



*The WSRC Team*

# Dental Care

*Issued October 2004*



# INTRODUCTION

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This document does not create an expressed or implied contract of employment.

The dental care benefits described in this Summary Plan Description are sponsored by Washington Savannah River Company LLC and Bechtel Savannah River, Incorporated (WSRC/BSRI), and administered by Washington Savannah River Company LLC (WSRC). Persons eligible to participate in the WSRC/BSRI Health Choice Dental Plan include those as described herein who are connected by employment with the WSRC Team. “The WSRC Team” pertains to Washington Savannah River Company LLC (WSRC), Bechtel Savannah River, Incorporated (BSRI), BWXT Savannah River Company, BNG America Savannah River Corporation and CH2 Savannah River Company.

The WSRC/BSRI Health Choice Dental Plan is a self-insured plan which uses funds from the U.S. government and contributions from plan participants to pay the cost of claims and administrative expenses. Blue Cross Blue Shield –SC has been hired to process claims under the Plan and not as an insurer.

You have two dental plan options available under Health Choice — Prime Choice and Standard Choice. You also have the option of electing no dental coverage. Prime Choice and Standard Choice cover many dental services and supplies. Both options provide benefits for preventive care at 100% of the reasonable and customary (R&C) amount. Prime Choice and Standard Choice both cover restorative services, but at different levels. Prime Choice also covers orthodontia treatment. It is important to know the differences in coverage and how much is paid by the two options for covered services.

Neither the Prime Choice nor Standard Choice Dental option involves a network of preferred dental providers, so the level of dental benefits will be the same from dentist to dentist under the option you choose.

This book provides the details of your Health Choice Dental options. Read it carefully and refer to it whenever you have a question about your dental benefits. However, if you find you need additional assistance, call the Blue Cross Blue Shield of South Carolina Customer Service Line at 1-800-325-6596.

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# PARTICIPATING IN DENTAL

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## Eligibility

If you are a full-service employee of the WSRC Team, you are eligible for dental coverage after you have completed one year of eligibility service. Prior service with the WSRC Team or a parent company of the WSRC Team may shorten or eliminate your waiting period for enrollment. Before your one year anniversary, you will be mailed enrollment information to your home address. You must return your enrollment form to the WSRC People Support Service Center within 60 days or you will be placed in a “waive” coverage status and will not be able to elect coverage until dental coverage is offered during open enrollment. Coverage will take effect on the first day of the month in which you meet the service requirement, if you elect to enroll.

Full-service employees are eligible to elect coverage after having completed one year of eligibility service.

Retirees of the WSRC Team (including BSRI Option A Craft retirees) with at least 15 years of eligibility service, and one year of credited service who retiree directly from a WSRC Team employer as a full service employee under the Normal, Early, Optional or Incapability provisions of the WSRC/BSRI Pension Plan, and eligible survivors, are also eligible for participation in the WSRC/BSRI Health Choice Dental Plan. If you transfer from a WSRC Team company to an Affiliate, as defined in the WSRC/BSRI Pension Plan, you are not eligible for the WSRC/BSRI Health Choice Dental Plan. Also, as a WSRC Team retiree, if you are reemployed as a full-time employee by an Affiliate entity your WSRC/BSRI Health Choice Dental Plan participation will end and will not be reinstated by a subsequent termination/retirement from the Affiliate.

WSRC Team employees with less than 15 years of eligibility service who have been approved for Long-Term Disability benefits are not provided dental coverage; however, continuation of dental coverage is available under provisions of COBRA. See “Coverage Continuation in Special Situations” of this book and COBRA continuation coverage in the General Information book.

Retirees of DuPont Savannah River Plant and their dependents are not eligible to participate in the WSRC/BSRI dental options described in this Summary Plan Description. Dependents of DuPont Retirees include those dependents that normally would be eligible for WSRC Team dental coverage due to their status as an active WSRC Team employee or retiree.

BSRI Option A Craft employees and BSRI employees participating in union benefits are not eligible for coverage under this plan.

## Special Rules for “Dual Couples”

“Dual couples” are WSRC Team employees (or WSRC Team retirees) who have a spouse who also works for (or is retired from) the WSRC Team. Dual couples cannot be covered both as a dependent and as an employee/retiree under the dental options. In addition, no dependent child may be covered by more than one WSRC Team “parent” employee or retiree.

For example, you may elect to cover your spouse and your child, while your spouse elects to “Waive” coverage. Alternatively, you may elect coverage for yourself and your child, while your spouse elects employee only coverage. When you make the latter choice in this exam-



ple, you and your spouse may elect to be covered by different dental options. But, you and your spouse may not cover each other or both cover the same child.

If you and your spouse are employees or retirees of the WSRC Team, you cannot be covered both as an employee and also as a dependent.

**Eligible Dependents**

Your eligible dependents include your lawful spouse (in accordance with state law in your state of residence) and your “children,” including your own children, legally adopted children or stepchildren who primarily reside with you, and children supported solely by you for whom you have been appointed legal guardian. Your adopted children are covered from the time they are legally placed with you. You will be required to provide proof of legal guardianship or adoption.

In order to be eligible for coverage, your “children” must: be unmarried; be under age 20; primarily reside with you in a regular parent/child relationship (or living at school while a full-time student); and you must be able to claim them as dependents on your current federal income tax return. Dental coverage may be extended up to age 25 for full-time students at accredited institutions. Starting at age 20, you are responsible for providing Blue Cross Blue Shield of South Carolina official documentation showing your dependent is a full time student at an accredited educational institution. Blue Cross Blue Shield of South Carolina will review student eligibility documentation every year, starting upon your child’s 20th birthday.

Your “children” also include children covered by a Qualified Child Medical Support Order which requires the Company to provide dental coverage for the children. The WSRC/BSRI Health Choice Dental Plan will comply with the terms of a Qualified Medical Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body, which directs the plan to cover a child of the employee/retiree enrolled under the health plan. Federal law provides that medical child support order must meet certain form and content requirements in order to qualify as a QMCSO. When an order is received, each affected participant and each child (or the child’s representative) covered by the order will be given notice of the receipt of the order and a copy of the plan’s procedure for determining if the order is valid. Coverage under the plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the WSRC People Support Service Center. The QMCSO must be properly served on the WSRC Team employee and will need to be qualified by the WSRC/BSRI Health Choice Dental Plan Administrator.

