

# WDS Dental Plan F



 **DELTA DENTAL**<sup>®</sup>  
**Washington Dental Service**

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

# Delta Dental PPO

## **Association of Washington Cities**

## **Employee Benefit Trust**

Delta Dental of Washington

Plan No. **00177 – Plan F**

## **Certificate of Coverage**

Effective: **January 1, 2014**

*We've recently simplified our name to Delta Dental of Washington.*

*You'll continue to receive the same great dental benefits, have the most choice in finding a favorite dentist, and experience our knowledgeable and friendly customer service.*

## **Questions Regarding Your Plan**

This is a self-funded dental plan (Plan) sponsored by the Association of Washington Cities Employee Benefit Trust. Delta Dental of Washington (DDWA) serves as the claims administrator for this Plan. If you have questions regarding this Plan, you may call:

Delta Dental of Washington Customer Service

(206) 522-2300

(800) 554-1907

Written inquiries may be sent to:

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

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

For the most current listing of Delta Dental participating dentists, visit our online directory at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com).

## **Communication Access for Individuals with Speech or Hearing Impairments or Disabilities**

Individuals with speech or hearing difficulties, impairments or disabilities may communicate with Delta Dental of Washington through the 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 Delta Dental of Washington 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 Delta Dental of Washington Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the Delta Dental of Washington 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.

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## Summary of Benefits

### Association of Washington Cities Employee Benefit Trust (“AWC Trust”)

#### Reimbursement Levels for Allowable Benefits

##### Delta Dental PPO Dentists

Class I .....	70-100%
Class II .....	70-100%
Class III .....	Constant 50%
TMJ procedures .....	Constant 50%

##### Non-Delta Dental PPO Dentists

Class I .....	70-100%
Class II .....	70-100%
Class III .....	Constant 50%
TMJ procedures .....	Constant 50%

#### Plan Maximums

Annual Plan Maximum per Person .....	\$1,500
Lifetime TMJ Maximum .....	\$5,000
Annual TMJ Maximum .....	\$1,000

All enrolled employees and enrolled dependents are eligible for Class I, Class II, and Class III covered dental benefits, and temporomandibular joint (TMJ) benefits.

Although the Plan pays the same percentage reimbursement levels for all Dentists, your out-of-pocket costs in many situations will be the lowest if you use a Delta Dental PPO Dentist. Here is the difference among the three types of Dentists.

Delta Dental PPO Dentists: these Dentists have agreed to provide their services, in most instances, at the lowest rates to persons enrolled in Delta Dental plans; will send their bills directly to DDWA for claims payment; and will not “balance bill” you for the difference between their regular rates and the rates they have agreed to use for persons enrolled in Delta Dental Plans.

Delta Dental Participating Dentists: these Dentists have agreed to provide their services, in most instances, at lower rates than their regular rates to persons enrolled in Delta Dental plans (but usually not as low as Delta Dental PPO Dentists); will send their bills directly to DDWA for claims payment; and will not “balance bill” you for the difference between their regular rates and the rates they have agreed to use for persons enrolled in Delta Dental Plans.

Non-Delta Dental Dentists (Nonparticipating Dentists): these Dentists have not agreed to provide their services at discounted rates, will not necessarily send their bills directly to DDWA for claims payment (you may have to pay them up-front and seek reimbursement from the Plan), and may “balance bill” you for the difference between their regular rates and the amount of the benefit payments paid by the Plan.

## **Introduction**

Welcome to the AWC Trust's Delta Dental PPO Plan, which is administered by Delta Dental of Washington (DDWA), the state's largest and most experienced dental benefits carrier. DDWA is a member of the nationwide Delta Dental Plans Association. With a Delta Dental Plan from DDWA, you join more than 50 million people across the nation who have discovered the value of our coverage. This benefit booklet is your Certificate of Coverage and sets forth, in summary form, an explanation of the coverage available under this dental Plan.

## **How to Use Your Plan**

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

## **Choosing a Dentist**

With DDWA, you may select any licensed dentist; however, your benefits may be paid at a higher level and/or your out-of-pocket expenses may be lower if you choose a participating Delta Dental dentist. Tell your dentist that you are covered by a DDWA dental plan and provide your identification number, the Plan name, and the group number.

