



## Dental Care Program Plan A

# Benefits Booklet

The benefits included in the booklet are effective October 1, 2010.  
The plan year remains October 1 - September 30.

**Your benefits continue to be paid based on the benefit year  
beginning September 1 and ending on August 31 of each year.**

## Introduction

Your WEA Select Dental Plan was designed specifically for school district employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Consulting (Employee Benefits Consultant), and Washington Dental Service (Dental Plan Underwriter).

The WEA is the policyholder for this Plan of dental benefits. The WEA retains full and exclusive authority, at its discretion, to determine the availability of this Plan. The Plan is not guaranteed to continue indefinitely. The Plan may be altered or terminated at any time.

All Plan Benefits and Limitations are reviewed by the WEA Benefits Services Advisory Board and approved by the WEA Board of Directors. Your suggestions for Plan improvements are always welcome and may be forwarded to the WEA or Aon Consulting.

**In order to understand how your benefits are paid, it is suggested that you review this booklet at the time of enrollment.** As dental expenses are incurred, you may wish to review the section that applies to those specific types of expenses.

## Questions Regarding Your Plan

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

Washington Dental Service Customer Service

(206) 522-2300

(800) 554-1907

You can reach us through Internet e-mail at [info@DeltaDentalWA.com](mailto:info@DeltaDentalWA.com).

Written inquiries may be sent to:

Washington Dental Service

Customer Service Department

P.O. Box 75983

Seattle, WA 98175-0983

For the most current listing of Washington Dental Service Participating Dentists, visit our online directory at [www.DeltaDentalWA.com/WEA](http://www.DeltaDentalWA.com/WEA).

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## **How To Use Your Plan**

### **Choosing a Dentist**

*You may select any licensed Dentist. Tell your Dentist you are covered by a Washington Dental Service dental Plan, and give your Dentist the Plan name and group number.*

### **Delta Dental Participating Dentists**

If you select a Dentist who is a WDS participating provider, that Dentist has agreed to provide treatment for Eligible Persons covered by WDS Plans according to the provisions of his or her Participating Dentist contract. You will not have to hassle with sending in claim forms. Participating Dentists complete claim forms and submit them directly to WDS. They receive payment directly from WDS. You will not be charged more than the Participating Dentist's approved fee or the fee that the WDS Dentist has filed with us. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

#### **Delta Dental PPO Dentists**

Delta Dental PPO Dentists must be Washington Dental Service/Delta Dental Participating Dentists in order to participate in the Delta Dental PPO network. Delta Dental PPO Dentists receive payment based on their Delta Dental PPO Filed Fees at the percentage levels listed on your Plan for Delta Dental PPO Dentists. Patients are responsible only for percentage coinsurance up to the Delta Dental PPO Filed Fees. Delta Dental PPO is a point-of-service Plan, meaning that you can choose any Dentist — in or out of the Delta Dental PPO network — at the time you need treatment. However, if you select a Dentist who is a Delta Dental PPO Dentist, your out-of-pocket expenses may be lower and you will receive a higher annual maximum (see "Plan Maximums").

#### **Delta Dental Premier<sup>®</sup> Dentists (non-PPO)**

Delta Dental Premier<sup>®</sup> Dentists also have contracts with WDS, but they are not part of the Delta Dental PPO network. Delta Dental Premier<sup>®</sup> Dentists will submit claim forms for you and receive payment directly from WDS. Their payments will be based on their pre-approved fees with WDS. They also cannot charge you more than these fees. You will be responsible only for stated deductibles, coinsurance and/or amounts in excess of the Plan maximum.

### **Nonparticipating Dentists in Washington State**

If you select a Dentist who is not a WDS Participating Dentist, you are responsible for having your Dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your Dentist may provide. You can also download claim forms from our Web site at [www.DeltaDentalWA.com/WEA](http://www.DeltaDentalWA.com/WEA). It is up to you to ensure that the claim is sent to WDS. Payment for services performed by a Nonparticipating Dentist will be based on actual charges or WDS's Maximum Allowable Fees for Nonparticipating Dentists, whichever is less. You will be responsible for any balance remaining. Please be aware that WDS has no control over Nonparticipating Dentists' charges or billing practices.

### **Out-of-State Dentists**

If you receive treatment from a Dentist outside Washington state, you are responsible for having the Dentist complete and sign a claim form. It is also up to you to ensure that the claim is sent to WDS. Payment will be based upon actual charges or WDS's Maximum Allowable Fees for Participating Dentists, whichever is less.

## **Claim Forms**

American Dental Association-approved claim forms may be obtained from your Dentist, or you may download claim forms from our Web site at [www.DeltaDentalWA.com/WEA](http://www.DeltaDentalWA.com/WEA).

