

Dental Assistance/Dental Plus Plans

INFORMATION ON DENTAL ASSISTANCE/DENTAL PLUS PLANS IS LISTED BELOW:

INTRODUCTION

Quality dental care is an essential part of your total health care program. Fluor Hanford, Inc., its PHMC Subcontractors, or Environmental Restoration Contractor, or its Subcontractors (the Sponsoring Companies) offer a program which offers several plan choices which will help pay the cost of dental care. These plans focus on routine basic diagnostic and preventive dental services but also provide assistance in paying for restorative and orthodontic care.

The Dental Assistance Plan is provided at no cost to employees and eligible dependents unless an alternative, contributory plan is elected. Among the alternative plans available in 1998 is the Dental Plus Plan which, like the Dental Assistance Plan pays benefits according to a set schedule of benefits. Dental Plus provides a higher level of benefits.

Benefits from the Dental Plus and Dental Assistance are "self-insured" by the sponsoring employers with claims administered by CIGNA. Dental Assistance and Dental Plus plans are described further in this Summary Plan Description.

A third contributory dental plan alternative, new in 1998 and available to many employees, is the Willamette Dental of Washington, Inc. Plan (WDW). Employees selecting this plan receive their dental care from a WDW provider at one of their facilities located in the Tri-Cities, Spokane, or in one of several locations in western Washington and western Oregon. This plan pays a majority of the cost of dental care. The employee/dependent will pay a copayment for each office visit, and for many services with the amount depending on the service received. Because this is a managed dental program, the employee's share of the cost for dental services will be lower than it would be under either the Dental Assistance or Dental Plus plans. Details of this program are available from WDW.

ELIGIBILITY

You and your eligible dependents are automatically eligible for dental coverage from your first day of employment provided you are a regular employee working a regular schedule of at least 20 hours per week. Dental Assistance is currently provided at no cost and is automatically provided unless you elect one of the other alternative plans.

You can elect one of the contributory plans when you first become eligible, and thereafter, during the annual open enrollment period which is held each fall. The coverage you elect will also apply to your eligible dependents.

Eligible dependents include:

- Your spouse, unless he or she is also employed by one of the sponsoring companies and has elected dental coverage as an employee.
- Your unmarried children under the age of 23 residing in your household, provided they are not in military service, employed full-time, or enrolled in any group plan of the Sponsoring Companies or their subsidiaries.

Coverage may be extended after age 23 for full-time students in a recognized course of study or training who are otherwise not covered for group dental benefits, other than coverage restricted to students, provided they meet the other eligibility criteria listed above and there has been no break in coverage. Coverage cannot be added or reinstated after age 23.

Dependent children who become physically handicapped or develop-mentally disabled before age 23 are eligible for coverage past age 23 provided they meet the other eligibility requirements listed above.

The term "children" includes:

- Your own natural children and children placed for adoption with you,
- Stepchildren who reside in your household, and
- Any other children residing in your household who are principally dependent upon you for maintenance and support.

If both you and your spouse are employed by any of the Sponsoring Companies, you may be covered as an employee, or as a dependent, but not both. Dental benefits for children will be paid as a dependent of one employee parent, but not both.

COST

There is currently no cost for the Dental Assistance Plan. If you elect an alternative plan, your required contribution will be based on the plan elected.

The employee cost for the contributory plans (in 1998, Dental Plus and WDW) is determined in advance of each annual open enrollment.

DENTAL ASSISTANCE AND DENTAL PLUS PLANS

THE DEDUCTIBLE

With the exception of preventive and diagnostic procedures (Class I), you must first pay a deductible before the plan will pay for dental care expenses.

The calendar year deductible is \$25 per individual or \$75 per family and applies to all except Class I services. There is no deductible required for Class I expenses.

During the last three months of the year, if you or a member of your family has dental expenses that are used to satisfy the deductible, that same amount will be carried over to help satisfy the deductible for that person in the following year. The deductible applies only to *covered* dental expenses and is based on the Schedule of Dental Services or your dentist's actual charge, whichever is less.

For example, your dentist's bill is \$60 but the maximum benefit payable for that service under the Plan is \$50. Your \$25 deductible would be taken from the lesser amount, \$50 in this case, and a \$25 benefit would be paid to you.

