FlexAbility Dental Plan

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Introduction

This Dental Plan section:

- Summarizes Dental Basic and Dental Plus features in a table to help you quickly compare and choose the right plan for you and your dependents.
- Defines the applicable benefit period, deductibles, and annual maximum benefits.
- Outlines which dental services are covered and which ones are not covered under these plans.
- Describes your choices in working with dental plan providers and links you to a list of providers.
- Explains how to appeal a claim and other membership policies in detail.

Delta PPO Network – Enhanced Benefit

Delta Dental is offering an enhanced benefit to participants who see dentists in the Delta Dental PPO network. In addition to receiving better rates on dental services, participants seeing a PPO network dentist will now receive an additional 10% off coverage on basic dental care (such as fillings and root canals). Deductibles and all other plan benefits remain the same. Please note that the PPO network is not a separate plan option; rather, it is an enhancement to our existing Dental Basic and Dental Plus plans.

Choosing a Dentist

With Washington Dental Service, you may select any licensed dentist; however, your benefits may be paid at a higher level and your out-of-pocket expenses lower if you choose a Washington Dental Service/Delta Dental PPO or Premier dentist.
When making your initial appointment with a Washington Dental Service dentist, simply tell your dentist’s office that you are covered by a Washington Dental Service plan (Group Name: PeaceHealth, Group# 339), and give them your Social Security number.

**Delta Dental PPO dentists**
Delta Dental PPO dentists complete claim forms and submit them directly to Washington Dental Service/Delta Dental. PPO dentists receive payment based on their pre-approved PPO fees and they cannot charge you more than these fees. You are responsible only for your stated deductibles, co-payments and/or amounts in excess of the program maximums.

**Delta Dental Premier dentists — (non-PPO)**
Delta Dental Premier dentists are members of our traditional fee-for-service plan, but they are not necessarily part of the PPO network. Delta Dental Premier dentists will still submit claims for you and receive payment directly from Washington Dental Service/Delta Dental. Their payment will be based upon their pre-approved fees with Washington Dental Service. They also cannot charge you more than these fees. You are responsible only for your stated deductibles, co-payments and/or amounts in excess of the program maximums.

**Finding a Delta Dental PPO or Delta Dental Premier dentist**
Many dentists belong to the Washington Dental Service / Delta Dental provider network. For a list of participating dentists in your area:

2. On the left toolbar, place your cursor over “Subscribers,” and then select "Find a Dentist."
3. Select the appropriate directory:
   - If you live in Washington State, click on "WDS Dentist Directory."
   - If you live outside of Washington or are seeking services outside of Washington, click on “Delta Dental Plans Association National Provider Directory.”
4. Select either the Delta Dental PPO or Delta Dental Premier plan directory.
5. Search for providers in your area by location, specialty, and/or name.

**Nonparticipating dentists**
You are not limited to visiting a Washington Dental Service/Delta Dental dentist. If you choose a nonparticipating dentist, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Washington Dental Service. Claim payments will be based on actual charges or Washington Dental Service’s maximum allowable fees for nonparticipating dentists in the state in which services are performed, whichever is less. You will be responsible for any balance remaining. Please be aware that Washington Dental Service has no control over nonparticipating dentists’ charges or billing procedures.

**Dental Plan Overview**

The dental plan claim administrator is Delta Dental – Washington Dental Service.
The FlexAbility Benefits Plan provides three dental plan options:

1. **Dental Basic**
   The Dental Basic option offers coverage for preventive, corrective and maintenance dentistry. This option does not include orthodontia coverage.

2. **Dental Plus**
   For a slightly higher premium, this plan offers a higher level of coverage. It includes all of the features of our Dental Basic plan, increases your annual benefit maximum to $1,500, and provides orthodontia coverage at 50% for children and adults to a lifetime maximum of $1,500 per covered individual.

3. **No Coverage – Opt Out**
   You may elect to waive dental coverage entirely and apply the credit toward other benefits or take it as cash. Note that you do not have to be covered under another dental plan to waive dental coverage.

The Dental Basic and Dental Plus plan options provide you and your family with comprehensive dental benefits and use the same network of providers (Delta Dental PPO and Delta Dental Premier). Through these networks you have a wide selection of dental health providers committed to providing you with the highest quality dental care for the lowest possible costs.

