DELTA DENTAL
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

Comprehensive Summary of your Washington Dental Service Individual Plan Options

Your Benefits – The Highlights

We want you to fully understand important information about your plan. Your benefit booklet, available online, contains the most comprehensive information. In addition, we have summarized key information in this document. Consider this your quick reference guide to your dental benefits.

Annual deductible per person per calendar year (Only applies to non-PPO or non participating dentists, waived for Class I benefits and dental accident benefits)	**$50** **$150**
Diagnostic and preventive services • Exams, Cleanings (2 per year) • Bitewing X-rays (2 per year) • Full mouth X-rays (once every 5 years) • Sealants (once in a 2 per year period) • Topical Fluoride(once per year)	**100%**
Basic Restorative services • Composite (tooth colored) fillings are covered for front teeth • Amalgam (silver) fillings for back teeth	**80%**
Major Restorative services • Crowns and gold restorations • Root Canals • Periodontics • Dentures	**50%***
Annual Benefit Maximum	**$1,000**

*The 12-month waiting period is waived if the subscriber was covered by WDS dental coverage for a minimum of three months within the past six months.

Eligibility

The term eligibility refers to who may be covered by a Washington Dental Service individual plan:

- Washington Dental Service Individual and Individual Plus Plans are only offered to permanent residents of Washington state.
- Two person plans may cover you and a spouse, you and a domestic partner, or you and an eligible dependent.
- Eligible dependents are children to age 25, or up to any age if they have a disability.
- You may add or remove dependents at any time, or change your address or your bank account information at any time by going online to www.DeltaDentalWa.com. Your premium may increase due to these changes. The online program will notify you of your new rate.

Out-of-Network Dentists

You may see any licensed dentist in Washington. If you see a dentist who is not on the Washington Dental Service network, there is a $50 annual deductible for individuals ($150 annual maximum for families). The deductible is waived for many benefits.

Benefit and Waiting Periods

You may need to wait for a designated period after your Washington Dental Service coverage becomes effective before receiving certain treatments or services:

- The benefit period starts the first day of the first month your coverage is effective, and ends December 31.
- After the first year of coverage, the benefit period is the 12-month period starting January 1 and ending December 31.
- Unless your waiting periods have been waived based on previous coverage through WDS, you will have 12-month waiting periods before we provide any coverage for crowns, endodontics, periodontics, or prosthodontics.

Premiums and Other Expenses

Premiums refer to the monthly amount you pay for coverage. You can also expect other expenses.

- For more extensive dental care treatment, 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.
- Premium rates may be updated every year on Jan 1. We will notify you within at least 60 days of the update, at which time you may choose a different plan.
- You may cancel at any time, but if you do, you must wait 24 months before re-enrolling.
- Premium payment is due on the 28th of the month prior to the month of coverage.
- Premium payment is made through electronic withdrawal from your bank account. Your coverage will be cancelled if we cannot successfully withdraw your premium two months in a row.

Please Note: This brief summary of benefits is not a contract. Please continue through your benefit booklet for complete information about your plan. Please feel free to call customer service at 800-286-1885 with any questions.

DENTAL CARE SERVICE CONTRACT

Offered by

WASHINGTON DENTAL SERVICE

Individual Plan

Coverage Contract

Welcome to the Delta Dental PPO dental plan, which is offered by Washington Dental Service (WDS), the state's largest and most experienced dental benefits carrier. WDS is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from Washington Dental Service, you join more than 54 million people across the nation who have discovered the value of our coverage.

This coverage Contract contains information you need to know concerning eligibility, enrollment, Plan benefits, and your rights under this WDS preferred provider (PPO) plan ("Individual Plan").

You have the right to review this Contract. If, for any reason, you are not satisfied with this Contract, you may return it to WDS within 10 days of the day you receive it. At such time, this Contract becomes null and void retroactive to the date it was issued. If no benefits were provided during the 10-day examination period, WDS will refund your Premium in full. WDS will also pay you an additional 10 percent of the refunded Premium amount if the refund is not made within 30 days of returning the Contract.

If you received benefits during the 10-day examination period, WDS will not refund any Premium paid, and benefits will continue until the end of the month for which benefits are paid.

Failure to return this Contract, in conjunction with payment of Premium, constitutes acceptance of the terms and conditions specified herein.

WDS agrees to underwrite and provide the benefits and services described in this Contract to you and your enrolled Eligible Dependents, provided you and your enrolled Eligible Dependents meet and comply with the provisions set forth herein.

