

Energy Northwest

DeltaCare[®]

Washington Counties Insurance Fund

Washington Dental Service, a Delta Dental Plan

Program No. **00500**

Effective **January 1, 2011**

Questions Regarding Your Plan

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

Washington Dental Service Customer Service

(206) 517-6329

(800) 650-1583

Written inquiries may be sent to:

Washington Dental Service

DeltaCare

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.

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

How to Use Your Plan

Choosing a Primary Care Dentist

When you enroll in the DeltaCare Dental Plan, you must complete an enrollment form indicating your dental office choices. Three choices are indicated and the first available office is assigned to you and your family. The choice of "primary care" dental office can be changed with proper notice to WDS, but participation in the plan must continue at least until the next open enrollment period. After you have enrolled, you will receive a membership card with the address and telephone number of your primary care dentist.

Your selected dental office is now the center for all of your dental needs. The "primary care" dental office will perform most dental services. For specialty care, the primary care dentist may elect to refer treatment to a DeltaCare Dental Plan specialist.

Appointments

To receive dental care, simply call your primary care dental office to make an appointment. Routine, non-emergency appointments will be scheduled within 90 days of the date of the request. You will not be required to travel more than 30 miles from your place of residence in order to receive routine dental care. *Dental services that are not performed by the assigned DeltaCare dental plan office or properly referred to a DeltaCare dental plan specialist will not be covered by the DeltaCare dental plan.*

Specialty Services

Your primary care dentist is responsible for coordinating all specialty care. Your primary care provider will perform the specialty treatment or refer you to a DeltaCare specialist. In some unique cases, the primary care dentist may refer you to a non-DeltaCare dental plan specialist, but prior authorization from WDS is required. You will not be required to travel more than 30 miles from the primary care dentist's office to receive specialty care services.

Emergency Care

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

Urgent Care

The primary care dentist will provide urgent dental care for a covered procedure that is required while an enrollee is within 35 miles of the office of the primary care dentist. If an enrollee requires urgent dental care and is more than 35 miles from the office of the primary care dentist, the plan will reimburse the enrollee for the cost of the urgent care providing the enrollee can be adequately screened and stabilized to allow further treatment by his/her assigned dentist. The maximum reimbursement is \$100 per 12-month calendar year. Urgent dental care shall be limited to listed procedures as described in American Dental Association code D9110 as seen in Schedule of Benefits and Co-payments: "Palliative (emergency) treatment of dental pain." Any further treatment of the cause of such urgent dental care requires pre-authorization from the plan if practical according to a prudent layperson if the care is to be performed by a non-primary care dentist. In cases that require immediate additional care beyond stabilization and in which palliative treatment is medically required, the plan will carefully review and consider additional reimbursable coverage beyond the \$100 maximum, according to the standard list of covered benefits under the plan.

Predetermination of Benefits

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." This will allow you to know in advance what procedures are covered, the amount WDS will pay toward the treatment and your financial responsibility.

Employee Eligibility and Termination

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

New employees are eligible on the first day of the month following completion of the waiting period established by your employer.

You must complete an enrollment form. WDS must receive the completed enrollment form within 60 days of your eligibility date. If the enrollment form is not received within 60 days, enrollment will not be accepted until the next open enrollment period.

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

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

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

You may change or terminate plan coverage only coincident with an open enrollment period.

Dependent Eligibility and Termination

Eligible dependents are your lawful spouse or state registered domestic partner and children from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. Spouses and children of married dependents are not eligible for coverage under this plan. Non-registered domestic partners are covered unless specifically excluded at the option of the group.

Domestic Partner is defined as follows:

"Domestic Partnership" is a relationship whereby two people:

- a) Share the same regular and permanent residence;
- b) Have a close personal committed relationship;
- c) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
- d) Are not married to anyone;
- e) Are each 18 years of age or older;
- f) Are not related by blood closer than would bar marriage in their state of residence;
- g) Were mentally competent to consent to contract when the domestic partnership began; and
- h) Are each other's sole domestic partner and are responsible for each other's common welfare.

Following termination of a domestic partnership a statement of termination must be filed with Group's Human Resources Department within 30 days of termination. Termination of domestic partnership includes death of a partner.

Application for another Affidavit of Domestic Partnership cannot be filed for 180 days following the filing of the statement of termination of domestic partnership with Group's Human Resources Department.

A child will be considered an eligible dependent as an adopted child if the following conditions are met: 1) the child has been placed with the eligible employee for the purpose of adoption under the laws of the state in which the employee resides; and 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment").

Coverage for an dependent child over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible person for support and maintenance, provided proof of incapacity and dependency is furnished to WDS within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. WDS reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

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

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

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

You may terminate coverage of an eligible dependent only coincident with a subsequent renewal or extension of the dental plan. Once an eligible employee terminates such eligible dependents coverage, the coverage cannot be reinstated, unless there is a change in family status.