## **Delta Dental Participating Dentists**

If you select a dentist who is a Delta Dental participating provider, that dentist has agreed to provide treatment for enrolled persons covered by DDWA plans. You will not have to hassle with sending in claim forms. Participating dentists complete claim forms and submit them directly to DDWA. They receive payment directly from DDWA. You will be responsible only for stated coinsurances, any amount over the Plan maximums, and any elective or other care you choose to receive outside the Plan's Covered Dental Benefits. You will not be charged more than the dentist's approved fee or the fee that the Delta Dental Dentist has filed with us. There are Delta Dental Participating Dentists in many parts of Washington and the rest of the United States.

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

Delta Dental Premier Dentists have contracted with DDWA to provide service at contracted fees, submit claim forms for you and receive payment directly from DDWA.

### **Delta Dental PPO Dentists**

Delta Dental PPO Dentists are Delta Dental Premier<sup>®</sup> Dentists who have agreed to participate in the PPO network. The Delta Dental PPO dentist has agreed to a negotiated fee which is often lower than the standard filed fee, and your plan may provide a higher payment level, which can lower your out-of-pocket costs. Patients are responsible only for percentage of coinsurance up to the PPO filed fees when using a Delta Dental PPO Dentist.

## **Nonparticipating Dentists**

If you select a dentist who is not a Delta Dental participating dentist, you are responsible for having your dentist complete and sign an appropriate claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You may also download a claim form from our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). It is up to you to ensure that the claim is sent to DDWA. Payment by DDWA to a nonparticipating dentist for services will be based on the dentist's actual charges or DDWA's maximum allowable fees for Nonparticipating Dentists, whichever is less. You will be responsible for any balance remaining after the Plan has paid the claim. Please be aware that DDWA has no control over Nonparticipating Dentists' charges or billing practices.

## **Finding a Dentist**

You can find the most current listing of Delta Dental Participating Dentists by going online to the Delta Dental of Washington website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). Click on the *Patients* tab and then on the *Find a Dentist* tab to begin your search. Be sure to click on the *Delta Dental PPO Plan* and follow the prompts. Delta Dental Participating Dentists are found under the *Delta Dental Premier* network.

## **Claim Forms**

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

DDWA does not normally provide benefits if the claim forms are not submitted within six months after the date of treatment or as soon as medically possible after six months. No claims will be accepted later than 12 months from the date of treatment unless the eligible person has been legally incapacitated from the date of treatment until the date the claim form is submitted.

## **Predetermination of Benefits**

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 of Plan benefits DDWA may pay and your expected financial responsibility.

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.

In the event your benefits are terminated and you are no longer eligible for the Plan, the predetermination is voided. DDWA will make claims payments based on your available benefits (maximum, deductible, and other limitations as described in your applicable benefit booklet) and the applicable Plan provisions when the treatment is provided.

## **Limitations and Exclusions**

Dental plans typically include limitations and exclusions, meaning that the plans do not cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this benefit booklet under the sections called "*Benefits Covered by Your Plan*," "*General Limitations*," and "*General Exclusions*." They warrant careful reading.

## **Reimbursement Levels**

Your Plan is an incentive plan. It is designed to encourage prevention by rewarding you for receiving preventive care and other dental services during each benefit period (each calendar year).

Your dental Plan offers three classes of covered treatment. Each class also specifies limitations and exclusions. For a summary of reimbursement levels for your Plan, see the “*Summary of Benefits*” section in the front of this benefit booklet.

Refer to the “*Benefits Covered by Your Plan*” section of this benefit booklet for specific covered dental benefits under this Plan.

### **Reimbursement Levels for Class I and Class II Procedures**

During your first benefit period in this dental Plan, the payment level for covered and allowable Class I (diagnostic and preventive) and Class II (basic) procedures is 100 percent. The payment level remains at 100 percent if you utilize your Plan benefits during your first benefit period and each benefit period thereafter. If you do not utilize the Plan benefits during a benefit period, the payment level decreases 10 percentage points in the following benefit period. The payment level will never decrease to lower than 70 percent.

If your payment level is less than 100 percent, you will increase your payment level for the next benefit period if you utilize your Plan benefits during the current benefit period. If you utilize benefits during a benefit period, the payment level in the following period will be increased by 10 percentage points. This increase will be made from the last payment level used by DDWA in making payment for you. The maximum amount of the payment level is 100 percent.

Each Enrolled Person establishes his or her own payment levels through utilization during benefit periods.

### **Reimbursement Levels for Class III Procedures**

The payment level for covered and allowable Class III (major) procedures is 50 percent. The incentive provision described above does not apply to Class III procedures.

### **Reimbursement Levels for Other Procedures**

The payment level for covered and allowable TMJ procedures is 50 percent. The incentive provision described above does not apply to TMJ procedures.