The terms "you" and "your" refer to the person(s) enrolled in this Individual Plan. The terms "we," "us" and "our" refer to WDS. The capitalized words used throughout this Contract have specific meanings. The definitions of capitalized words can be found in the Definitions section of this Contract.

Article I —Eligibility and Enrollment

1.01 Who Can Enroll in This Individual Plan

You are eligible for this Plan if you are and remain a permanent resident in Washington state and are over the age of 18 or are an emancipated minor and have no other dental coverage. A permanent resident is a person who lives in Washington state for a minimum of six months during the calendar year. WDS may require proof of residency from you upon request. Proof of residency may be in the form of a Washington state driver's license or identification card, voter's registration card, a current month's utility bill with your residence street address, or other similar verification.

You may enroll an Eligible Dependent(s) in this Individual Plan if:

(i) They are your spouse or domestic partner;

(ii) They are an Eligible Dependent child not over the age of 25; or

(iii) They are an Eligible Dependent child over the age of 25 who qualifies as a disabled Eligible Dependent (see *Continued Eligibility for a Disabled Dependent Child*).

Proof of eligibility for dependent coverage is not required upon application, but may be requested periodically.

1.02 Enrollment Changes

If you need to add or remove an Eligible Dependent(s) from this Plan, please see instructions on our Web site, www.DeltaDentalWA.com or call (800) 286-1885. See **When Coverage Begins** and **When Coverage Ends** for information on when dependents' eligibility for coverage begins and ends.

1.03 Payment Due Date/Grace Period

Your monthly payment must be made by scheduled electronic withdrawal from your checking or savings account. Your monthly payment for the upcoming month will be deducted from your account on the 28th day of each month or the next business day. If there are insufficient funds in your bank account for payment of Premium, on the due date, we will attempt to withdraw Premiums for two months on the due date at the end of the next month. This constitutes a grace period of more than 20 days. If there are still insufficient funds, WDS will immediately terminate this Contract for nonpayment of Premium, effective as of the last day of the month for which Premium payment was received.

1.04 Contract Renewal and Modifications

Each year on January 1, we will automatically renew your Contract for the next year unless you notify us in writing before December 15 that you want to cancel your Contract.

WDS reserves the right to change the provisions of this Contract, including the benefits and services provided and the applicable Premium, at the annual Plan renewal. Such changes shall be in effect for all Eligible Persons under this Individual Plan, and not specific to any single enrolled individual.

Thirty (30) days prior to December 15, we will notify you of Plan changes, including any Premium rate adjustments. During this Open Enrollment Period, you may choose another benefit option.

No notification is necessary if you accept the modification to the Contract. Lack of notification shall be interpreted as acceptance of the modification.

No modification of the terms of this Contract shall be binding upon WDS unless endorsed, in writing, and signed by an authorized officer of WDS. Such endorsement shall be deemed a part of this Contract, effective as of the effective date of the endorsement. Any amendment or Contract modification required by law or regulation shall become effective as of the effective date required by such law or regulation.

1.05 Premium Rate Adjustments

Premium rate adjustments may occur at the Contract renewal or as follows:

- There is a change in your family composition, i.e., the number of your enrolled Eligible Dependents changes;
- There is a change in government requirements that affects this Individual Plan's benefits; or
- You move from one rated region to another (i.e. you move from Eastern WA to Western WA, where the rates are different).

If you have pre-paid the Premium for a month in which a change in the Premium amount is scheduled to take effect, WDS will include a retroactive adjustment for the revised amount in your next month's automatic withdrawal from your bank account.

1.06 Premium Refunds

WDS will refund any Premium paid in advance for periods after the termination date of this Contract.

WDS has the right to terminate any persons found to be ineligible for this Individual Plan. In the case of ineligible persons enrolled in this Individual Plan, WDS will refund any Premium paid for ineligible persons. If WDS has paid claims for an ineligible person, the Subscriber is responsible for reimbursing WDS for the amount of claims paid.

Article II —Terms of Coverage

2.01 When Coverage Begins

Provided all applicable Premiums have been paid in advance for the first month, applications received by mail by the 15th of the month or online prior to the 25th of the month will be considered for an effective date of the first of the following month unless another future date (within 90 days of application date) is requested.

A spouse, domestic partner, or dependent is eligible to apply for coverage at any time. WDS will adjust the Premium on your next month's automatic withdrawal from your bank account.

A newborn shall be covered from and after the moment of birth. Adopted children are eligible on the date you or your spouse or domestic partner assume legal obligation for total or partial support of a child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children from the moment of birth.