A new family member, with the exception of newborns and adopted children, should be enrolled on the first day of the month following the date he or she qualifies as an eligible dependent (see "Special Enrollment").

A newborn shall be covered from and after the moment of birth, and an adopted child shall be covered from the date of assumption of a legal obligation for total or partial support. When additional premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment") but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Eligible employees who choose not to enroll an eligible dependent during the initial enrollment period of the dental plan may enroll the eligible dependent only during an open enrollment, except under special enrollment.

Special Enrollment Periods

Special enrollments are allowed under the following conditions:

1. Loss of Other Coverage

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

- You declined enrollment in this Plan.
- You lose eligibility in another health plan or your coverage is terminated due to the following:
 - Legal separation or divorce
 - Cessation of dependent status
 - Death of Employee

- Termination of employment or employer contributions
- Reduction in hours
- Loss of individual or group market coverage because of move from plan area or termination of benefit plan
- Exhaustion of COBRA coverage
- Your application to enroll in this Plan is received by WDS within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

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

Note: Eligible dependents may not enroll in this Plan unless the employee is a subscriber.

2. Marriage, Birth or Adoption

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

- Marriage or Domestic Partner Registration — WDS requests the application for coverage be made within 31 days of the date of marriage/registration. If enrollment and payment are not completed within the 31 days, the eligible dependent may be enrolled during the next open enrollment.

WDS considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefits booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. WDS and the group will follow all applicable state and federal requirements, including any applicable regulations.

- Birth — A newborn shall be covered from and after the moment of birth. WDS requests the application for coverage be made within 90 days of the date of birth. Enrollment may be completed at any time up to the fourth birthday. If enrollment is completed after 90 days, the enrollment becomes effective on the first day of the month in which enrollment occurs. Enrollment after the fourth birthday must be coincident with an Open Enrollment period.
- Adoption — WDS requests the application for coverage be made within 90 days of the date of assumption of a legal obligation for total or partial support of the child in anticipation of adoption. If an additional premium for coverage is required and enrollment and payment is not completed within the 90 days, the eligible dependent may be enrolled during the next open enrollment.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this contract, 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.

How to Report Suspicion of Fraud

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

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

Continuation of Coverage - "COBRA"

This Section Applies To Groups of 20 or More

Federal Health Benefit Continuation Provision Applicable to this group health care plan. (Part of The Consolidated Omnibus Budget Reconciliation Act known as "COBRA." Public Law 99-272 and as Amended by Public Law 104-191.)

An employee (and his/her family members) employed by the group affected by the above law, should be aware of the following terms, conditions and limitations as they apply to temporary continuation of group health care coverage upon the occurrence of certain qualifying events.

An employee covered by this group health care plan has a right to choose this continuation coverage if group health care coverage is lost because of reduced employment hours or termination of employment for reasons other than gross misconduct on the part of the employee.

The dependents of an employee covered by a group health care plan have the right to choose continuation coverage, if group coverage under the group health care plan is lost for any of the following five reasons:

- 1) The death of the employee;
- 2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- 3) Divorce or legal separation from the employee;
- 4) The employee becomes entitled to Medicare; or
- 5) The dependent ceases to be an "eligible dependent" under the group health care plan.

Under the law, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the group health care plan.

COBRA coverage begins on the date that coverage would otherwise have been lost due to a qualifying event. Coverage will end at the end of the maximum period.

When the employer is notified of a qualifying event, the employer in turn notifies the employee of his or her right to choose continuation coverage. Under the law, the employee has at least 60 days from the date he or she would lose coverage because of one of the events described above to inform the employer that continuation coverage has been chosen. The employer is required to notify the health care plan within 30 days of an employee's death, termination, reduction of hours or entitlement to Medicare.

If continuation coverage is not chosen, the group health care coverage will end.

Covered employees are eligible to continue coverage for 18 months when coverage is lost due to termination of employment or from reduction of hours. If continuation of coverage is chosen, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

If the covered employee's eligibility under this contract ends when he or she becomes entitled to Medicare benefits, then coverage may not be continued for the employee. However, coverage may be continued for any dependents for up to 36 months, from the covered employee's Medicare entitlement date. If the covered employee's eligibility under the contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement, then any dependents may continue coverage for up to: 1) 36 months from the covered employee's Medicare entitlement date; or 2) 18 months from the date the insured person's employment ended, (whichever is later).

Employees or dependents who are disabled at the time the employee terminates employment or hours reduced, or if they become disabled at any time during the first 60 days of COBRA coverage, are eligible for an additional 11 months of continued coverage from the date of the qualifying event. The total continued coverage period will not exceed 29 months from the date of the qualifying event. The individual must be determined as disabled by the Social Security Administration and must notify Group within 60 days of Social Security's determination date.

