

Delta Dental PPO

National Coverage

Puget Sound Health Partners

Washington Dental Service, a Delta Dental Plan

Program No. **09386**

Effective: **January 1, 2010**

Questions Regarding Your Program

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

Washington Dental Service Customer Service

(877) 719-4006

Written inquiries may be sent to:

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

You can also reach us through Internet e-mail at info@DeltaDentalWA.com.

For the most current listing of Washington Dental Service participating dentists, visit our online directory at www.DeltaDentalWA.com.

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

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

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

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

Reimbursement Levels for Allowable Benefits

Delta Dental PPO Dentists

*Class I.....	Constant 100%
Class II.....	Constant 80%
Temporomandibular Joint (TMJ) procedures	Constant 50%
*Annual Deductible per Person	\$50

Non-Delta Dental PPO Dentists

*Class I.....	Constant 100%
Class II.....	Constant 80%
Temporomandibular Joint (TMJ) procedures	Constant 50%
*Annual Deductible per Person	\$100

Plan Maximum

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

Benefit Period

Dental benefits are calculated within a “benefit period,” which is typically for one year. For this program, the benefit period is the 12-month period starting January 1 and ending December 31.

All participants are eligible for Class I, Class II and temporomandibular joint (TMJ) benefits.

*Annual deductible is waived for Class I covered dental benefits.

Introduction

Welcome to your Delta Dental PPO program from Washington Dental Service/Delta Dental. Washington Dental Service (WDS) is a member of the Delta Dental Plans Association (DDPA), the nation’s largest, most experienced dental benefits organization. It is made up of local, not-for-profit Delta Dental plans that provide a range of dental benefit programs. Delta Dental is unique in that its member plans contract with more than 121,000 dentists nationwide who provide dental care to subscribers at previously agreed-upon fee levels. WDS administers the **Puget Sound Health Partners** Delta Dental PPO dental plan.

This booklet sets forth in summary form an explanation of the coverage available under your dental program. The contract is on file with your Plan.

How to Use Your Program

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 benefits booklet *before* you go to the dentist. The 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 booklet does not answer all of your questions, or if you do not understand something, call a Washington Dental Service/Delta Dental 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 Washington Dental Service/Delta Dental, you may select any licensed dentist; however, your benefits may be paid at a higher level and 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 Delta Dental plan and provide your identification number, the program name, Puget Sound Health Partners and the group number — which is **09386**.

Delta Dental Participating Dentists

There are advantages to selecting a Delta Dental member dentist. First, you have a choice of more than 124,000 participating dentists nationwide. And, if you select a dentist who is a participant with Delta Dental, that dentist has agreed to provide treatment for eligible persons covered by Delta Dental programs according to the provisions of his or her member dentist contract. You will not have to hassle with claim forms or other paperwork. Participating dentists complete claim forms and submit them to Washington Dental Service/Delta Dental. Payment will be based on the pre-approved fees your dentist has filed with the local Delta Dental plan and will be sent directly to your dentist. You will be responsible only for stated coinsurance (see Coinsurance), deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered benefits.

You can find a participating dentist in your area by visiting the WDS Web site at www.DeltaDentalWA.com. Go to Looking for a Dentist and click on Read More. This will bring up the WDS Dentist Directory and the Delta Dental Plans Association National Provider Directory.

Delta Dental PPO Dentists

Delta Dental PPO dentists must be Delta Dental member dentists in order to participate in the PPO network. More than 63,000 dentists participate in this network nationwide. You can choose any dentist — in or out of the PPO network — at the time you need treatment. However, if you select a dentist who is part of the Delta Dental PPO network, your benefits will likely be paid at a higher level and your out-of-pocket expenses may be lower. 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 will be responsible only for your stated deductibles, coinsurance and/or amounts in excess of the program maximums.

Delta Dental Premier[®] Dentists (non-PPO)

Delta Dental Premier[®] dentists also have contracts with Delta Dental, 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 payments will be based on their pre-approved fees with Delta Dental. They also cannot charge you more than these fees. You will be responsible only for stated deductibles, coinsurance and/or amounts in excess of the program maximums.

