Delta Dental PPO

CITY OF SPOKANE ON BEHALF OF THE LEOFF I POLICE RELIEF AND PENSION FUND

Washington Dental Service
Program No. 00330

Effective January 1, 2007

Questions Regarding Your Program

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

Washington Dental Service Customer Service

(206) 522-2300

(800) 554-1907

Written inquiries may be sent to:

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

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

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

Communication Access for Individuals who are Deaf, Hard Of Hearing, Deaf-Blind and Speech-Disabled

Communications with WDS 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 WDS 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 WDS 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.

MySmile®Personal Benefits Center

Washington Dental Service is proud to present MySmile® Personal Benefits Center: a unique online tool that provides personalized strategies to improve the oral health of employees and their families. Here are examples of what it can do for you:

- MySmile gives personalized tips for improving oral health and lowering out-of-pocket costs
- Aids in tax preparation and financial planning
- Provides clear guidance for effectively using flexible spending accounts (FSAs)

Learn more about MySmile by visiting our website at www.DeltaDentalWA.com/MySmile

TABLE OF CONTENTS

This booklet sets forth in summary form an explanation of the coverage available under your dental program.

The contract is on file with your employer.

SUMMARY OF BENEFITS

Reimbursement Levels for Allowable Benefits for DeltaPreferred Option (PPO) Dentists

Class I ..... Constant 100%

Class II ..... Constant 50%

Class III ..... Constant 50%

Reimbursement Levels for Allowable Benefits for Non-DeltaPreferred Option (PPO) Dentists

Class I ..... Constant 80%

Class II ..... Constant 40%

Class III ..... Constant 40%

Plan Maximum

Annual Program Maximum per Person $350

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

All covered retirees are eligible for Class I, Class II, Class III Covered Dental Benefits and Dental Accident Benefits.

Welcome to the Delta Dental PPO Plan, Washington Dental Service's preferred provider organization (PPO) plan. Washington Dental Service, the state's largest and most experienced dental benefits carrier, is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from Washington Dental Service, you join approximately 2 million people who have discovered the value of our coverage.

HOW TO USE YOUR PROGRAM

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

Choosing A Dentist.
With the Delta Dental PPO program, you may select any licensed dentist, but you will receive higher benefits by seeking care from a participating Delta Dental PPO dentist. To find out whether your dentist is a member, ask him or her, check your plan's Directory of Dentists or go online to the Washington Dental Service/Delta Dental Web site at www.DeltaDentalWA.com and log onto the Subscriber home page to access the Find a Dentist directory. Tell your dentist you are covered by a Washington Dental Service/Delta Dental dental plan and give him or her your Social Security number, the program name and the group number, which is **00330**.

Participating Dentists

There are advantages to selecting a Delta Dental member dentist. First, you have a choice of more than 118,000 participating dentists nationwide. And, if you select a dentist who is a member of Delta Dental, that dentist has agreed to provide treatment for eligible persons covered by Delta Dental programs according to the provisions of his or her member dentist contract. You won't have to hassle with claim forms or other paper work. Participating dentists complete claim forms and submit them to Washington Dental Service. They receive payment directly from Washington Dental Service. You will not be charged for more than the approved fee or the fee that the participating dentist has on file with the Delta plan in his or her state. You may, however, be responsible for deductibles or copayments (see Copayment and/or Program Deductible section headings in this section) and for any elective care you choose to receive outside the covered benefits.

Delta Dental PPO Dentists must be Delta Dental member dentists in order to participate in the PPO network. More than 57,000 dentists participate in this network nationwide. PPO dentists receive payment based on their PPO filed fees at the percentage levels listed on your plan for participating PPO dentists. Patients are responsible for percentage copayments up to the PPO filed fees. Delta Dental PPO is a point-of-service plan, meaning that you can choose any dentist — in or out of the PPO network — at the time you need treatment. However, if you select a dentist who is part of the Delta Dental PPO network, your benefits will be paid at a higher level and your out-of-pocket expenses may be lower.

Non-PPO Member Dentists are members of Delta Dental Plans Association, but they are not part of the Delta Dental PPO network. Non-PPO member dentists receive payment based on their approved fees or filed fees at the percentage levels listed on your plan for non-PPO dentists.

Nonparticipating Dentists

If you select a dentist who is not a member of Delta Dental, you are responsible for paying the dentist and having him or her complete and sign claim forms. We accept any American Dental Association-approved claim form that your dentist may provide. It is up to you to ensure that the claim is sent to Washington Dental Service. The payment for services performed by a nonmember dentist is based upon the allowable fees for nonmember dentists in the state in which the services are performed.

Claim Forms.

American Dental Association-approved claim forms may be obtained from your dentist, or you may also download claim forms from our website at www.DeltaDentalWA.com. Washington Dental Service is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 18 months after the date the treatment is provided.

