Washington Public Employees and Retirees

DeltaCare® 2011

A managed care plan, with a select network of dentists

DeltaCare® 2011

Administered by:

DELTA DENTAL®

Washington Dental Service

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

Published under the direction of the Washington State Health Care Authority

SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by the Washington State Health Care Authority. This booklet, which explains program eligibility and general provisions, constitutes the certificate of coverage for enrollees in this dental plan. This certificate of coverage replaces and supersedes any and all previous certificates.

It is your responsibility to be informed about your benefits. To avoid penalty or loss of benefits, please note all plan predetermination requirements, service area restrictions and benefit limitations. If provisions within this booklet are inconsistent with any federal or state statute or rules, the language of the statute or rule will have precedence over that contained in this publication.

This booklet was compiled by the Washington State Health Care Authority, 676 Woodland Square Loop S.E., P.O. Box 42682, Olympia, Washington 98504-2682. If you have questions on the provisions contained in this booklet, please contact the dental plan.

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Certificate of Coverage

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For customer service, call the
Washington Dental Service DeltaCare® Client Services Team
At 1-800-650-1583

DeltaCare®, a managed care dental plan
Administered by Washington Dental Service

Introduction

Washington Dental Service (WDS) is a not-for-profit dental service corporation. WDS developed the DeltaCare program to address rising health care costs. The DeltaCare program offers subscribers and covered family members an economical choice for quality dental care. DeltaCare was founded on the principle of prevention – treating dental conditions before they become more serious and costly. The way DeltaCare has done this is to contract with a select network of dental offices that have agreed to meet quality standards and to deliver care at an economical cost.

DeltaCare customer service representatives are available toll-free (800) 650-1583, to enrollees from 8 a.m. to 5 p.m., Monday through Friday.

Terms Used in This Booklet

Appeal: An appeal is a written or oral request from an enrollee or, if authorized by the enrollee, the enrollee's representative to change a previous decision made by Washington Dental Service concerning: a) access to dental care benefits, including an adverse determination made pursuant to utilization review; b) claims handling, payment, or reimbursement for dental care and services; c) matters pertaining to the contractual relationship between an enrollee and Washington Dental Service or d) other matters as specifically required by state law or regulation.

Copayment: The dollar amount enrollees pay when receiving specific services.

Dental Emergency: 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.

Dental Necessity: A service is “dentally necessary” if it is recommended by the treating provider and if all of the following conditions are met.

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

1. The purpose of the service, supply or intervention is to treat a dental condition;

2. It is the appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;

3. The level of service, supply or intervention is known to be effective in improving health outcomes;

4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and

5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

- A health “intervention” is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a dental condition (i.e., disease, illness, injury, genetic or congenital defect or a biological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of “dental necessity,” a health intervention means not only the intervention itself, but also the dental condition and patient indications for which it is being applied.

- “Effective” means that the intervention, supply or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- An intervention, supply or level of service may be dentally indicated, yet not be a covered benefit or meet the standards of this definition of “dental necessity.” WDS may choose to cover interventions, supplies, or services that do not meet this definition of “dental necessity”, however, WDS is not required to do so.
- “Treating provider” means a health care provider who has personally evaluated the patient.
- “Health outcomes” are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- An intervention is considered to be new if it is not yet in widespread use for the dental condition and patient indications being considered.
- “New interventions” for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (See “existing interventions” below).
- “Scientific evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
- For “existing interventions,” the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of “dental necessity.” If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet WDS’s definition of “dental necessity” in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A level of service, supply or intervention is considered “cost effective” if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

Dependent: Eligible dependent covered under the enrollee.

Enrollee: The employee or retiree enrolled in this plan.

Experimental or Investigative: A service or supply that is determined by DeltaCare to meet any one of the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.

a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
b. The provider has not demonstrated proficiency in the service, based on knowledge, training, experience and treatment outcomes.
c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee’s health or safety.

Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols or scientific data from another provider studying the same service.

The documentation used to establish the plan criteria will be made available for enrollees to examine at the office of DeltaCare if enrollees send written requests.

If DeltaCare determines that a service is experimental or investigative, and therefore not covered, the enrollee may appeal the decision. DeltaCare will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with the enrollee's informed written consent.

Group: The employer or entity that is contracting for dental benefits for its employees.

HCA: Health Care Authority.

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

Member: Enrollee or dependent.

Plan: DeltaCare, a managed dental benefit plan of coverage.

Plan Designated Facility or Dentist: A licensed dentist or dental facility that has agreed to perform services under this plan.

Primary Care Dentist: Dentist or facility that enrollee or dependent has selected.

Subscriber: Employee or retiree eligible to enroll in this dental plan.

Retiree Participation

Retirees must be enrolled in a medical plan to enroll in the dental plan. If retirees enroll in the medical and dental plans, they must enroll the same eligible dependents under both plans. Once enrolled in the medical and dental package, retirees cannot change to "medical-only" for at least two years. The two-year requirement does not apply to retirees whose medical and dental coverage is terminated due to the retiree's return to employment and subsequent enrollment in active group coverage, including spouses' re-employment.

Choosing a Primary Care Dentist

When an employee enrolls in DeltaCare, he or she must complete an enrollment form indicating the employee's primary dental office choice. Participation in the program must continue at least until the next open enrollment period. However, the enrollee can select another DeltaCare dentist while on the program. He or she can call the DeltaCare client services team at (800) 650-1583 to request a change. The request must be received by the 20th of the month to be eligible by the first day of the following month with the newly chosen DeltaCare dentist.

The employee's selected dental office is now the center for all of his or her dental needs. The "primary care" dental office will perform most dental services. For specialty care, the primary care dentist may elect to refer treatment to a DeltaCare specialist.

After an employee has enrolled, a membership card is sent to him or her along with a letter that has the name, address and phone number of the assigned primary dental office. If there is a change in the primary dentists, a new letter with the updated information will be sent to the member. To receive all necessary dental care, the enrollee simply calls the assigned dental office to make an appointment.

WDS will make every attempt to assign you to your dentist of choice. If the dentist/dental office listed in your notification letter is not the dentist you have selected or you wish to change PCPs you may contact the DeltaCare client service team at (800) 650-1583 and they will do their best to assign you to your dentist of choice.