Nonparticipating Dentists

You are not limited to visiting a Delta Dental dentist. However, 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/Delta Dental in Seattle, Washington. Claim payments will be based on actual charges or WDS'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 Delta Dental has no control over nonparticipating dentists' charges or billing procedures.

Claim Forms

American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our Web site at www.DeltaDentalWA.com. 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 six months after the date the treatment is provided.

Predetermination of Benefits

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

Reimbursement Levels

Your dental plan offers two classes of covered treatment, and your reimbursement level will depend on whether or not you seek care from a Delta Dental PPO dentist. 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 booklet.

See “Benefits Covered by Your Program” for specific Class I and Class II covered dental benefits under this program.

Coinsurance

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

Program Maximum

For your program, the maximum amount payable by Washington Dental Service/Delta Dental for Class I and II covered dental benefits per eligible person is \$1,000 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 program maximum based on the incurred date.

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

Program Deductible

For Delta Dental PPO Dentists

Your program has a \$50 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of \$50 is made. Once each eligible person has satisfied the deductible during the period, no further deductible will apply to that eligible person until the next period. The deductible does not apply to Class I covered dental benefits.

For Non-Delta Dental PPO Dentists

Your program has a \$100 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of \$100 is made. Once each eligible person has satisfied the deductible during the period, no further deductible will apply to that eligible person until the next period. The deductible does not apply to Class I covered dental benefits.

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 booklet under the sections called “Benefits Covered by Your Program”, “General Limitations” and “General Exclusions.” They warrant careful reading.

Eligibility and Termination

An eligible participant is any person who is enrolled in the Puget Sound Health Partners Plan as a subscriber and has elected to subscribe to the Optional Supplemental Benefit plan for dental care for an additional monthly premium..

New participants are eligible on the first of the month following receipt of the enrollment form.

You must complete an enrollment form. Puget Sound Health Partners must receive a completed enrollment form at the time of enrollment. If the enrollment form is not received with the Puget Sound Health Partners initial enrollment, then enrollment will not be accepted until the next open enrollment period.

Coverage terminates at the end of the month in which you cease to be an eligible participant.

This plan provides coverage only for subscribers. No coverage is available under the terms of this plan for dependents.

Extension of Benefits

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

How to Report Suspicion of Fraud

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

- The National Insurance Crime Bureau (NICB). You can reach the NICB at 1 (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to www.insurance.wa.gov for more information.

Coordination of Benefits

If an eligible person is entitled to benefits under two or more group dental plans, the amount payable under this plan will be coordinated with any other plan. The amount paid by WDS, together with amounts from other group programs, will not exceed the total of the highest allowable dental expenses incurred.

The following rules establish the order of benefit payments:

- a. The benefits of the plan that does not have a coordination of benefits (COB) provision will be primary (the plan whose benefits are determined first).
- b. The benefits of the plan that covers the person as an employee, member, policyholder, subscriber or retiree will be determined before the benefits of a plan that covers the person as a dependent.
- c. If the person is a child whose parents are not separated or divorced:
The benefits of the plan covering the parent whose month and day of birth occurs earlier in the calendar year will be determined before the benefits of the plan of the parent whose month and day of birth occurs later in the calendar year. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.
- d. If the person is a child of parents who are separated or divorced or not living together, whether or not they have ever been married, if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, then the benefits are determined in the following order:
 - 1) The plan covering the custodial parent, first;
 - 2) The plan covering the spouse of the custodial parent, second;
 - 3) The plan covering the non-custodial parent, third; and
 - 4) The plan covering the spouse of the non-custodial parent, last.
- e. If a court decrees that one parent has financial or health care expenses or health care coverage responsibility, that plan is primary.
- f. The plan covering the person as a retired or laid-off employee or dependent of such person will be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person. This provision will not apply if neither plan has a provision regarding laid-off or retired employees that results in each plan determining its benefits after the other.
- g. If a person whose 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 the person as an employee, member, subscriber or retiree or covering the person 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.
- h. If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

If you are covered by more than one health plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

If you are covered by more than one health benefit plan, and you do not know which your primary plan is, 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 plan to determine which is primary and will let you know within 30 calendar days.