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

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

If a dependent is actively participating in COBRA and the covered employee becomes entitled to Medicare benefits then coverage may not be continued for the employee. However, coverage may be continued for any dependents for up to 36 months, from the covered employee's Medicare entitlement date. If the covered employee's eligibility under the contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement; then any Dependents may continue coverage for up to: 1) 36 months from the covered employee's Medicare entitlement date; or 2) 18 months from the date the insured person's employment ended (whichever is later).

COBRA payments are due within 45 days from the date of application. Payments must be made retroactively from the date of COBRA eligibility up through the current month of eligibility.

Dependents experiencing second qualifying events while under COBRA may extend coverage for an additional 18 months.

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

- 1) The employer no longer provides group health care coverage to any of its employees;
- 2) The premium for continuation coverage is not paid, or not paid on time, as provided by law;
- 3) You become covered under another group health care plan after the date you elect COBRA coverage. If, however, the new plan contains an exclusion or limitation for a pre-existing condition (as explained above), coverage does not end for this reason until the exclusion or limitation no longer applies;
- 4) You become entitled to Medicare after the date you elect COBRA coverage; or
- 5) The spouse is divorced from a covered employee and subsequently remarries and is covered under any group health care plan unless a pre-existing condition described above takes precedence.

Proof of insurability is not required to choose continuation coverage. However, under the law, the employee may have to pay all or part of the premium for the continuation coverage.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

Children's Health Insurance Plan Reauthorization Act (CHIPRA)

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

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

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

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

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

Conversion Option

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

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

Dental Limitations

Diagnostic

1. Examination is covered once in a six-month period;
2. Comprehensive oral evaluation is covered once in a three-year period as one of the two covered examinations in a calendar year per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations.
3. Full mouth or panorex x-rays limited to one set every 36 consecutive months;
4. Bitewing x-rays limited to not more than one series of four films in any six-month period;

Preventive

5. Prophylaxis limited to one treatment in a six-month period (includes periodontal maintenance following active therapy), three month periodontal maintenance would be alternate patient responsibility;
6. Topical application of fluoride or preventive therapies (*but not both*) is covered twice in a benefit period.
7. Fissure sealants are limited to non-carious, non-restored permanent first and second molars. The application of fissure sealants is a covered benefit only once in a two-year period.

Restorative

8. Restorations on the same surface(s) of the same tooth are covered once in a two-year period;
9. Crowns are covered once in a five-year period;
10. Stainless steel crowns on primary teeth are covered once in a two-year period;

Periodontics

11. Root planing/subgingival curettage is covered once in a 12-month period;
12. Limited occlusal adjustments are covered once in a 12-month period;
13. Periodontal surgery is covered once in a three-year period;
14. Soft tissue grafts are covered once in a three-year period;
15. Scaling and root planing must be done a minimum of six weeks and a maximum of six months prior to periodontal surgery or Localized delivery of antimicrobial agents;
16. One periodontal maintenance therapy treatment, specifically periodontal prophylaxis, is covered once in a six-month period and is to be charged at the applicable copayment level. Periodontal prophylaxis treatments over one in a six-month period are your responsibility;
17. Full mouth debridement is covered once in a three-year period;
18. Localized delivery of antimicrobial agents approved by WDS is limited to 2 sites per quadrant once in a 18 month period under certain conditions of oral health when performed at the suggested regimen for that therapy;

Endodontics

19. Root canal treatment on the same tooth is covered only once in a two-year period.

Prosthodontics

20. Full upper and/or lower dentures are not to exceed one each in any five-year period and only then if it is unserviceable and cannot be made serviceable;
21. Partial dentures are not to be replaced within any five-year period from initial placement unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
22. Denture relines are limited to one per denture during any 12 consecutive months except in the case of an immediate denture. In that case, a reline is a benefit six months after the initial placement;

General Anesthesia

23. General anesthesia is covered only when administered by a licensed Dentist or other participating plan approved licensed professional who meets the educational, credentialing and privileging guidelines established by that participating plan's state, when medically necessary, for children through age six, or a physically or developmentally disabled person, when administered in conjunction with covered dental procedures.

Dental Exclusions

1. General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist except when medically necessary, for children through age six, or a physically or developmentally disabled person, when administered in conjunction with covered dental procedures;
2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;

3. 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;
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth;
5. Application of desensitizing agents;
6. 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.
 - 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.
7. Dental services performed in a hospital and related hospital fees;
8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);
9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;
10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility;
11. Cysts and malignancies;
12. Laboratory examination of tissue specimen;
13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;
14. Accidental injury. 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. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;

16. Cases that in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
17. Prophylactic removal of impactions (asymptomatic, nonpathological);
18. Specialist consultations for non-covered benefits;
19. Implant placement or removal, appliance placed on or services associated with implants;
20. Orthodontic treatment that involves therapy for myofunctional problems, TMJ, dysfunctions, or hormonal imbalances causing growth and developmental abnormalities;
21. All other services not specifically included on the patient's co-payment schedule as a covered dental benefit;
22. Treatment of fractures and dislocations to the jaw;
23. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by WDS or as cited under "Out of Area Emergency Treatment;"