Appointments

Routine, non-emergency appointments will be scheduled and will occur within 90 days of the date of the request. Enrollees contact the selected dental office. Dental services that are not performed by the chosen DeltaCare office, or properly referred to a DeltaCare specialist, will not be covered by the DeltaCare program. To receive all necessary dental care, simply call the chosen dental office to make an appointment.

Specialty Services

The enrollee's primary care dentist will provide services or coordinate referrals for specialty care for all the dental services the enrollee needs within time lines appropriate for the enrollee's condition. The specialty care office must be within a reasonable distance (i.e. no more than 50 miles) from an enrollee's primary care dentist.

Emergency Care

DeltaCare Primary care dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, 365 days a year. If the Primary care dentist is unavailable or the employee or family member is out of the area, the member may seek treatment for the relief of pain from any licensed dentist. Treatment of emergency dental care, those rare dental health instances that may be life-threatening or cause severe bodily injury, shall not require predetermination if a prudent layperson acting reasonably would believe that such an emergency condition exists. DeltaCare would encourage the enrollee to seek a predetermination for such emergency care if at all practical, but would not require predetermination if the treatment is a listed procedure under the terms of coverage. The enrollee should notify DeltaCare after receiving emergency dental care within 15 days, or when practical, as to the extent of such emergency dental treatment.

Urgent Care

The Primary care dentist shall provide urgent dental care for a covered procedure which is required while an enrollee is within 50 miles of the office of the Primary care dentist. If an enrollee requires urgent dental care and is more than 50 miles from the office of the Primary care dentist, then under conditions on which the enrollee can be screened and adequately stabilized to allow for further treatment from the enrollee's assigned dentist. The Plan shall reimburse the enrollee for the cost of such urgent dental care which exceeds the enrollee's copayment, up to a $100 maximum per 12-month calendar year. Urgent dental care shall be limited to listed procedures, and as described in code D9110 as seen in the Schedule Of Benefits And Copayments: "Palliative (emergency) treatment of dental pain." Any further treatment of the cause of such urgent dental care would require predetermination from the Plan if practical according to a prudent layperson if the care is to be performed by a non-primary care dentist. In cases which require immediate additional care beyond stabilization and palliative treatment is medically required, the Plan will carefully review and consider additional reimbursable coverage beyond the $100 maximum and according to the standard list of covered benefits under the Plan.

Communication Access Assistance

For Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

Communications with WDS 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 WDS 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 WDS Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the WDS customer service representative.

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

Predetermination (estimate) of Benefits

For treatment that requires predetermination (see covered benefits section), the primary care dentist or specialist submits a claim form prior to commencing treatment. DeltaCare notifies the dentist of the level of coverage for all treatment submitted. Predeterminations are honored for up to six months from the issue date. Please check with your dentist for the benefit payment amount on the predetermination.

Schedule of Benefits and Copayments

The services covered under the DeltaCare dental plan are listed in the following schedule. These copayments are your total price, including lab work. All coverage is subject to the exclusions and limitations set forth in the benefit descriptions and the general exclusions.

Procedure	Description	Copayment	Notes
D0100 - D0999	**I. Diagnostic**		
D0120	Periodic oral evaluation – established patient	0	
D0125	Failed appointment .w/o 24 hr notice per 15 min appt time (not to exceed $25)	10*	
D0140	Limited oral evaluation-problem focused	0	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0	
D0150	Comprehensive oral evaluation - new or established (inactive) patient	0	
D0160	Detailed and extensive oral evaluation - Problem focused, by report	0	
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit)	0	
D0180	Comprehensive Periodontal Exam - GP	0	
	Copay for Specialist Exam - use above codes	0	R
D0210	Intraoral radiographs - complete series (including bitewings)	0	
D0220	Intraoral - periapical, first film	0	
D0230	Intraoral - periapical, each additional film	0	
D0240	Intraoral - occlusal film	0	
D0270	Bitewing - single film	0	
D0272	Bitewings - two films	0	
D0273	Bitewings - three films	0	
D0274	Bitewings - four films	0	
D0330	Panoramic film	0	
D0460	Pulp vitality tests	0	
D0470	Diagnostic casts	0	

Procedure	Description	Copayment	Notes
D1000 – D1999	**I. Preventative**		
D1110	Prophylaxis cleaning - adult	0	
D1120	Prophylaxis cleaning - child	0	
D1203	Topical application of fluoride excluding prophylaxis - child to age 19	0	
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients – child to age 19; 1 per 6 month period	0	
D1330	Oral hygiene instructions	0	
D1351	Sealant - per tooth	0	
D1510	Space maintainer - fixed, unilateral	20	
D1515	Space maintainer - fixed, bilateral	30	
D1520	Space maintainer - removable, unilateral	20	
D1525	Space maintainer - removable, bilateral	30	
D1550	Recementation of space maintainer	10	
D1555	Removal of fixed space maintainer	10	
D2000 – D2335	**III. Minor Restorative**		
D2140	Amalgam - one surface, primary or permanent	10	
D2150	Amalgam - two surfaces, primary or permanent	10	
D2160	Amalgam - three surfaces, primary or permanent	10	
D2161	Amalgam - four or more surfaces, primary or permanent	10	
D2330	Resin-based composite - one surface, anterior	15	
D2331	Resin-based composite - two surfaces, anterior	15	
D2332	Resin-based composite - three surfaces, anterior	15	
D2335	Resin-based composite - four or more surfaces or involving incisal angle	15	
D2391	Resin-based composite - one surface, posterior	50	
D2392	Resin-based composite - two surfaces, posterior	50	
D2393	Resin-based composite - three surface, posterior	50	
D2394	Resin-based composite - four or more surfaces, posterior	50	
D2510 – D2999	**IV. Major Restorative**		
D2510	Inlay - metallic - one surface	115	
D2520	Inlay - metallic - two surfaces	115	
D2530	Inlay - metallic - three surfaces	115	
D2543	Onlay - metallic - three surfaces	125	
D2544	Onlay metallic - four or more surfaces	125	
D2740	Crown - porcelain/ceramic substrate	155	
D2750	Crown - porcelain fused to high noble metal	175	
D2751	Crown - porcelain fused to predominantly base metal	125	
D2752	Crown - porcelain fused to noble metal	150	
D2790	Crown - full cast high noble metal	175	
D2791	Crown - full cast predominantly base metal	125	
D2792	Crown - full cast noble metal	150	
D2794	Crown - titanium	OP	
D2799	Provisional crown	OP	
D2910	Recement inlay	0	
D2915	Recement cast or prefabricated post and core	0	