### **Coinsurance**

DDWA will pay a predetermined percentage of the cost of your treatment (see “*Reimbursement Levels for Allowable Benefits*” under the “*Summary of Benefits*” section) as your Plan benefits and you are responsible for paying the balance. What you pay is called the coinsurance.

### **Plan Maximum**

For your Plan, the maximum amount payable by DDWA for Class I, II and III covered dental benefits per eligible person is \$1,500 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the Plan maximum based on the incurred date.

The lifetime maximum amount payable by DDWA for TMJ benefits is \$5,000 per eligible person, with a calendar year maximum of \$1,000 per eligible person.

### **Benefit Period**

Most dental benefits are calculated within a “benefit period,” which is typically for one year. For this Plan, the benefit period is the 12-month period starting the first day of January and ending the last day of December.

## Plan Deductible

This Plan does not have a deductible requirement.

## Employee Eligibility, Enrollment, and Termination

To qualify for eligibility under the Plan, employees must be employed (1) by an employer that participates in the AWC Trust ("Participating Employer") and offers this Plan; and (2) in a position for which the Participating Employer provides Plan benefits. Your employer may impose a probationary or waiting period before you become eligible. Please contact your employer or the AWC Trust for more information about the eligibility requirements for employees.

Eligible employees become enrolled employees after completing the enrollment process and upon receipt by DDWA of the required payments for Plan coverage.

If an employee does not apply for coverage within 30 days of first becoming eligible, the employee may only apply to enroll in this Plan during the open enrollment period of each year, unless the employee is eligible to join under the Special Enrollment Period provisions listed below. Coverage applied for during the open enrollment period is effective the first day of January following such enrollment.

You must complete an AWC Trust combined enrollment form. The AWC Trust must receive the completed form within 30 days of your eligibility date. All of your eligible dependents must be listed on the enrollment form in order to become enrolled.

Your coverage terminates at the end of the month in which you cease to be an eligible or enrolled employee, at the end of the calendar month for which a timely payment for your coverage was not made, or upon termination of the AWC Trust's Contract with DDWA, whichever occurs first. Under certain circumstances, benefits may be continued: See "*Continuation of Coverage*." Unless otherwise allowed by law (for example, under the terms of a Cafeteria Plan that your employer has adopted), your coverage cannot be terminated by you during a benefit period (you may terminate coverage during an open enrollment period).

In the event of a suspension or termination of compensation directly or indirectly as a result of a strike, lockout, or other labor dispute, an eligible employee may remain enrolled in the Plan by paying the applicable required contribution directly to the employer for a period not to exceed 6 months. Payment of the required contribution amounts must be made when due, or your Plan coverage may be terminated.

Plan coverage may be continued during a leave under the federal Family and Medical Leave Act (FMLA). For further information about the FMLA, contact your employer.

## Dependent Eligibility and Termination

Your dependents are eligible ONLY if your employer has agreed to provide dependent coverage. Check with your employer to determine if your dependents are eligible.

If your employer provides dependent coverage, your dependents listed below are eligible for Plan coverage:

- The person to whom you are legally married (spouse).
- Your registered domestic partner and if specifically included as eligible by your employer, your non-state registered domestic partner for whom an accurate and complete affidavit of qualifying domestic partnership has been submitted. Contact the AWC Trust for questions about whether your non-state registered domestic partner is eligible for the Plan.
- Your (or your spouse's or your domestic partner's) child who is under age 26 and who meets any of the following criteria:
  - your (or your spouse's or your domestic partner's) natural child, step child, adopted child, or child legally placed with you (or your spouse or your domestic partner) for adoption;

- a child for whom you (or your spouse or your domestic partner) have court-appointed legal guardianship;
- a child for whom you (or your spouse or your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO); or
- your (or your spouse's or your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or mental or physical disability that began before his or her 26th birthday.

Eligible Dependents may not enroll in this Plan unless the employee is an Enrolled Employee.

Dependent coverage terminates at the end of the month in which the employee's coverage terminates, or when the dependent ceases to be eligible to enroll or ceases to be enrolled, whichever comes first.

Unless otherwise allowed by law (for example, under the terms of a Cafeteria Plan that your employer has adopted), a dependent's coverage cannot be terminated during a benefit period (you may terminate coverage during an open enrollment period).