Orthodontic Limitations

1. This plan provides coverage for orthodontic treatment plans provided through DeltaCare panel orthodontists. The cost to the patient for the treatment plan are listed in the Schedule of Benefits and Co-payments and are subject to the following:
2. Orthodontic treatment must be provided by a DeltaCare orthodontist.
3. Plan benefits cover 24 months of active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of two years.
4. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee not to exceed \$75 per month.
5. Should a patient's coverage be canceled or terminated for any reason and if at the time of cancellation or termination the patient is receiving any orthodontic treatment, the patient — not DeltaCare — will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case, the patient's payment shall be based on the provider's maximum allowable fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment. It will be payable by the patient on such terms and conditions as are arranged between the patient and the orthodontist.
6. If treatment is not required or the patient chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the patient will be charged a consultation fee of \$25 in addition to diagnostic record fees.
7. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the dentist's WDS filed fee for the covered benefit.

8. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances.

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation;
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Treatment related to temporomandibular joint disturbances;
7. Supplemental appliances not routinely utilized in typical phase II orthodontics;
8. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed \$75 per month;
9. Restorative work caused by orthodontic treatment;
10. Phase I* orthodontics is an exclusion, as are activator appliances and minor treatment for tooth guidance and/or arch expansion;
11. Extractions solely for the purpose of orthodontics;
12. Transfer after banding has been initiated;
13. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

*Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Governing Administrative Policies

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

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

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

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

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

Partial Dentures

1. A removable cast metal partial denture is considered an adequate restoration of a case when more than one tooth is missing in a dental arch. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and the optional treatment, plus any copayment for the covered benefit.
2. If a cast metal partial denture will restore the case, the primary care dentist will apply the difference of the cost of such procedure toward any alternative treatments that the patient and dentist may choose to use. The patient must pay the difference in cost between the dentist's WDS file fees for the covered benefit and the optional treatment plus any copayment for the covered benefit.
3. An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. Patients will pay the applicable copayment for a cast metal partial denture.

Complete Dentures

4. If, in the construction of a denture, the patient and the primary care dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
5. Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either relining or repair.

Fillings and Crowns

6. Crowns will be covered only if there is not enough retention and resistance form left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
7. Porcelain or porcelain fused to metal crowns on all first, second or third molars are considered optional treatment; base metal crowns are considered adequate restorations. If upgrades are performed, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit. The patient must be permitted the option of the base metal crown as a benefit if desired.

8. The DeltaCare plan provides amalgam (posterior) and resin-based (anterior) restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration, such as a crown or jacket, is considered optional. If provided, the patient must pay the difference in cost between the dentist's WDS file fees for the covered benefit and the optional treatment plus any copayment for the covered benefit.
9. A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including, but not limited to, cosmetics, abrasion, erosion, restoring or altering vertical dimension, or the anticipation of future fractures, are not covered benefits.
10. Composite resin restorations in posterior teeth are considered optional treatment, with the exception of the buccal surfaces of the bicuspid. If provided, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
11. Anterior porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
12. A crown placed on a specific tooth is allowable only once in a five-year period from initial placement.
13. A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required.

Fixed Bridges

14. A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years or older. Such treatment will be covered if the patient's oral health and general condition permit.
15. Fixed bridges used to replace missing posterior teeth are considered optional. The patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
16. Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
17. Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement and shall be covered only when the replacement duplicates the original bridge.
18. Fixed bridges are not a benefit for patients under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Reconstruction

19. The DeltaCare plan provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, or for realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full mouth reconstructions and are not a benefit of the DeltaCare plan.

Specialized Techniques

20. Noble or titanium metal for removable appliances, crowns, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's WDS filed fees for the covered benefit and the optional treatment, plus any copayment for the covered benefit. (As long as the patient has the option of the benefit procedure.)

Preventive Control Programs

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

Stayplates

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

Frenectomy

24. The frenum can be excised when the tongue has limited mobility or if there is a large diastema between anterior teeth, or when the frenum interferes with a prosthetic appliance.

Pedodontia

25. DeltaCare must preauthorize pedodontic referrals. Benefits for dependent children through age three are covered at 100 percent of the agreed upon fee less any applicable copayments for covered benefits and children four years and older are at 50 percent of agreed upon fee less any applicable copayments for covered services.

Treatment Planning

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

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

Description of Benefits and Co-Payments

The services covered under the DeltaCare Dental Plan are listed in the following schedule. These co-payments are your total price, including lab work. All coverage is subject to the exclusions and limitations set forth in the benefit descriptions and exclusions.

