

Delta Dental Premier®

Seattle Pacific University

Washington Dental Service
Program No. 00333

Effective July 1, 2007

Questions Regarding Your Program

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

Washington Dental Service Customer Service

(206) 522-2300

(800) 554-1907

Written inquiries may be sent to:

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

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

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

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

Communications with WDS for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with WDS through specially trained communications assistants.

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) or 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial WDS Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the WDS customer service representative.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

MySmile® Personal Benefits Center

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

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

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

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

The contract is on file with your employer.

SUMMARY OF BENEFITS

Reimbursement Levels for Allowable Benefits

*Class I.....	Constant 100%
Class II.....	Constant 80%
Class III.....	Constant 50%
Orthodontic Procedures.....	Constant 50%

Plan Deductibles and Maximum

*Annual Deductible per Person.....	\$25
*Annual Deductible - Family Maximum.....	\$75
Annual Program Maximum per Person.....	\$1,750
Lifetime Orthodontic Benefits per Child.....	\$1,000

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 only.

Welcome to the Delta Dental Premier dental plan, which is administered by Washington Dental Service, the state's largest and most experienced dental benefits carrier. Washington Dental Service is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from Washington Dental Service, you join approximately 2 million people who have discovered the value of our coverage.

HOW TO USE YOUR PROGRAM

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

Choosing A Dentist.

With 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 **00333**.

Delta Dental 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 participating dentist contract. You won't have to hassle with sending in claim forms. 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 Washington Dental Service 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.

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. Copies of approved claim forms are available on our website at www.DeltaDentalWA.com. 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. You are responsible for any payments over the amounts of the allowable fees for nonparticipating dentist services.

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, or you may also download claim forms from our website at www.DeltaDentalWA.com. Washington Dental Service is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 12 months after the date the treatment is provided.

Predetermination of Benefits.

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a "predetermination of benefits." This will allow you to know in advance what procedures are covered, the amount Washington Dental Service will pay toward the treatment and your financial responsibility.

Benefit Period.

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

Reimbursement Levels.

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

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

Limitations And Exclusions.

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

Copayments.

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

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 \$1,750 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.

The lifetime maximum amount payable by WDS for Orthodontic Benefits is \$1,000 per eligible child.

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 \$25 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of \$25 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 \$75. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be \$75. 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.

WHO IS ELIGIBLE FOR COVERAGE?

Subscriber Eligibility

Eligible subscribers include:

- active, regular employees of Seattle Pacific University who regularly work a minimum 9 month work schedule and 20 hours per week; or
- retirees

for whom employer contributions are made.

Dependent Eligibility

Eligible dependents include:

- The subscriber's husband or wife;
- An eligible child who receives more than half of his/her support from the subscriber and is claimed as a dependent on the subscriber's tax return. An eligible child is one of the following:
 - A natural offspring of either or both the subscriber or spouse
 - A legally adopted child of either or both the subscriber or spouse
 - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
 - A legally placed ward of the subscriber or spouse living permanently in the home of the subscriber

Foster children are not eligible for coverage.

WHEN DOES COVERAGE BEGIN?

Enrollment

New employees are eligible on the first day of the month following or coinciding with date of hire. If an employee starts on the first work day of the month which is not the first of the month, they will start on the first.

When the subscriber becomes eligible to enroll, they must complete an enrollment form for themselves and any eligible dependents.

You become eligible to enroll in this program within 30 days of the following dates:

- For the subscriber and existing eligible family members, as of the date the subscriber becomes eligible as an employee or retiree.
- For a spouse and eligible children acquired through marriage, as of the date of marriage.
- For a natural newborn child as of the child's birthdate if born on or after the subscriber's effective date.
- For an adoptive child, as of the date the child is placed with the subscriber for the purpose of legal adoption.

WDS must receive the completed form within 30 days of subscriber's eligibility date. If the enrollment form is not received within 30 days, enrollment will not be accepted until the next open enrollment period.

Eligible subscribers or dependents who are not enrolled in a timely fashion may not enroll until the next open enrollment period, unless a new dependent is acquired or unless they qualify under the Special Enrollment Period (see page 6).