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.

Note: All health plans have timely claim filing requirements. If you or your provider fails 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.

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

In the event WDS makes payments in excess of the maximum amount, WDS shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

MySmile[®] Personal Benefits Center

Washington Dental Service is proud to present the MySmile[®] personal benefits center, a unique online tool that provides personalized strategies for improving your oral health. 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 our Web site at www.DeltaDentalWA.com/MySmile

Benefits Covered By Your Program

The following are the Class I and Class II covered dental benefits under this program that are subject to the limitations and exclusions contained in this booklet. Such benefits (*as defined*) are available only when provided by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS.

The amounts payable by WDS for Class I and Class II covered dental benefits are described elsewhere in this booklet.

Class I

Diagnostic

Covered Dental Benefits

- Routine examination (periodic oral evaluation)
- Comprehensive oral evaluation
- X-rays
- Emergency examination
- Specialist examination performed by a specialist in an American Dental Association recognized specialty
- WDS-approved periodontal susceptibility/risk tests

Limitations

- Routine examination is covered twice in a benefit period.
- Comprehensive oral evaluation is covered once in a three-year period from the date of service per eligible person per dentist. Additional comprehensive oral evaluations are allowed as routine examinations.
 - Comprehensive oral evaluations are considered as one of the two covered examinations per benefit period.
- Complete series (any number or combination of intraoral 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 are covered once in a five-year period from the date of service.
- Supplementary bitewing X-rays are covered once in a three-year 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 or elective second opinions
- Study models
- Caries susceptibility/risk tests

Preventive

Covered Dental Benefits

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

Limitations

- Prophylaxis and/or periodontal maintenance are limited to two covered procedures in a benefit period.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) may be covered up to a total of 4 times in a benefit period.

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

- Topical application of fluoride or preventive therapies (*but not both*) are limited to two covered procedures in a benefit period.
- Fissure sealants:
 - Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface.
 - The application of fissure sealants is a covered dental benefit only once in a two-year period per tooth.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)
- Cleaning of a prosthetic appliance

Periodontics

Covered Dental Benefits

- Prescription-strength fluoride toothpaste
- Antimicrobial mouth rinse

Limitations

- Prescription-strength fluoride toothpaste and antimicrobial mouth rinse are a covered dental benefit following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's WDS history must show a periodontal procedure within the previous 180 days.
- Antimicrobial mouth rinse is covered once per periodontal treatment.

- Antimicrobial mouth rinse is available for women during pregnancy without any periodontal procedure.

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

Class II

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

General Anesthesia

Covered Dental Benefits

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

Limitations

- General anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by WDS, or when medically necessary for a physically or developmentally disabled person, when in conjunction with Class I, II and TMJ covered dental procedures.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- General anesthesia for routine post-operative procedures is not a paid covered benefit.

Intravenous Sedation

Covered Dental Benefits

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

Limitations

- Intravenous sedation is covered in conjunction with certain covered oral surgery procedures, as determined by WDS.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- Intravenous sedation for routine post-operative procedures is not a paid covered benefit.

Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain

Limitations

- Palliative treatment is not a paid covered benefit when the same provider performs any other definitive treatment on the same date.

Restorative

Covered Dental Benefits

- Amalgam restorations (fillings) and, in anterior (front) teeth, resin-based composite or glass ionomer restorations are covered for the following reasons:
 - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
 - Fracture resulting in significant loss of tooth structure (missing cusp)
 - Fracture resulting in significant damage to an existing restoration
- Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspid.
- Stainless steel crowns
- For other restorations such as gold foils, crowns, veneers, inlays (as a single tooth restoration) or onlays, the allowance will be limited to the amount which otherwise would have been allowed for an amalgam restoration.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspid as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made. Any difference in cost will be the responsibility of the patient.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Stainless steel crowns are covered once in a two-year period from the seat date.