In the case of court-ordered coverage, an Eligible Dependent child becomes eligible on the date you or your spouse or domestic partner receives the order to provide medical coverage for the child, even if neither of you is the custodial parent. WDS requests that application for coverage and any applicable Premium be submitted within 30 days of the date of the court order. Coverage will be effective as of the date of the court order.

If you choose not to enroll an Eligible Dependent during your initial enrollment into the dental program, you may enroll the Eligible Dependent at any time.

2.02 Special Enrollment Provisions

Eligible Persons may have only one individual plan and are not allowed to have other active dental coverage while enrolled in this Individual Plan.

Note: When adding additional dependents to your Plan and when your monthly premium amount is not changed, we encourage enrollment as soon as possible to prevent delays in claims processing.

Please notify WDS within 60 days of the death of any Eligible Person.

If you relocate outside the state of Washington, please notify WDS within 60 days, and we will terminate coverage effective as of the last day of the month for which Premium payment is received.

2.03 Extension of Benefits

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

2.04 How to Report Suspicion of Fraud

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

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

2.05 When Coverage Ends

In the case of nonpayment of Premium, coverage ends on the last day of the month for which WDS received a Premium payment.

If you want to cancel your coverage, your request must be received by WDS online or in writing before the 15th of the month. If we receive your request after the 15th of the month, Premium will be collected and your coverage will be terminated on the last day of the following month. See **Payment Due Date/Grace Period**.

If your coverage under this Contract is terminated or cancelled for any reason, you will not be allowed to enroll in a WDS Individual Plan or the Individual Plan Plus for 24 months.

2.06 Fraudulent Information

In the event it is discovered that you have provided false or misleading information in connection with this Contract for the purpose of defrauding WDS, WDS shall inform the appropriate state and regulatory authorities, including, but not limited to, the Washington State Office of the Insurance Commissioner (OIC). It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine, and denial of insurance benefits.

2.07 Continued Eligibility for a Disabled Dependent Child

Coverage for an Eligible Dependent child may be continued after the child reaches the limiting age of 25, provided both of the following conditions are met:

- Your child is incapable of self-sustaining employment due to developmental disability or physical handicap; and
- Your child is dependent upon you or your spouse or domestic partner for total or partial support.

Proof of your child's dependence must be submitted to WDS within 31 days of the date your child reaches the limiting age. Thereafter, WDS may require that you resubmit proof of your child's continuing dependence. This proof is requested annually after the two-year period following the child’s attainment of the limiting age.

A disabled child continues to be eligible for coverage until any one of the following events occurs:

- You do not submit proof of the child's continuing dependence as a result of disability or physical handicap.
- You, your spouse, or your domestic partner are no longer covered under this Individual Plan.

A child who has reached the limiting age of 25 and is no longer eligible for coverage as a disabled dependent child may qualify for coverage as a Subscriber under this Individual Plan.

2.08 Continuation of Dependent Coverage

An enrolled Eligible Dependent (spouse, domestic partner, and/or child) may choose to continue their coverage under this Individual Plan as a Subscriber with his or her own policy in the event that:

- The Subscriber dies
- The Subscriber and spouse divorce
- The Subscriber and domestic partner terminate the domestic partnership

Eligible Dependents must continue to meet all other eligibility requirements and must take on the responsibility, as the new Subscriber, to pay any applicable Premiums.

2.09 Refund of Claims

WDS shall not be obligated to refund paid claims for treatment performed by WDS participating dentists when such treatment was performed in good faith and where eligibility was current and accurate at the time of treatment.

Article III —General Terms and Conditions

3.01 Applicable Law

This Contract shall be governed by, and construed in accordance with, the laws of the state of Washington.

3.02 Assignment of Benefits

The benefits of this Contract shall accrue to you and your enrolled Eligible Dependents. Neither this Contract, nor its payments or covered benefits and services, is assignable to a third party. WDS reserves the right to make benefit payments to your provider(s), as appropriate, subject to federal and/or state laws.

3.03 Binding Agreement

This Contract is binding on WDS and you, your enrolled Eligible Dependents, and your respective executors, administrators, successors and/or assignees. By election of coverage or payment of applicable Premiums, all of the terms, covenants and conditions contained in the Contract shall become valid and binding upon you and your enrolled Eligible Dependents.

This Contract shall not bind WDS until (i) Premium is received by WDS and (ii) claim(s) have been paid.

3.04 Coverage Limits

The covered dental benefits offered under this Contract are subject to the coverage limits and maximums described herein.