Procedure	Description	Copayment	Notes
D2920	Recement crown	0	
D2930	Prefabricated stainless steel crown - primary tooth	100	
D2931	Prefabricated stainless steel crown - permanent tooth	100	
D2932	Prefabricated resin crown anterior teeth only	100	Gap
D2940	Sedative filling	20	
D2950	Crown build-up (substructure) including any pins	0	
D2951	Pin retention - per tooth, in addition to restoration	0	
D2952	Post and core in addition to crown, indirectly fabricated	0	
D2953	Each additional indirectly fabricated post – same tooth	0	
D2954	Prefabricated post and core in addition to crown	0	
D2957	Each additional prefabricated post - same tooth	0	
D2970	Temporary crown (fractured tooth)	15	
D2971	Additional procedures to construct new crown under existing partial denture framework	0	
D2980	Crown repair	30	
D3000 - D3999	**V. Endodontics**		
D3110	Pulp cap-direct (excluding final restoration)	0	
D3120	Pulp cap-indirect (excluding final restoration)	0	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp	0	
D3221	Gross pulpal debridement, primary and permanent teeth	NB	
D3230	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	NB	
D3240	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	NB	
D3310	Root canal therapy - anterior (excluding final restoration)	100	
D3320	Root canal therapy - bicuspid (excluding final restoration)	125	
D3330	Root canal therapy - molar (excluding final restoration)	150	R
D3346	Retreatment of previous root canal therapy - anterior	100	R
D3347	Retreatment of previous root canal therapy - bicuspid	125	R
D3348	Retreatment of previous root canal therapy - molar	150	R
D3351	Apexification/recalcification - initial visit	10	R
D3352	Apexification/recalcification - interim visit	10	R
D3353	Apexification/recalcification - final visit	10	R
D3410	Apicoectomy/periradicular surgery - anterior	70	R
D3421	Apicoectomy/periradicular surgery - bicuspid	50	R
D3425	Apicoectomy/per. surgery molar (1st root)	100	R
D3426	Apicoectomy/periradicular surgery (additional root)	25	R
D3430	Retrograde filling - per root	5	R
D3450	Root amputation - per root	0	R
D3920	Hemisection including root removal	0	R
D4000 - D4999	**VI. Periodontics**		
D4210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	75	
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	35	
D4240	Gingival flap procedure - allowed only in conjunction with D4263/D4264	0	R

Procedure	Description	Copayment	Notes
D4241	Gingival flap procedure - allowed only in conjunction with D4263/D4264	0	R
D4245	Apically positioned flap	0	R
D4249	Crown lengthening - hard/soft tissue	35	R
D4260	Osseous surgery- four or more teeth per quadrant	100	R
D4261	Osseous surgery - one to three teeth per quadrant	75	R
D4263	Bone replacement Graft - first site in quadrant	100	R
D4264	Bone replacement Graft - each additional site in quadrant	50	R
D4270	Pedicle soft tissue graft procedure	100	R
D4271	Free soft tissue graft and donor site	50	R
D4341	Periodontal root planing - four or more teeth per quadrant	35	
D4342	Periodontal root planing - one to three teeth per quadrant	15	
D4355	Full Mouth debridement, once every 12months	25	
D4381	Site Specific Therapy	0	R
D4910	Periodontal maintenance following active therapy	35	
D5000 - D5899	**VII. Prosthodontics, removable**		
D5110	Complete denture, maxillary	140	
D5120	Complete denture, mandibular	140	
D5130	Immediate denture, maxillary	140	
D5140	Immediate denture, mandibular	140	
D5211	Maxillary partial denture, resin base	140	GAP
D5212	Mandibular partial denture, resin base	140	GAP
D5213	Maxillary partial denture - metal base with resin saddles	140	
D5214	Mandibular partial denture - metal base with resin saddles	140	
D5225	Maxillary partial denture - flexible base	OP	
D5226	Mandibular partial denture - flexible base	OP	
D5410	Adjust complete denture - maxillary	0	
D5411	Adjust complete denture - mandibular	0	
D5421	Adjust partial denture - maxillary	0	
D5422	Adjust partial denture - mandibular	0	
D5510	Repair broken complete denture base	15	
D5520	Replace missing or broken teeth - complete denture	15	
D5610	Repair resin saddle or base	15	
D5620	Repair cast framework	45	
D5630	Repair or replace broken clasp	30	
D5640	Replace broken teeth - per tooth	10	
D5650	Add tooth to existing partial denture	20	
D5660	Add clasp to existing partial denture	20	
D5670	Replace teeth and acrylic on cast metal framework (mandibular)	NB	
D5671	Replace teeth and acrylic on cast metal framework (maxillary)	NB	
D5710	Rebase complete maxillary denture	60	
D5711	Rebase complete mandibular denture	60	
D5720	Rebase maxillary partial denture	40	
D5721	Rebase mandibular partial denture	40	
D5730	Reline complete maxillary denture (chairside)	40	

Procedure	Description	Copayment	Notes
D5731	Reline complete mandibular denture (chairside)	40	
D5740	Reline maxillary partial denture (chairside)	40	
D5741	Reline mandibular partial denture (chairside)	40	
D5750	Reline complete maxillary denture (laboratory)	50	
D5751	Reline complete mandibular denture (laboratory)	50	
D5760	Reline maxillary partial denture (laboratory)	50	
D5761	Reline mandibular partial denture (laboratory)	50	
D5850	Tissue conditioning, maxillary	15	
D5851	Tissue conditioning, mandibular	15	
D5860	Overdenture - complete, by report	175	
D5861	Overdenture - partial , by report	175	
D6000-D6199	**VIII. Implant Services**		
	Pre-Implant Consultation Fees	$25	R
	Initial Implant Exam or Consultation		
	Detailed and Extensive Oral Evaluation	$ 125	R
	Implant Fees - Case Rates		
	Single Tooth	$2,800	R
	Two Teeth	$5,464	R
	Three Teeth	$7,644	R
	Full Denture (two implants)	$5,120	R
	Full Denture (three implants)	$6,885	R
	Each additional tooth	$2,095	R
D6200 - D6999	**IX. Prosthodontics, Fixed**		
D6210	Pontic - cast high noble metal	175	
D6211	Pontic - cast predominantly base metal	125	
D6212	Pontic - cast noble metal	150	
D6240	Pontic - porcelain fused to high noble metal	175	
D6241	Pontic - porcelain fused to predominantly base metal	125	
D6242	Pontic - porcelain fused to noble metal	150	
D6251	Pontic - resin with predominantly base metal	150	
D6252	Pontic - resin with noble metal	OP	
D6750	Crown - porcelain fused to high noble metal	175	
D6751	Crown - porcelain fused to predominantly base metal	125	
D6752	Crown - porcelain fused to noble metal	150	
D6780	Crown - 3/4 cast high noble metal	175	
D6790	Crown - full cast high noble metal	175	
D6791	Crown - full cast predominantly base metal	120	
D6792	Crown - full cast noble metal	150	
D6930	Recement bridge	0	
D6940	Stress breaker	65	
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	35	
D6972	Prefabricated post and core buildup	35	
D6973	Core buildup for retainer, including any pins	35	
D6976	Each additional indirectly fabricated post – same tooth	35	

