provide more than half of the child's support. In determining whether you provide more than half of the child's support, any student scholarships can be ignored, unless the child is not your natural or adopted child.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, the plan generally does not cover services you or an eligible dependent receives while not covered under the plan. However, the plan covers crowns, bridges, dentures, implants and root canals during the 31 days following termination of the eligible person's coverage if the dentist has started the course of treatment before the eligible person's coverage ends.

Services in connection with a prosthetic device, including the abutment crowns of a partial denture, are covered if the denture impressions were taken while the eligible person was covered under the plan. However, the prosthetic device must first be installed or delivered to the eligible person within 31 days following termination of coverage. Services are not covered if the denture impressions were taken before the date coverage became effective. If the impressions were taken after coverage terminated, the services must meet the requirements detailed in the preceding paragraph.

Services in connection with a crown required for the restoration of a tooth (independent of the use of the crown in connection with a partial denture) are covered if the tooth was prepared for the crown before coverage terminated and the crown is seated during the 31 days following termination of the eligible person's coverage. Otherwise, the crown must be installed according to the requirements described above.

The plan covers services and supplies in connection with covered orthodontia care if such services and supplies are provided during the three months following termination of the eligible person's coverage.

Special Enrollment Periods

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

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 employer.

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 Washington Dental Service hotline for Fraud & Abuse at (800) 211-0359 or (206) 985-5927. You may also want to alert any of the appropriate law enforcement authorities listed below:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at (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.

Coordination of Benefits

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

The following rules establish the order of benefit payments:

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

The benefits of the plan covering the parent whose month and day of birth occurs earlier in the calendar year will be determined before the benefits of the plan of the parent whose month and day of birth occurs later in the calendar year. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

- d. If the person is a child of parents who are separated or divorced or not living together, whether or not they have ever been married, if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, then the benefits are determined in the following order:
 - 1) The plan covering the custodial parent, first;
 - 2) The plan covering the spouse of the custodial parent, second;
 - 3) The plan covering the non-custodial parent, third; and
 - 4) The plan covering the spouse of the non-custodial parent, last.
- e. If a court decrees that one parent has financial or health care expenses or health care coverage responsibility, that plan is primary.

- f. The plan covering the person as a retired or laid-off employee or dependent of such person will be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person. This provision will not apply if neither plan has a provision regarding laid-off or retired employees that results in each plan determining its benefits after the other.
- g. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan.
- h. If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

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

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

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

Benefits Covered By Your Program

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

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

Class I

Diagnostic

Covered Dental Benefits

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

Limitations

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

Exclusions

- Study models.
- Elective second opinions.

Preventive

Covered Dental Benefits

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

Limitations

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

- Fissure sealants are available for children through age 14. If eruption of permanent molars is delayed, sealants 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 maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once in a three-year period per tooth.
- Replacement of a space maintainer previously paid for by Washington Dental Service is not a paid covered benefit.

Exclusions

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

Refer also to General Limitations and General Exclusions

Class II

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

General Anesthesia

Covered Dental Benefits

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

Limitations

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

Intravenous Sedation

Covered Dental Benefits

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

Limitations

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

Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain.

Limitations

- Palliative treatment is not a paid covered benefit when the same provider performs any other definitive treatment on the same date.

Oral Surgery

Covered Dental Benefits

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

Exclusions

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

Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth are a covered benefit. Services covered include periodontal scaling/root planing, gingivectomy, and limited adjustments to occlusion (eight teeth or fewer).
- *Refer to Class I Preventive for periodontal maintenance benefits.*

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

Limitations

- Periodontal scaling/root planing is covered once in a two-year period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

- Gingival curettage.
- Occlusal splints.
- Occlusal guard (nightguard).
- Major (complete) occlusal adjustment.

Endodontics

Covered Dental Benefits

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

Limitations

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

Exclusions

- Bleaching of teeth.

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

Class III

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

Restorative

Covered Dental Benefits

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

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- 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.
- Crowns, veneers, inlays (as a single tooth restoration — with Limitations) or onlays on the same teeth are covered once in a five-year period from the seat date.
- Payment for crowns, veneers, inlays (as a single tooth restoration — with Limitations) or onlays shall be paid upon the seat date.
- Inlays (as a single tooth restoration) will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.

- 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.
- WDS will allow the appropriate amount for an amalgam restoration or resin-based composite restoration toward the cost of a laboratory processed resin inlay (as a single tooth restoration – with Limitations), onlay, veneer or crown.
- Crown buildups are a Covered Dental Benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- Crown buildups are covered once in a two-year period from the date of service.
- Crown buildups are Not a Paid Covered Benefit within two years of a restoration on the same tooth from the date of service.
- Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are Not a Paid Covered Benefit.
- Post and core are covered once in a two-year period on the same tooth from the original date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is Not a Paid Covered Benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth, whether or not a removable partial denture is part of the treatment.
- Crowns or onlays are Not a Paid Covered Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are Not a Paid Covered Benefit.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are Not a Paid Covered Benefit.