3.05 Entire Agreement

This Contract constitutes the entire agreement between WDS and you. This Contract supersedes all previous communications, representations or agreements — either verbal or written — between WDS and you, with respect to the subject matter herein.

3.06 Equity of Application

This Contract is intended to apply equally to all Eligible Persons.

3.07 Force Majeure

In the event WDS is unable to perform its obligations hereunder by reason of fire, casualty, lockout, strike, labor condition, riot, war, act of God or by ordinance, law, order or decree of any legally constituted authority, then this Contract may, at the option of WDS, be suspended. During any period of suspension, WDS shall not be required to perform any service hereunder, nor shall WDS be liable for any damages arising from any event that precipitated the suspension. If this Contract is suspended pursuant to this provision, your obligation to make Premium payments shall also be suspended for the same period of time.

3.08 Headings

The headings of sections and paragraphs in this Contract are for convenience and reference purposes only and do not affect in any way the meaning or interpretation of any provision of this Contract.

3.09 Severability

If a court of competent jurisdiction deems any term, provision, endorsement or condition of this Contract invalid or unenforceable, the same shall be deemed severable from this Contract. However, the remainder of this Contract shall remain in full force and effect and shall in no way be affected, impaired or invalidated as a result of such decision.

Article IV —WDS Obligations

4.01 Provider Directories

The provider directory shall be available to Subscribers and online at www.DeltaDentalWA.com. WDS reserves the right to change the provider directory. The provider directory shall be produced once each year and shall constitute the sole printed provider directory for that year. Eligible Persons enrolled in the Plan shall be free to select a WDS participating dentist of his or her choice. WDS is not responsible for the availability of any particular participating dentist. If you do not have access to the Web site, to obtain the provider directory, you may contact WDS customer service at (800) 286-1885.

4.02 Claims

WDS shall be solely responsible for the investigation, administration and payment of all dental claims submitted under the Plan.

4.03 Appeals and Grievances

WDS shall have ultimate responsibility and authority for resolution of all complaints and grievances submitted by Eligible Persons that pertain to the Plan. WDS shall establish and maintain an effective process for responding to and resolving grievances relating to the dental benefits and coverage provided under the Plan. See Appeals of Denied Claims.

4.04 Compliance with Laws and Regulations

This Contract shall be in compliance with all pertinent federal and state laws and regulations, including, but not limited to, the applicable health care privacy and disclosure provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If this Contract, or any part hereof, is found not to be in compliance with any pertinent federal or state law or regulation, then WDS shall renegotiate the Contract for the sole purpose of correcting the noncompliance.

4.05 Confidentiality and HIPAA Compliance

WDS is considered a “Covered Entity” pursuant to the provisions of HIPAA. In recognition thereof, WDS will comply with all applicable privacy and security provisions of HIPAA concerning the protected health information of Eligible Persons. This provision shall survive the termination of the Contract.

Article V —Liability

5.01 Limitation of Liability

WDS shall not be liable for any act or omission by any dentist selected and utilized by an Eligible Person regardless of whether the dentist is a WDS participating dentist. Nothing contained in this Contract shall be construed as an obligation by WDS to render dental services.

Article VI —Contract/Certificate of Coverage

6.01 Summary of Benefits

1) Reimbursement Levels for Allowable Benefits

Delta Dental PPO Dentists

*Class I 100%
Class II 80%
Class III ..... 50% after 12-month wait period

Non- PPO/Non Participating Dentists

*Class I 100%
Class II 80%
Class III ..... 50% after 12-month wait period

Plan Deductible for Non- PPO/ Non Participating Dentists (only)

*Annual Deductible Per Person $50
*Annual Deductible — Family Maximum..... $150

Plan Maximum

Annual Program Maximum Per Person $1,000

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

All covered Subscribers and covered Eligible Dependents are eligible for Class I, Class II, Class III covered dental benefits and dental accident benefits.

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

2) Benefit Period

The benefit period starts the first day of the first month your coverage is effective and ends December 31. Thereafter, the benefit period is the 12-month period starting January 1 and ending December 31.

6.02 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 Contract *before* you go to the dentist. If this Contract does not answer all of your questions, or if you do not understand something, call a WDS Customer Service representative at (800) 286-1885. *Please be sure to consult your dentist regarding any charges that may be your responsibility before treatment begins.*

6.03 Choosing a Dentist

With WDS, you may select any licensed dentist; however, your benefits may be paid at a higher level and your out-of-pocket expenses may be lower if you choose a participating Delta Dental dentist. To determine the membership of your dentist or to find a new dentist, go to www.DeltaDentalWa.com and click on the *Patients* tab, then click on the *Find a Dentist* tab to begin your search. Be sure to select the Delta Dental PPO plan and follow the prompts.