Procedure	Description	Copayment	Notes
D6977	Each additional pre-fabricated post- same tooth	35	
D6980	Bridge Repair	NB	
D7000 - D7999	**X. Oral Surgery**		
D7111	Extraction, coronal remnants - deciduous tooth	10	
D7140	Extraction, erupted tooth or exposed root	10	
D7210	Surgical removal of erupted tooth	10	
D7220	Removal of impacted tooth - soft tissue	30	R
D7230	Removal of impacted tooth - partially bony	40	R
D7240	Removal of impacted tooth - completely bony	50	R
D7241	Removal of impacted tooth-completely bony w/complications	50	R
D7250	Surgical removal of residual tooth roots	50	R
D7280	Surgical exposure impacted/unerupted tooth - ortho	15	R
D7283	Placement of device to facilitate eruption of impacted tooth	15	R
D7286	Biopsy of oral tissue, soft	0	R
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces – per quadrant	0	
D7311	Alveoloplasty in conj. With extractions - one to three teeth per quad	0	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces – per quadrant	0	
D7321	Alveoloplasty not in conj. With extractions - one to three teeth per quad	0	
D7340	Vestibuloplasty	NB	R
D7350	Vestibuloplasty - ridge extension	NB	R
D7471	Removal of exostosis - maxilla or mandible	0	R
D7472	Removal of torus palatinus	0	R
D7473	Removal of torus mandibularis	0	R
D7510	Incision and drainage of abscess	0	R
D7960	Frenulectomy (frenectomy or frenotomy)	20	R
D7970	Excision of hyperplastic tissue - per arch	30	R
D8000 - D8999	**XI. Orthodontic Services**		
D8660	Initial orthodontic diagnostic work-up and x-rays	50	
D8070	Full Orthodontic Services	1500	
	Limited Orthodontic treatment of the primary dentition	Prorated	
	Limited Orthodontic treatment of the transitional dentition	Prorated	
	Limited Orthodontic treatment of the adolescent dentition	Prorated	
	Limited Orthodontic treatment of the adult dentition	Prorated	
	Final orthodontic diagnosis, work-up and x-rays	Included	
	Lost metal bands or loose brackets	*	
	* see orthodontic benefits per plan		
	Orthognathic Surgery	Lifetime max $5000	
	Orthognathic surgery	Pre-determination	
	Temporomandibular Joint Treatment	Lifetime max $5000	

Procedure	Description	Copayment	Notes
	TMJ consultation	30	
	TMJ treatment	Pre-determination	
D9000 - D9999	**XII. Additional Procedures**		
D9110	Palliative treatment	15	
D9211	Regional block anesthesia	0	
D9212	Trigeminal division block anesthesia	0	
D9215	Local anesthesia	0	
D9220	general anesthesia: up to 30 minutes (see General Exclusion, bullet #1)	50	R
D9241	Intravenous conscious sedation anesthesia: up to 30 minutes (see General Exclusion, bullet #1)	50	R
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0	
D9440	Office visit - after regularly scheduled hours (nights and weekends)	20	
D9940	Occlusal guards by report	50	
D9951	Occlusal adjustment - limited	35	
D9952	Occlusal adjustment - complete	50	

P	**= Predetermination recommended**
R	**= Referable to a specialist**
GAP	**= Guidelines apply**
NB	**= Not a Benefit on plan**
OP	**= Optional Treatment**

Unlisted dental procedures and treatments that are not specifically excluded will be assigned copayments consistent with those above, based upon comparative complexity and cost.

Basic Benefits

The following basic benefits will be covered subject to the copayment amounts:

1. Oral Examination - Exam of the mouth and teeth.
2. Prophylaxis - Cleaning, scaling and polishing of teeth.
3. Topical Fluoride Application - Applying fluoride to the exposed tooth surface.
4. Periapical and Bitewing X-rays - Dental x-rays of the inside of the mouth. Periapical x-rays reveal the entire tooth and surrounding bone and gum tissue. Bitewing x-rays reveal some of the upper and lower teeth in the same film.
5. Extractions - The surgical removal or pulling of teeth.
6. Fillings - Silver amalgam, resin based composites or Silicate or plastic restorative material is covered.
7. Palliative Emergency Treatment - Emergency treatment primarily for relief, not cure.
8. Space Maintainers - An appliance to preserve the space between teeth caused by premature loss of a primary tooth. The primary teeth are the first teeth, sometimes known as baby teeth.
9. Repair of Dentures and Bridges - Repair or reline artificial teeth.
10. Oral Surgery - Surgery for dental purposes pertaining to the gums, teeth or tooth structure and treatment of dislocations.
11. Apicoectomy - Surgical removal of the tip of the tooth root.
12. Endodontics - The prevention, diagnosis, and treatment of diseases and injuries of the tooth pulp, root and surrounding tissue. This includes pulpotomy, pulp capping and root canal treatment.

13. Periodontic Services and Periodontic Maintenance Procedures Services related to connective tissues around and supporting the teeth; surgical periodontic exams, gingival curettage, gingivectomy, osseous surgery including flap entry and closure, mucogingivoplastic surgery, frenectomy, periodontal grafts, root planing and curettage, and management of acute infection and oral lesions related to the tooth structure.