**Dental Basic versus Dental Plus**
The table below compares the Dental Basic and Dental Plus features to help you choose the right plan for you and your dependents. The Plan Features listed in this table are described in detail later in the section entitled "What Is Covered."

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Amount Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dental Basic</td>
</tr>
<tr>
<td>Preventive Care (Class I)</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Care (Class II)</td>
<td>80% (90% if seeing a PPO network provider)</td>
</tr>
<tr>
<td>Major Care (Class III)</td>
<td>50%</td>
</tr>
<tr>
<td>Accidental Injury</td>
<td>100%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
</tr>
<tr>
<td>Deductible - Waived for preventive care and orthodontia</td>
<td>$25 individual / $75 family</td>
</tr>
</tbody>
</table>
| Annual maximum benefit amount per individual (includes the cost of preventive care) | $1,000                                 | $1,500

Last Updated 10/4/2011
**Benefit Period**
To provide maximum flexibility, you may re-elect or change your dental plan option every year. The coverage period for both dental plan options is the 12 month calendar year (January 1 through December 31).

**Coinsurance**
Washington Dental Service will pay a predetermined percentage of the cost of your treatment (see chart above) and you are responsible for paying the balance. What you pay is called the coinsurance. It is paid even after a deductible is reached.

**Deductibles**
There is no deductible for dental services covered under Preventive Care or Accidental Injury, whether provided to you or another eligible member of your family.

For dental services covered under Basic Care and Major Care, an annual calendar year deductible of $25 applies to each eligible person, with a maximum calendar year deductible of $75 for each family. In other words, you pay the first $25 of care for each person in your family who uses these services.

Once an eligible person has satisfied the deductible amount for the period, no further deductible applies to that person until the next calendar year period. Likewise, once a family has satisfied the maximum deductible amount of $75 during the 12-month coverage period, no further deductible applies to any eligible member of that family until the next period. For example, if you pay the $25 deductible for three of your family members, your family deductible is satisfied: no deductible payments are required for any other eligible family members for the remainder of the calendar year period.

**Annual Maximum Benefit**
**Dental Basic.** The plan pays a maximum benefit of up to $1,000 towards covered dental services (including preventive care) for each eligible person for each calendar year. If you undergo a dental procedure requiring multiple treatments on different dates, all charges are applied to the annual maximum in effect on the date the procedure is completed.

**Dental Plus.** The plan pays a maximum benefit of up to $1,500 towards covered dental services (including preventive care) for each eligible person for each calendar year. Dental Plus covers orthodontia for adults and children at 50% up to a lifetime maximum of $1,500. If you undergo a dental procedure requiring multiple treatments on different dates, all charges are applied to the annual maximum in effect on the date the procedure is completed.

**Predetermination of Benefits**
If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, sometimes called a “predetermination of benefits.” This will allow you to know in advance what procedures may be covered, the amount Washington Dental Service may pay and your expected financial responsibility. A predetermination is not a guarantee of payment.

To do this:
• Have your dentist complete a standard claim form showing the estimated costs, and submit it to Washington Dental Service. (If your dentist is not part of the network, you must submit the claim form yourself.)
• Washington Dental Service reviews the claim form and lets either you or your dentist (depending on who submitted the claim) know what amounts will be covered by the plan.

Claim Forms
American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our Web site at www.deltadental.com. Washington Dental Service/Delta Dental is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 6 months after the date the treatment is provided. Orthodontic claims must be submitted within 6 months of the initial banding date.

Extension of Benefits
In the event an eligible person ceases to be eligible, or in the event of termination of this plan, Washington Dental Service shall not be required to pay for services beyond the termination date, except for the completion (within 3 weeks) of procedures requiring multiple visits to complete that were started while this coverage was in effect, which are otherwise benefits under the terms of this plan. Please call customer service to see if your procedure qualifies for this extension.

Additional Procedures
In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the program. In such instances, the program will pay the proper percentage of the lowest fee. The balance of treatment cost remains the cover individual’s responsibility.