MAXIMUM AMOUNT PAYABLE

The plans pay up to an annual maximum of \$1,000 for each covered person for Classes I, II and III.

The lifetime maximum benefit for orthodontia (Class IV) is \$1,000 (Dental Assistance) or \$1,200 (Dental Plus) and includes the preliminary study, X-rays, braces and active monthly treatment. This lifetime maximum benefit is in addition to the calendar year maximum benefit for Classes I, II, and III.

ALTERNATE BENEFIT PROVISION

The Alternate Benefit Provision applies when more than one dental service or supply can treat the same dental problem. Sometimes, for example, either a crown or a filling can repair a tooth. Alternate Benefit identifies the different services, which meet acceptable dental standards, that could treat your dental problem.

If more than one service could treat your case equally well, the Dental Plan pays for the less expensive treatment. If you wish, you may still obtain the more expensive treatment (a crown, for example, when a filling would do). In that case, you will pay the difference between the Plan's payment for the filling and your dentist's charge for the crown.

PRETREATMENT REVIEW

Pretreatment Review is a system designed to assist you and your dentist in understanding what your dental benefits will pay before any services are provided.

When charges for proposed dental services are expected to be more than \$100, you should have your dentist submit a claim form to the Claims Administrator showing the proposed service and fees.

The Claims Administrator will then indicate the benefits that will be payable for each dental service provided, according to the Schedule of Dental Services that applies to you, and will return the claim form to your dentist.

You and your dentist can then discuss the proposed procedure and the benefits you will receive. When the treatment is completed, your dentist will fill in the date each service was performed and resubmit the claim for payment.

If this Pretreatment Review process is not followed, it will not invalidate your claim. The expenses that will be incurred as will be determined by the Claims Administrator and are subject to the Alternate Benefits Provision.

Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time the services are completed.

CONTINUATION OF INSURANCE DURING ABSENCES

IF YOU ARE LAID OFF

In the event of a layoff, dental coverage for you and your eligible dependents may be continued for a maximum of one year should no other coverage be available. In addition, you must make the required monthly contribution in advance.

IF YOU TAKE A LEAVE OF ABSENCE

You can continue coverage for you and your eligible dependents during an approved leave of absence (except for military service) as long as you pay the required monthly contribution in advance.

IF YOU BECOME TOTALLY DISABLED

If you become totally disabled and cannot work, coverage under the plan will continue at no cost for you and your eligible dependents for one year from the last day worked provided your continuity of service is maintained.

IF YOU DIE

In the event of your death, The Sponsoring Companies will continue the dental coverage for your eligible dependents for 31 days.

COVERED EXPENSES

The Dental Assistance/Dental Plus plans cover the following classes of dental benefits:

DENTAL BENEFITS				
CLASS	DESCRIPTION OF BENEFIT	ANNUAL DEDUCTIBLE (DENTAL ASSISTANCE & DENTAL PLUS)	MAXIMUM	
			DENTAL ASSISTANCE	DENTAL PLUS
I	Diagnostic and preventive services, including oral exams, X-rays, and cleanings Fluoride treatment for children under age 19 and sealant treatments for molars for children under age 14 are also	None	\$1,000 per person/year	\$1,000 per person/year

	covered			
II	Basic dental treatment, such as anesthesia, fillings, root canal therapy and treatment of the gums	\$25/individual \$75/family		
III	Major dental treatment, such as crowns, dentures, and bridges			
IV	Orthodontia		\$1,000 lifetime maximum	\$1,200 lifetime maximum

HOW MUCH THE PLAN WILL PAY

In order for the Plan to pay for any benefits, dental treatment must be essential for the care of your teeth and be performed by or under the direction of a dentist.

Covered Dental Expenses will not include, and no payment will be made for, expenses incurred for the performance of any dental service not listed in the *Schedule of Dental Services* unless the Claims Administrator agrees to accept such expenses as Covered Dental Expenses.

A temporary dental service will be considered an integral part of the final dental service rather than a separate service.

To submit the expenses to the Claims Administrator for consideration, each dental service should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and nomenclature and/or by narrative description.

If expenses incurred for a dental service not listed in the Schedule are accepted by the Claims Administrator, the Covered Dental Expense for that dental service will be determined by the Claims Administrator and will be consistent with those listed in the Schedule.