Your disabled/handicapped dependent child may continue coverage if your unmarried child is all of the following: incapable of sustaining employment by reason of a disabling mental handicap, mental illness, or physical handicap; is dependent on the employee for at least 51% of support and maintenance; the disability began before age 20 or age 25 if enrolled as a full-time college student; and written proof of such dependency and incapability is furnished to BCBS – SC for evaluation. Your child must remain continuously disabled beyond the age limit to be eligible for continued coverage. You will be requested to periodically provide proof of total and permanent disability to continue the child’s eligibility under the Health Choice Dental options.

Dependents of DuPont/SRP retirees are ineligible for WSRC/BSRI Health Choice Dental coverage as noted under the “Eligibility” section.

Important information concerning surviving spouses and dependent children is noted on Page 22, “If you die...”

The WSRC Team reserves the right to request, at any time, documentation as proof of any dependent’s eligibility, as well as the right to remove any ineligible dependent retroactively from coverage, including the right to seek reimbursement for claims paid on any ineligible dependent.

To add a dependent to your coverage, you must submit a “Health Care Enrollment/Change Form” to WSRC People Support Service Center, Building 703-47A, Aiken, SC 29808 no later than 60 days from a Qualifying Family Status Change Event.

## **Enrolling for Coverage**

During the Health Choice enrollment process, you will be asked to elect:

- Prime Choice, Standard Choice or no dental coverage, and
- Coverage for yourself only, you and one dependent, or you and two or more dependents.

If you fail to enroll for dental coverage, you and your dependents will not have any WSRC/BSRI dental coverage until dental coverage is offered during a future open enrollment period. The only exception to this is if you lose coverage under another plan and request to enroll in the WSRC/BSRI Dental Plan within 60 days of when your coverage ended under the other plan; you will be required to provide documentation of when your coverage ended.

If you elect to cover your dependents, you must enroll them in the same option you elect for yourself. Coverage for your eligible dependents begins at the same time as your coverage if you elect to cover them, or on the effective date of a Qualifying Change in Status, whichever applies. You must name the dependents to be covered and provide their Social Security numbers.

You cannot change plans during the year even if you have a “Qualifying Change in Status.”

## **Election Lock-In**

The option to make changes to your dental coverage is offered by the WSRC Team during open enrollment every other calendar year, locking you into your election for two years. The option to make changes to your dental coverage is only offered during open enrollment conducted during even numbered calendar years (example: 2006) for coverage effective the following two calendar years, beginning January 1 (example: January 2007-December 2008). The lock-in applies to both the option you elect, and to the dependents you elect to cover (unless you have a “Qualifying Change in Status,” in which case you would be allowed to change your level of coverage — employee only, employee +1 or employee +2 or more dependents — but would not be allowed to change your dental plan option — Prime or Standard Choice). The lock-in encourages careful planning and reduces the frequency of movement into and out of the options — to help control the cost of coverage. Note: If you retire during the year of your dental lock-in you cannot switch plans, however, according to “Qualifying Change in Status” rules you can change the dependents you wish to cover and/or you can decline coverage as a retiree.



### **Mid-Year Changes/Qualifying Changes in Status**

Consider your Health Choice Dental option carefully. You will not be able to change your Health Choice Dental election during the lock-in period unless you have a “Qualifying Change in Status” (marriage, new birth, spouse loses coverage, etc.) under Internal Revenue Service rules. The “Benefits Overview and General Information” book has information on what is a “qualifying change in status.” You can enroll in coverage and change the number of dependents consistent with the qualifying change of status; however, you will not be eligible to change plans regardless of the qualifying “change in status.”

You must notify the WSRC People Support Service Center of any family status change within sixty (60) days. To request a change, you must submit a “Health Care Enrollment/Change Form” to the WSRC People Support Service Center, Building, 703-47A, Aiken, SC, 29808, no later than sixty (60) days from a qualifying family status change event. Qualifying family status changes that are approved will be effective as of the “event” date, as long as the WSRC People Support Service Center is notified within sixty (60) days.

The table below includes examples of some typical “Qualifying Change in Status” events and provides a description of when coverage ends or begins for covered dependents that lose or gain eligibility as a result of the event.

Do not call Blue Cross Blue Shield with information on a Qualifying Change in Status. Instead, contact WSRC People Support Service Center at 725-7772 or toll free at 800-368-7333.

| <b>Event</b>   | <b>When Coverage Ends/Starts</b>  |
|--|---|
| Divorce  | Date shown on the adjudicated divorce decree  |
| Dependent child graduates from college or is no longer a full-time student and is over the age 20  | Date of graduation or date student is no longer considered full-time student  |
| Dependent child marries  | Dependent loses coverage on the date of the marriage  |
| Adoption/Custody   | Date finalized and signed by the judge; date of placement for adoption  |
| Loses or gains eligibility under another plan  | Date other coverage started or ended as shown on an official document from the other insurance carrier or employer  |
| Termination of spouse’s or dependents employment that results in loss of eligibility for coverage under their employer’s plan                            | Documented date that the other coverage ended   |
| Dependent between the ages of 20 and 25 returns to school as a full-time student and meets all the other eligibility requirements for dependent children | Can be added back on the day school starts. (Documentation of full-time student status will be required by BCBS)  |
| Changes in coverage under other employer’s plan or open enrollment under other employer’s plan   | Can elect or drop coverage and is effective on the date of the other employer’s change, or start of plan year; documentation from other employer will be required |
| Employee’s commencement or return from FMLA leave  | Change can be made consistent with leave effective on either the start, or return date from leave   |

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## **Identification Cards**

If you enroll in the Blue Choice HMO medical option and also choose either the Prime or Standard Choice Dental option, you will automatically receive a “Dental Only” identification card from Blue Cross Blue Shield of South Carolina (as a supplement to your Blue Choice HealthCare Plan ID card). However, if you enroll in one of the other available medical options (Prime, Standard or Basic Choice Medical), your Blue Cross Blue Shield of South Carolina identification card will provide information for medical purposes and will also serve as identification which your dental provider can use to verify your eligibility for dental coverage and to assist in filing a dental claim.

## **When Coverage Ends**

Your coverage ends when you no longer elect to be covered by one of the dental options, provided your lock-in period has ended. Your coverage also ends when you no longer meet the eligibility definitions.