Exclusions

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

Oral Surgery

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 General Anesthesia or Intravenous Sedation for additional 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

Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth are a covered dental benefit.
- Services covered include:
 - Periodontal scaling/root planing
 - Gingivectomy
 - Limited adjustments to occlusion (eight teeth or fewer)
 - WDS-approved localized delivery of antimicrobial agents
- *Refer to Class I Preventive for periodontal maintenance benefits.*

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

Limitations

- Periodontal scaling/root planing is covered once in a three-year period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month 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.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

- Localized delivery of antimicrobial agents approved by WDS is a covered dental benefit under certain conditions of oral health.
 - Localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
 - Localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
 - Localized delivery of antimicrobial agents is not a paid covered benefit when used for the purpose of maintaining non-covered dental procedures.

Exclusions

- Gingival curettage

Endodontics

Covered Dental Benefits

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

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.

Exclusions

- Bleaching of teeth

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

Temporomandibular Joint Benefits

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

“Dental Services” are those that are:

- 1) Appropriate, as determined by WDS, for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- 2) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;

- 3) Recognized as effective, according to the professional standards of good dental practice; and
- 4) Not experimental or primarily for cosmetic purposes.

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

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

The maximum amount payable by WDS for dental services related to the treatment of TMJ disorders shall be \$1,000 per eligible person, after the application of deductibles and coinsurance, in any calendar year, and a lifetime benefit of \$5,000 per covered individual. The amounts payable for TMJ benefits during the benefit year shall not be applied to the eligible person's annual maximum for Class I and Class II covered dental benefits.

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

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

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

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

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 eligible person's responsibility.

General Limitations

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.

3. General anesthesia/intravenous (deep) sedation is not a paid covered benefit except as specified WDS for certain oral surgery procedures. General anesthesia is not a paid covered benefit except when medically necessary for a physically or developmentally disabled person, when in conjunction with covered dental procedures.

General Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
2. Application of desensitizing agents
3. Experimental 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, WDS, 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.

Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
 - b. Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental may be appealed to WDS. 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 eligible person.
 - c. Whenever WDS makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, WDS shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.
4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections
5. Prescription drugs
6. In the event an eligible person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.

7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment
8. Broken appointments
9. Patient management problems
10. Completing claim forms
11. Habit-breaking appliances
12. Orthodontic services or supplies
13. 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, 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 program as covered dental benefits.

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

Frequently Asked Questions about Your Dental Benefits

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. Delta Dental, the nation's largest, most experienced dental benefits company, provides dental coverage to nearly one out of every four Americans with dental coverage. WDS is a member of the Delta Dental Plans Association.

What Is A Delta Dental Plan “Participating Dentist”?

A Delta Dental participating dentist is a dentist who has signed an agreement with WDS — or with any of the other Delta Dental plans located in all 50 states — stipulating that he or she will provide dental treatment to subscribers covered by the plan's group dental care programs. Approximately three out of every four U.S. dentists now participate in the Delta Dental Plans Delta Dental Premier network. Delta Dental participating dentists complete claim forms and submit them directly to WDS.

Can I choose my own dentist?

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

How Can I Obtain A List Of Delta Dental Participating Dentists?

You can obtain a directory of participating dentists either from your employer or go online to the Washington Dental Service/Delta Dental Web site at www.DeltaDentalWA.com. Go to Looking for a Dentist and click on Read More. This will bring up the WDS Dentist Directory and the Delta Dental Plans Association National Provider Directory.

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 forms from our Web site at www.DeltaDentalWa.com. **Note:** If your dentist is a Delta Dental Service participating provider, he or she will complete and submit claim forms for you.

What is the mailing address for Dental Service 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 Washington Dental Service at P.O. Box 75983, Seattle, WA 98175-0983.

Who do I call if I have questions about my dental plan benefits?

If you have questions about your dental benefits, call WDS's customer service department at (877) 719-4006. Questions can also be addressed via e-mail at cservice@DeltaDentalWa.com.

Why does WDS pay less for tooth-colored fillings on my back teeth?