In any event, surgical implants of any type, including prosthetic appliances attached to them, instruction for plaque control or oral hygiene, bite registrations, splinting or dental services that do not have uniform professional endorsement, will not be accepted by the Claims Administrator as Covered Dental Expenses.

SCHEDULE OF DENTAL BENEFITS

CLASS I

Procedure Code	Category/Description	Maximum Covered Expense	
		Dental Assistance	Dental Plus
DIAGNOSTIC			
Oral Examination			
Not associated with other services (limited to two per calendar year)			
0150	<i>Comprehensive Oral Evaluation - New or Established - Initial</i>	\$18.00	\$25.00
120	Periodic	\$14.00	\$19.00
X-Rays			
X-rays in connection with routine oral examinations are limited to: one set of full-mouth X-rays every three years, and two sets of supplementary bitewing X-rays in a calendar year.			
210	Intraoral-complete series (including bitewings)	\$46.00	\$58.00
220	Intraoral-single, each	\$ 9.00	\$11.00
240	Intraoral-occlusal, single, each	\$17.00	\$17.00
270	Bitewing - single, each	\$ 9.00	\$14.00
274	Bitewing - complete series (4)	\$22.00	\$26.00
321	Temporomandibular joint, single film	\$56.00	\$93.00
330	Panoramic-maxillary and mandibular, single film (including bitewings)	\$40.00	\$44.00
Test and Laboratory Examinations			

7285	Biopsy and examination of oral tissue: hard	\$95.00	\$140.00
7286	Biopsy and examination of oral tissue: soft	\$76.00	\$122.00
Test and Laboratory Examinations			
460	Pulp vitality tests	\$13.00	\$ 19.00
PREVENTIVE			
Prophylaxis			
Limit of two prophylaxes (cleaning, scaling and polishing) in any calendar year.			
1110	Adults - all methods	\$32.00	\$38.00
1120	Children - all methods	\$21.00	\$28.00
Fluoride Treatments			
Limited to individuals under age 19 and limited to one treatment per calendar year.			
1203	Topical application of fluoride, per treatment (excluding prophylaxis)	\$18.00	\$28.00
Space Maintainers			
1510	Fixed, cast type, unilateral	\$ 62.50	\$107.50
1515	Fixed, cast type, bilateral	\$125.00	\$215.00
1520	Removable, acrylic, unilateral	\$ 45.50	\$ 69.00
1550	Recementation of space maintainer	\$ 21.00	\$53.00

CLASS II

Procedure Code	Category/Description	Maximum Covered Expenses
	Dental Assistance	Dental Plus
ANESTHESIA		

A dental service for anesthesia will be considered in this schedule only when and if:

- it is medically necessary and administered with oral or dental surgery, and
- the anesthetic agent produces a state of semi- or unconsciousness with absence of pain over the entire body

9220	General anesthesia	\$ 94.00	\$163.00
9241	Intravenous conscious sedation	\$ 45.00	\$ 61.75
EXTRACTIONS			
Primary / Permanent Teeth			
7140	Extraction, erupted tooth or exposed root	\$ 32.00	\$ 40.00
Surgical Removal of Impacted Tooth			
A malpositioned tooth partially or completely covered by tissue or bone.			
7220	Soft tissue impactions	\$ 71.00	\$ 92.00
7230	Partially covered by bone	\$101.00	\$125.00
7240	Completely covered by bone	\$124.00	\$149.00
Dental Root Resection			
3410	Apicoectomy (cutting out the tip portion of a tooth root) - one	\$159.00	\$250.00
Alveolectomy (Removal of a Bony Ridge of Teeth Sockets)			
7310	Single area	\$52.00	\$ 82.00
Alveolectomy (Removal of a Bony Ridge of Teeth Sockets)			
7320	Two or more areas involving the total of not less than six teeth	\$81.00	\$161.00
7320	Maxillary (upper jaw bone) and mandibular (lower jaw	\$81.00	\$161.00