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 Washington Dental Service will pay toward the treatment and your financial responsibility.

Benefit Period.

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

Reimbursement Levels.

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

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

Limitations And Exclusions.

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

Copayments.

A copayment policy is typical of most benefit plans. This means the carrier (Washington Dental Service) will pay a predetermined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the copayment.

Program Maximum.

The program maximum is the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period. You are personally responsible for paying costs above the annual maximum.

For your program, the maximum amount payable by Washington Dental Service for Class I, II and III covered dental benefits (including dental accident benefits) per eligible person is $350 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

Retiree Eligibility And Termination.

Eligible retirees are all retirees for whom employer contributions are made.

New retirees are eligible on the first day of retirement.

There is no coverage available for dependents under this plan.

BENEFITS COVERED BY YOUR PROGRAM

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

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

CLASS I

DIAGNOSTIC

Covered Dental Benefits

— Routine examination (periodic oral evaluation).
— Comprehensive oral evaluation.
— X-rays.
— Emergency examination.
— Palliative treatment for pain.
— Specialist examination performed by a specialist in an American Dental Association recognized specialty.
— WDS-approved periodontal susceptibility/risk tests.

Limitations

— Routine examination is covered twice in a benefit period.
— Comprehensive oral evaluation is covered once in a 3-year period as one of the two covered examinations in a benefit period per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a Delta Dental participating dentist.
— Complete series (any number or combination of intraoral and/or extraoral x-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex x-rays are covered once in a 3-year period.
— Supplementary bitewing x-rays are covered twice in a benefit period.
— Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a covered benefit.

Exclusions

— Consultations or elective second opinions.
— Study models.

PREVENTIVE

Covered Dental Benefits

— Prophylaxis (cleaning).
— Periodontal maintenance.
— Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations

— Prophylaxis and/or periodontal maintenance procedures will be limited to 2 procedures in a benefit period.
— Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) *may be* covered up to a total of 4 times in a benefit period. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*
— Replacement of a space maintainer previously paid for by WDS is not a covered benefit.

Exclusions

— Topical application of fluoride or preventive therapies.
— Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits).
— Fissure sealants.
— Cleaning of a prosthetic appliance.

REFER ALSO TO GENERAL EXCLUSIONS

CLASS II

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

GENERAL ANESTHESIA

Covered Dental Benefits

— General anesthesia when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Limitations

— General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II and III covered dental procedures. Either general anesthesia or intravenous sedation (*but not both*) is covered when performed on the same day.
— General anesthesia for routine post-operative procedures is not a covered benefit.

INTRAVENOUS SEDATION

Covered Dental Benefits

— Intravenous sedation when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Limitations

— Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS. Either general anesthesia or intravenous sedation (*but not both*) is covered when performed on the same day.

— Intravenous sedation for routine post-operative procedures is not a covered benefit.

RESTORATIVE

Covered Dental Benefits

— Amalgam restorations and, in anterior teeth, resin-based composite or glass ionomer restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).

— Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids.

— Stainless steel crowns.

Limitations

— Restorations on the same surface(s) of the same tooth are covered once in a 2-year period.

— If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.

— Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a covered benefit.

— Stainless steel crowns are covered once in a 2-year period.

— **Refer to Class III Limitations if teeth are restored with crowns, veneers, inlays or onlays.**

Exclusions

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

ORAL SURGERY

Covered Dental Benefits

— Removal of teeth.

— Preparation of the mouth for insertion of dentures.

— Treatment of pathological conditions and traumatic injuries of the mouth

— Refer to Class II General Anesthesia or Intravenous Sedation for additional information.

Exclusions

— Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of natural teeth.

— Tooth transplants.

— Materials placed in extraction sockets for the purpose of generating osseous filling.

PERIODONTICS

Covered Dental Benefits

— Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planing and periodontal surgery.

— Limited adjustments to occlusion (8 teeth or less).

— WDS-approved localized delivery of antimicrobial agents.

— **Refer to Class I Covered Dental Benefits and Limitations for periodontal maintenance benefits.**

— **Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and occlusal guard (nightguard)**.

Limitations

— Periodontal scaling/root planing is covered once in a 3-year period.

— Periodontal surgery (per site) is covered once in a 3-year period.

— Soft tissue grafts (per site) are covered once in a 3-year period.

— Limited occlusal adjustments are covered once in a 12-month period.

— Localized delivery of antimicrobial agents approved by WDS are a covered benefit under certain conditions of oral health. Localized delivery of antimicrobial agents is limited to 2 teeth per quadrant and up to 2 times (per tooth) in a benefit period. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

— Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.

— Localized delivery of antimicrobial agents is not a covered benefit when used for the purpose of maintaining non-covered dental procedures or implants.

— Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit.

Exclusions

— Periodontal splinting.

— Gingival curettage.

ENDODONTICS

Covered Dental Benefits

— Procedures for pulpal and root canal treatment.

— Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

Limitations

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

— Re-treatment of the same tooth is allowed when performed by a different dental office.

— **Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.**

Exclusions

— Bleaching of teeth.

REFER ALSO TO GENERAL EXCLUSIONS

CLASS III

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

PERIODONTICS

Covered Dental Benefits

— Under certain conditions of oral health, services covered are occlusal guard (nightguard), repair and relines of occlusal guard (nightguard) and complete occlusal equilibration. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

Limitations

— Occlusal guard (nightguard) is covered once in a 3-year period.
— Repair and relines done more than 6 months after the initial placement are covered.
— Complete occlusal equilibration is covered once in a lifetime.

RESTORATIVE

Covered Dental Benefits

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

Limitations

— Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a 5-year period.
— Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.
— Inlays (as a single tooth restoration) will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
— If a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.
— WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration – with limitations), onlay, veneer or crown.
— Crown buildups are a covered benefit when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
— Crown buildups are covered once in a 2-year period.

— Crown buildups are not a covered benefit within 2 years of a restoration on the same tooth.
— Crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a covered benefit.
— Cast post and core are covered once in a 5-year period on the same tooth in keeping with the policy for all cast restorations.
— A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
— Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
— Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit.
— Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit.

Exclusions

— Copings.

PROSTHODONTICS

Covered Dental Benefits

— Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device.
— Surgical placement or removal of implants or attachments to implants.

Limitations

— Replacement of an existing prosthetic device is covered only once every 5 years and only then if it is unserviceable and cannot be made serviceable.
— Inlays are a covered benefit on the same teeth once in a 5-year period only when used as an abutment for a fixed bridge.
— Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
— Replacement of implants and superstructures is covered only after 5 years have elapsed from any prior provision of the implant.
— Crowns in conjunction with overdentures are not a covered benefit.
— **Full, immediate and overdentures** - WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
— **Temporary/interim dentures** - WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 6 months.
— Root canal treatment performed in conjunction with overdentures is limited to 2 teeth per arch and is paid at the Class III payment level.

— **Partial dentures** - If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
— **Denture adjustments and relines** - Denture adjustments and relines done more than 6 months after the initial placement are covered. Subsequent relines or rebases (*but not both*) will be covered once in a 12-month period.

Exclusions
— Duplicate dentures.
— Personalized dentures.
— Cleaning of prosthetic appliances.
— Copings.

REFER ALSO TO GENERAL EXCLUSIONS

ACCIDENTAL INJURY

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

GENERAL LIMITATIONS

- Dentistry for cosmetic reasons is not a covered benefit.
- 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 are not a covered benefit.
- General anesthesia/intravenous (deep) sedation is not a covered benefit, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a covered benefit except when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

GENERAL EXCLUSIONS

- 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.
- Application of desensitizing agents.

- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, Washington Dental Service, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

  Any denial of benefits by Washington Dental Service on the grounds that a given procedure is deemed experimental, may be appealed to 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.
- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.
- Prescription drugs.
- In the event an eligible person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
- Broken appointments.
- Patient management problems.
- Completing claim forms.
- Habit breaking appliances or orthodontic services or supplies.
- TMJ services or supplies.
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- All other services not specifically included in this program as covered dental benefits.

Washington Dental Service shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the Contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.

Frequently Asked Questions About Your Dental Benefits

What is a Washington Dental Service "participating dentist"?
A Washington Dental Service participating dentist is a dentist who has signed an agreement with Washington Dental Service stipulating that he or she will provide dental treatment to subscribers covered by Washington Dental Service's group dental care programs. WDS participating dentists submit claims directly to Washington Dental Service for their patients.

Can I choose my own dentist?
See "Choosing A Dentist" under the "How To Use Your Program" section in the front of this booklet.

How can I obtain a list of Washington Dental Service participating dentists?
You can obtain a Washington Dental Service Directory of Dentists from your employer or by going to our Internet Web site at **www.DeltaDentalWA.com** and selecting the "Find a Dentist" option.

How can I get claim forms?
You can obtain American Dental Association-approved claim forms from your dentist. You can also obtain a copy of approved claim forms from our website at **www.DeltaDentalWa.com**.

What is the mailing address for Washington Dental Service claim forms?
If you see a Washington Dental Service participating dentist, the dental office will submit your claims for you. If your dentist is a nonparticipating dentist, you may send your claims to Washington Dental Service at P.O. Box 75983, Seattle, WA 98175-0983.