Tooth-colored fillings, or fillings made of resin-based composite, are considered to be cosmetic. Dental amalgams, or what we normally think of as silver fillings, are less expensive and clinically equivalent to resin-based composite. Because of this, your plan reimburses your dentist for the least costly clinically equivalent fillings in back (posterior) teeth. If you have questions about this, feel free to discuss them with your dentist.

Do I have to get an "estimate" before having dental treatment done?

If your dental care will be extensive, 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.

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 subscriber requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits.

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.

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

CARIES SUSCEPTIBILITY TEST — A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

COMPLAINT — An oral or written report by a subscriber 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 Contract, subject to the limitations set forth in Benefits Covered by Your Program.

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

DELIVERY DATE — The date a prosthetic appliance is permanently cemented into place.

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.

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

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

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

EXCLUSIONS — Those dental services that are not contract benefits set forth in Benefits Covered by Your Program and all other services not specifically included as a Covered Dental Benefit set forth in Benefits Covered by Your Program.

FILED FEES — Approved fees that participating WDS 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 Program.

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.”

NOT A PAID COVERED BENEFIT — Any dental procedure that, under some circumstances, would be covered by WDS, but is not covered under other conditions Examples are listed in Benefits Covered by Your Program.

OCCUSAL 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.

OCCUSAL GUARD — A removable dental appliance — sometimes called a nightguard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (nightguard) is typically used at night.

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

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

OVERDENTURE — A removable denture constructed over existing natural teeth or implanted studs.

PALLIATIVE TREATMENT — Services provided for emergency relief of dental pain.

PANOREX 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.

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.

PROPHYLAXIS — Cleaning and polishing of teeth.

PROSTHODONTICS — The replacement of missing teeth by artificial means such as bridges and dentures.

PULPOTOMY — The removal of nerve tissue from the crown portion of a tooth.

RESIN-BASED COMPOSITE — A tooth colored filling, made of a combination of materials, used to restore teeth.

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

ROOT PLANING — A procedure done to smooth roughened root surfaces.

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

SEAT DATE — The date a crown, veneer, inlay or onlay is permanently cemented into place on the tooth.

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

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

Urgent Predetermination Requests

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

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

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

Appeals Review Process

If your claim for dental benefits has been completely or partially denied, you have the right to request a formal review of the decision. Either you, or your authorized representative (see below), must submit your request for a review within 60 days from the date your claim was denied (please see your explanation of benefits form). A request for review must be submitted in writing, and include the following information:

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

Please submit your request for review to:

Puget Sound Health Partners
Attn: Appeals
32129 Weyerhaeuser Way S, Ste 201
Federal Way, WA 98001

If you have questions regarding your appeal rights please contact Puget Sound Health Partners Member Services Department, from 8:00 a.m. to 5:00 p.m., Monday through Friday at (253) 779-8830 or toll free at 1-866-789-PSHP (7747).

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

Puget Sound Health Partners (PSHP) will review your appeal request and make a determination within 60 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.

Appeal 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, PSHP will consult with a dental professional advisor.

Denied Appeal Decisions

If PSHP decides to deny your appeal review in part or whole of what you requested, we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Entity (IRE) for a Level 2 Appeal Reconsideration.

Approved Appeal Decisions

If PSHP decides to approve your appeal review in part or whole of what you requested, we must authorize or provide the coverage we have agreed to provide within 60 days after we receive your appeal.

Authorized Representative

You may authorize any individual (such as a relative, friend, advocate, an attorney, or any dental physician) to act as your representative and file an appeal on your behalf.. The representative (including attorneys) and you must sign, date, and complete a representative form or submit Durable Power of Attorney documentation. The appeal process will not begin 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 forwarded to the Independent Review Entity (IRE) MAXIMUS Federal Services, Inc for dismissal.

Subrogation

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

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

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

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

Your Rights and Responsibilities

At WDS our mission is to provide quality dental benefit products throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between WDS, our 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 take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have The Right To:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta 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 WDS customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our Web site at DeltaDentalWA.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

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

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

WDS, 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 allows 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 WDS and your benefits, visit our Web site at www.DeltaDentalWA.com.