Code	Description	DeltaCare Standard 10A
00100 - 00999	Diagnostic	
D0120	Periodic oral examination – established patient	0
D0140	Limited oral evaluation-problem focused - GP (Specialist use 00190)	15
D0145	Oral evaluation – patient under age 3	0
D0150	Comprehensive oral evaluation - GP (Specialist use 00190)	0
D0160	Detailed and extensive oral evaluation - Problem focused, by report - GP (Specialist use 00190)	0
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit) - GP (Specialist use 00190)	0
D0180	Comprehensive Periodontal Exam-GP (Specialist use 00190) R	
D0190	Specialist Exam	0
D0210	Intraoral - complete series, including bitewings	0
D0220	Intraoral - periapical, first film	0
D0230	Intraoral - periapical, each additional film	0
D0240	Intraoral - occlusal film	0
D0270	Bitewing - single film	0
D0272	Bitewings - two films	0
D0273	Bitewings – three films	0
D0274	Bitewings - four films	0
D0330	Panoramic film	0
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
01000 - 01999	Preventive	
D1110	Prophylaxis - adult	0
D1120	Prophylaxis - child	0
D1203	Fluoride excluding prophylaxis - child	0
D1206	Topical fluoride varnish	0

D1330	Oral hygiene instruction	0
D1351	Sealant - per tooth	5
D1510	Space maintainer - fixed, unilateral	24
D1515	Space maintainer - fixed, bilateral	34
D1520	Space maintainer - removable, unilateral	25
D1525	Space maintainer - removable, bilateral	32
D1550	Recementation of space maintainer	10
D1555	Removal of fixed space maintainer	10
02000 - 02335	Minor Restorative	
D2140	Amalgam - one surface, primary or permanent	0
D2150	Amalgam - two surfaces, primary or permanent	0
D2160	Amalgam - three surfaces, primary or permanent	0
D2161	Amalgam - four or more surfaces, primary or permanent	0
D2330	Resin - one surface, anterior	0
D2331	Resin - two surfaces, anterior	0
D2332	Resin - three surfaces, anterior	0
D2335	Resin - four or more surfaces	0
D2391	Resin-based composite - one surface, posterior	OP
D2392	Resin-based composite -two surface, posterior	OP
D2393	Resin-based composite - three surface, posterior	OP
D2394	Resin-based composite - four or more surface, posterior	OP
02510-02999	Major Restorative	
D2510	Inlay - metallic - one surface	OP
D2520	Inlay - metallic - two surfaces	OP
D2530	Inlay - metallic - three surfaces	OP
D2540	Onlay - metallic per tooth	OP
D2542	Onlay- metallic- two surfaces	OP
D2543	Onlay - metallic - three surfaces	OP
D2544	Onlay metallic - four or more surfaces	OP
D2642	Onlay - porcelain/ceramic - two surfaces	OP
D2643	Onlay - porcelain/ceramic - three surfaces	OP
D2644	Onlay - porcelain/ceramic - four or more surfaces	OP
D2710	Crown - resin (indirect) GAP	210
D2720	Crown - resin with high noble metal	OP
D2721	Crown - resin with predominantly base metal	125
D2722	Crown - resin with noble metal	OP
D2740	Crown - porcelain/ceramic substrate	237
D2750	Crown - porcelain fused to high noble metal	OP
D2751	Crown - porcelain fused to predominantly base metal	212
D2752	Crown - porcelain fused to noble metal	OP
D2780	Crown-3/4 cast high noble metal	OP
D2781	Crown-3/4 cast predominantly base metal	228
D2782	Crown-3/4 cast noble metal	OP

D2783	Crown-3/4 porcelain/ceramic	OP
D2790	Crown - full cast high noble metal	OP
D2791	Crown - full cast predominantly base metal	206
D2792	Crown - full cast noble metal	OP
D2799	Provisional crown	0
D2910	Recement inlay	25
D2920	Recement crown	17
D2930	Prefabricated stainless steel crown - primary tooth	47
D2931	Prefabricated stainless steel crown - permanent tooth	35
D2932	Prefabricated resin crown anterior teeth only	35
D2940	Sedative filling GAP	0
D2950	Crown build-up (substructure) including any pins	35
D2951	Pin retention - per tooth, in addition to restoration	0
D2952	Indirectly fabricated post and core in addition to crown	49
D2953	Each additional indirectly fabricated post - same tooth.	49
D2954	Prefabricated post and core in addition to crown	0
D2957	Each additional prefabricated post - same tooth	0
D2970	Temporary crown (fractured tooth)	10
03000 - 03999	Endodontics	
D3110	Pulp cap-direct (excluding final restoration)	0
D3120	Pulp cap-indirect (excluding final restoration)	0
D3220	Therapeutic pulpotomy (excluding final restoration)	0
D3221	Gross pulpal debridement, primary and permanent teeth	0
D3230	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	0
D3240	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	0
D3310	Root canal therapy - anterior	100
D3320	Root canal therapy - bicuspid	125
D3330	Root canal therapy – molar - R	0
D3346	Retreatment of previous root canal therapy – anterior - R	0
D3347	Retreatment of previous root canal therapy – bicuspid - R	0
D3348	Retreatment of previous root canal therapy – molar - R	100
D3351	Apexification/recalcification - initial visit - R	0
D3352	Apexification/recalcification - interim visit - R	0
D3353	Apexification/recalcification - final visit - R	0
D3410	Apicoectomy/periradicular surgery – anterior - R	0
D3421	Apicoectomy/periradicular surgery - bicuspid - R	0
D3425	Apicoectomy/per. surgery molar (1st root) - R	0
D3426	Apicoectomy/periradicular surgery (additional root) - R	0
D3430	Retrograde filling - per root - R	50
D3450	Root amputation - per root	0
D3920	Hemisection including root removal	0