Waivers of Coverage

If an employee wants to decline coverage when first eligible, the Group requires the employee to sign a written waiver. Unless the employee qualifies under “Special Enrollment,” the employee then loses the right to enroll in this plan for two years after the date the waiver was signed. The employee can then enroll during the first open enrollment period after the two year period ends. Please see “Special Enrollment” and “Open Enrollment” later in this section.

Special Enrollment – Eligible Employees

Voluntary Waiver of Coverage

If you didn’t enroll when you were first eligible because of a required personal premium contribution and your position with the employer has changed such that you are now eligible without said required personal premium contribution, you may enroll within 30 days of the change in the employee’s position.

Involuntary Loss of Other Coverage

If you didn’t enroll in this plan when you were first eligible because you weren’t required to do so, you may later enroll outside of the annual open enrollment period if each of the following requirements is met:

- You were covered under group health coverage or a health insurance plan at the time coverage under this plan was previously offered
- You stated in writing the reason you declined coverage under this plan at the time this coverage was previously offered
- Your coverage under the other group health coverage or health insurance plan was terminated as a result of one of the following:
 - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or the reduction in the number of hours of employment)
 - Termination of employer contributions toward such coverage
 - You were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted

When your completed enrollment application is received and any required subscription charges from the Group within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment application. If your completed enrollment application is not received within 30 days of the date prior coverage ended, please see the “Open Enrollment” provision later in this section.

Special Enrollment - Subscriber And Dependent

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer’s group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under “Special Enrollment” in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents.

A retiree subscriber may also enroll dependents who have involuntarily lost insurance or newly acquired dependents in the case of marriage, birth or adoption.

Children Covered Under Medical Child Support Orders

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. A subscriber, 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.

When the completed enrollment application is received within 30 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date the application is received for coverage. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures. If the subscriber is not enrolled on the date of the order, the subscriber will be allowed to enroll in order to enroll the child. However, no other dependents have the right to enroll.

A retiree subscriber may enroll a dependent covered under a medical child support order within 30 days of the date of the order. No other dependents have the right to enroll.

Open Enrollment

Within each 12-month period during this program, an open enrollment period shall be authorized to allow eligible subscribers to change their participation elections and enroll eligible dependents.

WHEN DOES COVERAGE END?

Coverage will end without notice on the last day of the monthly period for which required contributions have been paid in which one of these events occurs:

For the subscriber and dependents when;

- The plan terminates.
- The date on which the subscriber fails to meet the minimum eligibility requirements.
- The next required monthly charge for coverage isn't paid when due or within the grace period.
- The subscriber dies or is no longer eligible as a subscriber.
- On the date the subscriber is no longer actively employed.
- For a spouse when his or her marriage to the subscriber is annulled or he or she becomes legally separated or divorced.
- For a child when he or she is no longer eligible as a dependent.

For the retiree subscriber and dependents when;

- The plan terminates.
- The next required monthly charge for coverage isn't paid when due or within the grace period.
- The retiree subscriber or dependent is no longer eligible as a subscriber.
- For a spouse when his or her marriage to the retiree subscriber is annulled or he or she becomes legally separated or divorced.
- For a child when he or she is no longer eligible as a dependent

Notice: The subscriber and retiree subscriber must promptly notify the Claims Administrator when an enrolled family member is no longer eligible to be enrolled as a dependent under this program.

Termination of the Plan

The Plan Administrator has established the Health Benefit with the intention and expectation that it will continue indefinitely, but will have no obligation to maintain the Plan for any length of time. The Plan Administrator reserves the right to amend or terminate, in whole or part, this Plan at any time without liability. Termination and Plan amendments affecting enrollees will be communicated to them. Upon termination of the Plan, the rights of the enrollees to benefits are limited to claims incurred up to the date of termination.

COBRA for Eligible Employees

Under certain circumstances, you and your enrolled dependents may have the right to continue coverage at your own expense beyond the time coverage would ordinarily have ended.