WDS shall not be obligated to pay for treatment performed if claim forms are not submitted for payment in a timely manner after the date of such treatment. Written notice of claim for benefits must be received by WDS within 12 months after the date of treatment or as soon as medically possible. No claims will be accepted later than one year from the date of treatment unless the Eligible Person is legally incapacitated throughout the year. For groups with optional orthodontia coverage, the initial banding date is the treatment date considered in the timely filing.

## **Information Needed For Claim Submission**

1. Employee's name and address
2. Employee's Identification Number
3. Patient's name and birthdate
4. Name of Plan (WEA-Plan #186)
5. Name of Employer (School District)

Note: Possession of this booklet is not proof of eligibility. Terms and conditions are set forth in a contract between the Washington Education Association and Washington Dental Service which is on file with the WEA Benefit Services Division.

## **Who Is Eligible**

### **Employee**

Eligible Employees are all active full-time employees for whom the District makes timely payment of the monthly dues.

Employees hired after the Plan is in effect become eligible on the first day of the month for which the District makes payment of the monthly dues.

*All Eligible Employees must participate in this Plan, regardless of any coverage under any other Plan.*

School Board members are not eligible for coverage unless they are paid employees of the school district and meet WEA eligibility requirements. School Board members who receive compensation for their services as board members are not considered employees for this purpose.

### **Dependent**

If dependent coverage is provided by the Plan, your Eligible Dependents are your spouse, registered domestic partner of any state or domestic partner who meets the requirements of and completes the "Declaration of Domestic Partnership", and children, including biological children, stepchildren and adopted children from birth up to age 26. Spouses and children of married dependents are not eligible for coverage under this Plan. Dependents in the military service are not eligible.

Wherever spouse is stated in this contract, an eligible domestic partner would also be included.

## **Child Developmental Disability**

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

## **Legal Guardianship/Non-Parental Custody**

A child will be considered an Eligible Dependent as an adopted child if the following conditions are met: 1) the child has been placed with the Eligible Employee for the purpose of adoption under the laws of the state in which they reside; and 2) the Eligible Employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. If premium is required, notification of placement of a child for adoption and payment of any additional required monthly dues must be furnished to WDS within 60 days from the date of placement.

Children under legal guardianship (legal wards) or under a legal non-parental custody decree may be enrolled for coverage if the following conditions are met:

- The legal guardianship/non-parental custody must have been awarded in accordance with the laws of the state in which the guardianship/non-parental custody is obtained. Documentation must be provided, including the court order and petition for guardianship/non-parental custody, stating the reason and authority of the guardianship/non-parental custody.
- The guardian/person with non-parental custody must be either the subscriber or the subscriber's spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same Plan.
- The child must be under age 26.

## **Self-Payment Provisions**

### **Labor Dispute**

If compensation is suspended directly or indirectly as a result of strike, or lockout or other labor dispute, subscription charges may be paid for yourself and your Eligible Dependents directly to the employer for up to six months. This period of coverage will not extend any other period of continued coverage provided by your Plan.

When the subscriber's compensation or wage is so suspended or terminated, the subscriber shall be notified immediately in writing by the participating employer group. A notice will be mailed to the address last on record with the participating employer group that the subscriber may pay subscription charges to the participating employer group as they are due as provided in this section.

## **Continuation During Leave of Absence**

Coverage for the subscriber and any enrolled dependents on an official leave of absence or sabbatical may be continued for up to 18 months. The leave of absence period must begin at the end of the last month of coverage paid from fringe benefit funds earned during active employment. If you do not elect continued coverage at this time or if you terminate coverage at any time during your leave of absence, you may not enroll on the Plan until you return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during your leave of absence, you will immediately be eligible for COBRA (see below). To be eligible for COBRA, you must elect coverage under COBRA within 60 days after coverage under the leave of absence provision terminates.

*A district approved leave beyond 18 months does not entitle the subscriber (or enrolled dependents) to extend coverage under this leave of absence provision.* If your leave extends beyond this 18 months of continued coverage, you and your enrolled dependents may be eligible for an additional 18 months of continued coverage through COBRA. If you do not return to work after your leave of absence or if another consecutive district-approved leave is granted without another period of active employment, COBRA will also be available. The maximum period of extended coverage under any circumstance is 36 months, i.e., up to 18 months of continued coverage under the leave of absence provisions and up to 18 months of COBRA continuation.

Additional coverage under this provision may be elected if you return to employment and are granted further official leaves of absence or sabbaticals.

Example:

- Employee is granted a leave of absence and is no longer actively at work as of March 20.
- Employee's active work results in fringe benefit dollars for March, which pay for April benefits.
- Employee will receive sick leave through the district leave-sharing program for 2 months.