Coverage for your dependents ends when you no longer elect to cover them (during an annual enrollment for dental coverage, provided your lock-in period has ended), they no longer meet the eligibility requirements, a “Qualifying Family Status Change” occurs (as a result, you elect to eliminate a dependent from dental coverage), or your coverage ends. You will be required to provide proof of the qualifying event within 60 days of the event; otherwise, your dependents will not have coverage under your WSRC/BSRI option, they will not be eligible for COBRA continuation coverage, and you will not be able to receive a refund of any premium contribution overpayments. In the event of a divorce, the “60-day clock” begins at the date of the final divorce decree.

If you terminate employment, coverage for you and your dependents ends on the last day of your applicable pay period. Premium contributions are not pro-rated in accordance with your termination date. In other words, you’ll have to pay the full premium contribution for the pay period in which you terminate employment. In certain situations, you and your dependents may be eligible to continue coverage. See “Coverage Continuation In Special Situations” on Page 22 of this book and COBRA continuation coverage in the Overview and General Information book. You must provide notice and proof of a qualifying event within 60 days to receive any premium refunds.

## **Your Cost for Coverage**

You and the WSRC Team share in the cost for Health Choice Dental coverage. The amount of your premium contribution depends on the dental option you elect, and whether you elect coverage for yourself only or you and your dependents. As an active employee, your premium contributions are deducted from your pay before Social Security and federal and state income taxes are computed and withheld. If you are a retiree or survivor, your premium contribution is deducted from your after-tax monthly pension benefit. The premium contribution is reviewed annually and may even increase during enrollment. You will be notified of your premium contribution amount at the time of annual enrollment.

## HOW THE DENTAL OPTIONS WORK

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### Similarities and Differences of Prime and Standard Choice

The Prime Choice and Standard Choice Dental options offer identical coverage for Preventive dental services only. There is no deductible for preventive services under either option. Preventive services are covered at 100% of reasonable and customary charges (R&C). However, there are major differences between the Prime and Standard options for other (non-preventive) types of dental services.

Prime Choice pays orthodontics at 50% of R&C up to a lifetime maximum of \$1,500. For example, for R&C expenses of \$2,500, Prime Choice pays \$1,250. For R&C expenses of \$3,000 or more, Prime Choice pays \$1,500.

### Prime Choice

#### *Maximum Annual Benefit*

The maximum benefit (the most the option will pay) in any calendar year for each person covered under the Prime Choice dental option is \$2,000 for preventive and Minor and major restorative services combined. However, payments made by the Plan for TMJ/TMD and orthodontics do not count toward the maximum annual Benefit amount.

#### *TMJ and Other Temporomandibular Disorders (TMD)*

Under Prime Choice, benefits for treatment of TMJ and other Temporomandibular Disorders (TMD) are paid at 50% of R&C up to a maximum lifetime benefit of \$500 for each covered person. Temporomandibular Disorders are diseases or conditions that result in pain and dysfunction of the jaws. TMD includes jaw muscle pain, jaw joint (TMJ) conditions, and jaw growth and movement problems. The lifetime maximum is applied as long as you are covered by a WSRC/BSRI dental option, even if you elect to be covered under Standard Choice and then return to Prime Choice.

### Orthodontics

Prime Choice covers both adult and child orthodontics. The benefit level is 50% of R&C but not more than \$1,500 for each covered person in a lifetime. The lifetime maximum of \$1,500 is applied even if participant changes coverage from prime choice to Standard Choice and then return to Prime Choice. To be covered, services must be incurred (actually rendered by the dentist) during the same year that you are enrolled in the Prime Choice option. .

### Standard Choice

While this option covers preventive services at 100% of the R&C amount, all other covered services are paid — after you've met a \$25.00 individual (\$50.00 family) yearly deductible — at 50% of the R&C level for covered charges. Some services (for example, TMJ and orthodontics) are not covered under Standard Choice, but are covered under Prime Choice. The maximum benefit for preventive and minor and major restorative services combined under the Standard Choice dental is \$1,000 for each covered person in a calendar year.

## Summary of the Dental Options

| Option Features         | Prime Choice Dental                                 | Standard Choice Dental   |
|-------------------------|---|--|
| Preventative            | 100% R&C  | 100% R&C   |
| Minor Restorative       | 80% R&C   | 50% R&C  |
| Major Restorative       | 60% R&C   | 50% R&C  |
| TMJ and TMD             | 50% R&C, \$500 lifetime maximum                     | None   |
| Orthodontics            | 50% R&C, \$1,500 lifetime maximum (child and adult) | None   |
| Annual Deductible       | None  | \$25 per person/\$50 per family<br>None on covered non-preventative services |
| Maximum annual benefit* | \$2,000 per person per year                         | \$1,000 per person per year  |

\* Dental option payments for preventive and minor and major restorative care have a combined dollar limit for each person. This limit — the maximum annual benefit — is available each year. Payments for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount under the Prime Choice Dental option, however there is a maximum lifetime benefit as indicated in the table above for TMJ/TMD and orthodontics.

## Your Share of Expenses

Regardless of which dental option you elect, there are certain expenses that you are responsible for:

- The deductible (for non-preventive services under the Standard Choice Dental option only) and coinsurance (for non-preventive services under both the Prime and Standard Dental options),
- Any expenses above the R&C level,
- Expenses not covered by the option you elect,
- Charges that exceed the maximum annual benefit,
- Charges that exceed the lifetime maximum benefit (TMJ/TMD and orthodontics), and
- Any charges for procedures that exceed or differ from widely accepted dental practice (refer to “Alternate Course Of Treatment” on Page 9).

## Pre-Treatment Estimate

A pre-treatment estimate — also called predetermination of benefits — is not mandatory, but it is strongly advised. Both dental options pay based on the level of treatment that Blue Cross Blue Shield of South Carolina determines is “adequate and necessary” according to widely accepted dental practices. Since dental care can be expensive, it’s a good idea to find out in advance how much will be paid because benefits are limited to the course of treatment which Blue Cross Blue Shield, upon review, determines is appropriate. By getting a pre-treatment estimate, you’ll know whether the services are covered under Blue Cross Blue Shield’s

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dental treatment guidelines. You'll also know how much of the dentist's charges Blue Cross Blue Shield will pay. This way, you can avoid misunderstandings about your coverage.

If your dentist recommends a procedure that differs from widely accepted dental practice, then you will be required to pay the difference between your dentist's bill and the amount covered by Prime Choice or Standard Choice.

