Washington Dental Service, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today, as part of the nation's largest dental benefits provider, we serve approximately 1.9 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 Delta Dental 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.**

Delta Dental PPO

WBBA
WASHINGTON BIOTECHNOLOGY & BIOMEDICAL ASSOCIATION

Washington Dental Service
Program No. 00778 Plan D

Effective January 1, 2006

Your ID Cards are enclosed

MySmile

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

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

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

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

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

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 new 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.

The items of information which you may request Washington Dental Service to provide you are:

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 1-800-367-4104. 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 Identification Cards

Here are two copies of your Washington Dental Service Identification card. The card contains important information that should be given to your dentist when you or your eligible dependent(s) receive treatment. At the time of treatments, please provide your name, the information on your card and your Social Security Number to your dental office so the office can submit your claim to Washington Dental Service. **Your ID Card is not proof of coverage.**

Please refer to your dental benefits booklet for specific eligibility and coverage information.

If you need a replacement card, a printable version may be obtained by visiting our website at **www.deltadentalwa.com**.

Tear here →

DELTA DENTAL®

Washington Dental Service

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

Name: _____

Group Name: **Washington Biotechnology & Biomedical Association**

Group Number: **00778 Plan D**

This card is for identification only and is not a guarantee of coverage. For benefits information. visit us at www.deltadentalwa.com.

DELTA DENTAL®

Washington Dental Service

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

Name: _____

Group Name: **Washington Biotechnology & Biomedical Association**

Group Number: **00778 Plan D**

This card is for identification only and is not a guarantee of coverage. For benefits information. visit us at www.deltadentalwa.com.

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.

With your Delta Dental Plan from Washington Dental Service, you join more than 1.9 million people who have discovered the value of our coverage. We offer you:

More dentists. More choices. With a Delta Dental plan, you have access to the states largest network of dentists. Because we partner with nine out of ten dentists in Washington State, chances are, your dentist is a member of Washington Dental Service.

Hassle Free. Dental is all we do. So it's not surprising that, from remarkably knowledgeable customer service representatives to state-of-the-art technology systems, we've got responsive service down to a science.

Comprehensive coverage. Washington Dental Service has a reputation for being among the first to include new treatments based on proven scientific advances in our plans.

Please call the customer service number printed on your card if you have any questions or need assistance.

Customer Service
1-800-554-1907

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

Customer Service
1-800-554-1907

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

Written comments, documents, or other information may be submitted in support of an appeal. Upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision will be provided. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any consideration.

The review will be conducted by someone different from the original decision-makers and without deference to the initial decision. If the appeal is based in whole or in part on a medical judgment including a determination as to whether a particular treatment, drug or other item is experimental, investigational, or not based on the provisions of the contract, WDS will consult with a dental professional who has appropriate training and experience. In such a case, the professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any expert whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination.

If after review the matter has not been resolved to the satisfaction of all parties, any person aggrieved thereby may submit the matter to nonbinding mediation conducted pursuant to mediation rules of the American Arbitration Association or the Judicial Arbitration and Mediation Service, or other such organization, as agreed to by both parties. If no agreement is reached between both parties on the desired mediation rules within 15 days, then WDS will choose from the above services.

Predetermination Appeals

If a predetermination is required by WDS or is requested by an eligible person, or his/her designee and an adverse decision is rendered, any person aggrieved thereby shall have the right to appeal the same to WDS orally or in writing. In the event of such an appeal, the question will be re-evaluated and communicated to the appealing party within 15 days by the Dental Director, or his/her designee, unless WDS notifies the aggrieved person that an extension is necessary, in which case the decision shall be communicated within 30 days absent informed, written consent of the aggrieved person for a longer extension. An appeal shall be evaluated by a dentist who was not involved in the decision which is the subject of the appeal.