In the above example, the 18-month leave of absence coverage period would officially begin on May 1, because April 1 is the last month of fringe benefit funds from active employment. The total extended coverage for sick leave and the leave of absence would be 18-months, at which time the district would need to provide the employee notice of access to COBRA continuation for 18 additional months (total 36-months). If the above leave of absence had been started prior to the March payroll cutoff for benefits, the leave period would begin April 1.

Employer-paid continuation of coverage may be available for up to 12 weeks in the event of leave covered under the Family and Medical Leave Act of 1993. Please check with your local payroll office for additional information.

## **Reduction in Force**

For those participating employer groups who do not provide COBRA under this Plan, the following provision will apply:

Coverage for Reduction In Force (RIF) subscribers and their enrolled dependents may be continued on a self-paid basis through the group for up to 12 months from the date of lay-off.

## **Termination of Benefits**

Coverage for you and your Eligible Dependents will terminate if you cease to be eligible as previously defined, or if the Plan is terminated.

An individual's dependent's coverage will terminate at the end of the month in which the dependent is no longer eligible as previously defined.

For the purpose of this Plan, termination of employment will be considered to occur on the last day of the calendar month for which premiums are paid from fringe benefit funds earned during active employment.

If you are terminating employment due to retirement, you may apply for the WEA sponsored WDS Retiree Dental Plan. To be eligible you must receive monthly retirement benefits from the Washington State Retirement System (TRS or PERS). You must apply for Retiree Coverage while still covered as an Active Employee or covered under COBRA. Contact WDS to receive application materials.

## **Continuation of Group Coverage—COBRA**

### **For participating employer groups with 20 or more employees (as described by COBRA)**

When group coverage is lost because of a “qualifying event” shown below, federal law and regulations require that the participating employer group offer qualified Enrollees an election to continue their group coverage for a limited time. (These laws and regulations are referred to in this Plan as “COBRA.”) Continued coverage is not automatic. Under COBRA, a qualified Enrollee must apply for continued coverage within a certain time period and may also have to pay the subscription charges for it.

*If subscriber or any enrolled dependents do not elect COBRA coverage at this time, they may not enroll on the Plan at a later date.*

The participating employer group must fulfill all of the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the participating employer group, Plan sponsor or administrator and to the “group health Plan.” WDS is not the COBRA Plan administrator, and our actions pertaining to COBRA continuation coverage under this Plan shall not be construed as relieving the participating employer of its responsibility under COBRA. We provide coverage only to the extent that Enrollees are entitled to continued coverage under COBRA and only to the extent of the other terms and Limitations of this Plan.

The following summary of continued coverage is taken from COBRA. Enrollees’ rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by the courts and federal regulatory agencies.

## **Qualifying Events and Length of Coverage**

Please contact the participating employer group immediately when one of the qualifying events below occurs. The continuation periods listed extend from the date of the qualifying event.

- The participating employer group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of one of the two qualifying events:
- The subscriber’s work hours are reduced.
- The subscriber’s employment terminates, except for discharge due to actions defined by the participating employer group as gross misconduct.

However, if one of the events listed above follows the covered employee’s entitlement to Medicare by less than 18 months, the participating employer group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

COBRA coverage can be extended if an Enrollee who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (IASDI) or Title XVI (SSI) or the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination. To be eligible for the extended continuation period, you must give the group a copy of the determination of disability during the 18-month continuation period and no later than 60 days after you receive the determination.

- The participating employer group must offer the covered spouse or children an election to continue coverage for up to 36 months if their coverage is lost because of one of the four qualifying events:
- The subscriber dies.
- The subscriber and spouse legally separate or divorce.
- The subscriber becomes entitled to Medicare.
- A child loses eligibility for dependent coverage.

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. The extended period will end no later than 36 months from the date of the first qualifying event.

A covered spouse or child is eligible for continued coverage due to a divorce, legal separation, or a child's loss of dependent eligibility only if the participating employer group is notified no more than 60 days after either the qualifying event date or the date the dependent's coverage ends, whichever is later.

## **Conditions of Continued Coverage**

For continued coverage to become effective, all of the requirements below must be met:

1. You must notify the participating employer group if the "qualifying event" is legal separation or divorce, or a child's loss of eligibility for dependent coverage.
2. You must elect continued coverage no more than 60 days after either the date coverage was to end because of the qualifying event, or the date of the participating employer group notified you of your right to elect continued coverage, whichever is later.
3. You must send your first subscription charge payment to the participating employer group no more than 45 days after the date you elected continued coverage.
4. Subsequent subscription charges must be paid on a timely basis to the participating employer group.