Delta Dental Participating Dentists

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

Delta Dental PPO Dentists

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

Delta Dental Premier Dentists (non-PPO)

Delta Dental Premier® dentists also have contracts with WDS, but they are not part of the Delta Dental PPO network. Delta Dental Premier dentists will submit claim forms for you and receive payment directly from WDS. Their payments will be based on their pre-approved fees with WDS. 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 maximum.

Nonparticipating Dentists in Washington State

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

Out-of-State Dentists

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

Dentists, Specialists and Licensed Professionals

A Dentist is an individual who is legally authorized to practice dentistry at the time and in the place services are performed. This Contract provides for covered services only if those services are performed by or under direction of a licensed Dentist or other WDS-approved Licensed Professional. A "Licensed Dentist" does not mean a dental mechanic or any other type of dental technician.

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

A Licensed Professional is an individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to a denturist, hygienist and radiology technician.

6.04 Claim Forms

American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our Web site at www.DeltaDentalWA.com. WDS 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.

6.05 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” to WDS. This will allow you to know in advance what procedures may be covered, the amount WDS may pay, and your expected financial responsibility. A predetermination is not a guarantee of payment.

6.06 Reimbursement Levels

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

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

6.07 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 Contract under the sections called “Benefits Covered by Your Program”, “General Limitations” and “General Exclusions.” They warrant careful reading.

6.08 Coinsurance

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

6.09 Program Maximum

For your program, the maximum amount payable by WDS for Class I, II and III covered dental benefits (including dental accident benefits) per Eligible Person is $1,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

6.10 Benefits Covered By Your Program

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

The amounts payable by WDS for Class I, II, and III covered dental benefits are described in the section called “Summary of Benefits.”

1) 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 from the date of service per Eligible Person per dentist. Additional comprehensive oral evaluations are allowed as routine examinations.
  - Comprehensive oral evaluations and specialist examinations are considered as one of the two covered examinations per benefit period.
- 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 through age 14.
- Supplementary bitewing X-rays are covered once in a benefit period over age 14.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits.

Exclusions

- Consultations or elective second opinions
- Study models

Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)
- Fissure sealants
- Topical application of fluoride or preventive therapies, e.g. fluoridated varnishes
- Space maintainers (with limitations)

Limitations

- Prophylaxis will be limited to two covered procedures in a benefit period.
- Topical application of fluoride or preventive therapies (*but not both*) is covered twice in a benefit period through age 19.
- Fissure sealants through age 18:
  - 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 lifetime per tooth..
- Space maintainers through age 17:
  - Used to maintain space for eruption of permanent teeth

Exclusions

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

Periodontics

Covered Dental Benefits

- Prescription-strength fluoride toothpaste
- Antimicrobial mouth rinse

Limitations

- Prescription-strength fluoride toothpaste and antimicrobial mouth rinse are a covered benefit following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's WDS history must show a periodontal procedure within the previous 180 days.
- Antimicrobial mouth rinse is covered once per periodontal treatment.

- Antimicrobial mouth rinse is available for women during pregnancy without any periodontal procedure.

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

2) Class II

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

Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain

Limitations

- Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Restorative

Covered Dental Benefits

- Amalgam restorations (fillings) and, in anterior (front) teeth, resin-based composite or glass ionomer restorations are covered for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- Stainless steel crowns

Limitations

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

Exclusions

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

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

3) Class III

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 WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, and III covered dental 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 WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS.
- 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.

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 General Anesthesia or Intravenous Sedation for information.*

Exclusions

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

Note: ***There is a 12-month wait period for the remainder of Class III benefits.***

Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- Services covered include:
  - Periodontal maintenance
  - Periodontal scaling/root planing
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or less)
- WDS-approved localized delivery of antimicrobial agents

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

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

Exclusions

- Periodontal splinting
- Gingival curettage
- Occlusal guard (nightguard)
- Major (complete occlusal adjustment

Endodontics

Covered Dental Benefits

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

Limitations

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

Exclusions

- Bleaching of teeth

Restorative

Covered Dental Benefits

- 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

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a seven-year period from the seat date.
- If a 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 (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin onlay, veneer, crown, or inlay (as a single tooth restoration – with limitations).
- 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.
- 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 seven-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 seven-year period on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Crowns or onlays are not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a paid covered benefit.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

- Copings

Prosthodontics

Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Inlays (only when used as a retainer for a fixed bridge)
- Removable partial dentures
- Adjustment or repair of an existing prosthetic device

Limitations

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

- **Full, immediate and overdentures** — WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch.
- **Temporary/interim dentures —** WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Partial dentures —** If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period.