	bone) involving not less than six teeth in each area		
7450	Excision of radicular or dentigerous cyst-extensive (a cyst attached to the end of tooth root, or a cyst containing one or more teeth)	\$92.00	\$144.00
ENDODONTICS			
3110	Pulp capping (treatment of exposed nerve without removing the nerve)	\$17.00	\$ 24.00
3220	Vital Pulpotomy (removal of a portion of the nerve of the tooth)	\$41.00	\$ 53.00
ROOT CANAL THERAPY			
3310	Single canal	\$176.00	\$215.00
3320	Double canal	\$220.00	\$265.00
3330	Three canals or more	\$286.00	\$343.00
OTHER CUTTING OPERATION			
Gingivectomy or Gingivoplasty			
Surgical Removal of Diseased Portion of the Gums			
4210	Per quadrant	\$111.00	\$180.00
4240	Gingival flap procedure, including root planning - four or more contiguous teeth or bounded teeth spaces per quadrant	\$ 55.00	\$ 83.00
Osseous Surgery (Involving Bone)			
With or Without Gingivectomy or Gingivoplasty			
4260	Per quadrant	\$311.00	\$424.00
4220	With gingival curettage	\$ 55.00	\$ 83.00

	(scraping) - per quadrant		
Osseous Surgery (Involving Bone)			
With or Without Gingivectomy or Gingivoplasty			
4271	Soft tissue grafts (grafts of the gums)	\$174.00	\$290.00
7460	Removal of soft tissue cyst (cyst in the mouth)	\$ 93.00	\$105.00
7510	Incision and drainage of intraoral abscess	\$ 38.00	\$ 56.00
7960	Frenulectomy (cutting of the membrane under the tongue or on the inside of the middle of either lip)	\$ 76.00	\$125.00
RESTORATIVE			
Amalgam and Resin Restorations			
2140	Amalgam-1 surface permanent	\$ 29.00	\$ 37.00
2150	Amalgam-2 surfaces permanent	\$ 37.00	\$ 48.00
2160	Amalgam-3 or more surfaces permanent	\$ 49.00	\$ 60.00
2330	Resin - one surface, anterior	\$ 35.00	\$ 47.00
2331	Resin - two surfaces, anterior	\$ 47.00	\$ 63.00
2332	Resin - three surfaces, anterior	\$ 69.00	\$ 85.00
2391	Resin - one surface, posterior-permanent	\$ 71.75	\$ 95.00
2392	Resin - two surfaces, posterior-permanent	\$ 91.00	\$120.75
2393	Resin - three or more	\$116.25	\$154.00

	surfaces, posterior-permanent		
2394	Resin - four or more surfaces, posterior-permanent	\$116.25	\$154.00
Gold Inlay Restorations			
2510	Inlay, gold-1 surface	\$182.00	\$291.00
2520	Inlay, gold-2 surfaces	\$220.00	\$321.00
2530	Inlay, gold-3 surfaces	\$249.00	\$328.00
2542	Onlay, metallic, two surfaces per tooth (in addition to above)	\$ 75.00	\$100.00
Crowns, Single Restorations Only			
2710	Plastic (acrylic)	\$175.00	\$285.00
2720	Plastic processed to metal	\$287.00	\$356.00
2740	Porcelain	\$293.00	\$368.00
2750	Porcelain fused to metal	\$304.00	\$367.00
2790	Gold (full cast)	\$289.00	\$355.00
2930	Stainless steel, primary tooth	\$ 63.00	\$ 80.00
2931	Stainless steel, permanent tooth	\$63.00	\$ 80.00
Other Restorative Services			
2910	Recement inlays	\$ 19.00	\$ 29.00
2920	Recement crowns	\$ 20.00	\$ 32.00
2940	Fillings (sedative)	\$ 19.00	\$ 32.00

CLASS III

Procedure Code	Category / Description	Maximum Covered Expenses	
	Dental Assistance	Dental Plus	
PROSTHODONTICS-REMOVABLE			
Complete Dentures Including Six Months of Post-Delivery Care			
5110	Complete upper	\$263.00	\$318.00
5120	Complete lower	\$260.00	\$318.00
5130	Immediate upper	\$276.00	\$321.00
5140	Immediate lower	\$276.00	\$325.00
Partial Dentures (Including Routine Post-Delivery Care)			
5211	Upper partial-resin base (including any conventional clasps, rests and teeth)	\$297.00	\$346.00
5212	Lower partial-resin base (including any conventional clasps, rests and teeth)	\$297.00	\$346.00
5213	Upper partial-cast metal base with resin saddles (including any conventional clasps, rests and teeth)	\$320.00	\$369.00
5214	Lower partial-cast metal base with resin saddles (including any conventional clasps, rests and teeth)	\$307.00	\$348.00
Additional Units for Partial Dentures			
5660	Add clasp to existing partial denture	\$ 45.00	\$ 45.00
Repairs to Dentures			
5510	Repair broken complete denture base	\$ 30.00	\$ 37.00