MySmile Program
Washington Dental Service offers the MySmile personal benefits center, a unique online tool that provides personalized strategies for improving your oral health and that of your family members. Here are examples of what MySmile can do for you:

• Allows you to check your plan coverage and eligible benefits
• Lets you search for a dentist near your home or work place
• Lets you check the status of current claims and view previous payments
• Provides access to printable ID cards
• Provides personalized ways you can improve your oral health

For more about MySmile, visit the website here.

What Is Covered
Many dental conditions can be treated properly in more than one way. This plan is designed to help offset your dental expenses and to cover treatments necessary to maintain good dental health.
The Dental Basic and Dental Plus plans provide identical coverage for Preventive Care, Basic Care, Major Care, and Accidental Injury. In addition, Dental Plus provides coverage for Orthodontia. The specific services covered are listed below.

To be eligible for payment, charges must be included in the "Services Covered" section under each type of care. Services or treatments not covered by the plans are listed in the "Services Not Covered" section under each type of care. Additional dental services not covered by these plans are listed in the section entitled "What Is Not Covered."

**Preventive Care (Class I)**
Both plans cover 100 percent of the preventive care services listed below. You do not need to meet a deductible to receive these services. (Please note - the cost of preventive care services applies to your annual maximum benefit.)

**Services Covered**
- Routine examination, twice in a benefit period (calendar year)
- Complete series (any number or combination of intraoral and/or extraoral x-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex X-rays once in a three-year period
- Comprehensive oral evaluation is covered once in a 3-year period as one of the two covered examinations in a benefit period (calendar year) per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a Delta Dental Participant Dentist.
- Supplementary bitewing X-rays, twice in a benefit period (calendar year)
- Emergency examination
- Palliative treatment for pain
- Examination by a specialist in a specialty recognized by the American Dental Association
- Cleaning (prophylaxis) and/or periodontal maintenance procedures will be limited to twice in a benefit period (calendar year)
- Fluoride applications or preventive therapies (but not both) twice in a benefit period (calendar year) up to the patient's 19th birthday
- Fissure sealants, once in a three-year period per tooth for children through age 14; the tooth must be a permanent molar with incipient or no caries (decay) on an intact occlusal surface. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending dentist
- Space maintainers that are used to maintain space for eruption of permanent teeth
- WDS-approved periodontal susceptibility/risk tests

**Services Not Covered**
- Diagnostic services and X-rays that are related to the jaw joints, also called the temporomandibular joints
- Consultations or elective second opinions
- Study models
- Tests for susceptibility to decay (caries)
- Plaque control programs such as oral hygiene instruction, dietary instruction, and home fluoride kits
- Cleaning of a prosthetic appliance
- Replacement of a space maintainer previously paid for by WDS

**Basic Care (Class II)**
Both plans cover 80 percent (90 percent if seeking care from a PPO dentist) of the cost of basic care services listed below. Payments you make for these services apply to your calendar year deductible. For more information on dental plan deductibles, go to [Deductibles](#).

**General Anesthesia**
General anesthesia, when medically necessary, for children through age six (6), or a physically or developmentally disabled person, when in conjunction with Preventive care, Basic care, Major care and Orthodontic covered dental procedures. General anesthesia is covered only when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington or as determined by the state in which the services are rendered.

**Palliative Treatment**

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

**Restorative**

**Services Covered**
- 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), or fracture resulting in significant damage to an existing restoration using amalgam, resin-based composite or glass ionomer restorations.
- Stainless steel crowns are covered once in a two-year period.
- Restorations on the same surface(s) of the same tooth, once in a two-year period.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids), an amalgam allowance will be made that can be applied to that procedure.

**Services Not Covered**
- Restorations to correct vertical dimension or to restore the occlusion.
- Overhang removal, copings, re-contouring, or polishing of restoration.

**Oral Surgery**

**Services Covered**
- Removal of teeth.
- Preparation of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic injuries of the mouth.
- General anesthesia/IV sedation only when administered by a licensed dentist or other WDS approved licensed professional who meets the educational, credentialing and privileging, guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with a covered oral surgery procedure.

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

**Periodontics**

**Services Covered**
- Surgical and non-surgical procedures for treatment of the tissues supporting the natural teeth.
- Gingivectomy.
- Limited adjustments to occlusion (8 teeth or less) such as smoothing of teeth or reducing of cusps, once in a 12-month period.
- Periodontal scaling/root planing, once in a 12-month period.
- General anesthesia/IV sedation only when administered by a licensed dentist or other WDS approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with covered periodontal surgery procedure.