If you are an employee covered under this Plan you have the right to elect continuation of coverage if you lose coverage under the Plan because of any one of the following “qualifying events”:

- Termination (for reasons other than your gross misconduct) of your employment;
- Reduction in the hours of your employment;
- Leave of absence – Refer to “Leave of Absence” section for further information.

If you are the spouse of an employee covered by the Plan you have the right to elect continuation of coverage if you lose coverage under the Plan because of any of the following “qualifying events”:

- The death of your spouse (employee);
- Termination of your spouse’s (employee’s) employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the spouse’s Employer;
- Spouse’s (employee) leave of absence;
- Divorce or legal separation from your spouse (employee); or
- Your spouse (employee) becomes entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the Plan, he or she has the right to elect continuation of coverage if they lose coverage under the Plan because of any of the following “qualifying events”:

- The death of the employee;
- A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours;
- The employee becomes entitled to Medicare; or
- The dependent ceases to be an "eligible dependent" under Seattle Pacific University Group Health Plan.

Continuation Coverage for Retiree Subscriber Dependents

Retiree subscriber dependents may be eligible for continued coverage because of:

- Death of retiree subscriber
- Divorce or legal separation from the retiree subscriber
- The retiree subscriber's entitlement to Medicare Benefits
- Loss of dependent child status

These individuals will receive coverage for the same length of time as they would have received under COBRA.

Continuation Eligibility for a Disabled Child

Coverage may continue for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all of the following are met:

- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the employee for support and maintenance.
- The subscriber is covered under this program.
- The child's subscription charges, if any, continue to be paid.

Leave of Absence

Coverage for a subscriber and enrolled dependents may be continued for up to 6 months when the employer grants the subscriber a medical leave of absence. Periods of medical and personal leave of absence count toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993 (Public Law 1033). Refer to the Employer's Benefits Handbook for information regarding personal leaves of absence or additional details.

A serious health condition that makes the employee unable to perform the functions of the position of such employee and terminates their coverage under the Plan, they will be allowed to re-enroll in the Plan upon return to active employment at the conclusion of a period not to exceed that defined by FMLA. Furthermore, the employee will not be subject to the Preexisting Conditions Provision of this Plan.

Labor Dispute

A subscriber may pay subscription charges through the Group to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike or other labor dispute.

The 6-month labor dispute period counts toward the maximum COBRA continuation period.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for subscribers and covered dependents.

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 custodyHowever, 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.

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.
- Specialist examination performed by a specialist in an American Dental Association recognized specialty.
- WDS-approved periodontal susceptibility/risk tests.

Limitations

- Routine examination is covered twice in a benefit period.
- Comprehensive oral evaluation is covered once in a 3-year period as one of the two covered examinations in a benefit period per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a Delta Dental participating dentist.
- Complete series (any number or combination of intraoral and/or extraoral x-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex x-rays are covered once in a 5-year period.
- Supplementary bitewing x-rays are covered once 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.
- 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 2-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.

PERIODONTICS

Covered Dental Benefits

- Prescription strength fluoride toothpaste
- Antimicrobial mouth rinse dispensed in a dental office.

Limitations

- Prescription strength fluoride toothpaste and antimicrobial mouth rinse is a covered benefit following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's WDS history must show a periodontal procedure within the 180 days.
- Antimicrobial mouth rinse is covered once per periodontal treatment.
- Antimicrobial mouth rinse is available for women during pregnancy without any periodontal procedure.

REFER ALSO TO GENERAL EXCLUSIONS

CLASS II

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

GENERAL ANESTHESIA

Covered Dental Benefits

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

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II, III and Orthodontic 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.

PALLIATIVE TREATMENT

Covered Dental Benefits

- Palliative treatment for pain.

Limitations

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

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 bicuspid.
- 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 bicuspid as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a covered benefit.
- Stainless steel crowns are covered once in a 2-year period.
- **Refer to Class III Limitations if teeth are restored with crowns, veneers, inlays or onlays.**

Exclusions

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

ORAL SURGERY

Covered Dental Benefits

- Removal of teeth.
- Preparation of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic injuries of the mouth
- **Refer to Class II General Anesthesia or Intravenous Sedation for additional information.**

Exclusions

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

PERIODONTICS

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planing and periodontal surgery.
- Limited adjustments to occlusion (8 teeth or less).
- WDS-approved localized delivery of antimicrobial agents.
- **Refer to Class I Covered Dental Benefits and Limitations for periodontal maintenance benefits.**
- **Refer to Class II Occlusal Guard (nightguard) for benefits and limitations on occlusal guard (nightguard).**
- **Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration.**

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.