Exclusions

- Duplicate dentures
- Personalized dentures
- Cleaning of prosthetic appliances
- Surgical placement or removal of implants or attachments to implants.
- Copings

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

4) Accidental Injury

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

5) Additional Procedures

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

6) 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 including 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 WDS for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a paid covered benefit except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

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

WDS shall determine whether services are covered dental benefits in accordance with standard dental practice and the limitations and exclusions in this Contract. Should there be a disagreement regarding the interpretation of such benefits, the Eligible Person 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.

6.11 Benefit Determinations

1) Predetermination of Benefits

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

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, WDS may request additional information, request an extension of 15 days, and pend the predetermination until all of the information is received. Once all of the information is received, a determination will be made within 15 days. If information is not received by WDS within 45 days of being requested, the predetermination will be denied.

2) 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 condition, WDS will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

No predetermination is required for otherwise covered dental benefits for medically necessary evaluation and treatment of an emergency dental condition which is the emergent and acute onset of a symptom or symptoms, including severe pain that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person’s oral health in serious jeopardy.

3) Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to WDS for payment, modification or denial of services. 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

6.12 Appeals of Denied Claims

1) 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 Plan 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 call Customer Service at 1-800-286-1885.

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

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

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

2) Appeals Committee

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

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

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedures appeals and will send you a written notification of its decision. Upon request, you will be granted access to and copies of all relevant information used by the Appeal Committee in making its decision. In the event the Appeal Committee 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 WDS's final decision. If you disagree with this the outcome of your appeal there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

6.13 Authorized Representative

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

6.14 Subrogation

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

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

— include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;

— repay WDS those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;

— cooperate fully with WDS in asserting its rights under the Contract, to supply WDS with any and all information and execute any and all instruments WDS reasonably needs for that purpose.

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

6.15 Your Rights and Responsibilities

At WDS our mission is to provide quality dental benefit products to Subscribers throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between WDS, our Subscribers and our participating 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.

1) You Have The Right To:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (WDS member/nonmember), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact WDS customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our Web site at DeltaDentalWA.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for treatment, payment or health care operations, or as permitted or required by law.

- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational, or religious background.

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

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

Article VII —Definitions

The following definitions will apply to this Contract unless otherwise set forth herein:

7.01 "Contract" means this Contract between WDS and individual.

7.02 "Eligible Dependent" means a Subscriber's legal spouse, domestic partner, and/or children.

7.03 "Eligible Persons" means persons eligible for and enrolled in WDS Individual Dental Plan.

7.04 "OIC" means the Office of the Insurance Commissioner.

7.05 "Open Enrollment Period" means the month of December, during which time Subscribers may select a new Plan.

7.06 "Plan" means the WDS dental coverage provided pursuant to the terms of this Contract.

7.07 "Premium" means the monthly amount payable by Eligible Persons as set forth in Appendix A.

7.08 "Subscriber" means the primary person who is eligible for and enrolled in a WDS Individual Dental Plan and who elects the dental coverage provided by WDS.

Article VIII —Entire Agreement

This Contract constitutes the entire agreement and understanding between the WDS and the Subscriber hereto, including any appendices or exhibits as may be incorporated herein.

WASHINGTON DENTAL SERVICE
POST OFFICE BOX 75983
SEATTLE, WASHINGTON 98175-0983

By

Title

Dated

Appendix A

Financial Obligations

The monthly Premium payable by Subscriber under this Contract term during the period ***(contract starting date)*** through ***(contract ending date)*** shall be:

2011 Individual Plus Rates

	Individual Plan Plus
	West
	Rate
Individual	$53.75
Individual + Spouse/Domestic Partner	$107.49
Individual + Child(ren)	$120.62
Individual + Spouse/Domestic Partner + Child(ren)	$174.36

Legislative Surcharge Clause — If any governmental unit shall impose any new tax or assessment or increases the rate of any current tax or assessment that is measured directly by the payments made to WDS by Subscriber, then WDS is authorized to increase the monthly Premium by the amount of such new tax, assessment or increase.