**Services Not Covered**
- Occlusal guard (nightguard) and occlusal splints
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Crowns as part of periodontal therapy
- Major (complete) occlusal adjustment
- Periodontal appliances
- Gingival curettage

**Endodontics**

**Services Covered**
- Procedures for pulpal and root canal therapy.
- Pulp exposure treatment, pulpotomy, and apicoectomy.
- Root canal treatment on the same tooth, once in a two-year period.
- General anesthesia/IV sedation only when administered by a licensed dentist or other WDS approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with a covered endodontic surgical procedure.
**Services Not Covered**
- Bleaching of teeth.

**Major Care (Class III)**
The plan covers 50 percent of the cost of major care services listed below. The deductible amount applies to any payments for major care services. For more information on dental plan deductibles, go to **Deductibles**.

**Restorative Services Covered**
- Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp) using crowns, veneers, inlays, (as a single tooth restoration – with limitations), and onlays (whether they are gold, porcelain, WDS-approved gold substitute castings, (except processed resin) or combinations of these) when verification is provided by the attending dentist that teeth cannot be restored with filling materials such as amalgam or resin-based composite.
- Crowns, veneers, inlays (as a single tooth restoration – with limitations), or onlays on the same teeth, once in a five-year period.
- If a tooth can be restored with a filling material such as amalgam or resin-based composite, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.
- WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of laboratory processed resin onlay, veneer, crown, or inlay (as a single tooth restoration – with limitations). Payment for onlays, veneers, crowns, or inlays (as a single tooth restoration – with limitations) shall be paid upon the seat date.
- Inlays (as a single tooth restoration) shall be paid up to the allowance of an amalgam restoration. The balance is the patient’s responsibility.
- Crown buildups, subject to limitation, are a covered benefit when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology. Crown buildups are covered once in a 2-year period.
- Post and core, subject to limitation is covered once in a 5-year period on the same tooth.

**Services Not Covered**
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are restorations with defective margins when there is no decay or other significant pathology present.
Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology.
- Crown buildup for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a covered benefit.
- Crown buildups are not a covered benefit within 2 years of a restoration on the same tooth.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit.
- Copings are excluded.

Prostodontics

Services Covered
- Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) removable partial dentures, and the adjustment or repair of an existing prosthetic device
- Surgical placement or removal of implants or attachments to implants
- Replacement of an existing prosthetic device once every 5 years and then only if it is unserviceable and cannot be made serviceable
- Replacement of implants and superstructures is covered only after 5 years have elapsed from any prior provision of the implant
- The appropriate amount will be allowed for a full, immediate, or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment
- The amount of a reline will be allowed toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 6 months.
- Root canal therapy performed in conjunction with overdentures, limited to two teeth per arch and paid at the 50% or major care payment level.
- If a partial denture can be replaced with a cast chrome and acrylic partial denture, an allowance will be made for the cost of such a partial denture toward the cost of any other procedure that may be provided to restore a partial denture.
- Denture adjustments and relines done more than six months after the initial placement, except as noted above.
- Subsequent relines and jump rebases (but not both), once in a 12-month period.
- Inlays are a covered benefit on the same teeth once in a 5-year period only when used as an abutment for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid up on the delivery date.

Services Not Covered
- Duplicate dentures.
- Personalized dentures.
- Cleaning of prosthetic appliances.
- Crowns in conjunction with overdentures.
Accidental Injury
The plan pays 100 percent of dental expenses that are a direct result of an accidental injury, as long as the accidental injury claims do not exceed the unused portion of the annual maximum benefit.

- You pay for charges that exceed the unused portion of the annual maximum benefit.
- You or your covered family member must be eligible under the plan at the time the accidental bodily injury occurred.
- A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects.
- Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

If you are injured through someone else's fault
If you receive benefits through this plan and from a third party for an injury or condition caused by another person, you must include in your insurance claim or liability claim the amount of those benefits.

After you are compensated for your loss, any money recovered in excess of full compensation must be used to reimburse WDS on behalf of the Plan Sponsor.