Prosthodontic Services

Dentures, bridges, partial dentures, related items — including crowns placed on dental implants — and the adjustment or repair of an existing prosthetic device are covered under this benefit.

Replacement of missing teeth with full or partial dentures, crowns or bridges is limited to the charge for the standard procedure.

These services do not include and do not cover:

1. Personalized restoration, precision attachments and special techniques.
2. Replacement of an existing denture, crown or bridge less than five years after the date of the most recent placement.
3. Denture replacements made necessary by loss, theft or breakage.

Implant Services

Dental implant Services are now available to PEBB members enrolled in the DeltaCare Dental Plan offered by Washington Dental Service. Implant Services will be available at select dental offices experienced in providing dental implants. Implant Services will not be available at every participating DeltaCare dental office location.

Enrollees who have been determined by their Primary Care Provider to be candidates for dental implants will be referred to the nearest select dental office trained in the surgical placement of implants.

Washington Dental Service strongly suggests that any implant services be submitted to Washington Dental Service for predetermination prior to commencement of treatment.

Initial Implant Exam or Consultation is subject to a copayment by the subscriber. However, should the enrollee or an enrolled dependent initiate implant services at the office performing the initial Implant Exam or Consultation, the copayment for the Initial Implant Exam or Consultation will be deducted from the copayment of the implant service provided.

Orthodontic Services

Washington Dental Service strongly suggested that orthodontic treatment be submitted to, and predetermined by, WDS prior to commencement of treatment.

Initial orthodontic diagnostic work-up and x-rays are subject to a copayment. However, should the enrollee or an enrolled dependent undergo orthodontic treatment, the initial orthodontia copayment will be deducted from either the partial or full orthodontia copayment.

The copayment for limited orthodontic treatment will be prorated according to the extent of orthodontia services provided. The length of treatment of full orthodontic treatment is not limited. Orthodontic treatment must be provided by a DeltaCare orthodontist.

Temporomandibular Joint Treatment

All treatments of temporomandibular joint disorders (TMJ) must be predetermined before treatment begins. Benefits will be denied if treatment is not predetermined.

Services covered shall include but are not limited to: TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device (occlusal guard), removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis and manipulation under anesthesia.

Benefits for surgical and nonsurgical treatment of TMJ are paid at 70% to a lifetime maximum of $5,000. Annual maximum of $1,000. Covered services must be: 1) appropriate for the treatment of a disorder of the temporomandibular joint; 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; 4) not investigational; and 5) not primarily for cosmetic purposes. All services must be provided or ordered by the enrollee's dentist. Any procedures that are performed in conjunction with TMJ services, and are covered benefits under another portion of the dental plan, are not covered under this portion.

Orthognathic Surgery

All orthognathic treatment must be authorized before treatment begins. Benefits will be denied if treatment is not preauthorized (predetermined).

Orthognathic treatment performed by a licensed dentist or physician is defined as the necessary surgical procedures or treatment to correct the malposition of the maxilla (upper jawbone) and/or the mandible (lower jawbone).

Benefits for orthognathic treatment are paid at 70%. The lifetime maximum for orthognathic benefits is $5,000.

Complications will be covered only if treatment begins within 30 days of the original treatment.

Dental Limitations and Exclusions

Limitations

Diagnostic

- Examination is covered once in a 6-month period;
- Full mouth or panorex x-rays limited to one set every 36 consecutive months;
- Bitewing x-rays limited to not more than one series of 4 films in any 6-month period;

Preventive

- Prophylaxis limited to one treatment in a 6-month period.
- Topical application of fluoride or WDS-approved fluoride varnish is covered twice in a calendar year through the age of 18. Preventive therapies (e.g., fluoridated varnishes) approved by DeltaCare are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy. Children through age 18 are eligible for either topical application of fluoride or preventive therapies, but not both, as described above. Topical application of fluoride or WDS-approved fluoride varnish will be covered when recommended by the DeltaCare provider twice in a calendar year for adults;
- Fissure sealants are limited to non-carious, non-restored permanent first and second molars through the age of 14. The application of fissure sealants is a covered benefit only once in a 3-year period.

Restorative

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period;
- Crowns are covered once in a 5-year period;
- Stainless steel crowns on primary teeth are covered once in a 2-year period;

— Crowns on implants are covered as a specialty procedure once in a 5 year period, may be referred to specialist.

Periodontics

- Root planing/subgingival curettage is covered once in a 12-month period;
- Limited occlusal adjustments are covered once in a 12-month period;
- Site specific therapies (localized delivery of antimicrobial agents) approved by DeltaCare are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy;
- Periodontal surgery is covered once in a 3-year period;
- Soft tissue grafts are covered once in a 3-year period;
- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment;
- One periodontal maintenance therapy treatment, specifically periodontal prophylaxis, is covered once in a 6-month period and is to be charged at the applicable copayment level. Periodontal prophylaxis treatments over one in a 6-month period will be a benefit if in the professional judgment of the DeltaCare primary care dentist the services are necessary for the oral health of the patient. Limited to one cleaning every three months.
- Full-mouth debridement is covered once in a 3-year period;

Endodontics

- Root canal treatment on the same tooth is covered only once in a 2-year period;

Prosthodontics

- Full upper and/or lower dentures are not to exceed one each in any 5-year period and only then if it is unserviceable and cannot be made serviceable;
- Partial dentures are not to be replaced within any 5-year period from initial placement unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible:
- Denture relines are limited to one per denture during any 12 consecutive months except in the case of an immediate denture then a reline is a benefit 6 months after the initial placement;

Accidental Injury

- Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;
- Accidental injury benefits are payable at 100% for an eligible person up to a maximum of $1,600 per patient for any 12-month period. Dental accidental injury benefits shall be limited to services provided to an eligible person when evaluation of treatment and development of a written treatment plan is performed within 30 days from the date of injury and shall not include any services for conditions caused by an accident occurring prior to the patient's eligibility date.
- Accidental injury. 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;

Implant Limitations

- This benefit is limited to surgical placement of implants where the bone and soft tissues are sound and healthy.
- Additional surgery required to improve the site in order to support an implant is not covered.