### ***When and How to Request a Pre-Treatment Estimate***

If you need a course of dental treatment that may cost \$200 or more, you should have your dentist complete a pre-treatment plan and submit it to Blue Cross Blue Shield of South Carolina. It's important to do this before your treatment begins. However, in case of an emergency, get the care you need as soon as possible. Then file your claim in the usual way.

To file a pre-treatment plan and receive an estimate of the dental option's payment, follow these steps:

- Take a Blue Cross Blue Shield of South Carolina Dental Services Claim Form to your dentist. These forms are available from SRS Stores (Item 26-8121.00), the electronic file server (OSR 5-342) or Blue Cross Blue Shield Customer Service.
- Check the block, "Dentist's Pre-Treatment Estimate," and complete other requested information.
- Ask your dentist to complete an itemized list of services to be performed, including the cost of each service and the estimated length of treatment. Have your dentist refer to the instructions on the reverse side of the claim form to assist in completion of the pre-treatment estimate of benefits.
- Have your dentist attach any other materials that could be used to evaluate the treatment plan, such as x-rays or study models.
- Mail the claim form with the itemized list and supporting materials to Blue Cross Blue Shield of South Carolina.
- Blue Cross Blue Shield will review the pre-treatment plan and determine the amount of coverage based on the dental option you are enrolled in. If necessary, the information will be forwarded to a dental consultant for approval or determination of an alternate treatment plan.
- Blue Cross Blue Shield will notify you and your dentist, in writing, about the amount your option will pay. Remember, an alternate treatment, service, or supply may be recommended if Blue Cross Blue Shield considers the treatment program submitted by your dentist to not be necessary according to widely accepted dental practice standards.
- Your dentist should review the pre-treatment plan with you before doing the work. You should sign the pre-treatment plan to show that you understand the treatment and the dental benefits payable.
- After you have received services, your dentist should complete a claim for the actual services provided and return it to Blue Cross Blue Shield of South Carolina.



### ***In Case of Conflict***

While you can go ahead with any course of treatment — even a more expensive one, recognize that payment will be based on what Blue Cross Blue Shield of South Carolina considers to be “necessary, appropriate and adequate” according to widely accepted standards of dental practice for your condition. Some examples of the types of dental treatment where reimbursement may be denied totally or in part include the unnecessary removal of impacted wisdom teeth and the installation of crowns, inlays and onlays, when a less expensive alternative treatment would be as effective. Refer to “Alternate Course Of Treatment” below for more information.

### **Alternate Course of Treatment**

An alternate course of treatment applies when more than one dental service or supply can treat the same dental problem. Sometimes, for example, either a crown or a filling could work adequately well. All services must meet widely accepted dental practice standards.

If alternate services and supplies can be used that will equally treat your dental problems, both dental options will always pay benefits based on the less expensive alternate services or supplies. The standards developed by Blue Cross Blue Shield are based on the services and supplies that are customarily used by dentists throughout the United States, taking into account the current condition of the patient.

# COVERED DENTAL SERVICES

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Covered dental services and allowable benefits under the Prime Choice and Standard Choice Dental options are described as follows:

Preventive care services are covered at 100% of R&C under both Prime Choice and Standard Choice with no deductible required.

## Preventive Care

- Routine oral examinations by a dentist: two times in a calendar year,
- Tests and laboratory examinations: when needed for diagnosis, prevention and treatment of dental problems,
- General routine cleaning and scaling of teeth, performed by a licensed Dental Hygienist or a dentist: two times in a calendar year,
- Periodontal cleaning and scaling of gums and tissues surrounding the teeth — two times in a calendar year (only following periodontal surgery or for specific dental needs such that there is a history of active periodontal scaling/cleaning as evidenced by the periodontal chart and notes),
- Emergency dental services: treatment for the relief of pain,
- Fluoride treatments: for dependent children under age 20 two times in a calendar year, regardless of the type of fluoride used,
- Application of sealants: for dependent children under age 14 once per tooth every 36 months,
- Space maintainers: for dependent children under age 20:
  - installation of fixed or removable appliances to keep teeth from moving, and the adjustment of these appliances when required because of a change in the condition of the mouth,
- Dental x-rays:
  - full mouth (panoramic) x-ray: once every 36 months,
  - bite-wing x-rays: two times in a calendar year,
  - any dental x-ray required to diagnose a specific condition.

Under Standard Choice, both minor and major restorative services are covered at 50% of R&C after the deductible has been met.

## Minor Restorative Services

- Fillings: amalgam or composite restorations,
- Oral surgery: surgical procedures in and around the mouth, including removal of cysts, malpositioned or impacted teeth partially or fully covered by tissue, when medically necessary,
- Extractions: simple or complex removal of teeth, including removal of badly decayed teeth, when medically necessary,
- General anesthesia: when medically necessary and administered in conjunction with covered dental services,

- Endodontics: treatment of diseases of the pulp, such as root canal therapy, dental root resection, pulp capping, minor pulpotomy and major apicoectomy, where indicated,
- Periodontics: treatment of diseases of the gums and tissues surrounding the teeth,
  - Prime Choice only: splinting of teeth when necessary and as an integral part of a periodontic treatment plan,
  - Both Options: surgical treatment of diseases of the gums and tissues surrounding the teeth,
- Denture repair:
  - relining, rebasing, repairs and adjustments more than six months after installation or replacement, but not more than once every 36 months,
- Other repairs:
  - repair of crowns, inlays, onlays and gold fillings
  - repair and recementing of bridges.

## Major Restorative Services

- Prosthodontics — replacement of one or more natural teeth lost or extracted while you are covered under the options (except wisdom teeth). Refer to the Glossary of Terms for an explanation of “natural teeth.” Prosthodontic treatment includes:
  - initial installation of fixed bridgework to replace teeth extracted while you are covered by the options,
  - crowns, inlays, onlays, gold fillings and precision attachments and abutments for dentures and bridgework, when necessary,
  - initial installation of removable complete or partial dentures, including adjustment during the six months following installation,
  - adding teeth to an existing partial or complete removable denture,
  - replacing an existing complete or partial denture or fixed bridgework which is at least 5 years old with a new denture or partial because it cannot be made serviceable,
  - replacing a temporary denture with a permanent full denture within 12 months of when it was installed.