Orthodontia: Dental Plus Only
Dental Plus provides orthodontia coverage for you, your spouse, your legally domiciled adult and your unmarried children up to age 23 if they meet the Internal Revenue Code’s definition of a dependent. Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

It is strongly suggested that all orthodontic treatment be submitted to, and authorized by, WDS prior to commencement of treatment.

The benefit pays 50% of the treatment cost up to a lifetime maximum benefit of $1,500. Not more than half the lifetime maximum ($750) is payable by WDS during the “construction phase” of treatment. Subsequent payments of WDS’ responsibility shall be made on a monthly basis, providing the employee is eligible and the dependent is in compliance with the age limitation.

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

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

**Services Not Covered**
- Charges for replacement or repair of an appliance.
- Orthognathic surgery
- No benefits will be provided for services considered inappropriate and unnecessary, as determined by WDS.
- Charges for the treatment plan in the event treatment is terminated before completion.

**Limitations - Payment is limited to:**
- Completion, or through limiting age (refer to Dependent Eligibility and Termination.), whichever occurs first.
- Treatment received after coverage begins (claims must be submitted to WDS within 6 months of the start of coverage). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing. Treatment that began prior to the start of coverage will be prorated. The initial payment and periodic payments charged by the provider prior to coverage beginning will be deducted from the amount considered for payment.
- Termination of the treatment plan prior to completion of the case.
- Termination of the contract.

**Benefits for Treatment Already In Progress**
If you or one of your dependents is already undergoing orthodontia treatment, you can still receive benefits under this plan. The amount of benefit you are eligible for will be pro-rated based on the amount of treatment you have left to complete.

**For example:**
You elect the Dental Plus plan, effective January 1, 2011. Your dependent son started orthodontia treatment a year ago in January 2010. He requires one more year of treatment. In this case, WDS will pro-rate the benefit based on the total cost of the orthodontia treatment plan, and the number of months remaining in that treatment program.

<table>
<thead>
<tr>
<th>Starting Date:</th>
<th>January 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Treatment:</td>
<td>24 months</td>
</tr>
<tr>
<td>Remaining Treatment:</td>
<td>12 months</td>
</tr>
<tr>
<td>Total Cost:</td>
<td>$3,600</td>
</tr>
<tr>
<td>Average Monthly Cost:</td>
<td>$150 ($3,600 divided by 24)</td>
</tr>
<tr>
<td>Pro-rated Amount Paid:</td>
<td>$150 x 12 = $1,800</td>
</tr>
<tr>
<td>Pro-rated Balance:</td>
<td>$3,600 - $1,800 = $1,800</td>
</tr>
</tbody>
</table>

**Plan Pays:**
(50% of the $1,800 balance up to a lifetime maximum of $1,500)
50% x $1,800 = $900
(Payable in 12 equal payments of $75/each)
What Is Not Covered

- Services for injuries or conditions that are compensable under Workers' Compensation or Employers' Liability laws, and services provided by any federal, state, or provincial government agency or provided without cost by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- Dentistry for cosmetic reasons.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.
- Application of desensitizing agents.
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider if 1) the services are in general use in the dental community in the State of Washington; 2) the services are under continued scientific testing and research; 3) the services show a demonstrable benefit for a particular dental condition; and 4) they are proven safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request. Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental, may be appealed to WDS. By law, WDS must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual. Whenever WDS makes an adverse determination and delay would jeopardize the covered individual’s health, WDS shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two (72) hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered individual’s health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in andy independent review under WAC 284-43-630.
- Services with respect to treatment of jaw (temporomandibular) joints.
- General anesthesia/intravenous (deep) sedation, except as specified by WDS for certain oral, periodontal or endodontic surgical procedures. General anesthesia except when medically necessary, for children through age six (6), or a physically or developmentally disabled person, when in conjunction with covered dental procedures. General anesthesia for routine post-operative procedures is not a covered benefit.
- Analgesics (such as nitrous oxide) conscious sedation, euphoric drugs, injections or prescription drugs.
- In the event an Eligible Person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
• Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
• Broken appointments.
• Patient management problems.
• Completing claim forms.
• Habit-breaking appliances.
• Orthodontic services or supplies – excluded under Dental Basic option only.
• WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the contract but shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.
• This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage.
• All other services not specifically included in this program as covered dental benefits.