## Special Enrollment Periods

Enrollment is allowed at open enrollment periods, and also during Special Enrollment Periods, which are triggered by the following situations:

### 1. Loss of Other Coverage

If you and/or your eligible dependents involuntarily lose coverage under another dental plan, you may apply for coverage under this Plan if all of the following conditions are met:

- At the last time you were offered coverage under this Plan (such as the last open enrollment period), you had other dental coverage and declined to enroll in this Plan due to the other dental coverage;
- You lose eligibility in the other dental plan or your coverage in the other dental plan is terminated due to one of the following:
  - Legal separation or divorce
  - Cessation of dependent status
  - Death of employee
  - Termination of employment
  - Termination of employer contributions to the other dental plan
  - Reduction in hours
  - Employer's termination of dental plan coverage for a group of similarly-situated individuals
  - Exhaustion of COBRA coverage
- Your application to enroll in this Plan is received by DDWA within 30 days of losing other coverage. Coverage will be effective the first day of the month following receipt of the enrollment application.

If these conditions are not met, you and/or your eligible dependents must wait until the next Open Enrollment Period to enroll in the Plan.

DDWA or the AWC Trust may require confirmation that when you were last offered the Plan you had other dental coverage.

### 2. Marriage, Domestic Partnership, Birth, or Adoption

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

- Marriage or Domestic Partnership — You may enroll yourself and/or your eligible dependents in the Plan within 30 days of the date of marriage/domestic partnership. Enrollment is effective as of the first day of the month following receipt of the enrollment application. If enrollment is not completed within the 30 days, you and/or your eligible dependents may not be enrolled until the next open enrollment period.
- Birth — You may enroll yourself and/or your eligible dependents in the Plan within 60 days of the date of the birth of a child. Coverage is effective as of the date of birth. If enrollment is not completed within 60 days, you and/or your eligible dependents may not be enrolled until the next open enrollment period.
- Adoption — You may enroll yourself and/or your eligible dependents in the Plan within 60 days of the date of adoption or the date of assumption of a legal obligation for total or partial support of the child in anticipation of adoption. Coverage is effective as of the date of adoption or the date of assumption of the legal obligation. If enrollment is not completed within 60 days, you and/or your eligible dependents may not be enrolled until the next open enrollment period.

## **Benefits for Services after Termination of Coverage**

When a person's Plan coverage is terminated or in the event of termination of this Plan, the Plan will not provide benefits for services provided after the termination date. The exception will be for the completion (within three weeks of the termination date) 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.

## **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 DDWA 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 1 (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Washington State 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.

## **Continuation of Coverage — “COBRA”**

The following is a brief summary of the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and as thereafter amended. Interpretation and administration of the provisions will be subject to regulations issued by the federal government. For more information about your rights and obligations under COBRA, please contact the AWC Trust.

1. You and/or your eligible dependents may elect to continue coverage at your own expense for as long as 18 months from the day your eligibility ends because:
  - (a) your employment terminates (other than due to gross misconduct); or
  - (b) you no longer satisfy the requirements for hours worked.
2. Your eligible dependents may elect to continue coverage for as long as 36 months from the day their eligibility ends because:
  - (a) you die;
  - (b) you and your spouse are legally separated;
  - (c) your marriage is ended by divorce;
  - (d) your domestic partnership ends; or
  - (e) a child is no longer an eligible dependent.

Should you or your dependents wish to continue coverage following legal separation, divorce, termination of domestic partnership, or a child's loss of eligibility, one of you must notify the AWC Trust within 60 days of the separation, divorce, termination of domestic partnership, or loss of eligibility of your interest in the continuation option. Following this notification, the Plan Administrator will provide you with additional information, including your cost of the coverage and the payment procedures and requirements under the Plan. The AWC Trust will automatically provide this information following your termination, reduction in hours, or death.

If you have a child or adopt a child during the period of COBRA coverage, you may elect to cover that child.

Continued coverage under this section must begin on the day after dental coverage under the Plan ends; there can be no lag in coverage. You or your dependents must pay the required contribution rates, including any retroactive amount due, from the day the coverage would have otherwise ended.