04000 - 04999	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	0
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	0
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant (for use with covered procedure D4263,D4264) - P, R	0
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant (for use with covered procedure D4263,D4264) - P, R	0
D4245	Apically positioned flap - P, R	0
D4249	Crown lengthening - hard/soft tissue - P, R	0
D4260	Osseous surgery - four or more contiguous teeth or bounded teeth spaces per quadrant - P, R	0
D4261	Osseous surgery - one to three teeth per quadrant - P, R	0
D4263	Bone replacement Graft - first site in quadrant	0
D4264	Bone replacement Graft - each additional site in quadrant	0
D4270	Pedicle soft tissue graft procedure	0
D4271	Free soft tissue graft and donor site	0
D4341	Periodontal root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	35
D4342	Periodontal root planing - one to three teeth per quadrant	10
D4355	Full Mouth debridement, once every 12 months	0
D4381	Site Specific Therapy	16
D4910	Periodontal maintenance following active therapy	35
05000 - 05899	Prosthodontics, Removable	
D5110	Complete denture, upper	305
D5120	Complete denture, lower	305
D5130	Immediate denture, upper	530
D5140	Immediate denture, lower	530
D5211	Upper partial denture, resin base - GAP	202
D5212	Lower partial denture, resin base - GAP	202
D5213	Upper partial denture - metal base with resin saddles	331
D5214	Lower partial denture - metal base with resin saddles	331
D5281	Unilateral partial denture	140
D5410	Adjust complete denture - upper	10
D5411	Adjust complete denture - lower	10
D5421	Adjust partial denture - upper	10
D5422	Adjust partial denture - lower	10
D5510	Repair broken complete denture base	26
D5520	Replace missing or broken teeth - complete denture	24
D5610	Repair resin saddle or base	37

D5620	Repair cast framework	59
D5630	Repair or replace broken clasp	47
D5640	Replace broken teeth - per tooth	32
D5650	Add tooth to existing partial denture	42
D5660	Add clasp to existing partial denture	47
D5670	Replace teeth and acrylic on cast metal framework (mandibular)	165
D5671	Replace teeth and acrylic on cast metal framework (maxillary)	165
D5710	Rebase denture - complete, upper	121
D5711	Rebase denture - complete, lower	121
D5720	Rebase denture - partial, upper	162
D5721	Rebase denture - partial, lower	163
D5730	Reline denture - complete upper (chairside)	57
D5731	Reline denture - complete lower (chairside)	57
D5740	Reline denture - partial upper (chairside)	55
D5741	Reline denture - partial lower (chairside)	55
D5750	Reline denture - complete upper (laboratory)	100
D5751	Reline denture - complete lower (laboratory)	100
D5760	Reline denture - partial upper (laboratory)	96
D5761	Reline denture - partial lower (laboratory)	96
D5820	Temp partial stay plate, upper	NB
D5821	Temp partial stay plate, lower	NB
D5850	Tissue conditioning, upper - denture	10
D5851	Tissue conditioning, lower - denture	10
D5860	Overdenture - complete, by report	314
D5861	Overdenture - partial , by report	342
06200 - 06999	Prosthodontics, Fixed	
D6210	Pontic - cast high noble metal	OP
D6211	Pontic - cast predominantly base metal	202
D6212	Pontic - cast noble metal	OP
D6240	Pontic - porcelain fused to high noble metal	OP
D6241	Pontic - porcelain fused to predominantly base metal	212
D6242	Pontic - porcelain fused to noble metal	OP
D6250	Pontic - resin with high noble metal	OP
D6251	Pontic - resin with predominantly base metal	70
D6252	Pontic - resin with noble metal	OP
D6608	Onlay - porcelain/ceramic, two surfaces	OP
D6609	Onlay - porcelain/ceramic, three or more surfaces	OP
D6610	Onlay - cast high noble metal, two surfaces	OP
D6611	Onlay - cast high noble metal, three or more surfaces	OP
D6612	Onlay - cast predominantly base metal, two surfaces	OP
D6613	Onlay - cast predominantly base metal, three or more surfaces	OP