OCCLUSAL GUARD (NIGHTGUARD)

Covered Dental Benefits

- Occlusal guard (nightguard) for any reason, including bruxism and repair and relines of occlusal guard (nightguard).

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.

REFER ALSO TO GENERAL EXCLUSIONS

CLASS III

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

PERIODONTICS

Covered Dental Benefits

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

Limitations

- Complete occlusal equilibration is covered once in a lifetime.

RESTORATIVE

Covered Dental Benefits

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

Limitations

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a 5-year period.
- Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.
- Inlays (as a single tooth restoration) will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- If a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.

- WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration – with limitations), onlay, veneer or crown.
- Crown buildups are a covered benefit when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- Crown buildups are covered once in a 2-year period.
- Crown buildups are not a covered benefit within 2 years of a restoration on the same tooth.
- Crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a covered benefit.
- Cast post and core are covered once in a 2-year period on the same tooth in keeping with the policy for all cast restorations.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit.

Exclusions

- Copings.

PROSTHODONTICS

Covered Dental Benefits

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

Limitations

- Replacement of an existing prosthetic device is covered only once every 5 years and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered benefit on the same teeth once in a 5-year period only when used as an abutment for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Replacement of implants and superstructures is covered only after 5 years have elapsed from any prior provision of the implant.
- Crowns in conjunction with overdentures are not a covered benefit.

- **Full, immediate and overdentures** - WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- **Temporary/interim dentures** - WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 6 months.
- Root canal treatment performed in conjunction with overdentures is limited to 2 teeth per arch and is paid at the Class III payment level.
- **Partial dentures** - If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Denture adjustments and relines** - Denture adjustments and relines done more than 6 months after the initial placement are covered. Subsequent relines or rebases (*but not both*) will be covered once in a 12-month period.

Exclusions

- Duplicate dentures.
- Personalized dentures.
- Cleaning of prosthetic appliances.
- Copings.

REFER ALSO TO GENERAL EXCLUSIONS

ACCIDENTAL INJURY

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

ORTHODONTIC BENEFITS FOR ELIGIBLE CHILDREN

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable by WDS for Orthodontic Benefits rendered to an eligible child shall be \$1,000. Not more than \$500 of the maximum, or one-half of WDS's total responsibility shall be payable for treatment during the "construction phase". Subsequent payments of WDS's responsibility shall be made on a monthly basis, providing the employee is eligible and the dependent is in compliance with the age limitation.

WDS will pay a constant 50% of the lesser of the Maximum Allowable Fees or the fees actually charged for Orthodontic Benefits.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the secondary payment of benefits, the secondary payment is not covered.

Covered Dental Benefits

- Treatment of malalignment of teeth and/or jaws.
- Orthodontic records: Exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations - Payment is limited to:

- Completion, or through limiting age (refer to **Dependent Eligibility And Termination.**), whichever occurs first.
- Termination of the treatment plan prior to completion of the case.
- Termination of the contract.

Exclusions

- Charges for replacement or repair of an appliance.
- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by WDS.

GENERAL LIMITATIONS

- Dentistry for cosmetic reasons is not a covered benefit.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth are not a covered benefit.
- General anesthesia/intravenous (deep) sedation is not a covered benefit, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a covered benefit except when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

GENERAL EXCLUSIONS

- Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- Application of desensitizing agents.
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, Washington Dental Service, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

Any denial of benefits by Washington Dental Service on the grounds that a given procedure is deemed experimental, may be appealed to Washington Dental Service. By law, Washington Dental Service must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual.

- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.
- Prescription drugs.
- In the event an eligible person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.

- Broken appointments.
- Patient management problems.
- Completing claim forms.
- Habit breaking appliances with exception of an occlusal guard (nightguard).
- TMJ services or supplies.
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- All other services not specifically included in this program as covered dental benefits.