Authorized Representative

Eligible person may authorize another person to represent them and with whom they want WDS to communicate regarding specific claims or an appeal. The authorization must be in writing, signed by Eligible Person, and include all the information required in an appeal. (An assignment of benefits, release of information, or other similar form that eligible person may sign at the request of their health care provider does not make your provider an authorized representative). You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

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 The Washington Biotechnology & Biomedical Association.

SUMMARY OF BENEFITS

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

*Class I ..... Constant 100%

Class II ..... Constant 80%

Class III ..... Constant 50%

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

*Class I ..... Constant 80%

Class II ..... Constant 70%

Class III ..... Constant 40%

Plan Maximum and Deductible

*Annual Deductible per Person $50

*Annual Deductible - Family Maximum $150

Annual Program Maximum per Person $2,000

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 employees and covered dependents are eligible for Class I, Class II, Class III Covered Dental Benefits and Dental Accident Benefits.

*Annual deductible is waived for Class I Covered Dental Benefits and Dental Accident Benefits.

Welcome to the DeltaPreferred Option dental 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 1.9 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 benefit 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.

Urgent Claim Review

Dental benefit coverage typically does not require urgent claim review. Urgent care claims require notification or approval prior to receiving dental care when a delay in treatment could seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician who has knowledge of the medical condition or a dentist who has knowledge of the dental condition. These are rare dental situations and require determination by a physician or dentist with knowledge of the condition.

WDS will provide notice of the benefit determination, in writing or electronically, within 72-hours after receipt of all necessary information. When practical, WDS may provide notice of denial orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain prior authorization in an emergency. The claim will be evaluated after treatment. The eligible person or the dental office may obtain information regarding covered benefits anytime prior to treatment.

If an urgent care claim is filed improperly, WDS will notify the eligible person within 24 hours along with instructions on how to file properly. If additional information is needed to process the claim, the eligible person will be notified of the information needed within 24 hours after the claim is received. The eligible person then has 48 hours to provide the requested information.

WDS will notify the eligible person of the determination no later than 48 hours after receipt of the requested information or at the end of the 48-hour period within which the eligible person was to provide the additional information.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Appeals

Should a claim be denied, in whole or in part, the eligible person has a right to a full and fair review. The request to have a denied claim reviewed must be submitted orally or in writing and within 180 days from the date the claim was denied. Further consideration will not be allowed after 180 days.

A final benefit determination will be made within 30 days following receipt of an appeal.

An appeal must include name, identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits.

Send your appeal to:

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

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

Initial Claim Determination
An initial claim determination will be performed on all properly submitted claims within 30 days of receipt. The 30-day period may be extended for an additional 15 days, however, if the claim determination is delayed for reasons beyond our control. In that case, we will notify the subscriber prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from the subscriber, the notice will describe the specific information we need, and the subscriber will have 45 days from the receipt of the notice to provide the information. Without complete information, the subscriber claim will be denied.

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

- the specific reason or reasons for the denial,
- reference to the specific plan provision on which the denial is based,
- a description of any additional material or information necessary for the eligible person to complete the claim and an explanation of why such material or information is necessary to process the claim, and
- the appropriate information as to the steps to be taken if the eligible person wishes to appeal the decision.

Predetermination Claims
Predetermination of claims requires notification or approval prior to receiving dental care. The claims administrator will provide notice of the claim decision within 15 days after receiving the claim. If a predetermination is filed improperly, the claims administrator will provide notification of the improper filing and how to correct the filing within 5 days after receipt of the predetermination. If additional information is required, the claims administrator will notify the eligible person of what information is needed within 15 days after the claim is received. The claims administrator may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension the eligible person has 45 days to provide this information. Once the information is received the claims administrator will make a determination within 15 days. If the information is not provided within 45 days, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Choosing A Dentist.
With Washington Dental Service, you may select any licensed dentist. Tell your dentist that you are covered by a Washington Dental Service dental plan and give him or her your Social Security number, the program name and the group number — which is **0778 Plan D**.