## **When Continued Cobra Coverage Ends**

Continued coverage will end on the last day for which subscriptions charges have been paid in the monthly period in which the first of the following occurs:

1. The applicable continuation period expires.
2. The next monthly subscription charge is not paid when due or within the grace period.
3. If you have extended COBRA coverage due to disability, it will end if Social Security determines that you are no longer disabled. In this case, coverage terminates at the end of the month that begins at least 30 days after Social Security's decision. For example, if Social Security decides on March 15 that you are not disabled, your coverage would end May 31. You must provide the participating employer group with a copy of the determination within 30 days after the date of the termination.
4. You become covered under another group dental Plan after the date you elect COBRA coverage. If, however, the new Plan contains an exclusion or limitation for your preexisting condition, coverage does not end for this reason until the exclusion or limitation no longer applies.
5. You become entitled to Medicare after the date you elect COBRA coverage.

6. The participating employer group ceases to offer this WEA Select Dental Plan. However, you should contact your participating employer group regarding participation in any other group dental Plan offered to your bargaining unit/employee classification.

## How The Plan Works

Your Plan encourages regular dental care. During the first *Benefit Period*, (September 1 through August 31), 70% of covered benefits are paid. This increases by 10 percent yearly (on September 1), *providing you use the Plan at least once each Benefit Period*, to a maximum of 100%. Failure to use the Plan once each Benefit Period causes your level to drop 10 percent below the last level of payment, but never below the original 70%. You and each of your dependents create your own percent level. Percent levels do not affect the established constant 50% Payment Level for the cost of allowable prosthetics (Dentures, Bridges and Implants).

	Benefit Period*	Payment Level*
Payment Levels for Class I & Class II Covered Dental Benefits	1	70%
	2	80%
	3	90%
	4	100%
Class III Benefits - Dentures, Bridges, Implants & Occlusal Guards (Nightguards)	All years	Constant 50%
Temporomandibular Joint Benefit - \$1,000 per Benefit Period \$5,000 lifetime benefit	All years	Constant 50%

\*Providing benefits are used at least once during each Benefit Period (September 1 through August 31).

*Prosthetics (such as Dentures, Bridges, Implants, partials and related items) and TMJ benefits are NOT under the incentive period Payment Levels. They are limited to a constant 50% Payment Level.*

## Predetermination of Benefits

If your dental care will be extensive, you may ask your Dentist to complete and submit a request for an estimate, sometimes called a “predetermination of benefits.” This will allow you to know in advance what procedures may be covered, the amount WDS may pay and your expected financial responsibility.

*Please check with your Dentist for the benefit payment amount and the amount of your maximum benefit used to date on predeterminations of benefits.*

A predetermination is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made and is not a guarantee of payment.

A predetermination of benefits is valid for 12 months. In the event your benefits are terminated and you are no longer eligible, the predetermination is voided. WDS will make payments based on your available benefits (maximum, deductible and other Limitations as described in your benefits booklet) and the current Plan provisions when the treatment is provided.

## **Additional Procedures**

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the Plan. In such instances, the Plan will pay the proper percentage of the lowest fee. The balance of treatment cost remains the Eligible Person's responsibility. If you or your Dentist has any questions about how a claim will be paid, please have your Dentist submit a Predetermination of Benefits.

## **Plan Maximums**

**The maximum amount payable by WDS for all Covered Dental Benefits per Eligible Person each Benefit Period (September 1 through August 31):**

Delta Dental PPO Dentists: .....	\$2,000
Delta Dental Premier Dentists, non PPO Dentists .....	\$1,750

Charges for dental procedures requiring multiple treatment dates shall be considered incurred on the date the service is completed. Amounts paid for such procedures will be applied to the Plan maximum based on such incurred date. For example, if a tooth is prepped for a Crown on August 20 and the Crown is seated on September 5, then the amount paid for such Crown will be based on benefits available on the date of September 5.

The lifetime maximum amount payable by Washington Dental Service for TMJ benefits is \$5,000 per Eligible Person, with a Benefit Period maximum of \$1,000 per Eligible Person.

## **Transfer of Benefits**

If you transfer from one school district to another, but maintain continuous coverage under a WEA Select Dental Plan (186, 187 or 188), the claim history, incentive level (if transferring from one incentive Plan to another), maximum and deductible information for you and your dependents will continue, since your coverage is under the WEA/WDS Plan.

If you transfer from a school district with a non-WEA Select Dental Plan, to a district with a WEA Select Dental Plan, you are a new Enrollee on the WEA/WDS Plan. You and your dependents will be subject to all Plan maximums and deductibles, if applicable.

## **Accidental Injury**

WDS will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused Plan maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

## **Coinsurance**

WDS will pay a predetermined percentage of the cost of your treatment (see Reimbursement Levels for Allowable Benefits under the Summary of Benefits) and you are responsible for paying the balance. What you pay is called the coinsurance.

## **Extension of Benefits**

In the event a person ceases to be eligible, or in the event of termination of this Plan, WDS shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this Plan.