## TMJ and Other Temporomandibular Disorders (TMD)

### — Prime Choice Only

- Non-surgical treatment for problems specifically related to the treatment of the Temporomandibular Disorders, limited to:
  - dental splints to prevent clenching and/or grinding of teeth,

Covered TMJ/TMD services are paid at 50% of R&C under Prime Choice, up to a maximum lifetime benefit of \$500. Before undergoing treatment for TMJ/TMD, follow the pretreatment estimate procedures described earlier in this book. Standard Choice does not cover braces. Prime Choice pays 50% of R&C up to a maximum lifetime benefit of \$1,500.



- removable occlusal appliances,
- biofeedback therapy, and
- physical therapy based on Blue Cross Blue Shield's TMD Treatment Guidelines.

### **Orthodontics (Braces) — Prime Choice Only**

- Diagnosis, installation, and related services and supplies, as necessary for treatment,
- All services related to the straightening or repositioning of the teeth, including fixed or removable orthodontic appliances and full-banded treatment, under Prime Choice only – for both adults and children.

The Dental Plan's payment of orthodontic services is based on the assumption that a portion of the charge is incurred at the time the appliance is installed and that the balance is billed over the period of time the appliance is expected to remain in place. For this reason, the "set-up" fee is paid immediately and the balance of benefits available is paid on a monthly basis after services have been received. Orthodontic benefits are based on the treatment plan and continue until the maximum benefit has been paid or the individual's coverage ceases, whichever occurs first. If coverage terminates after orthodontic treatment has begun but before treatment is complete, then no further benefits are available when coverage ceases, even though the orthodontic treatment may have begun prior to termination of coverage. You should follow the pre-treatment estimate procedure as described previously before beginning orthodontic treatment. Also, caution should be used when setting aside money in the Health Care Flexible Spending Account for out-of-pocket orthodontic expenses, so that you do not set aside too much or too little money.

Standard Choice does not cover braces. Prime Choice pays 50% of R&C up to a maximum lifetime benefit of \$1,500.

## EXPENSES NOT COVERED UNDER EITHER OPTION

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You are not covered for the following dental expenses under Prime Choice or Standard Choice dental.

- Work done primarily for cosmetic purposes, except orthodontics,
- Work done while you're not covered under the dental options,
- Replacement of teeth removed or lost before coverage is effective, except:
  - when existing partial dentures, fully removable dentures or fixed bridgework cannot be repaired and were installed before the replacement waiting period (see prosthodontics, Page 11),
  - when replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while you're covered,
- Replacement of lost or stolen prosthetic devices,
- Replacement of lost or stolen orthodontic retainers,
- Extra (spare) sets of dentures or other appliances,
- Charges you're not required to pay, or charges that wouldn't normally be paid if you didn't have insurance,
- Work furnished or paid for because of service in the armed forces of any government,
- Services or supplies not recommended by your dentist as necessary for proper dental treatment,
- Missed appointments,
- Completion of claim forms or filing of claims,
- Educational programs, such as training in plaque control or oral hygiene, or dietary instructions,
- Charges for sealants for dependents age 14 and over,
- Implants — placing artificial teeth or supports surgically into the jawbone,
- Treatment of dental diseases or injuries resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government,
- Charges for any condition or injury where the participant is entitled to payment or benefits (whether or not such payment of benefits has been applied for or paid) under any federal, state or local laws. This exclusion includes, but is not limited to, any benefits provided or payable under Workers' Compensation Laws, the Veteran's Administration or any state or federal hospital for which the participant is not legally obligated to pay. This exclusion applies if the participant receives any payment in whole or in part, and it applies to any settlement or other agreement, including any settlement of "doubtful and disputed" claims or "clincher" agreements, or any other agreement regardless of how characterized, and/or if the agreement or release specifically excludes payment for medical expenses.



- Periodontal splinting — the temporary wiring or permanent binding together of teeth, except when necessary under Prime Choice for TMJ/TMD,
- “Habit-breaking” services or appliances (for example, an appliance to aid in the prevention of thumb-sucking), unless included as a part of orthodontic treatment under Prime Choice Dental,
- Charges for services that are considered a component of a procedure,
- Charges which, in the judgment of Blue Cross Blue Shield, exceed the reasonable and customary charge for the service or supply provided,
- Appliances, restorations and procedures to alter vertical dimension (changing the height of upper or lower teeth),
- Experimental procedures or those not recognized by the dental profession,
- General anesthesia, nitrous oxide or analgesia, except when medically necessary in connection with oral surgery or when a physical or mental condition requires its use,
- Dental services or supplies that are covered expenses under any other benefit plan or program provided by WSRC, such as dental work performed within 72 hours of accidental injury that is covered under the Health Choice medical options,
- Charges for dental services already covered under the other dental option if you switch from Standard Choice to Prime Choice or vice versa,
- Any supply item or procedure billed separately that should appropriately be built into the charge for the office visit or dental procedure (such as infection control, sterilization procedures, or supplies including latex gloves, mask and bib),
- Items billed separately for services benefiting the attending dentist or office staff rather than for the diagnosis and treatment of the patient, such as routine pre-treatment testing for HIV,
- Treatment by other than a dentist, except that scaling or cleaning of teeth and application of fluoride may be done by a licensed dental hygienist if rendered under the supervision and guidance of the dentist,
- Charges related to complications of non-covered procedures,
- Services, supplies or devices which, in the judgement of Blue Cross Blue Shield of South Carolina, are not necessary to treat a specific dental condition, (or to prevent a dental problem other than the specific Preventive Care Services described on Page 10), and
- Services not reported within fifteen (15) months from the date of service.

## COORDINATION OF BENEFITS

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If you have dental coverage under another employer's group dental plan in addition to this one — through your spouse, for example — the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate duplicate payments, your coverage under Prime Choice or Standard Choice is coordinated with payments from other group dental plans through which you have coverage. When the WSRC/BSRI dental plan is the secondary plan, it will pay up to the amount of Total Covered Charges as determined by Blue Cross Blue Shield, but the Blue Cross Blue Shield payment will not exceed the difference between the Total Covered Charges and the primary plan's payment. At no time will the WSRC Plan, operating as a secondary plan, pay more than it would have if it would have been the primary plan.

Please note that "other insurance" information must be updated on an annual basis with Blue Cross Blue Shield of South Carolina.

### Which Plan Pays First

The plan that pays first is the one that covers you as an employee.