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

Frequently Asked Questions About Your Dental Benefits

What is a Washington Dental Service “participating dentist”?

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

Can I choose my own dentist?

See “Choosing A Dentist” under the “How To Use Your Program” section in the front of this booklet.

How can I obtain a list of Washington Dental Service participating dentists?

You can obtain a Washington Dental Service Directory of Dentists from your employer or by going to our Internet Web site at www.DeltaDentalWA.com and selecting the “Find a Dentist” option.

How can I get claim forms?

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

What is the mailing address for Washington Dental Service claim forms?

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

Whom do I call if I have questions about my dental plan benefits?

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

Why does Washington Dental Service pay less for tooth-colored fillings on my back teeth?

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

Do I have to get an “estimate” before having dental treatment done?

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

I am divorced. If my former spouse and I both have dental coverage, whose plan covers the children first?

It usually depends on who has financial responsibility for the children. If the parents have joint custody, then the parent with the birthday earliest in the calendar year has primary coverage. If the custodial parent does not have financial responsibility, the parent who does has primary coverage. For more information, see the *Coordination of Benefits* section in this book.

My former spouse and I are divorced. What kind of documentation do I need to provide to Washington Dental Service to maintain the children’s dental coverage?

A parenting plan or statement of financial responsibility is required to verify which parent has primary coverage and which has secondary coverage for children in a divorce situation.

What is Delta Dental?

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

GLOSSARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nightguard — See Occlusal Guard.

Not A Covered Benefit — Refers to any dental service covered in “Benefits Covered By Your Program” that has been subjected to a limitation(s).

Occlusal Adjustment — Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

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

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

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

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

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

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

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

Prophylaxis — Cleaning and polishing of teeth.

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

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

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

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

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

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

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

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

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

CLAIM REVIEW AND APPEAL

Predetermination of Benefits

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

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

Urgent Predetermination Requests

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

without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

Informal Review

If your claim for dental benefits has been denied, either in whole or in part, you have the right to request an informal review of the decision. Either you, or your Authorized Representative, must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your Explanation of Benefits form)
- The name of the dentist

Please submit your request for a review to:

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

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

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

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

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

Appeals Committee

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

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

The Appeal Committee will review your claim and make a determination within 60 days of receiving your request or within 20 days for Experimental/Investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

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

Authorized Representative

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

SUBROGATION

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

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

- include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
- repay Washington Dental Service those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;
- cooperate fully with Washington Dental Service in asserting its rights under the Contract, to supply Washington Dental Service with any and all information and execute any and all instruments Washington Dental Service reasonably needs for that purpose.

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

YOUR RIGHTS UNDER ERISA

As a participant in the **Seattle Pacific University** employee benefit health and welfare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive, a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your right under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial all, within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report for the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that the plan fiduciaries misused the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

SUMMARY PLAN DESCRIPTION

REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

NAME AND ADDRESS OF EMPLOYER

Seattle Pacific University
3307 Third Avenue West
Seattle, WA 98119

EMPLOYER IDENTIFICATION NUMBER (EIN): 91-0565553

PLAN NUMBER: 507

PLAN YEARS

The financial records of the Plan are kept on a Plan Year basis. The Plan Year begins on each July 1

PLAN ADMINISTRATOR

The Employer named above.

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

TELEPHONE NUMBER OF PLAN ADMINISTRATOR

206-281-2809

AGENT FOR SERVICE OF LEGAL PROCESS

Seattle Pacific University
3307 Third Avenue West
Seattle, WA 98119

TYPE OF PLAN AND ADMINISTRATION

Self-funded employee welfare benefit plan that is a group health plan. The ERISA Plan provides hospital and medical benefits. Third-party administration by Washington Dental Service under the terms and conditions of its administrative services contract with the group.

The contract is issued by Washington Dental Service.

Effective date July 1, 2007

FUNDING

The Plan is funded by the payment of dues required by the contract.

DISCLOSURE INFORMATION

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

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

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

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Healthy teeth for a wonderful smile – that is what we are all about!

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