3. Any eligible person's continued coverage will end on the earliest of:
  - (a) the day the Plan terminates;
  - (b) the day your payment is due and unpaid;
  - (c) the day the eligible person becomes covered under any other group dental plan unless such other plan contains an exclusion or limitation regarding pre-existing conditions that applies to the eligible person;
  - (d) the day an eligible person again becomes covered under this Plan;
  - (e) the day coverage has been continued for the period of time provided in paragraphs 1 and 2 above;
  - (f) the day your former employer ceases to participate in the Plan; or
  - (g) the day the person becomes entitled to Medicare.
4. If you become eligible for continued coverage for 18 months, under paragraph 1 above, you may extend your COBRA coverage for an additional 11 months (for a total of 29 months) if the federal Social Security Administration (SSA) determines that you were disabled at the time the termination of employment or reduction of hours occurred, or if disability occurs at any time during the first 60 days of COBRA coverage, provided that you notify the AWC Trust of the SSA determination of disability within 60 days of the determination and during the 18-month continuation period; and further provided that you notify the AWC Trust within 30 days of any determination by the SSA that you are no longer disabled.

### **MySmile® Personal Benefits Center**

The MySmile® personal benefits center, available on Delta Dental of Washington's website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com), is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in the PPO 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.

For your convenience, your DDWA dental benefits ID card can be found — and printed — directly from the middle of your MySmile personal benefits center portal page.

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

Delta Dental of Washington and the AWC Trust are committed to protecting the privacy of your dental health information.

The DDWA's Notice of Privacy Practices under the Health Insurance Portability and Accountability Act (HIPAA) requires DDWA to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). You may also request a printed copy by calling the DDWA privacy hotline at (206) 985-5963. The AWC Trust's Notice of Privacy Practices under the Health Insurance Portability and Accountability Act ("HIPAA") is available by calling (800) 562-8981 or by visiting <http://www.awcnet.org/Portals/0/Documents/Trust/HIPAAPrivacyPolicyAWCTrust.pdf>.

## **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. For further information on this act, please contact the AWC Trust at (800) 562-8981.

## **Conversion Option**

If your dental coverage stops because your employment or eligibility ends or the AWC Trust's dental Plan is terminated, you may apply directly to DDWA 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 DDWA 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.

## **Necessary vs. Not Covered Treatment**

You and your provider should discuss which services may not be covered dental benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your Plan. However, there are certain treatments that remain the responsibility of the patient.

## **Benefits Covered By Your Plan**

The following are the covered dental benefits under this Plan and are subject to the limitations and exclusions (refer also to "*General Limitations and General Exclusions*") contained in this benefit booklet. Such benefits (*as defined*) are available only when provided by a licensed dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

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

The amounts payable by the Plan for covered dental benefits are described in your "*Summary of Benefits*" section of this benefit booklet.

## **Class I Benefits**

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### **Class I Diagnostic**

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#### **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 a 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 panoramic X-ray is covered once in a three-year period from the date of service.
  - Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.
- 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 benefits. See "*Temporomandibular Joint Benefits*" section.

### Exclusions

- Consultations
- Study models

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## Class I Preventive

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### Covered Dental Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure sealants
- Topical application of fluoride or preventive therapies (e.g. fluoridated varnishes)
- Space maintainers
- Preventive resin restoration

### Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period.
  - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- 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. See "Predetermination of Benefits" for additional information.*

- Topical application of fluoride or preventive therapies (*but not both*) is limited to two covered procedures in a benefit period.
- Fissure sealants:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, fissure sealants will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.

- Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- The application of a fissure sealant is a covered dental benefit once in a three-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 17.
- Preventive resin restorations:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
  - The application of a preventive resin restoration is a covered dental benefit once in a three-year period per tooth from the date of service.
  - The application of preventive resin restoration is not a paid covered benefit for three years after a fissure sealant or preventive resin restoration on the same tooth from the date of service.

#### **Exclusions**

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

## **Class II Benefits**

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### **Class II Sedation**

#### **Covered Dental Benefits**

- General anesthesia when administered by a licensed Dentist or other 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 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 DDWA, 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 Orthodontic covered dental benefits (if your employer provides orthodontic benefits).
- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- General anesthesia or intravenous sedation for routine postoperative procedures is not a paid covered benefit.

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### **Class II Palliative Treatment**

#### **Covered Dental Benefits**

- Palliative 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.

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## **Class II Restorative**

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### **Covered Dental Benefits**

- Restorations (fillings)
- Stainless steel crowns
- Crowns, veneers, inlays (as a single tooth restoration – with limitations), 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 (e.g., missing cusps, broken incisal edge)
- 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 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
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being the responsibility of the enrolled person.
- 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.
- A crown, implant-supported crown, veneer or onlay on the same tooth is covered once in a five-year period from the original seat date.
- Payment for a crown, inlay, veneer, or onlay shall be based upon the seat date.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing and 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.
- A crown buildup or a post and core are covered once in a two-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within two years of a restoration 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.
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations without overt pathology is not a paid covered benefit.