If your child is covered by more than one plan, the plan which covers the parent whose birthday falls first in the year (month and day) pays for the dependent child before the plan covering the other parent. However, if you are separated or divorced, the plan of the parent who has custody of the child (provided that the parent hasn't remarried) will pay before the plan of the parent who doesn't have custody. If you're divorced, but have remarried and have custody of your child, your plan will pay before the child's stepparent's plan, and the stepparent's plan will pay before the plan of the children's non-custodial parent. If a court gives financial responsibility for the child's dental care expenses to one parent, then that parent's dental plan will pay before any other plan. When none of these situations apply, the plan under which you're covered the longest will pay first.

Other plans include any dental coverage available from:

- Group, fraternal, blanket or franchise insurance,
- Prepayment coverage,
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans, and
- Government programs, except Medicare.

Keep in mind that if both you and your spouse are employed by (or retirees of) the WSRC Team, under the "Special Rules for Dual Couples" (explained on Page 1), you cannot be covered under the dental options as both an employee and as a dependent of another employee. As a result, you cannot have duplicate coverage under the WSRC/BSRI Health Choice dental options.

Each employee is covered only as an employee or as a dependent. A child is regarded as a dependent of only one employee, not both. No coordination of benefits is applicable since only one dental plan is involved.

If you and your spouse (through another employer) both cover your children, the plan of the parent whose birthday is first in the year will pay first.

## Right of Reimbursement/Subrogation

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In the event participant benefits are provided to or on behalf of a participant under the terms of this Plan, the participant agrees, as a condition of receiving benefits under the Plan, to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of and to her person, firm corporation, or organization. The Plan shall be subrogated, at its expense, to the rights of recovery of such participant against any such liable third party.

If, however, the participant receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the participant agrees to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the injury or illness. The plan's right of recovery applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the participant has been made whole or fully compensated for his/her injuries.

The Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP), malpractice, or any other insurance coverages which are paid or payable.

The Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Plan.

The Participant shall not do anything to hinder the Plan's right of subrogation and/or reimbursement. The participant shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of subrogation and/or reimbursement, including a assert a claim or lawsuit against the third party or any insurance coverages to which the participant may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold benefits due the Participant under the Plan document. Failure to reimburse the Plan as required will entitle the Plan to deny future benefit payments for all Beneficiaries under this policy until the subrogation/reimbursement amount has been paid in full.

## OVERPAYMENTS

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If Blue Cross Blue Shield issues a benefit payment, either to you or your provider, that exceeds the benefit amount you were entitled to, the Plan has the right to collect the overpayment from you or your provider. The process Blue Cross Blue Shield will follow in collecting overpayments includes:

- Send written request to be refunded, or
- Reduce the amount of the overpayment from future benefit payments.

## CLAIMS FILING

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Dental Services Claim Forms are available on-site via the electronic file server (OSR 5-342), Human Resource Web Page, Dental Section, or by calling Blue Cross Blue Shield Customer Service. Complete your portion of the claim form and take it with you when you go to your dentist. Your dentist may offer to file claims for you when you provide the necessary insurance information.

If you believe  
your claim wasn't  
paid correctly, call  
Blue Cross Blue Shield  
Customer Service  
at 1-800-325-6596.

Your dentist may give you an itemized bill. Blue Cross Blue Shield can accept an itemized bill without a completed claim form as long as the following information appears clearly on the bill:

- Employee's name and Social Security number,
- Patient's name and date of birth,
- Date of service,
- Diagnosis or reason for treatment,
- Type of treatment or name of each procedure performed,
- Charge for each service, and
- In the case of an accidental injury — description of the injury and the date of occurrence.

Here are the steps to follow when filing a claim:

1. Always get a pre-treatment estimate whenever you are planning to have dental work expected to cost more than \$200.
2. File claims promptly or have your dentist file your claims so you don't lose track of expenses. Remember, if you don't file a claim within the specified time limit after you incurred a dental expense (that is, within 15 months from the date of service), it will not be covered by your Health Choice Dental option. You should "cluster" the bills for each individual family member onto a separate claim form, and then put the bills in order by type of service and date. Use the correct form and/or an itemized bill. If you are coordinating benefits with another plan that is primary (such as your spouse's employer's dental insurance plan that pays first), attach a copy of the other plan's Explanation of Benefits statement to the Dental Services Claim Form. Keep a copy for your records — the claim form and all attachments — of the documents you send to Blue Cross Blue Shield.
3. Submit the claim form to:  
**Blue Cross Blue Shield of South Carolina**  
**Claims Service Center**  
**P.O. Box 100300**  
**Columbia, SC 29202**
4. Blue Cross Blue Shield will send you written notification, called an explanation of benefits (EOB), regarding the determination of your claim submission. Blue Cross Blue Shield claim determinations will be in writing, or in electronic form, within the following time-periods from the claim receipt:

- .....
- Post-Service Claims – within 30 days. Most claims are considered post-service claims since they are usually filed after your health care provider has already rendered services.
  - Pre-Service Claims – within 15 days. Pre-service claims include any claim for a benefit which, with respect to the terms of the Plan, conditions receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining dental care. An approval means only that a service is Medically Necessary for treatment of a claimant's condition, but is not a guarantee or verification of benefits. Payment is subject to claimant's eligibility, Pre-existing Condition Limitations and all other Plan limits and exclusions. Actual benefit determination will be made when Blue Cross Blue Shield processes the post-service claim.
  - Urgent Care Claims - as soon as possible taking into account the medical circumstances, but no later than seventy-two (72) hours for pre-service urgent care claims. Urgent care claims include claims for dental care or treatment that if processed under normal pre-service claim review timeframes could seriously jeopardize the claimant's life or health, jeopardize claimant's ability to regain maximum function, or in the opinion of the Physician (with knowledge of the claimant's current medical condition) subject claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim. A Provider may be considered your authorized representative, without your specific designation as such, when the claim approval request is for Urgent Care Claims.

For pre-service and post-service claims, Blue Cross and Blue Shield may use a 15 calendar day extension, if it is necessary for reasons beyond the control of the Plan. If an extension is required, Blue Cross Blue Shield will notify you within the initial notification periods noted above.

5. If you are required to submit additional information for Blue Cross and Blue Shield to make a determination, the initial notification deadlines noted above will be suspended (from the time you are contacted for such additional information until you return the requested information.) For Post-Service Claims and Pre-Service Claims, you must respond with the missing information within 60 days or Blue Cross Blue Shield will deny your claim. For an Urgent Care Claim, you should respond as soon as possible, no later than 48 hours or Blue Cross Blue Shield will deny your claim.
6. If need further explanation regarding the decision to deny or reduce the amount of your claim, or you have additional information that may change that decision, you should first, contact a Blue Cross Blue Shield of South Carolina Customer Service Representative (at the toll-free number listed on your Blue Cross Blue Shield of South Carolina insurance identification card) for further explanation of the denial.