- This benefit includes restoration of implants to replace single missing teeth and implants placed to support full or removable partial dentures and the full or partial denture that attaches to the implant.
- This benefit does not include an implant-supported bridge to replace multiple missing teeth.
- Implant services will only be covered if the entire implant procedure (including surgery and prosthetics) is performed while a Member or Dependent is covered under the Contract.

Orthodontic Limitations

This program provides coverage for orthodontic treatment plans provided through DeltaCare Primary Care orthodontists. The cost to the patient for the treatment plan is listed in the Schedule of Benefits and Copayments subject to the following:

1. Orthodontic treatment must be provided by a DeltaCare orthodontist.
2. Plan benefits cover active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits.
3. Should a patient's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the patient and not DeltaCare will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the patient's payment shall be based on the provider's allowable fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the patient on such terms and conditions as are arranged between the patient and the orthodontist.
4. If treatment is not required or the patient chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the patient will be charged a consultation fee of $25 in addition to diagnostic record fees.
5. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the dentist's maximum allowable fee.
6. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances.

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation;
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
7. Treatment related to temporomandibular joint disturbances;
8. Supplemental appliances not routinely utilized in typical Phase II orthodontics;
9. Restorative work caused by orthodontic treatment;
10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
11. Extractions solely for the purpose of orthodontics;
12. Treatment in progress at inception of eligibility (except for Orthodontic treatment plans transferred to WDS from Willamette);

13. Transfer after banding has been initiated (except for Orthodontic treatment plans transferred to WDS from Willamette;
14. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

*Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Orthognathic Surgery Limitations

1. Services that would be provided under medical care including but not limited to, hospital and professional services.
2. Diagnostic procedures not otherwise covered under this plan.
3. Any procedures that are performed in conjunction with orthognathic surgery and are covered benefits under another portion of this plan.

General Exclusions

— General anesthesia, intravenous and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary for enrolled members through age 6, or physically or developmentally disabled;

— Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;

— Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which 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;

— Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion without sensitivity 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.

— Dental services performed in a hospital and related hospital fees. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:

a. A hospital setting for the dental care must be medically necessary.
b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
c. Prior to hospitalization, a request for predetermination of dental treatment performed at a hospital is submitted to and approved by DeltaCare. Such request for predetermination must be accompanied by a physician's statement of dental necessity.

If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.

— Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);

— Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;

— Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility (except for Orthodontic treatment plans transferred to WDS from Willamette);

— Cysts and malignancies;

— Laboratory examination of tissue specimen;

— Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;

- Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
- Prophylactic removal of impactions (asymptomatic, nonpathological);
- Specialist consultations for non-covered benefits;
- Orthodontic treatment which involves therapy for myofunctional problems, TMJ, dysfunctions, micrognathia, macroglossia, or hormonal imbalances causing growth and developmental abnormalities;
- All other services not specifically included on the patient's copayment schedule as a covered dental benefit;
- Treatment of fractures and dislocations to the jaw;
- Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Care or Urgent Care".

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The patient must pay the difference in cost between the dentist's maximum allowable fees for the covered benefit and the optional treatment plus any copayment for covered benefits.

Failure to pay a scheduled copayment at the time of service may prevent future dental services from being rendered. Emergency services that are required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability and death, are exempt.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five-year limitation for replacement.

Partial Dentures

1. A removable cast metal partial denture is considered an adequate restoration of a case when more than one tooth is missing in a dental arch. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and the optional treatment, plus any copayment for the covered benefit.
2. If a cast metal partial denture will restore the case, the Primary Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the patient and dentist may choose to use. The patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and the optional treatment plus any copayment for the covered benefit.
3. An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. Patient shall pay the applicable copayment for a cast metal partial denture.

Complete Dentures

4. If, in the construction of a denture, the patient and the Primary Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

5. Full upper and/or lower dentures are not to exceed one each in any five-year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either reline or repair.

Fillings and Crowns

6. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
7. Porcelain or porcelain fused to metal crowns on all 1st, 2nd or 3rd molars are considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
8. The DeltaCare program provides amalgam and resin restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
9. A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including, but not limited to cosmetics, abrasion, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.
10. Composite resin restorations in posterior teeth are not considered optional treatment.
11. Anterior porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
12. A crown placed on a specific tooth is allowable only once in a five-year period from initial placement.
13. A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required.

Fixed Bridges

14. A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years or older. Such treatment will be covered if the patient's oral health and general condition permits.
15. Fixed bridges used to replace missing posterior teeth are considered optional. The patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
16. Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.
17. Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement and shall be covered only when the replacement duplicates the original bridge.
18. Fixed bridges are not a benefit for patients under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Reconstruction

19. The DeltaCare program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Full mouth reconstruction is considered an extensive treatment plan which involves 10 or more crowns or units of fixed bridgework. Treatment plans for full mouth reconstruction require predetermination and may involve annual treatment planning limitations.

Specialized Techniques

20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's allowable fees for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Preventive Control Programs

21. Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed copayments, if any. Irrigation, infusion, special toothbrush, etc., are considered optional treatment. If performed, the patient is responsible for the cost.
22. Follow-up examinations for reevaluation, particularly periodontal reevaluation, are considered to be part of the general service rendered.

Stayplates

23. Stayplates in conjunction with fixed or removable appliances, are only a benefit to replace recently extracted anterior permanent teeth during a healing period.

Frenectomy

24. The frenum can be excised when the tongue has limited mobility; or has a large diastema between teeth; or when the frenum interferes with a prosthetic appliance.

Pedodontia

25. Benefits for dependent children through age three are covered at 100% of the agreed upon fee less any applicable copayments for covered benefits and children four years and older are at 50% of agreed upon fee less any applicable copayments for covered services.

Treatment Planning

26. The objective of this program is to see that all patients are brought to a good level of oral health and that this level of oral health is maintained. To achieve those objectives takes treatment planning. Priorities have been established on the following basis:
    1. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the patient's overall oral health.
    2. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the patient's oral health.
    3. Priority is given to replacement of missing teeth causing a gross lack of function.
    4. Exceptions are made to this treatment planning concept based on individual circumstances.

Eligibility

Eligibility for Public Employees Benefits Board (PEBB) benefits is based on rules in Washington Administrative Code (WAC). PEBB rules are codified in chapter 182-12 WAC and are accessible through the PEBB Rules and Policies section on the PEBB website at www.pebb.hca.wa.gov.