## **Benefits Covered By Your Plan**

The following are the Covered Dental Benefits under this Plan that are subject to the Limitations and Exclusions contained in this booklet. Such benefits (as defined) are available only when provided by a licensed Dentist or other WDS-approved Licensed Professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS.

### **Class I**

70-100% Incentive Level

## **Diagnostic**

### **Covered Dental Benefits**

- Diagnostic evaluation for routine or emergency purposes
- X-rays

### **Limitations**

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same Dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same Dentist is paid as Periodic Oral Evaluation.
- Routine evaluation is covered twice in a Benefit Period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a Benefit Period.
- A complete series or a panorex X-ray is covered once in a five-year period from the date of service.
  - Any number or combination of X-rays billed for same date of service that equals or exceeds the allowed fee for a complete series will be paid as a complete series.
- Supplementary bitewing X-rays are covered twice in a Benefit Period.
- Diagnostic services and X-rays related to Temporomandibular Joints (jaw joints) are Not a Paid Covered Benefit under Class I Covered Dental Benefits, see TMJ benefit section.

### **Exclusions**

- Consultations
- Study models

## **Preventive**

### **Covered Dental Benefits**

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure Sealants
- Topical application of Fluoride, including fluoridated varnishes
- Space maintainers

### **Limitations**

- Prophylaxis and/or periodontal maintenance is covered twice in a Benefit Period.
- Under certain conditions of oral health, Prophylaxis or periodontal maintenance (but not both) may be covered up to a total of four times in a Benefit Period.

**Note:** *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a predetermination of benefits to determine if the treatment is a Covered Dental Benefit. A predetermination is not a guarantee of payment.*

- Topical application of Fluoride is covered twice in a Benefit Period.
- Fissure Sealants:
  - Payment for application of Sealants will be for permanent molars with no restorations on the occlusal (biting) surface.
  - The application of a fissure Sealant is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
- Space maintainers are covered once in the patient's lifetime for the same missing tooth or teeth through age 17.

### **Exclusions**

- Plaque control program (oral hygiene instruction, dietary instruction and home Fluoride kits)

## **Periodontics**

### **Covered Dental Benefits**

- Prescription-strength Fluoride toothpaste
- Antimicrobial rinse

### **Limitations**

- Prescription-strength Fluoride toothpaste and antimicrobial rinse are Covered Dental Benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office
- Proof of a periodontal procedure must accompany the claim or the enrollee's WDS history must show a periodontal procedure within the previous 180 days.
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

*\*\*\*Refer also to General Limitations and General Exclusions\*\*\**

## **Class II**

70-100% Incentive Level

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

## **Sedation**

### **Covered Dental Benefits**

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

### **Limitations**

- General Anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III, TMJ or optional (see your Summary of Benefits insert for coverage) Orthodontic Covered Dental Benefits.
- Intravenous Sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS.
- Either General Anesthesia or Intravenous Sedation (but not both) are covered when performed on the same day.
- General Anesthesia or Intravenous Sedation for routine post-operative procedures is Not a Paid Covered Benefit.

## **Palliative Treatment**

### **Covered Dental Benefits**

- Palliative (emergency) treatment for pain

### **Limitations**

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

## **Restorative**

### **Covered Dental Benefits**

- Amalgam restorations (fillings) and, in anterior (front) teeth, Resin-Based Composite or glass ionomer restorations are covered for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- Resin-Based Composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspid.
- Stainless steel Crowns
- Crowns, Veneers or onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as Amalgam or resin-based composites.
- Crown buildups
- Post and core on endodontically treated teeth

### **Limitations**

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- If a Resin-Based Composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspid as noted above), it will be considered as a cosmetic procedure and an Amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are Not a Paid Covered Benefit.
- Stainless steel Crowns are covered once in a two-year period from the Seat Date.
- Payment for a Crown, Veneer or onlay shall be made based upon the Seat Date.
- An Inlay (as a single tooth restoration) will be considered as a cosmetic procedure and an Amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- If a tooth can be restored with a filling material such as Amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.

- A Crown buildup is Not a Covered Benefit within two years of a restoration on the same tooth from the date of service.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
  - Crown buildups are covered once in a two-year period on the same tooth from the date of service.
  - Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are Not a Paid Covered Benefit.
- A post and core is covered once in a two-year period on the same tooth from the date of service.
- A Crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial Denture is Not a Paid Covered Benefit unless the tooth is decayed to the extent that a Crown would be required to restore the tooth, whether or not a removable partial Denture is part of the treatment.
- Crowns and/or onlays are Not a Paid Covered Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are Not a Paid Covered Benefit.