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If you wish to file a voluntary written appeal with Blue Cross Blue Shield of South Carolina, you must write to the address indicated on your Blue Cross Blue Shield of South Carolina insurance identification card. Your letter must state that an appeal has been requested and all pertinent information regarding the claim in question must also be included your letter. You have 180 days from the initial claim determination made by Blue Cross Blue Shield of South Carolina (that they provided to you as an EOB, in writing or in electronic form) to file an appeal. After that date, the Plan will consider the disposition of the claim to be final. Blue Cross Blue Shield will respond within the following timeframes from when your appeal request is received:

- 30 days for Post-Service Claims. (If you still do not agree with the Blue Cross Blue Shield decision, you can submit a second voluntary appeal to Blue Cross Blue Shield within 90 days after receiving the Blue Cross decision on your first appeal. Blue Cross Blue Shield will complete the second level appeal process within 30 calendar days after receiving your second appeal request.)
  - 15 days for Pre-Service Claims first level appeal. (If you a file a second voluntary appeal of a Pre-Service claim, Blue Cross Blue Shield will complete the second level appeal process within 15 calendar days after receiving your second appeal request.)
  - As soon as possible taking into account medical circumstances that require action, but not later than 72 hours for Urgent Care Claims.
7. Your final appeal request to the Plan must be submitted within 180 days from the initial claim determination made by Blue Cross Blue Shield of South Carolina (that they provided to you as an EOB, in writing or in electronic form) to file an appeal.. Your appeal must be in writing and include all pertinent information regarding the claim in question. Your appeal should include the members name, address, identification number, and any other information, documentation or materials that support the members appeal. It should include all documents, records, questions or comments necessary for a complete review, including reference to the specific Plan provisions that you feel were misinterpreted or inaccurately applied. The WSRC/BSRI Health Choice Dental Plan Administrator will decide the appeal within a reasonable period of time, but no later than 60 days after receipt of the appeal. (You will be notified if there are special circumstances that cause the review to take longer.) Your appeal to the Plan should be sent to:

**Washington Savannah River Company**  
**Attn: Health Care Dental Plan Administrator**  
**Building 703-47A**  
**Aiken, SC 29808**



In deciding an appeal regarding an adverse benefit determination that is based in whole or in part on a medical or dental judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Plan will obtain a consult from a health care professional who has the appropriate training and experience in the field involved in the medical or dental judgment.

The WSRC/BSRI Health Choice Dental Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by the WSRC Health Choice Dental Plan Administrator is final and binding.

The exhaustion of the claim and appeal procedure is mandatory for resolving any claim arising under this Plan. Applicable law requires you to pursue all claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

As a participant in the WSRC/BSRI Health Choice Dental Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents that govern the dental options dictate the actual operation of the Plan and the payment of benefits. For more information on your ERISA rights and administration of the Plan, refer to the Benefits Overview General Information booklet.

## COVERAGE CONTINUATION IN SPECIAL SITUATIONS

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**If you are laid off or terminate your employment with the WSRC Team,** coverage for you and your dependents will end on the last day of the pay period in which you are a full-service employee. You may be able to continue your coverage by electing COBRA continuation coverage. See information on COBRA continuation coverage below and in the General Information book.

**If you die,** coverage for your dependents will end on the last day of the pay period in which you die, unless they are eligible to receive survivor benefits under the provisions of the WSRC/BSRI Pension Plan and pay the required monthly premium contribution. However, to continue receiving dental benefits, survivors must also meet the definition of “Eligible Dependents” as described on page 2. Parents and step-parents are not eligible for Health Choice survivor coverage. Also, if your surviving spouse re-marries, the new spouse and his/her children cannot be added to your survivor’s WSRC/BSRI dental coverage. (Note that a dependent child will no longer be covered by the WSRC/BSRI dental options upon reaching age 20, unless he/she is a full-time student at an accredited institution in which case dental coverage will continue until the child’s survivor pension benefit ceases at age 21.)

**If survivor benefits do not apply,** your dependents will be eligible to continue their coverage by electing COBRA continuation coverage. However, if your death is a result of an occupational injury or illness while you were a full-service employee of the WSRC Team or while receiving Special Benefits for Occupational Related Disabilities under the Disability Income Plan, dental coverage may be continued for your survivors as outlined above. Your survivors will be notified of the option(s) available.

**If you retire,** with at least 15 years of eligibility service and one year of credited service, directly from a WSRC Team employer as a full service employee (including BSRI Option A Craft employees) under the Normal, Early, Optional or Incapability provisions of the WSRC/BSRI Pension Plan you, and your eligible survivors, are eligible for participation in the WSRC/BSRI Health Choice Dental Plan. If you transfer from a WSRC Team company to an Affiliate, as defined in the WSRC/BSRI Pension Plan, you are not eligible for the WSRC/BSRI Health Choice Dental Plan. Also, as a WSRC Team retiree, if you are re-employed as a full time employee by an Affiliate entity, your WSRC/BSRI Health Choice Dental Plan participation will end and will not be reinstated by a subsequent termination/retirement from the Affiliate. If you elect coverage for yourself (and/or your dependents if you desire to cover them) you will be required to pay the applicable after-tax monthly premium contribution. Coverage for your dependents will continue in effect as long as they continue to be eligible dependents and you elect to cover them.

**If you become eligible for Long-Term disability,** your dental coverage terminates on the last day of the pay period prior to your Long Term disability benefits beginning. You will be eligible to continue your dental coverage under COBRA continuation coverage.

**If you are on a paid leave of absence,** your Health Choice dental coverage for yourself and your dependents will continue as if you were actively at work.



**If you are on an approved Unpaid Leave of Absence** (Unpaid LOA) such as a Family and Medical Leave, you will be able to continue your Health Choice dental coverage for yourself and your dependents, if you elected to cover them, as long as you pay the required monthly premium contribution in advance. When you return from the Unpaid LOA as an active employee, your premium contributions will resume on a pre-tax deduction basis from your WSRC Team paycheck. Before your Unpaid LOA begins, be sure to contact the WSRC People Support Service Center for additional information and instructions on making the required premium contributions.