D6614	Onlay - cast noble metal, two surfaces	OP
D6615	Onlay - cast noble metal, three or more surfaces	OP
D6720	Removal of impacted tooth - soft tissue - R	OP
D6721	Removal of impacted tooth - partially bony - R	OP
D6722	Removal of impacted tooth - completely bony -R	OP
D6750	Removal of impacted tooth-completely bony w/complications -R	OP
D6751	Crown - porcelain fused to predominantly base metal	213
D6752	Crown - porcelain fused to noble metal	OP
D6780	Crown - 3/4 cast high noble metal	OP
D6781	Crown - 3/4 cast predominantly base metal	231
D6783	Crown - 3/4 cast noble metal	OP
D6790	Crown - full cast high noble metal	OP
D6791	Crown - full cast predominantly base metal	208
D6792	Crown - full cast noble metal	OP
D6930	Recement bridge	27
D6940	Stress breaker	61
D6970	Indirectly fabricated post and core in addition to bridge retainer	21
D6972	Prefabricated post and core buildup	44
D6973	Core buildup for retainer, including any pins	26
D6976	Additional indirectly fabricated post - same tooth	26
D6977	Each additional pre-fabricated post- same tooth	26
D6980	Bridge Repair	NB
07000 - 07999	Oral Surgery	
D7111	Coronal remnants - deciduous tooth	20
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	30
D7210	Surgical removal of erupted tooth	0
D7220	Removal of impacted tooth - soft tissue	0
D7230	Removal of impacted tooth - partially bony	0
D7240	Removal of impacted tooth - completely bony	0
D7241	Removal of impacted tooth-completely bony w/complications	0
D7250	Surgical removal of residual tooth roots	0
D7286	Biopsy of oral tissue, soft	0
D7310	Alveoloplasty in conj. with extraction – four or more teeth or tooth spaces - per quad	0
D7320	Alveoloplasty not in conj. with extraction – four or more teeth or tooth spaces - per quad	0
D7340	Vestibuloplasty	0
D7350	Vestibuloplasty - ridge extension	0
D7471	Removal of lateral exostosis - (maxilla or mandible) - R	0
D7472	Removal of torus palatinus - R	0

D7473	Removal of torus mandibularis – R	0
D7510	Incision and drainage of abscess – R	0
D7960	Frenulectomy (frenectomy or frenotomy) – R	0
D7970	Excision of hyperplastic tissue - per arch	13
09000 - 09999	Additional Procedures	
D9110	Palliative treatment	10
D9211	Regional block anesthesia	0
D9212	Trigeminal division block anesthesia	0
D9215	Local anesthesia	0
D9220	General anesthesia: up to 30 minutes	NB
	General anesthesia: up to 30 minutes <i>Covered when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.</i>	0
D9310	Consultation –diagnostic service provided by dentist or physician other than requesting dentist or physician	0
D9440	Office visit - after regularly scheduled hours	20
D9940	Occlusal Guards by report	20
D9951	Occlusal adjustment - limited	0
D9952	Occlusal adjustment - complete	NB
D0125	Failed Appointment without 24 hr notice per 15 min of appt time	10

08000 – 08999 XI. Orthodontic Procedures		DeltaCare Local Ortho Plan A
D8660	<i>Pre-orthodontic treatment visit [applied to treatment fee if patient proceeds with treatment]</i>	25
D8660 D0210	Records solely for the purpose of Orthodontics: * <i>applied to treatment fee if patient proceeds Intraoral- complete series (including bitewings)</i>	
D0340	Cephalometric film	200
D0330	Panoramic film	
D0322	Tomographic survey	
D0350	Oral/facial images (includes intra and extra oral images)	
D0470	Diagnostic casts	
D8660 00210 00470	Post-records: Intraoral - complete series (including bitewings) Diagnostic casts * <i>applied to treatment fee if patient proceeds</i>	70
D8020 D8030	Limited orthodontic treatment **	NB
D8070 D8080	Comprehensive orthodontic tx transitional dentition [*] Comprehensive orthodontic tx adolescent dentition [*]	1200
D8090	Comprehensive orthodontic tx of the adult dentition [*]	1600

D8670	Periodic orthodontic treatment visit (as part of contract-first 24 months)	Inclusive of total case fee
D8670	Periodic orthodontic treatment visit beyond 24 months	75
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [*]	0
NB	OP = Optional Treatment NB= Not a benefit	
Co-payment	Co-payment= patients payment responsibility per item	
P	P = Pre-authorization required	
R	R = Referable to a specialist	
GAP	GAP = Guidelines apply	
GP	GP = General Dentist responsibility	

***Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee, not to exceed \$75 per month.*

Plan benefits 24 months of active comprehensive orthodontic treatment. It includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of two years. For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee, not to exceed \$75/month.