Exclusions

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

Prosthodontics

Covered Dental Benefits

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

Limitations

- Replacement of an existing prosthetic device is covered only once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered benefit on the same teeth once in a five-year period from the delivery date only when used as an abutment for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Surgical placement or removal of implants or attachments to implants is not a paid covered benefit.
- Crowns in conjunction with overdentures are not a paid covered benefit.
- Porcelain and resin inlay bridges are not a paid covered benefit.

- **Full, immediate and overdentures** — Washington Dental Service will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- Root canals in conjunction with overdentures are not a paid covered benefit.
- **Partial dentures** — If a more elaborate or precision device is used to restore the case, Washington Dental Service will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Temporary partial dentures** — Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.
- Fixed prosthodontics for children under 16 years of age are not a paid covered benefit.
- **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.
- **Implants** — Washington Dental Service will allow the appropriate amount for a crown and/or appliances constructed on implants. Such allowance will be paid at the Class III payment level. Any additional cost is your responsibility. Washington Dental Service will not pay for any replacement placed within five years from the date of placement.

Exclusions

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

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

Orthodontic Benefits for Adults and Eligible Children

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

The lifetime maximum amount payable by Washington Dental Service for orthodontic benefits provided to an eligible person shall be \$1,800. Not more than \$900 of the maximum, or one-half of Washington Dental Service's total responsibility shall be payable for treatment during the "construction phase". Subsequent payments of Washington Dental Service's responsibility shall be made on a monthly basis throughout the length of treatment submitted, providing the employee is eligible and the dependent is in compliance with the age limitation.

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

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

Covered Dental Benefits

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

Limitations

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

Exclusions

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

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

General Limitations

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

General Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
2. Application of desensitizing agents.

3. Experimental services or supplies, which include:
 - a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, Washington Dental Service, in conjunction with the American Dental Association, will consider them if:
 - i) The services are in general use in the dental community in the state of Washington;
 - ii) The services are under continued scientific testing and research;
 - iii) The services show a demonstrable benefit for a particular dental condition; and
 - iv) They are proven to be safe and effective.

Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
 - b. Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental, may be appealed to Washington Dental Service. By law, Washington Dental Service must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual.
4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.
5. Prescription drugs.
6. In the event an eligible person fails to obtain a required examination from a Washington Dental Service-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
8. Broken appointments.
9. Patient management problems.
10. Completing claim forms.
11. Habit-breaking appliances.
12. TMJ services or supplies.
13. This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this program as covered dental benefits.

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

Frequently Asked Questions about Your Dental Benefits

What Is 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. Delta Dental, the nation's largest, most experienced dental benefits company, provides dental coverage to nearly one out of every four Americans with dental coverage. Washington Dental Service is a member of the Delta Dental Plans Association.

What Is A Delta Dental Plan “Participating Dentist”?

A Delta Dental participating dentist is a dentist who has signed an agreement with Washington Dental Service — or with any of the other Delta Dental plans located in all 50 states — stipulating that he or she will provide dental treatment to subscribers and their dependents covered by the plan's group dental care programs. Approximately three out of every four U.S. dentists now participate in the Delta Dental Plans Delta Dental Premier network. Delta Dental participating dentists complete claim forms and submit them directly to Washington Dental Service.

Can I choose my own dentist?

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

How Can I Obtain A List Of Delta Dental Participating Dentists?

You can obtain a directory of participating dentists by going online to the Washington Dental Service/Delta Dental Web site at www.DeltaDentalWA.com. Go to Looking for a Dentist and click on Read More. This will bring up the Washington Dental Service Dentist Directory and the Delta Dental Plans Association National Provider Directory. If you do not have access to the online directory, you may call Washington Dental Service's customer service department at (206) 522-2300 or call toll-free at (800) 554-1907 for assistance in obtaining a list of participating dentists.

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 Delta Dental Service participating provider, he or she will complete and submit claim forms for you.

What is the mailing address for Dental Service claim forms?

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

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

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

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

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

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.

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

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

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

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

Glossary

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

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

APICOECTOMY — Surgery on the root of a tooth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NIGHTGUARD — See “Occlusal Guard”.

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

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

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

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

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

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

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

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

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

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

PROPHYLAXIS — Cleaning and polishing of teeth.

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

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

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

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

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

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

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

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

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

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

Claim Review and Appeal

Predetermination of Benefits

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

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

Urgent Predetermination Requests

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

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

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

Informal Review

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

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

Please submit your request for a review to:

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

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

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

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

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

Appeals Committee

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

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

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedures appeals and 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 Washington Dental Service can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.

Subrogation

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

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

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

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

Subscriber Rights and Responsibilities

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

You Have The Right To:

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

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

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

MySmile[®] Personal Benefits Center

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

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

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

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

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

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