### Exclusions

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

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## Class II Oral Surgery

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### Covered Dental Benefits

- Removal of teeth
- Preparation of the mouth for insertion of dentures
- Treatment of pathological conditions and traumatic injuries of the mouth
- Refer to “*Class II Sedation*” for Sedation information.

### Exclusions

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

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## Class II Periodontics

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### 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)
  - Localized delivery of antimicrobial agents
- Refer to “*Class I Preventive*” for periodontal maintenance benefits.
- Refer to “*Class II Sedation*” for Sedation information.
- Refer to “*Class III Periodontics*” for occlusal equilibration and occlusal guard.

**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. See “Predetermination of Benefits” for additional information.*

### 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) for implants and natural teeth 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 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.

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## **Class II Endodontics**

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### **Covered Dental Benefits**

- Procedures for pulpal and root canal treatment services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy
- Refer to “*Class II Sedation*” for Sedation information.

### **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 dentist other than the dentist who performed the original treatment and if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

### **Exclusions**

- Bleaching of teeth

## **Class III Benefits**

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## **Class III Periodontics**

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### **Covered Dental Benefits**

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard
  - Complete occlusal equilibration

**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. See “Predetermination of Benefits” for additional information.*

### **Limitations**

- Occlusal guard (nightguard) is covered once in a three-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.

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## **Class III Prosthodontics**

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### **Covered Dental Benefits**

- Full and immediate dentures
- Removable and fixed partial dentures (fixed bridges)

- Inlays when used as a retainer for a fixed partial denture (fixed bridge)
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

#### **Limitations**

- Replacement of an existing prosthetic appliance is covered once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- 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.
- Implants and superstructures are covered once every five years.
- Crowns in conjunction with overdentures are not a paid covered benefit.
- **Temporary dentures** — DDWA 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, relines, repairs and rebases done more than six months after the initial placement are covered.
  - Subsequent adjustments and repairs are covered.
  - Subsequent relines or rebases will be covered once in a 12-month period.
  - An adjustment or reline performed more than 6 months after a rebase will be covered.

#### **Exclusions**

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance
- Copings

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### **Temporomandibular Joint Benefits**

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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 DDWA, 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.

The maximum amount payable by DDWA for dental services related to the treatment of TMJ disorders shall be \$1,000 per enrolled person, after the application of deductibles, if applicable, and coinsurance, in any benefit period, and a lifetime benefit of \$5,000 per enrolled individual. The amounts payable for TMJ benefits during the benefit period shall not be applied to the enrolled person's annual Plan maximum.

*It is strongly suggested that a TMJ treatment plan be submitted to, and a predetermination be made by, DDWA prior to commencement of treatment. A predetermination is not a guarantee of payment. See "Predetermination of Benefits" for additional information.*

In addition to the limitations and exclusions set forth in this benefit 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.

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## **Well Baby Checkups**

For your infant child, Delta Dental of Washington offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in the 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 service. When visiting a physician with your infant (age 0-3 years), DDWA will reimburse the physician on your behalf for specific services performed, up to the amount listed below:

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

Please see the "*Benefits Covered by Your Plan*" section of this benefit booklet for any other limitations. Also, please be aware that DDWA has no control over the charges or billing practices of non-dentist providers, such as your family physician, or your financial responsibility to non-dentist providers.

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## **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.

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## **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 enrolled person by any federal or state or provincial government agency or provided without cost to the enrolled person by any municipality, county, or other political subdivision, other than medical assistance in Washington 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 services or supplies, which include:
  - a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them 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.
- b. 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.
  - c. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA 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 enrolled person.
  - d. Whenever DDWA makes an adverse determination and delay would jeopardize the enrolled person's life or materially jeopardize the enrolled person's health, DDWA 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 enrolled person's health or ability to regain maximum function, DDWA 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 enrolled person fails to obtain a required examination for certain treatments from a DDWA-appointed consultant dentist when requested to do so by the Plan, 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 (unless your employer has elected to provide these benefits)
  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.

*DDWA, acting on behalf of the Plan, 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, you have the right to appeal the determination in accordance with the Claims Review and Appeal process in this benefits booklet.*

## **Frequently Asked Questions about Your Dental Benefits**

### **What is a Delta Dental "Participating Dentist"?**

A Delta Dental Participating Dentist is a dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to participants and their dependents covered by DDWA's group dental care plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients. Participating Dentists are found in the *Delta Dental Premier* network.