Appendix B

HIPAA

WASHINGTON DENTAL SERVICE

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

This Notice Describes How Health Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

PROTECTING YOUR HEALTH INFORMATION

Washington Dental Service is committed to protecting the privacy of your health information. Washington Dental Service is required by federal and state law to maintain the privacy of your protected health information ("PHI"). This Notice refers to Washington Dental Service and Delta Dental Plan of Washington as "we," "us" and "our." This Notice explains our privacy practices, our legal duties, and your rights concerning your PHI. PHI means any information that is identifiable to you as your health information, including information regarding your dental care and treatment, payment for your dental care or treatment, and identifiable factors such as your name, age, address and Social Security number. We will follow the privacy practices that are described in this Notice while it is in effect.

We collect PHI for a number of reasons, including to pay claims, determine your dental benefits, and to provide an explanation of benefits to you. We receive PHI from you and from dental care providers. For example, we receive PHI as a part of enrollment information and when dentists submit claims for reimbursement for covered benefits.

We protect your PHI by treating all your personal information that we collect as confidential. Our employees receive privacy training and have access to your PHI only when there is an appropriate reason, such as to administer your dental benefits or provide services to you. The amount of PHI our employees may access is the minimum necessary to perform their jobs. We only disclose PHI to a company that provides services to us or acts on our behalf if the company agrees to protect and maintain the confidentiality of your PHI. Physical, electronic and procedural safeguards that comply with federal and state regulations are maintained to guard your PHI.

USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION

We will not use or disclose PHI unless we are allowed or required by law. The main reasons for which we use or disclose your PHI are to evaluate and process requests for coverage and claims for benefits. The following are some examples of how we may use or disclose your PHI without your authorization.

- **Treatment:** We may use or disclose your PHI for treatment activities of a dental care provider. For example, we may inform you or your dental care provider about treatment alternatives or other benefits that may be offered under your dental benefit coverage. If your dentist refers you to another dental professional, we may disclose your PHI to that dental professional so that he or she can treat you.
- **Payment:** We may use and disclose your PHI for our payment activities, including determining whether a specific treatment is a covered benefit, paying your dental benefit claims, and coordinating benefits with another health plan.
- **Health Care Operations:** We may use or disclose your PHI for internal operations. For example, we may use your claims information to analyze data for cost control, planning, or fraud and abuse protection.
- **Business Associates:** We may also share your PHI with third-party "business associates" who perform certain activities for us. We require these business associates to protect your PHI in the same way that we do.
- **Enrolled Dependents and Family Members:** Generally, we will mail Explanation of Benefit ("EOB") forms and other mailings containing PHI to the address we have on record for the subscriber of the dental plan. If you are unable to consent to the disclosure of your PHI, such as in an emergency, we may disclose your PHI to a family member or a friend to the extent necessary to help with your dental care or payment for your dental care. We will only do so if we determine that the disclosure is in your best interest. If you are a minor, we may disclose PHI to parents or guardians, consistent with state laws.

Appendix B

HIPAA

Other Permitted or Required Disclosures

- **As Required by Law:** We must disclose PHI when required to do so by law.
- **Public Health Activities:** We may disclose your PHI to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence:** We may disclose your PHI to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities:** We may disclose your PHI to government oversight agencies; for example, the state Insurance Commissioner, for activities authorized by law.
- **Judicial and Administrative Proceedings:** We may disclose PHI in response to a court or administrative order. We may also disclose PHI in certain cases in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may disclose PHI under limited circumstances to a law enforcement official for law enforcement purposes.
- **Coroners, Funeral Directors, Organ Donation:** We may release PHI to coroners or funeral directors or in connection with organ or tissue donation.
- **Research:** Under certain circumstances, we may disclose PHI about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety:** We may disclose your PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions:** We may disclose PHI as required by military authorities or to authorized federal officials for national security intelligence activities.
- **Workers Compensation:** We may disclose your PHI to the extent necessary to comply with state law for workers compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. If you sign an authorization, you may revoke it at any time in writing, although this will not affect information that we disclosed before you revoked the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding PHI that we maintain about you.

Right to Access Your PHI: You have the right to review and receive a copy of your PHI that is contained in records that we maintain for enrollment, payment, claims determination or dental management activities, or that we use to make enrollment, coverage or payment decisions about you. Your request to review and/or obtain a copy of your PHI records must be made in writing. We may charge a fee for the cost of producing, copying and mailing your requested information, but we will tell you the cost in advance. The right does not include a right to obtain copies of information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to other state or federal laws that prohibit us to release such information. Also, we may limit your access to PHI if we determine that providing the information could possibly harm you or another person. If we limit access based upon a belief that it could harm you or another person, you have the right to request a review of that decision.