**If, while on an Unpaid LOA, you should fail to make your premium payments** in a timely manner (that is, by no later than 31 days after the beginning of the month), your Health Choice dental coverage for you and your dependents will be terminated retroactively to the beginning of the month for which the premium contribution was not made. When you return as an active employee from the Unpaid LOA, the Health Choice dental coverage that you had just prior to the Unpaid LOA will resume, with premium contributions deducted on a pre-tax basis from your WSRC Team paycheck. However, you and your dependents would have forfeited Health Choice dental coverage during the period of time that you did not pay the required premium contributions. Dental claims incurred by you or your dependents during that uncovered period of time will not be paid by the WSRC Team.

## **COBRA Continuation Coverage**

Under federal law — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) — you and your eligible dependents may be entitled to continue your dental coverage for up to 18, 29, or 36 months depending on the reason for loss of coverage. Subsequent qualifying events also will determine the length of COBRA coverage. In order to be eligible for COBRA continuation coverage, you or your eligible dependents must have lost coverage under certain circumstances (such as termination of employment, divorce or death). In a divorce situation, WSRC People Support Service Center must be notified within 60 days after the effective date of the final divorce decree, or COBRA continuation coverage cannot be offered to your dependents. For more information on continuing coverage under COBRA, see the Benefits Overview and General Information book.

# **DISCLAIMER**



Neither Blue Cross Blue Shield nor the WSRC Team is responsible in any way for services received from dental care providers under this plan and no guarantees are made as to the competency of the providers or the quality of services. All malpractice issues on the part of the patient or family must be directed solely at the provider of the service.

# ERISA INFORMATION

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As a participant in WSRC's benefits program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). The official documents which govern the dental options dictate the actual operation of the Plan and the payment of benefits. For more information on your ERISA rights and administration of the Plan, refer to the General Information book.

**Plan Information:**

**Type of plan:** A self-insured welfare plan that provides dental benefits

**Plan Name:**

Health Choice Dental Plan (Prime Choice and Standard Choice)

**Plan Sponsor:**

Washington Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI)

**Employer Identification Numbers of The WSRC Team:**

|   |            |
|---|------------|
| Washington Savannah River Company:      | 82-0510443 |
| Bechtel Savannah River, Incorporated:   | 94-3077224 |
| BWXT Savannah River Company:            | 54-1804131 |
| BNG America Savannah River Corporation: | 54-1813446 |
| CH2 Savannah River Company:             | 02-0693747 |

**Plan Number:**

501

**Plan Year:**

January 1 - December 31

**Plan Administrator:**

Washington Savannah River Company  
WSRC/BSRI Dental Plan Administrator  
Building 703-47A  
Aiken, South Carolina 29808

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**Claims Administrator:**

**Blue Cross and Blue Shield of South Carolina  
I-20 at Alpine Road  
Columbia, South Carolina 29219**

**Agent for Legal Process:**

**Corporate Service Company  
5000 Thurmond Mall Blvd.  
Columbia, SC 29201  
PH: 800-927-9800**

Eligibility for benefits should not be viewed as a guarantee of employment. Also, while the WSRC Team intends to continue providing a comprehensive benefits program, the WSRC Team reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refer to the General Information book.

# GLOSSARY OF HELPFUL TERMS

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## **Apicoectomy**

Amputation of the root end of the tooth.

## **Bridgework**

Artificial teeth joined to inlayed or crowned natural abutment teeth on either side. A fixed bridge for anterior teeth may require two abutments on either side. A removable bridge is currently called a partial denture.

## **Coinsurance**

The percentage you pay for covered services. Your coinsurance amounts for non-preventive dental services are either 20%, 40% or 50%, depending on the specific dental service and the Health Choice dental option you choose.

## **Crown**

A restoration which replaces the enamel on the visible portion of a tooth by covering the entire coronal surface, generally with porcelain, acrylic or metal.

## **Deductible**

Under the Standard Choice Dental option, the initial amount of non-preventive dental expenses you are responsible for each year before the plan pays benefits. There is no deductible for Preventive Care services.

## **Eligibility Service**

Eligibility Service is the service one earns while employed by the WSRC Team and service recognized by an affiliate entity at a WSRC Team Company. Eligibility service is the adjusted service date of an employee entered into the Human Resources Payroll System.

## **Endodontics**

Treatment of disease or injury of the root and tissues surrounding the apex (end) of the root of the tooth.

## **Lifetime Maximum**

The most benefits the plan will pay for an individual during his or her lifetime.

## **Orthodontics**

The movement of teeth in the correction of malocclusion (bad bite).

## **Periodontics**

Treatment of diseases of the gums, connective tissue and bone surrounding and supporting the teeth.

## **Post-Service Claims**

Most claims are considered post-service claims since they are usually filed after your health care provider has already rendered services.

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### **Pre-Service Claims**

Any claim for a benefit which, with respect to the terms of the Plan, conditions receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining dental care. An approval means only that a service is Medically Necessary for treatment of a claimant's condition, but is not a guarantee or verification of benefits. Payment is subject to claimant's eligibility, Pre-existing Condition Limitations and all other Plan limits and exclusions. Actual benefit determination will be made when Blue Cross Blue Shield processes the post-service claim.

### **Prophylaxis**

The prevention of disease through the cleaning, scaling and polishing of teeth.

### **Prosthetics**

The installation of complete or partial dentures to replace missing "natural" teeth. Natural teeth do not include:

- Congenitally missing teeth,
- Diastema: a space between two adjacent teeth in the same arch, and
- Tooth roots when the mal-conditioned tooth existed prior to the effective date of coverage.

### **Reasonable and Customary**

The basis for payment of covered services. The reasonable and customary charge for any given treatment is the lower of:

- The dentist's usual charge, or
- What Blue Cross Blue Shield determines to be the most common charge for a particular service in the dentist's geographic area.

Blue Cross Blue Shield takes many factors into account, such as the degree of skill needed, the complexity of the procedure, the range of services and supplies, and the prevailing charge in other areas.

### **Space Maintainer**

An appliance to prevent adjacent teeth from moving into space left by a prematurely lost baby tooth.

### **Urgent Care Claims**

Claims for dental care or treatment that if processed under normal pre-service claim review timeframes could seriously jeopardize the claimant's life or health, jeopardize claimant's ability to regain maximum function, or in the opinion of the Physician (with knowledge of the claimant's current medical condition) subject claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim. A Provider may be considered your authorized representative, without your specific designation as such, when

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