Employees (referred to in this book as “employees,” “subscribers” or “enrollees”) are eligible for enrollment in PEBB dental plans as described in the PEBB eligibility rules in chapter 182-12 WAC.

Retired or permanently disabled employees (referred to in this book as “retirees,” “subscribers” or “enrollees”) of state government, higher education, participating K-12 school districts, educational service districts and participating employer groups are eligible for enrollment in PEBB dental plans in accordance with PEBB rules in chapter 182-12 WAC. Retiree and surviving dependent dental enrollment is contingent upon enrollment in a PEBB medical plan.

Surviving dependents (referred to in this book as “subscribers” or “enrollees”) who meet eligibility criteria are eligible for enrollment in PEBB dental plans in accordance with PEBB rules in chapter 182-12 WAC. Surviving dependents will lose their right to enroll in PEBB coverage if they do not apply to enroll or defer coverage within the timelines stated in PEBB rules or do not maintain continuous comprehensive employer-sponsored health plan coverage during a deferral.

Eligibility criteria for surviving dependents of an eligible employee or an eligible retiree are outlined in WAC 182-12-265. Eligibility criteria for surviving dependents of emergency service personnel who are killed in the line of duty are outlined in WAC 182-12-250.

To be enrolled in a health plan, a dependent must be eligible under WAC 182-12-260 and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The PEBB program verifies the eligibility of all dependents and reserves the right to request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB Program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB Program is unable to verify a dependent's eligibility within a specified time.

The following are eligible as dependents under the PEBB eligibility rules:

1. Lawful spouse.
2. Effective January 1, 2010, Washington State-registered domestic partners, as defined in RCW 26.60.020(1).
3. Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's Washington State-registered domestic partner, or children specified in a court order or divorce decree. In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's Washington State-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program.

   Eligible children include:

   a. Children up to age 26.
   b. Effective January 1, 2011, children of any age with disabilities, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such condition occurs before age 26.

- The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
- The subscriber must notify the PEBB Program, in writing, no later than 60 days after the date that a child age 26 or older no longer qualifies under this eligibility. For example, children who become self-supporting are not eligible as of the last day of the month in which they become capable of self-support.
- Children age 26 and older who become capable of self-support do not regain eligibility under these criteria if they later become incapable of self-support.
- The PEBB Program will certify the eligibility of children with disabilities periodically.

4 Parents.

a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
   - The parent maintains continuous enrollment in a PEBB medical plan;
   - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
   - The subscriber continues enrollment in PEBB insurance coverage; and
   - The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not add additional dependents to their insurance coverage.

Enrollment

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules can be found in the PEBB Rules and Policies section of the PEBB website at www.pebb.hca.wa.gov.

A subscriber or subscriber's dependent is eligible to enroll in only one PEBB dental plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents employed by PEBB participating employers may be enrolled as a dependent under one parent, but not more than one.

Employees are required to enroll in a dental plan under their employing agency. Employees must submit an Employee Enrollment/Change form no later than 31 days after the date the employee becomes eligible for PEBB benefits. If the employee does not meet this requirement, the employee will be enrolled in the Uniform Dental Plan and any eligible dependents cannot be enrolled until the next open enrollment.

Retirees and surviving dependents may enroll in dental. If a retiree or surviving dependent chooses to enroll in a dental plan, at retirement or during an open enrollment, the retiree or surviving dependent must maintain dental coverage for no less than two years, and any dependents enrolled on the subscriber's account will be enrolled in dental as well. The retiree or surviving dependent must return the appropriate enrollment form(s), as instructed on the form, within the time limits required in PEBB rules. (See WAC 182-12).

Subscribers must submit the appropriate forms within the time frames described in PEBB rules. Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB Program. In addition to the appropriate forms indicating dependent enrollment, the PEBB Program may require the subscriber to provide documentation or evidence of eligibility or evidence of the event that created the special open enrollment.

If a subscriber wants to enroll their eligible dependent(s) when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the appropriate forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-12-171, or 182-12-250.

If a subscriber wants to make an enrollment change during the annual open enrollment, the subscriber must submit the appropriate forms no later than the last day of the annual open enrollment.

A subscriber may make an enrollment change outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependent (or both).

Exception: A retiree or surviving dependent may cancel a dependent's enrollment at any time. Surviving dependents of emergency service personnel may not add newly acquired dependents. Retirees or survivors who have deferred their PEBB retiree insurance coverage may only enroll as described in WAC 182-12-200, WAC 182-12-205 or WAC 182-12-250.

The following events create a special open enrollment:

1. Subscriber's dependent becomes eligible under PEBB rules:
    a. through marriage or registering a domestic partnership with Washington's Secretary of State,
    b. through birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. through legal custody or legal guardianship, or
    d. when a child becomes eligible as an extended dependent;
2. Subscriber's dependent no longer meets PEBB eligibility criteria because:
    a. subscriber has a change in marital status or Washington State-registered domestic partnership status, including legal separation documented by a court order;
    b. a child dependent turns age 26;
    c. a child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or
    d. a dependent dies;
3. Subscriber or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
4. Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility for group health coverage or the employer contribution toward insurance coverage;
5. Subscriber or a dependent has a change in residence that affects health plan availability;
6. Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);
7. Subscriber or a dependent becomes eligible for a medical assistance program under the Department of Social and Health Services, including Medicaid or the Children's Health Insurance Program (CHIP), or the subscriber or a dependent loses eligibility in a medical assistance program.

To make an enrollment change during a special open enrollment, the subscriber must submit the appropriate forms no later than 60 days after the event that creates the special open enrollment, except as provided for newborns and newly adopted children as stated below:

If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber must submit the appropriate enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Subscribers are required to remove dependents within 60 days of the date the dependent no longer meets the eligibility criteria in WAC 182-12-250 or 182-12-260. The PEBB Program will remove a subscriber's enrolled dependent the last day of the month in which the dependent ceases to meet the eligibility criteria. Consequences for not submitting notice within 60 days of any dependent ceasing to be eligible may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

When Coverage Begins

For an employee and the employee’s eligible dependent, enrolled when the employee is newly eligible, dental plan enrollment will begin when the employee’s insurance coverage begins as described in WAC 182-12-114. PEBB dependent eligibility is defined in WAC 182-12-260 and dependent enrollment requirements are described in WAC 182-12-262.