Appendix B

HIPAA

Right to Amend Your PHI: You have the right to request that we amend your PHI. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. We may deny your request for certain reasons, including if you ask us to change information that we did not create. If we deny your request to amend your records, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in future disclosures of that information.

Right to an Accounting of Disclosures by Us: You have the right to receive a report of disclosures we or our business associates have made of your PHI. The list will not include our disclosures related to your treatment, our payment or health care operations, disclosures made to you or with your authorization, or certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. We will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for creating and sending those additional reports.

Right to Request Restrictions on Use and Disclosure of Your PHI: You have the right to request that we restrict or limit how we use or disclose your PHI for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed in an emergency.

Right to Receive Confidential Communications: You have the right to request that we use a certain method to communicate with you about your PHI or that we send your PHI to a certain alternative location. If you advise us that disclosure of all or any part of your PHI could endanger you, we will comply with any reasonable request, provided you specify an alternative means of communication.

Right to Paper Copy of this Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are also entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain the Notice in written form.

PRIVACY QUESTIONS AND COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. For more information on how to file a written complaint, call the Privacy Officer at the number listed below. Your privacy is one of our greatest concerns and there is never any penalty to you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Requests for forms, comments and complaints should be sent to:

Washington Dental Services
Attn: Privacy Officer
P.O. Box 75688
Seattle, WA 98175
Phone: (206) 985-5963 (Privacy Hotline)
Fax: (206) 528-7373
E-mail: Regulatorycomp@deltadentalwa.com

Changes to this Notice: We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our web site at www.DeltaDentalWa.com. You may request a copy of a Notice at any time by contacting us at the number above.

Customer Service inquiries: 800-522-1300

Appendix C

Privacy Statement (GLBA)

Washington Dental Service Privacy Statement

At Washington Dental Service, our mission — our business — is to improve the oral health of people in Washington state. We do this by championing research into progressive new treatments, by making proven innovations available through our family of Delta Dental Plans, by working closely with member dentists, and by offering smooth and efficient claims-handling services.

In all of these business activities, information gathering and sharing play vital and necessary roles. We want to assure you that while our first priority is to improve your oral health, we are also committed to safeguarding your privacy. That's why we want you to understand how we use "nonpublic personal information" such as your name, address and Social Security number to administer your dental benefits coverage and serve you better.

In our efforts to deal appropriately with nonpublic personal information, the board of directors of Washington Dental Service directed the formation of the Health Information Oversight Committee in 1996. This committee, composed of dentists, physicians and qualified public representatives and consumers, established Washington Dental Service's policies for nonpublic personal information disclosure. Oversight of these policies is now part of the WDS Board of Director's Audit Committee's function. We value this oversight for its integrity and capacity to review our activities and practices.

Confidentiality and Security

In compliance with state and federal standards, as well as our own commitment to privacy, Washington Dental Service maintains physical and electronic safeguards to protect nonpublic personal information. Policies and procedures have also been implemented which limit access to this information on a "need-to-know" basis, when services are provided to our subscribers.

Information We Collect

In order to administer your dental coverage, Washington Dental Service collects demographic data, dental history and other nonpublic personal information. This information is used for positive identification, accurate record keeping and claims processing. Most of the information we have about you comes directly from you in the form of applications, forms and other communications. We also gather nonpublic personal information from dentists and other dental care providers, regional dental consultants, other Delta Dental Plans and other sources as permitted by law.

Information We Share

In the process of administering your dental benefits coverage, we may share or verify nonpublic personal information. Information is shared for the purpose of administering your dental benefits, and it is shared with select parties who need the information to help us to better serve you, or as permitted by law.

Your other health care benefit companies — Demographic information such as your name, address and Social Security number, as well as information about your dental coverage, treatment and history may be shared with other benefit companies through which you and your family members may also be covered. We do this to ensure the highest level of continuity between your benefits.

Dental providers — Washington Dental Service may share your demographic profile, dental benefit information and dental history with your dentist. The same types of information may also be disclosed to regional dental consultants — dentists we contract to review subscribers' dental care for quality and continuity. Both your dentist and our regional dental consultants are bound to protect your privacy according to applicable state and federal laws and regulations.

Business associates — Washington Dental Service is committed to providing you with the highest quality products delivered with the highest level of service. To ensure the efficient delivery of services, we enlist the help of outside resources — such as customer service and claims processing companies — as well as printing and mailing firms. These associates are granted access to the minimal amount of personal information necessary to perform their jobs.

If you have questions or concerns about our policies and practices, please call our automated privacy hotline number: (206) 526-7695 or toll-free (888) 338-0172.