#### **Exclusions**

- Overhang removal
- Copings
- Re-contouring or polishing of restoration

### **Oral Surgery**

#### **Covered Dental Benefits**

- Major and minor oral surgery which includes the following general categories:
  - Removal of teeth
  - Preprosthetic surgery
  - Orthognathic surgery
  - Treatment of pathological conditions
  - Temporomandibular Joint abnormalities
  - Treatment of traumatic facial injuries
  - Ridge extension for insertion of Dentures (vestibuloplasty)
- *Refer to Class II Sedation for General Anesthesia or Intravenous Sedation information.*

#### **Exclusions**

- Iliac crest or rib grafts to Alveolar ridges
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling

### **Periodontics**

#### **Covered Dental Benefits**

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Services covered include:
  - Periodontal scaling/Root Planing
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or fewer)
  - WDS-approved Localized Delivery of Antimicrobial Agents
- *Refer to Class I Preventive for periodontal maintenance benefits.*
- *Refer to Class III Periodontics for occlusal equilibration and Occlusal Guard benefits.*

**Note:** *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a predetermination of benefits to determine if the treatment is a Covered Dental Benefit. A predetermination is not a guarantee of payment.*

## Limitations

- Periodontal scaling/Root Planing is covered once in a three-year period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
  - Periodontal surgery must be preceded by scaling and Root Planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- Limited Occlusal Adjustments are covered once in a 12-month period from the date of service.
- Localized Delivery of Antimicrobial Agents approved by WDS is a Covered Dental Benefit under certain conditions of oral health.
  - Localized Delivery of Antimicrobial Agents is limited to two teeth per quadrant and up to two times (per tooth) in a Benefit Period.
  - Localized Delivery of Antimicrobial Agents must be preceded by scaling and Root Planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
  - Localized Delivery of Antimicrobial Agents is Not a Paid Covered Benefit when used for the purpose of maintaining non-covered dental procedures.

## Exclusions

- Gingival curettage

## Endodontics

### Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy

### Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.
- *Refer to Class III Prosthodontics for root canals placed in conjunction with a prosthetic appliance.*

### Exclusions

- Bleaching of teeth
- Pulp cap

*\*\*\*Refer also to General Limitations and General Exclusions\*\*\**

## Class III

50% Payment Level

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

## Periodontics

### Covered Dental Benefits

- Occlusal Guard (Nightguard)
- Repair and relines of Occlusal Guard (Nightguard)
- Under certain conditions of oral health, a complete occlusal equilibration is a Covered Dental Benefit

**Note:** *Complete occlusal equilibration is available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a predetermination of benefits to determine if the treatment may be covered. A predetermination is not a guarantee of payment.*

### Limitations

- Occlusal Guard (Nightguard) is covered once in a four-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

## Prosthodontics

### Covered Dental Benefits

- Dentures
- Fixed partial Dentures (fixed Bridges)
- Inlays when used as a retainer for a fixed partial Denture (Bridge)
- Removable partial Dentures
- Adjustment or repair of an existing prosthetic device
- Surgical placement or removal of Implants or attachments to Implants

### Limitations

- Payment for Dentures, fixed partial Dentures (fixed Bridges); Inlays (only when used as a retainer for a fixed Bridge) and removable partial Dentures shall be paid upon the delivery date.
- Replacement of Implants and superstructures is covered only after five years have elapsed from any prior provision of the Implant.
- Crowns in conjunction with overdentures are Not a Paid Covered Benefit.
- **Full, immediate and overdentures** — WDS will allow the appropriate amount for a full, immediate or Overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III Payment Level.
- **Temporary/interim Dentures** — WDS will allow the amount of a reline toward the cost of an interim partial or full Denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

### Exclusions

- Duplicate Dentures
- Personalized Dentures
- Maintenance or cleaning of a prosthetic device or appliance, except for Implant maintenance
- Copings

*\*\*\*Refer also to General Limitations and General Exclusions\*\*\**

## Temporomandibular Joint Benefits

For the purpose of this Plan, Temporomandibular Joint (TMJ) treatment is defined as dental services provided by a licensed Dentist for the treatment of disorders associated with the Temporomandibular Joint. TMJ disorders shall include those disorders that have one or more of the following characteristics: pain in the musculature associated with the Temporomandibular Joint, internal derangements of the Temporomandibular Joint, arthritic problems with the Temporomandibular Joint, or an abnormal range of motion or limitation of motion of the Temporomandibular Joint.

“Dental Services” are those that are:

- 1) Appropriate, as determined by WDS, for the treatment of a disorder of the Temporomandibular Joint under all the factual circumstances of the case;
- 2) Effective for the control or elimination of one or more of the following, caused by a disorder of the Temporomandibular Joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- 3) Recognized as effective, according to the professional standards of good dental practice; and
- 4) Not experimental or primarily for cosmetic purposes.

Services covered will be both surgical and non-surgical. Non-surgical procedures shall include but are not limited to:

TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device, removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis, and manipulation under anesthesia.