### **What is a Delta Dental “PPO Dentist”?**

A Delta Dental PPO Dentist is a dentist who is a Delta Dental Participating Dentist and who has agreed to participate in the PPO network. The Delta Dental PPO Dentist has agreed to a negotiated fee which is often lower than the standard filed fee (and may be lower than the fee of a Delta Dental Participating Dentist).

### **Can I choose my own dentist?**

See “*Choosing a Dentist*” under the “*How to Use Your Plan*” section in the front of this benefit booklet.

### **How can I get claim forms?**

You can obtain American Dental Association-approved claim forms from your dentist. You can also obtain a copy of the approved claim form from our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). **Note:** If your dentist is a Delta Dental participating provider, he or she will complete and submit claim forms for you.

### **What is the mailing address for DDWA claim forms?**

If you see a Delta Dental participating dentist, the dental office will submit your claims for you. If your dentist is not a participating dentist, it will be up to you to ensure that the dental office submits your claims to Delta Dental of Washington at P.O. Box 75983, Seattle, WA 98175-0983.

### **Who do I call if I have questions about my Plan benefits?**

If you have questions about your dental benefits under this Plan, call DDWA’s customer service department at (206) 522-2300 or call toll-free at (800) 554-1907. Questions can also be addressed via e-mail at [cservice@DeltaDentalWA.com](mailto:cservice@DeltaDentalWA.com).

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

You may ask your dentist to complete and submit a request for an estimate, called a “predetermination of benefits.” The estimates provided do not represent a guarantee of payment, but they provide you with estimated costs and benefits for your procedure.

### **What is Delta Dental?**

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

## **Glossary**

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

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

**Apicoectomy** — Surgery on the root of a tooth.

**Appeal** — An oral or written communication by a participant 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 dental care services or benefits.

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

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

**Certificate of Coverage** — means this benefits booklet which describes in summary form the essential features of the contract coverage, and to or for whom the benefits hereunder are payable.

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

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

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

**Coping** — A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. 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 and exclusions of the Plan.

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

**DDWA** — Delta Dental of Washington, a non-profit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

**Delta Dental** — Delta Dental Plans Association, which is a nationwide non-profit organization of health care service plans, which offers a range of group dental benefit plans.

**Delta Dental PPO Dentist** — A Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO Participating Dentist Agreement between the Participating Plan and such Dentist, which includes looking solely to Delta Dental for payment of the Plan's Covered Dental Benefits.

**Delta Dental Participating Dentist** — 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 Delta Dental and such Dentist, which includes looking solely to Delta Dental for payment of the Plan's Covered Dental Benefits.

**Dentist** — A licensed dentist legally authorized to practice dentistry at the time and in the place services are performed. This Plan provides benefits for services only if those services are performed by or under direction of a licensed Dentist or other DDWA-approved Licensed Professional. A 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** — Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in "*Dependent Eligibility and Termination*."

**Eligible Employee** — Any employee who meets the conditions of eligibility set forth in "*Employee Eligibility and Termination*."

**Eligible Person** — An Eligible Employee or an Eligible Dependent.

**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** — Also known as a “limited oral evaluation – problem focused.” 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.

**Enrolled Dependent, Enrolled Employee, Enrolled Person** — Any Eligible Dependent, Eligible Employee, or Eligible Person, as applicable, who has completed the enrollment process and for whom the monthly contributions for Plan coverage have been paid.

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

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

**Filled Resin** — Tooth-colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

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

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

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

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

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

**Intraoral X-rays Complete Series (including bitewings)** — A series of radiographs which display the root and coronal portions of all the teeth in the mouth.

**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** — Those dental services that are subject to restricting conditions set forth in “*Benefits Covered by Your Plan.*”

**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** — A licensed Dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written Participating Dentist Agreement between a member of the Delta Dental Plans Association and such Dentist.

**Not a Paid Covered Benefit** — Any dental procedure that, under some circumstances, would be covered by DDWA, 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.

**Open Enrollment Period** — The annual period in which Eligible Employees can enroll or disenroll themselves and their Eligible Dependents in the Plan.

**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.

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

**Participating Plan** — Delta Dental of Washington, and any other member of the Delta Dental Plans Association, with which Delta Dental contracts to assist in administering the Plan benefits described in this benefits booklet.

**Payment Level** — The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the “*Summary of Benefits*” and “*Reimbursement Levels*” sections of this benefits 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.