Delta Dental Premier Participating Dentists
If you select a dentist who is a Washington Dental Service participating dentist, that dentist has agreed to provide treatment for eligible persons covered by Washington Dental Service programs according to the provisions of his or her Delta Dental participating dentist contract. You won't have to hassle with sending in claim forms. Delta Dental Premier participating dentists complete claim forms and submit them directly 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 Delta Dental Premier participating dentist has filed with us. You may, however, be responsible for copayments (see Copayment heading in this section) and for any elective care you choose to receive outside the covered benefits.

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

Delta Dental Premier participating dentists (non-PPO) are members of Delta Dental Premier, Washington Dental Service's traditional fee-for-service plan, but they are not part of the Delta Dental PPO network. Payments to Delta Dental participating (non-PPO) dentists are based on their Delta Dental Premier filed fees at the percentage levels listed under the group's benefits for non-PPO dentists.

Nonparticipating Dentists in Washington State
If you select a dentist who is not a Washington Dental Service participating dentist, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. It is up to you to ensure that the claim is sent to Washington Dental Service. Since Washington Dental Service does not have fees on file for nonparticipating dentists, the payment for services performed by a nonparticipating dentist is based upon actual charges or Washington Dental Service's allowable fees for nonparticipating dentists, whichever is less.

Out-of-state dentists

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

Claim Forms.

American Dental Association-approved claim forms may be obtained from your dentist. Washington Dental Service is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 6 months after 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.

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 dental 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. It is paid even after a deductible is reached.

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.

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.

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 Delta Dental 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.

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 $2,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

Program Deductible.
Most dental plans have a specific dollar deductible. It works like your car insurance deductible. During a benefit period, you may have to personally pay a portion of your dental bill before your carrier — Washington Dental Service — will contribute to your bill.

Your program has a $50 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of $50 is made. Once each eligible person has satisfied the deductible during the period, no further deduction will apply to that eligible person until the next period. The maximum deductible per family each benefit period is $150. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be $150. Once a family has satisfied the maximum deductible amount during the period, no further deduction will apply to that family until the next succeeding period. The deductible does not apply to Class I covered dental benefits or dental accident benefits.

Employee Eligibility And Termination.
Eligible employees are all full-time employees for whom Member Group contributions are made.

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

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

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

In the event of a suspension of compensation 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 Washington Dental Service may terminate the coverage.

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

The "Continuation of Coverage" legislation passed into federal law (PL 99-272 and as amended by PL 104-191) requires that should certain qualifying events occur which would have previously terminated coverage, employee coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits up to 18 months, or until you are covered under another group dental plan, by self-paying the required premium.

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

Dependent Eligibility And Termination.
If dependent coverage is included in the program, eligible dependents are your lawful spouse and unmarried children, including biological children, stepchildren, foster children and adopted children.

Children are covered from birth through age 24.

An unmarried child over the limiting age may continue to be an eligible dependent providing all of the following conditions are met: 1) the child is incapable of self-support because of a physical handicap or developmental disability that commenced prior to reaching the limiting age, 2) a physician's certificate is submitted to WDS within 31 days following attainment of the limiting age, and 3) the child was an eligible dependent upon attainment of the limiting age.

A new family member, with the exception of newborns and adopted children, must be enrolled on the first day of the month following the date he or she qualifies as an eligible dependent. A newborn shall be covered from and after the moment of birth, and an adopted child shall be covered from the date of placement for the purpose of adoption, provided that if this program requires payment of an additional monthly premium for coverage of such child, enrollment of the newborn or adopted child and payment to Washington Dental Service of all applicable premiums is completed within 90 days after the date of birth or placement to assure coverage. If no additional premium is required, Washington Dental Service requests completion of the enrollment process for the newborn or adopted child within 90 days after the date of birth or placement, but coverage will be provided in any event. To enroll a newborn or adopted child, a parent must complete a new enrollment form provided by Washington Dental Service. If an additional premium for coverage is required and enrollment and payment is not completed for a newborn or adopted child within said 90 days, such child may be enrolled coincident with any renewal or extension of the Contract.