*It is strongly suggested that a TMJ treatment Plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment.*

In addition to the Limitations and Exclusions set forth in this booklet, the following also apply to TMJ benefits:

Any procedures, which are defined as TMJ services as stated above, but which, may otherwise be services covered under the provisions of this Plan, shall be considered defined under the Plan and subject to all the terms and provisions thereof, and are not covered under this TMJ portion of the Plan.

*\*\*\*Refer also to General Limitations and General Exclusions\*\*\**

## **Well Baby Checkups**

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

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

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

## **General Limitations**

1. Dentistry for cosmetic reasons is Not a Paid Covered Benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are Not a Paid Covered Benefit.
3. General Anesthesia/Intravenous (deep) sedation is Not a Paid Covered Benefit, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures. General Anesthesia is Not a Paid Covered Benefit except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

## General Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the Eligible Person by any federal or state or provincial government agency or provided without cost to the Eligible Person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
2. Application of desensitizing agents
3. Experimental procedures, services or supplies:
  - a. Procedures, services or supplies whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider these procedures if:
    - i) The services are in general use in the dental community in the state of Washington;
    - ii) The services are under continued scientific testing and research;
    - iii) The services show a demonstrable benefit for a particular dental condition; and
    - iv) They are proven to be safe and effective.

Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
  - b. Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental may be Appealed to WDS. WDS will respond to such Appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the Eligible Person.
  - c. Whenever WDS makes an adverse determination and delay would jeopardize the Eligible Person's life or materially jeopardize the covered person's health, WDS shall expedite and process either a written or an oral Appeal and issue a decision no later than seventy-two hours after receipt of the Appeal. If the treating Licensed Professional determines that delay could jeopardize the Eligible Person's health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).
4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections
5. Prescription drugs
6. In the event an Eligible Person fails to obtain a required examination from a WDS-appointed consultant Dentist for certain treatments, no benefits shall be provided for such treatment.
7. Hospitalization charges and any additional fees charged by the Dentist for hospital treatment
8. Broken appointments
9. Behavior management
10. Completing claim forms
11. Habit-breaking appliances
12. Orthodontic services or supplies
13. This Plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

14. All other services not specifically included in this Plan as Covered Dental Benefits.

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

## **Glossary & Terms**

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

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

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

**Benefit Period** — means the 12 month period from September 1 through August 31.

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

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

**Coping** — A thin thimble of a Crown with no anatomic features. It is placed on teeth prior to the placement of either an Overdenture or a large span Bridge. The purpose of a Coping is to allow the removal and modification of the Bridge without requiring a major remake of the Bridgework, if the tooth is lost.

**Covered Dental Benefits** — Those dental services that are covered under this plan, subject to the Limitations set forth in "Benefits Covered by Your Plan".

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

**Delta Dental Participating Dentist** — means a licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental Participating Dentist agreement between WDS and such Dentist.

**Dentist** — means a licensed Dentist legally authorized to practice Dentistry at the time and in the place services are performed. This Plan provides for covered services only if those services are performed by or under direction of a licensed Dentist or other WDS-approved Licensed Professional. A "licensed Dentist" does not mean a dental mechanic or any other type of dental technician.

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

**Eligible Dependent** — means any dependent of an Eligible Employee who meets the conditions of eligibility set forth in this booklet.

**Eligible Employee** — means any employee who meets the conditions of eligibility set forth in this booklet.

**Eligible Employer** — means any eligible: 1) Division of Washington Public Schools; 2) The WEA and its Affiliates.

**Eligible Person** — means an employee or a dependent who meets the conditions of eligibility set forth in this booklet.

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

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

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

**Enrollee** — The subscriber or any Eligible Dependent enrolled for coverage under this Plan.

**Exclusions** — Those dental services that are not Plan benefits set forth in “Benefits Covered by Your Plan” and all other services not specifically included as a Covered Dental Benefit set forth in “Benefits Covered by Your Plan”.

**Filed Fees** — Approved fees that WDS Participating Dentists have agreed to accept as the total fees for the specific services performed.

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

**Full Time Employment** — means actively employed on a full-time basis normally required for his or her occupation.

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

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

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

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

**Licensed Professional** — An individual legally authorized to perform services as defined in his or her license. Licensed Professional includes, but is not limited to, denturist, hygienist and radiology technician.

**Limitations** — Restricting conditions placed on Covered Dental Benefits, such as age, period of time covered and waiting periods, under which a group or individual is insured.

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

**Maximum Allowable Fees** — The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a Covered Dental Benefit.

**Nightguard** — See “Occlusal Guard.”

**Nonparticipating Dentist** — means any dentist who has not entered into a Participating Provider agreement with WDS, and has not agreed to accept WDS' Filed Fees as the total fees for specific services performed.

