

Business Health Trust

Group #00158 & 00159

Effective October 1, 2010, the following benefit information has been revised or added in your Benefit Booklet. We have identified the section that is changing with all **changes in bold print**.

Dependent Eligibility and Termination

Eligible dependents are your lawful spouse **or state registered domestic partner** and children from birth through age **25**. Children include biological children, stepchildren, foster children and adopted children. Spouses and children of married dependents are not eligible for coverage under this plan.

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

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

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

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

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

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

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

Special Enrollment Periods

Special enrollments are allowed under the following conditions:

1. Loss of Other Coverage

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

- You declined enrollment in this plan.
- You lose eligibility in another health plan or your coverage is terminated due to the following:
 - Legal separation or divorce.
 - Cessation of dependent status.
 - Death of employee.
 - Termination of employment or employer contributions.
 - Reduction in hours.
 - Loss of individual or group market coverage because of move from plan area or termination of benefit plan.
 - Exhaustion of COBRA coverage.
- Your application to enroll in this plan is received by WDS within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

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

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

2. Marriage, Birth or Adoption

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

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

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

- **Birth** — A newborn shall be covered from and after the moment of birth. WDS requests the application for coverage be made within 90 days of the date of birth. If an additional premium for coverage is required and enrollment and payment is not completed within the 90 days, the eligible dependent may be enrolled during the next open enrollment.
- **Adoption** — WDS requests the application for coverage be made within 90 days of the date of assumption of a legal obligation for total or partial support of the child in anticipation of adoption. If an additional premium for coverage is required and enrollment and payment is not completed within the 90 days, the eligible dependent may be enrolled during the next open enrollment.

Coordination of Benefits

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

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

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

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

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plans* or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
 - a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
 - b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.

- 2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
 - b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
 - c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
 - d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
 - e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
 - I. The *Plan* covering the *Custodial Parent*, first;
 - II. The *Plan* covering the spouse of the *Custodial Parent*, second;
 - III. The *Plan* covering the *noncustodial Parent*, third; and then
 - IV. The *Plan* covering the spouse of the *noncustodial Parent*, last
- 3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MySmile[®] Personal Benefits Center

The MySmile[®] personal benefits center, available on Washington Dental Service's Web site at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your plan network, review your recent dental activity, check details of your plan coverage, view and print your ID card, check the status of current claims, and more.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

Children's Health Insurance Program Reauthorization Act (CHIPRA)

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

- Employees and dependents that are eligible but not enrolled for coverage may enroll under the following conditions:

- An employee or dependent loses Medicaid or CHIP coverage due to loss of eligibility, and the employee requests coverage within 60 days after the termination.
- An employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage within 60 days after the termination.

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

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

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

Conversion Option

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

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

American Recovery and Reinvestment Act (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under COBRA. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 and lasts for the time period established by law for those eligible for COBRA due to an involuntary termination period, as defined by the ARRA.

Well Baby Checkups

For your infant child, Washington Dental Service offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of services. When visiting a participating physician with your infant (age 0-3), WDS will reimburse the physician on your behalf for specific services performed, up to the amount listed below:

- Oral Evaluation: Reimbursed up to \$43
- Topical application of fluoride: Reimbursed up to \$36

Please see the "Benefits Covered by Your Plan" section of this booklet for any other limitations. Also, please be aware that Washington Dental Service has no control over the charges or billing practices of non-dentist providers which may affect the amount Washington Dental Service will pay and your financial responsibility.

Benefits Covered By Your Program

Class I

Diagnostic

Limitations

- **Comprehensive oral evaluation is covered once in a three-year period from the date of service per eligible person per dentist. Additional comprehensive oral evaluations are allowed as routine examinations.**
 - **Comprehensive oral evaluations are considered as one of the two covered examinations per benefit period.**

Preventive

Limitations

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

Class II

Restorative

Covered Dental Benefits

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

Limitations

- **WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin onlay, veneer, crown or inlay (as a single tooth restoration – with limitations).**

Periodontics

Limitations

- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
 - **Periodontal surgery must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.**

Prosthodontics

Covered Dental Benefits

- Inlays (only when used as a **retainer** for a fixed bridge)

Limitations

- Inlays are a covered dental benefit on the same teeth once in a seven-year period from the delivery date only when used as a **retainer** for a fixed bridge.
- **Implant maintenance procedures, including:**
 - **Removal of prosthesis**
 - **Cleansing of prosthesis and abutments**
 - **Reinsertion of prosthesis**

Exclusions

- **Maintenance or cleaning** of prosthetic appliances
 - **Except for implant maintenance**

Additional Procedures (new section)

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

General Exclusions

3. Experimental services or supplies, which include:
 - c. **Whenever WDS makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, WDS shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).**

The final paragraph of General Exclusions has been updated:

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

Glossary

The following definitions have been added:

EMERGENCY DENTAL CONDITION — The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

EMERGENCY EXAMINATION — Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

OPEN ENROLLMENT PERIOD — The annual period in which subscribers can select benefits programs and add or delete eligible dependents.

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