The above procedures are performed as needed and deemed necessary by your attending panel dentist subject to the limitations and exclusions of the plan. Please refer to those sections for further clarification of benefits.

Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures such as a crown where a filling would restore a tooth are considered optional treatment. The patient must pay the difference in cost between the dentist's WDS file fees for the covered benefit and the optional or more expensive treatment plus any applicable copayment.

Any procedure not listed may be available from a primary care dentist. In the case of procedures not listed, the enrollee is responsible for paying the primary care dentist's maximum allowable fee. "Maximum Allowable Fee" is the fee that the primary care dentist most frequently charges to and collects from uninsured patients. "Uninsured" means not covered by a government program or private group plan. The enrollee should ask the primary care dentist who will perform a procedure that is not listed, and what the primary care dentist's allowable fee is for that procedure in advance of receiving the services.

[In the case of dental services not listed, primary care dentist agrees to inform the enrollee in advance of providing any such treatment, that such services are not covered, that the enrollee is responsible for payment, and the allowable fee for such services as a condition precedent to charging the enrollee for such services.]

If services for a listed procedure are performed by the assigned primary care dentist, the enrollee pays the specified co-payment. Listed procedures that require a dentist to provide specialized services, and are referred by the assigned primary care dentist, must be prior authorized in writing by the plan administrator. The enrollee pays the co-payment specified for such services.

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.

Bitewing X-ray — An x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.

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

Covered Dental Benefit - Those dental services that are covered under this plan, subject to the limitations set forth in Benefits Covered by Your Plan.

Crown — That portion of the human tooth covered by enamel.

Endodontics — That branch of dentistry that deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

Exclusions — Dental services that are not a contract benefit set forth in Benefits Covered by Your Plan and all other services not specifically included as a covered dental benefit set forth in Benefits Covered by Your Plan.

Fluoride — A substance when topically applied or applied to drinking water is effective in resisting tooth decay.

General Anesthesia — A drug or gas that produces unconsciousness and insensibility to pain.

Implant — A graft or insert set firmly onto or deeply into the alveolar area prepared for its insertion. It may support a crown or crowns, a bridge abutment, a partial denture or a complete denture.

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

Intravenous Sedation — A form of sedation where 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 their license. Licensed professional includes, but is not limited to, dentist, hygienist and radiology technician.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured. Dental services that are subject to restricting conditions set forth in Benefits Covered By Your Plan.

Localized delivery of antimicrobial agents — Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees — The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Not a Covered Benefit — Any dental service covered in Benefits Covered By Your Plan that has been subjected to a limitation(s).

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.

Panorex X-ray — An x-ray system using two points of rotation to obtain a panoramic view of the dental arches.

Periodontics — That branch of dentistry that deals with the prevention and treatment of diseases of the bone and soft tissues surrounding the teeth.

Prophylaxis — The control of dental and oral diseases by preventive measures, especially the mechanical cleansing of the teeth.

Prosthodontics — That branch of dentistry that deals with the replacement of missing teeth or oral tissues by artificial means, such as crowns, bridges and dentures.

Restorative — A process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, crown, bridge or denture designed to restore proper dental function.

Root Planing — A procedure done to smooth roughened root surfaces.

Sealants — A resinous material designed for application to the surfaces of posterior teeth in order to seal the surface irregularities and prevent tooth decay.

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

Claim Review and Appeal

Predetermination of Benefits

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

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

Urgent Predetermination Requests

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

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

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

Informal Review

If your claim for dental benefits has been denied, either in whole or in part, you have the right to request an informal review of the decision. Either you, or your authorized representative, 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:

Attn: Appeals Coordinator
Washington Dental Service
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 dental benefits booklet.

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

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

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

Appeals Committee

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

Your request for a review by the Appeals Committee must be made within 90 days of the postmarked 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 Appeal Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

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

Authorized Representative

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

Coordination of Benefits

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

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

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

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

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

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

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

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

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

"Allowable Expense" is a dental care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the *Plans* covering you. When coordinating benefits, any *Secondary Plans* must pay an amount which, together with the payment made by the *Primary Plan*, does not exceed the higher of the allowable expenses. In no event will a *Secondary Plan* be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

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

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

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

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

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

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

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

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

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

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

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

- 1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
 - a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
 - b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
- 2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a) If a court decree states that one of the parents is responsible for the *Dependent* child’s dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
 - b) If a court decree states one parent is to assume primary financial responsibility for the *Dependent* child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
 - c) If a court decree states that both parents are responsible for the *Dependent* child’s dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
 - d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the *Dependent* child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or

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

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

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

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

“COBRA or State Continuation Coverage:” If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

Subrogation

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, 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.

What this means to you is 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.

Eligible Persons 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 Web site at deltadentalwa.com
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To receive the best oral health care possible, it is your responsibility to:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents which 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.

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.