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.

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.

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.

Frequently Asked Questions About Your Dental Benefits

What is a Washington Dental Service "Delta Dental participating dentist"?
A Washington Dental Service Delta Dental 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 Delta Dental 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 Delta Dental 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.

What is the mailing address for Washington Dental Service claim forms?
If you see a Washington Dental Service Delta Dental 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.

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 will pay toward the treatment and your financial responsibility.

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

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

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. You, a custodial parent, a state agency or an alternate recipient may enroll a dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for coverage pursuant to a QMCSO may not enroll dependents for coverage under the plan.

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

The "Continuation of Coverage" legislation passed into federal law (PL 99-272 and as amended by PL 104-191) requires that should certain qualifying events occur which would have previously terminated coverage, dependent coverage may continue for a period of time on a self-pay basis.

If a dependent no longer meets the eligibility requirements due to the death or divorce of the employee, or does not meet the age requirement for children, coverage may continue up to 3 years, or until the dependent is covered under another group dental plan, by self-paying the required premium.

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

COORDINATION OF BENEFITS

If an eligible person is entitled to benefits under two or more group dental plans, the amount payable under this plan will be coordinated with any other plan. The amount paid by Washington Dental Service, together with amounts from other group programs, will not exceed 100% of dental expenses incurred and the total amount payable by Washington Dental Service will not exceed the amount that would have been paid for covered benefits if no other program was involved.

The following rules establish the order of benefit payments:

a. The benefits of the plan that does not have a coordination of benefits (COB) provision will be primary (the plan whose benefits are determined first).

b. The benefits of the plan that covers the person as an active employee will be determined before the benefits of a plan that covers the person as a dependent.

c. If the person is a child whose parents are not separated or divorced:

   The benefits of the plan covering the parent whose month and day of birth occurs earlier in the calendar year will be determined before the benefits of the plan of the parent whose month and day of birth occurs later in the calendar year.

d. If the person is a child of parents who are separated or divorced, then the benefits are determined in the following order:

   (1) The plan of the parent with custody

   (2) The plan of the new spouse of the parent with custody

   (3) The plan of the parent without custody

   (4) The plan of the new spouse of the parent without custody

   However, if the court decrees financial responsibility for the child's health care, the plan of the parent with the financial responsibility is the primary plan.

e. The plan covering the person as a retired or laid-off employee or dependent of such person will be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person. This provision will not apply if neither plan has a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other.

f. If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

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

- 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, injections or 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.

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.

MySmile

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 (FSA's)

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

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.
— Examination by a specialist in an American Dental Association recognized specialty.
— WDS-approved caries and 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.
— Fissure sealants.
— Topical application of fluoride or preventive therapies (e.g. fluoridated varnishes).
— Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations
— Prophylaxis and/or periodontal maintenance procedures will be limited to 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.*
— Topical application of fluoride or preventive therapies (*but not both*) is covered twice in a benefit period.
— Fissure sealants are available for children through age 14. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending Dentist. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once in a 3-year period per tooth.
— Replacement of a space maintainer previously paid for by WDS is not a covered benefit.

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

REFER ALSO TO GENERAL EXCLUSIONS

— 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 jump rebases (*but not both*) will be covered once in a 12-month period.

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.

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.
— 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.
— 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.

CLASS II

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), an amalgam allowance will be made for such procedure. The difference in cost is your responsibility.
— 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 and surgical extractions.
— Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures.
— Treatment of pathological conditions and traumatic facial injuries.
— **Refer to Class II General Anesthesia or Intravenous Sedation for additional information.**

Exclusions

— Iliac crest or rib grafts to alveolar ridges.
— Ridge extension for insertion of dentures (vestibuloplasty).
— 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

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.*