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**Dental Claims**

All dental claims are processed by the Claims Administrator WDS.  

**How to obtain claim forms**
Claim forms can be obtained from WDS by calling (800) 554-1907.

**When to submit claims**
Submit claims as soon as possible after the dental work has been done. All claims must be submitted to WDS within 6 months after the expenses were incurred, or the claims will not be reimbursed.

**Claim Review and Appeal**

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

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

**Urgent Predetermination Requests**
Should a predetermination request be of an urgent nature, where a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, WDS will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours. Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

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

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

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

**Appeals of Denied Claims**

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

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

Please submit your request for a review to:

**Washington Dental Service**
**Attn: Appeals Coordinator**
For oral appeals, please refer to the phone numbers listed on the inside front cover of your benefit booklet.

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

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

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

**Appeals Committee**

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

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

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

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

**Authorized Representative**

You may authorize another person to represent you and to whom WDS can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.
If your claim is denied
If your claim is denied in whole or in part and you want the decision reviewed, you must file a written request for a review within 60 days of the date your claim was denied. Explain why you believe the service should be covered and include any supporting information.

Send your appeal to:

    WDS
    Customer Service
    PO. Box 75983
    Seattle, WA 98175-0983

Customer Service will forward your appeal to the Dental Director, who will review your appeal to determine if the service in question qualifies as a covered expense. You will be notified in writing of the decision within 60 days of when WDS receives your appeal.

If the review results in your claim being denied again, you can appeal this decision to:

    WDS Dental Director
    PO. Box 75983
    Seattle, WA 98175-0983

Your appeal will then be evaluated by the Dental Director and a WDS consultant dentist. You will be notified of the decision.

If your appeal is denied, you can appeal this decision in writing within 60 days to the Plan Administrator:

    FlexAbility Plan Administrator
    PeaceHealth
    14432 SE Eastgate Way, Suite 300
    Bellevue, WA 98007-6412

You will receive a response to your appeal from the Plan Administrator by mail within 90 days after the Plan Administrator receives the appeal. If the Plan Administrator needs more than 90 days to review your appeal, you will be notified of the delay and the reasons for it.

If the claim is again denied, no additional appeals will be considered unless accompanied by additional supporting dental information.

To contact the Claims Administrator
We encourage all members to make suggestions on how WDS can improve their service. Call or write:
End of Coverage

Your coverage terminates at the end of the month in which you cease to be an eligible employee. (See the Health Benefit Protection section in the "What You Need to Know" section of the FlexAbility handbook.)

When going on an approved leave of absence, employees in some regions may need to elect Continuation Coverage for dental benefits in order to avoid waiting periods upon returning from leave of absence.

Coverage for your dependent(s) terminates at the end of the month in which your coverage terminates, or when the dependent ceases to be an eligible dependent, whichever occurs first.

The only services that WDS pays for after the date that coverage ends would be the cost to complete (within three weeks) any single procedures (root canals, crowns, bridges, partial or full dentures) that were already started before the coverage was terminated and that would have been covered under the terms of the contract.

Removed Disclosure

Subscriber Rights and Responsibilities

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

In order to obtain this information, you must call (206) 522-2300 or 1 (800) 554-1907. A WDS employee will take your name and send you the information you requested. If you are an enrollee of a dental care plan with WDS, we may also refer you to your benefit booklet for additional information about your plan that may be useful. You can also write WDS and request the information at PO Box 75983, Seattle, WA 98175-0983.

You have the right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta member / non-member), 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 Washington Dental Service customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com

● Appeal in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.

● Have your individual health information kept confidential and used only for resolving health care decisions or claims.

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

To receive the best oral health care possible, it is your responsibility to:

● Know your benefit coverage and how it works.

● Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.

● Ask questions about treatment options that are available to you regardless of coverage levels or cost.

● Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.

● Read carefully and ask questions about all forms and documents which 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 Washington Dental Service to assist with the processing of claims.

● If applicable, pay the dental office the appropriate co-payments amount at time of visit.

● Respect the rights, office policies and property of each dental office you have the opportunity to visit.

● Inform your dentist and your employer promptly of any change to your or a family member’s address, telephone, or family status.