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

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

Do I have to get an "estimate" before having dental treatment done?
If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a "predetermination of benefits." This service is very helpful because it will allow you to know in advance what procedures are covered, the amount Washington Dental Service should pay toward the treatment and your financial responsibility. The estimates provided do not represent a guarantee of payment but provide you only with estimated costs and benefits for your procedure

I am divorced. If my former spouse and I both have dental coverage, whose plan covers the children first?
It usually depends on who has financial responsibility for the children. If the parents have joint custody, then the parent with the birthday earliest in the calendar year has primary coverage. If the custodial parent does not have financial responsibility, the parent who does has primary coverage. For more information, see the *Coordination of Benefits* section in this book.

My former spouse and I are divorced. What kind of documentation do I need to provide to Washington Dental Service to maintain the children's dental coverage?
A parenting plan or statement of financial responsibility is required to verify which parent has primary coverage and which has secondary coverage for children in a divorce situation.

What is Delta Dental?
Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide employer groups with dental benefits coverage. Washington Dental Service is a member of the Delta Dental Plans Association.

GLOSSARY

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

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

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

Bitewing x-ray — An x-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gumline, as well as a portion of the roots and supporting structures of these teeth.

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

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

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

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

Comprehensive Oral Evaluation – Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

Coping - A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge for the purpose of allowing the removal and modification (if the tooth is lost) of the bridge without requiring a major remake of the bridge work.

Covered Dental Benefit - Those dental services which are covered under this program, subject to the limitations set forth in Benefits Covered By Your Program.

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

Delivery Date — The date a prosthetic appliance is permanently cemented into place.

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

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

Exclusions — Dental services which are not a contract benefit set forth in Benefit Covered By Your Program and all other services not specifically included as a Covered Dental Benefit set forth in Benefit Covered By Your Program.

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

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

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

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

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

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

Intravenous (I.V.) Sedation — A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

Licensed Professional – means an individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to, denturist, 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 which are subject to restricting conditions set forth in Benefits Covered By Your Program.

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

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

Nightguard — See Occlusal Guard.

Not A Covered Benefit — Refers to any dental service covered in "Benefits Covered By Your Program" 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.

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

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

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

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

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

Periodic Oral Evaluation (routine examination) - An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

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

Prophylaxis — Cleaning and polishing of teeth.

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

Qualified Medical Child Support Order (QMCSO) - means an order issued by a court under which an employee must provide medical coverage for a dependent child. QMCSOs are often issued, for example, following a divorce or legal separation.

Resin-based composite — A tooth colored filling, made of a combination of materials, used to restore teeth.

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

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

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

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

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

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

CLAIM REVIEW AND APPEAL

Predetermination of Benefits
A predetermination is a request made by your dentist to WDS to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but 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:

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

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

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

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

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

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

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

The Appeal Committee will review your claim and make a determination within 60 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.

SUBROGATION

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

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

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

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

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

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

DISCLOSURE INFORMATION

In accordance with section 4 of ESSB 6392, Chapter 312, Laws of 1996, the Managed Care Entities Disclosure Act, WDS is pleased to provide important information about our various dental care plans. The goal of this law is to provide individuals who are making health care decisions for themselves and their families with as much information as possible to make the best decisions. Washington Dental Service fully supports this principle and supplies most of the required information in enrollee benefit booklets, which are supplied to each enrollee at the start of their coverage.

<u>The items of information which you may request Washington Dental Service to provide you are</u>:

1a) the availability of a point of service plan and how the plan operates within the coverage

1b) documents, instruments or other information referred to in the enrollment agreement

1c) procedures to be followed for consulting a provider other than the primary care provider (applies primarily to capitation plans)

1d) existence of plan list or formulary for prescription drugs, for plans with that specific benefit

1e) procedures that must be followed for obtaining prior authorization for health care services

1f) reimbursement or payment arrangements, between a carrier and a provider

1g) circumstances under which a plan may retrospectively deny coverage for care that had prior authorization

1h) copy of all grievance procedures for claim or service denial and for dissatisfaction with care

1i) description and justification for provider compensation programs, including any incentive or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists

2) Enrollees of Washington Dental Service dental care plans may, at any time, freely contract to obtain other forms of dental care or health care services outside Washington Dental Service plan coverage for any reason they choose, however, the enrollee must pay for all such services.

In order to obtain this information, you must call 1-800-554-1907. A Washington Dental Service employee will take your name and send you the information you requested. If you are an enrollee of a dental care plan with Washington Dental Service, we may also refer you to your benefit booklet for additional information about your plan that may be useful. You can also write Washington Dental Service and request the above information at P.O. Box 75983, Seattle, WA 98175-0983.

Washington Dental Service, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today, as part of the nation's largest dental benefits provider, we serve approximately 2 million people through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large 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. Healthy teeth for a wonderful smile – that is what we are all about!

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

Amt 01/2007
00330B012007-01