**Plan** — The dental benefits as provided and described in this Certificate of Coverage and its accompanying contract.

**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.

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

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

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

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

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

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

**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.

## **Claim Review and Appeal**

### **Predetermination of Benefits**

A predetermination is a request made by your dentist to DDWA 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, DDWA 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, DDWA will review the request within 72 hours from receipt of the request and all supporting documentation. When practical, DDWA 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 Plan provisions.

### **Initial Benefit Determinations**

An initial benefit determination is conducted at the time of claim submission to DDWA for payment, modification or denial of services. In accordance with regulatory requirements, DDWA 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

This appeals process is mandatory for Enrolled Persons wishing to dispute denials of claims. You must exhaust these appeals before you bring any type of legal action for denial of benefits.

### Informal Review

If your claim for dental benefits has been completely 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 EOB 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 EOB form).
- The name of the dentist.

Please submit your request for a review to:

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

For oral appeals, please call one of the telephone numbers listed on the inside front cover of this benefit booklet.

If you file your appeal in writing, you may include any written comments, documents or other information that you believe supports your claim.

DDWA 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.

Whenever the Plan makes an adverse determination and delay would jeopardize the enrolled person's life or materially jeopardize the enrolled person's health, DDWA, acting on behalf of the Plan, shall expedite and process either a written or an oral informal review and issue a decision no later than 72 hours after receipt of the request for informal review. If the treating Licensed Professional determines that delay could jeopardize the enrolled person's health or ability to regain maximum function, DDWA, acting on behalf of the Plan, shall presume the need for expeditious review.

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, DDWA will consult with a dental professional advisor.

### Formal Appeal

If you are dissatisfied with the outcome of the informal review, you have the right to request that your claim be reviewed formally by the DDWA 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 DDWA 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 must be in writing and 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 DDWA 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 will send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based, in whole or in part, on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, DDWA will consult with a dental professional advisor.

The decision of the DDWA Appeals Committee is final. If you disagree with the outcome of your appeal, you may have other avenues available for further action, including legal action.

## Authorized Representative

You may authorize another person to represent you and to whom DDWA 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 or any document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

## Coordination of Benefits

Coordination of this Plan's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Dental Plan*. *Dental 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 *Dental Plan* without considering any other *Dental Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Dental 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 *Dental 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 *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**”, except as outlined below, means any health 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 as the *secondary plan*, Delta Dental of Washington must pay an amount which, together with the payment made by the *primary plan*, cannot be less than the same *allowable expense* as the *secondary Plan* would have paid if it was the *primary plan*. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the *allowable expense*.

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 maximum allowable amount, 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 this plan's negotiated fee 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 *Dental 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 *Allowable Expense* of the *Primary Plan* or the *Secondary Plan up to this plan's allowable expense*. 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. 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*, DDWA has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, DDWA 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 the Plan. The Plan will prorate any attorneys' fees against the amount owed.

To the extent of any amounts of Plan benefits paid by DDWA for an enrolled person on account of services made necessary by an injury to or condition of his or her person, the Plan shall be subrogated to his or her rights against any third party liable for the injury or condition. DDWA shall, however, not be obligated to pay Plan benefits on behalf of the Plan for such services unless and until the enrolled 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 the Plan those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received; and
- Cooperate fully with the Plan and DDWA in asserting the Plan's rights to supply DDWA and the Plan with any and all information and execute any and all instruments DDWA and/or the Plan reasonably needs for that purpose.

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

## **Your Rights and Responsibilities**

DDWA and the Plan work to provide access to quality dental benefit products to employers and employees throughout Washington through DDWA's network, the largest network of participating dentists in the state of Washington. All parties 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 process work.

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

- Seek care from any licensed dentist in Washington, or nationwide. The Plan's reimbursement for such care varies depending on your choice (Delta Dental member/nonmember), 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 DDWA customer service personnel during established business hours to ask questions about your oral health benefits under this Plan. Alternatively, information is available on our website at [www.DeltaDentalWA.com](http://www.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 level 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 DDWA to assist with the processing of claims, predeterminations or appeals.
- If applicable, pay the dental office the appropriate co-payment amount at the time of the visit.
- Respect the rights, office policies, and property of each dental office you have the opportunity to visit.
- Inform your dentist, the AWC Trust, and your employer promptly of any change to your or a family member's address, telephone, or family status.

Delta Dental of Washington, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today we cover more than 50 million people nationwide through our Delta Dental plans.

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

To learn more about DDWA and your benefits, visit our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com).



Benefits provided through

 **DELTA DENTAL®**  
**Washington Dental Service**

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

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