5520	Repair missing or broken teeth-complete denture (each tooth)	\$ 19.00	\$ 32.00
5630	Repair or replace broken clasp	\$ 52.00	\$ 52.00
5640	Replace broken teeth-per tooth	\$ 19.00	\$ 32.00
5730	Reline complete upper denture (chairside)	\$ 67.00	\$ 85.00
Repairs to Dentures			
5731	Reline complete lower denture (chairside)	\$ 67.00	\$ 85.00
5750	Reline complete upper denture (laboratory)	\$106.00	\$106.00
5751	Reline complete lower denture (laboratory)	\$106.00	\$106.00
PROSTHODONTICS-FIXED			
Bridge Pontics			
6210	Cast gold	\$204.00	\$236.00
6240	Pontic-porcelain fused to high noble metal	\$224.00	\$241.00
6241	Pontic-porcelain fused to predominantly base metal	\$224.00	\$241.00
6242	Pontic-porcelain fused to noble metal	\$224.00	\$241.00
6250	Pontic-resin with high noble metal	\$208.00	\$238.00
6251	Pontic-resin with predominantly base metal	\$208.00	\$238.00
6252	Pontic-resin with noble metal	\$208.00	\$238.00
Inlay - Abutments			

6602	Inlay - cast high noble metal, two surfaces	\$149.00	\$203.00
6603	Inlay - cast high noble metal, three or more surfaces	\$186.00	\$215.00
Bridge Retainers - Crowns			
6720	Crown-resin with high noble metal	\$210.00	\$246.00
6721	Crown-resin with predominantly base metal	\$210.00	\$246.00
6722	Crown-resin with noble metal	\$210.00	\$246.00
6750	Crown-porcelain fused to high noble metal	\$224.00	\$245.00
6751	Crown-porcelain fused to predominantly base metal	\$224.00	\$245.00
Bridge Retainers - Crowns			
6752	Crown-porcelain fused to noble metal	\$224.00	\$245.00
6780	Crown-3/4 cast high noble metal	\$200.00	\$242.00
6790	Crown-full cast high noble metal	\$204.00	\$228.00
6791	Crown-full cast predominantly base metal	\$204.00	\$228.00
6792	Crown-full cast noble metal	\$204.00	\$228.00
Repairs			
6980	Replace broken facing with other facing	\$ 43.00	\$ 43.00
Other Services			
6950	Precision attachment	\$ 77.00	\$117.00

CLASS IV

Procedure Code	Category / Description	Maximum Covered Expense	
	Dental Assistance	Dental Plus	
ORTHODONTIA			
Comprehensive Orthodontic Treatment			
8080	Comprehensive orthodontic treatment of the adolescent dentition	\$ 379.00	\$ 408.00
8080	First month of active treatment, including all active and retention appliances	\$ 314.00	\$ 343.00

MISSING TOOTH PROVISION

During the first 24 months you or an eligible family member is covered by the Dental Assistance or Dental Plus Plan, initial replacement of missing teeth will be reimbursed at 50 percent of the amount usually paid. This restriction is removed after 24 months.

WHAT THE PLAN DOES NOT COVER

- Anything covered by Workers' Compensation.
- Charges you are not legally required to pay.
- Unnecessary care or treatment.
- Cosmetic dentistry
- Replacement of a lost or stolen appliance.
- Replacement of dentures or bridgework within five years after being installed. However, the plan will cover replacement if (a) you lost additional natural teeth, or (b) the bridge or denture is damaged beyond repair as a result of an injury while insured.
- Expenses for surgical implants of any kind, including prosthetic appliances attached to them, instruction for plaque control or oral hygiene, bite registrations, splinting or dental services that do not have uniform professional endorsement.
- Replacing dentures or bridgework that can be repaired.

- Charges for completing claim forms.