**Not a Paid Covered Benefit** — Any dental procedure that, under some circumstances, would be covered by WDS, but is not covered under other conditions. Examples are listed in “Benefits Covered by Your Plan”.

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

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

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

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

**Overdenture** — A removable Denture constructed over existing natural teeth or Implanted studs.

**Palliative Treatment** — Services provided for emergency relief of dental pain.

**Participating Dentist** — means any Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Participating Provider agreement entered into between WDS and such Dentist.

**Payment Level** — means the applicable percentage of allowable fees for Covered Dental Benefits which will be paid by WDS as set forth in this booklet.

**Periodic Oral Evaluation (Routine Examination)** — An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

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

**PPO Dentist** — Is a Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written PPO Provider agreement.

**Prophylaxis** — Cleaning and polishing of teeth.

**Prosthodontics** — The replacement of missing teeth by artificial means such as Bridges and Dentures.

**Pulpotomy** — The removal of nerve tissue from the Crown portion of a tooth.

**Resin-Based Composite** — A tooth colored filling, made of a combination of materials, used to restore teeth.

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

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

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

**Seat Date** — The date a Crown, Veneer, Inlay or Onlay is permanently cemented into place on the tooth.

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

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

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

**WDS** — means Washington Dental Service, a not-for-profit dental service corporation.

## **Claim Review and Appeal**

### **Predetermination of Benefits**

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

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

### **Urgent Predetermination Requests**

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

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

### **Initial Benefit Determinations**

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

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

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

## **Appeals of Denied Claims**

### **Informal Review**

If your claim for dental benefits has been wholly or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see below), must submit your request for a review within 180 days from the date your claim was denied (please see your explanation of benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your explanation of benefits form)
- The name of the Dentist

Please submit your request for a review to:

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

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

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

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

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

### **Appeals Committee**

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

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

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedures Appeals and sends you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

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

## Authorized Representative

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

## If You Have a Question Regarding Your Claim:

- 1) You may obtain a claim information request form from your payroll office; or
- 2) You may call the WDS Customer Service Department at (206) 522-2300 or 1-800-554-1907.

## WEA Claim Appeal

In the event the claim Appeal is denied, the letter shall also include notice of the WEA claim review process noted below. In addition to the above review by the Appeals Committee, at any point in time after a claim for services rendered has been denied, the patient can Appeal the denied claim to the WEA Benefit Services Advisory Board.

The Board shall conduct a hearing at which the participant shall be entitled to present his or her position and any evidence in support thereof, and the Board will determine if additional benefits should be provided, to the extent there are WEA funds available to cover such additional benefits. Thereafter, the Board shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Consulting at (206) 467-4646.

Furthermore, any costs incurred in connection with claim Appeals such as attorneys fees, travel expenses and so forth are not covered, nor will the Board have access to dental information without the written permission of the Enrollee.

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

## Coordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

- If you are covered by two or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

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

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

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

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

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

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

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

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

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

- 1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
  - a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
  - b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
- 2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - a) If a court decree states that one of the parents is responsible for the *Dependent* child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
  - b) If a court decree states one parent is to assume primary financial responsibility for the *Dependent* child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;

- c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
  - d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
  - e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
    - I. The *Plan* covering the *Custodial Parent*, first;
    - II. The *Plan* covering the spouse of the *Custodial Parent*, second;
    - III. The *Plan* covering the *noncustodial Parent*, third; and then
    - IV. The *Plan* covering the spouse of the *noncustodial Parent*, last
- 3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Subrogation**

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

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

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

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

## **How to Report Suspicion of Fraud**

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the WDS hotline for Fraud & Abuse at (800) 211-0359 or (206) 985-5927. You may also want to alert any of the appropriate law enforcement authorities listed:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to [www.insurance.wa.gov](http://www.insurance.wa.gov) for more information.

## **MySmile® Personal Benefits Center**

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

## **Health Insurance Portability and Accountability Act (HIPAA)**

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

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

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

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

## **Conversion Option**

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

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

## **Your Rights and Responsibilities**

At WDS our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of Participating Dentists in the state of Washington. We view our benefit packages as a partnership between WDS, our Enrollees and our Participating Dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

### **You Have The Right To:**

- Seek care from any licensed Dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (WDS Participating/Nonparticipating), but you can receive care from any Dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to Specialists when services are required to complete a treatment, diagnosis or when your primary care Dentist makes a specific referral for specialty care.
- Contact WDS customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our Web site at [DeltaDentalWA.com](http://DeltaDentalWA.com).
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.

- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

### **To Receive the Best Oral Health Care Possible, It Is Your Responsibility To:**

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your Dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to WDS to assist with the processing of claims, predeterminations or Appeals.
- If applicable, pay the dental office the appropriate co-payments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.

Inform your Dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

### **Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled**

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

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

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

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

Plan Sponsored by



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

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