COORDINATION OF BENEFITS (COB)

When you or a family member is covered by more than one group dental plan, the Coordination of Benefits provision allows the reimbursement of dental expenses to be shared by those plans. This provision also limits the combined benefits you can receive from all plans to 100 percent of any necessary, reasonable and customary covered expense.

To accomplish this coordination, a primary payer must be designated as well as a secondary payer. If you and your spouse both work and are covered under each other's plans, the plan where the person incurring the claims is employed is the primary payer and pays first.

If you and your spouse both work and both of you cover your dependent children, the plan that covers the spouse whose birthday falls first within the calendar year will be the primary payer.

CLAIM SUBMITTED FOR EMPLOYEE		
Primary Payer	Secondary Payer	
Employee's Plan	Spouse's Plan	Up to 100% of Allowable Expense
CLAIM SUBMITTED FOR SPOUSE		
Spouse's Plan	Employee's Plan	Up to 100% of Allowable Expense
CLAIM SUBMITTED FOR CHILDREN		
Parent's Plan with Date of Birth <i>First</i> in the Year	Parent's Plan with Date of Birth <i>Later</i> in the Year	Up to 100% of Allowable Expense

An "allowable expense" is any necessary, reasonable and customary expense covered, at least in part, by one of the plans involved.

If the person is a dependent child of divorced or legally separated parents, the order will be as follows:

- If there is a court decree that sets forth a financial duty for the health care expenses of the child, the plan of the parent with such financial duty will pay first.
- If the parent with custody has not remarried, his or her plan will pay before the plan of the parent without custody.

- c. If the parent with custody has remarried, his or her plan will pay before the plan of the stepparent or the parent without custody; and the plan of the stepparent will pay before the plan of the parent without custody.

If the above rules do not decide which plan will pay first, the plan that has covered the person for the longest time will pay first.

An exception to the above rules occurs if a plan covers a person for whom the claim is made as a laid off or retired employee, or as his or her dependent, the benefits of that plan will be determined after those of a plan that covers such person as an employee who is not laid off or retired, or as his or her dependent.

The Claims Administrator may, without the consent of any person, release or obtain any information that it deems necessary for determining benefits in accordance with the Coordination of Benefits provision in the Group Plan.

Any person claiming benefits under this Plan will furnish the Claims Administrator any information it deems necessary for this purpose.

If, at any time, the Claims Administrator determines that it has made payments that are in excess of the amount necessary to satisfy the conditions of Coordination of Benefits provision in the Group Plan, it will have the right to recover the overpayments.

If payments are made under another plan which, in accordance with the Coordination of Benefits provision in the Group Plan, should have been made under this Plan, the Claims Administrator will have the right to pay any organization making the payments any amount it determines will satisfy the intent of that provision. This amount will be considered as benefits paid under this Plan.

Coordination of Benefits does not apply in cases where both spouses are covered by a FH sponsored plan.

The Claims Administrator will be discharged from liability to the extent of the paid amount.

HOW TO FILE A CLAIM

There are two ways claims can be processed:

1. You may pay the provider directly and then submit a claim and be reimbursed, or
2. You may authorize the Claims Administrator to make payment directly to the provider (physician, hospital, laboratory, etc.) by completing the "Assignment of Benefits" section on the back of your claim form.

Dental claim forms are available from Central Stores, stock number 551653, or you can download it from site forms, form number A-6002-643 [electronic form](#).

A claim form with an *original signature* of the *employee* must accompany each claim for benefits.

Please follow the instructions on the claim form and be sure to answer all questions fully so that your claim will be processed as quickly as possible.

If you are covered by more than one plan, you should file *first* with the "primary plan" as described above. Then, when you receive an Explanation of Benefits (EOB) from that plan, file with the "secondary plan" and include a copy of the EOB from the primary plan.

WHEN YOUR COVERAGE ENDS

Dental coverage will be discontinued when:

- You terminate your employment for any reason other than death, disability, layoff, or leave of absence.
- You cease to make the required contributions.
- The Plan is terminated.
- You or your dependents no longer meet the eligibility requirements.

In some instances, you may be able to continue coverage for yourself and your eligible dependents beyond the normal termination date by paying the premium yourself under "COBRA" provisions. Contact Benefits Administration for details.