Retiring or permanently disabled employees and surviving dependents must meet the procedural and eligibility requirements in chapter 182-12 WAC, which require the employee to submit the appropriate enrollment form(s), as instructed on the forms, to enroll in or defer enrollment in PEBB retiree insurance coverage within 60 days after their employer paid or COBRA coverage ends.

Eligible retirees who are enrolling in a PEBB health plan after deferring coverage should refer to WAC 182-12-200 and 182-12-205 for coverage effective dates. For eligible dependents, dental coverage begins on the first day of the month in which the retiree or survivor’s dental coverage begins if the retiree or survivor lists the dependent on the enrollment form and the dependent meets PEBB eligibility criteria.

For an enrollee enrolled in accordance with PEBB rules during the annual open enrollment, dental coverage will begin on January 1 of the upcoming year.

For an enrollee enrolled in accordance with PEBB rules during a special open enrollment, dental coverage will begin the first of the month following the event that created the special open enrollment or, in cases where the event occurs on the first day of the month, dental coverage will begin on that date.

Exceptions:

- If adding a child due to birth or adoption (or a subscriber assuming a legal obligation for total or partial support in anticipation of adoption), health plan coverage will begin on the day the child is born or adopted. If adding a dependent other than the child, such as a spouse, then coverage begins the first of the month in which the event occurs.
- For a child with disabilities enrolled in accordance with PEBB rules, dental coverage begins on the first day of the month that eligibility is certified by the PEBB Program.

Changing Dental Plans

Subscribers may change health plans at the following times:

During annual open enrollment: Subscribers may change health plans during the annual open enrollment.

During a special open enrollment: Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. The following events create a special open enrollment:

1. Subscriber's dependent becomes eligible under PEBB rules:
    a. through marriage or registering a domestic partnership with Washington's Secretary of State,
    b. through birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. through legal custody or legal guardianship, or
    d. when a child becomes eligible as an extended dependent;
2. Subscriber's dependent no longer meets PEBB eligibility criteria because:
    a. subscriber has a change in marital status or Washington State-registered domestic partnership status, including legal separation documented by a court order;
    b. a child dependent turns age 26;
    c. a child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or
    d. a dependent dies;
3. Subscriber or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
4. Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility for group health coverage or the employer contribution toward insurance coverage;
5. Subscriber or a dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location but the subscriber does not select a new health plan, the PEBB Program may enroll the subscriber in the Uniform Medical Plan or Uniform Dental Plan;
6. Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);
7. Subscriber or a dependent becomes eligible for a medical assistance program under the Department of Social and Health Services, including Medicaid or the Children's Health Insurance Program (CHIP), or the subscriber or a dependent loses eligibility under a medical assistance program;
8. Seasonal employees whose off-season occurs during the annual open enrollment. They may select a new health plan upon their return to work;
9. Subscriber or an eligible dependent becomes entitled to Medicare, enrolls in or disenrolls from a Medicare Part D plan;
10. Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's or an enrolled dependent's physician stops participation

with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists.

NOTE: If an enrollee's dentist or other dental practitioner discontinues participation in an enrollee's plan, the enrollee may not change plans until the next open enrollment period, except as provided in WAC 182-08-198(2). Also, if an enrollee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change plans, except as outlined above.

See the Enrollment section in this booklet for details on where to submit forms.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any individual who ceases to be eligible for PEBB insurance, coverage ends on the last day of the month in which eligibility ends.
2. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
3. For an enrollee who declines the opportunity or is ineligible to continue enrollment in a PEBB plan under one of the options for continuing PEBB benefits described in this certificate of coverage, medical coverage ends for the enrollee at midnight on the last day of the month in which he or she ceases to be eligible.
4. If the subscriber stops paying monthly premiums, coverage ends for the subscriber and enrolled dependents on the last day of the month for which the last full premium was paid. A full month's premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or cancels his or her coverage before the end of the month.

When dental plan enrollment ends, the enrollee may be eligible for continuation of coverage if application is made within the time limits explained in the Continuing Benefits sections of this booklet.

The enrollee is responsible for timely payment of premiums and reporting changes in eligibility or address.

As a PEBB plan enrollee it is the enrollee's responsibility to pay premiums when due. If the enrollee's coverage is canceled due to delinquency, the enrollee's eligibility to participate in PEBB benefits will end.

Failure to report changes can result in loss of premiums and loss of the enrollee and his or her dependents' right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB Program, please call PEBB Customer Service staff at 1-800-200-1004.

Options for Continuing Benefits

Subscribers and their dependents covered by this dental plan may be eligible to continue enrollment during temporary or permanent loss of eligibility. There are four continuation coverage options you may be eligible for as a PEBB enrollee:

- COBRA
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) Coverage
- PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical plan and dental plan coverage. COBRA coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is only available to individuals who meet eligibility and procedural requirements defined in Washington Administrative Code (WAC) 182-12-171 or surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or 182-12-265. These rules are accessible through the PEBB Rules and Policies section of the PEBB website www.pebb.hca.wa.gov.

All four options are administered by the PEBB Program. Refer to your PEBB Initial Notice of COBRA and Continuation Coverage Rights booklet for specific details or call the PEBB Program Customer Service at 1-800-200-1004.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to 26 weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Employees and Dependents Options for Continuing PEBB Benefits."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to this dental plan or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA, in writing, by mail sent to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

Appealing a Determination of Ineligibility for Insurance Coverage

Any employee, retiree, survivor, or Dependent who disagrees with a decision regarding eligibility for PEBB insurance coverage may request reconsideration of the decision. Guidance on filing an eligibility appeal may be obtained in chapter 182-16 WAC (which governs PEBB eligibility appeals), on PEBB's website under "How Do I" (www.pebb.hca.wa.gov), or by calling the PEBB Appeals Manager through the PEBB Program customer service phone line at 1-800-200-1004.

Relationship to Law and Regulations

The language of this Certificate of Coverage (COC) is based on the rules that administer the HCA's PEBB Program in chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, the rules shall govern. This agreement between the HCA and the contracted vendor for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

Release of Information

Enrollees may be required to provide the Uniform Dental Plan or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, dental records. Coverage could be denied if enrollees fail to provide such information when requested.

When a Third Party is Responsible for Injury or Illness (Subrogation)

To the extent of any amounts paid by DeltaCare for an eligible person on account of services made necessary by an injury to or condition of his or her person, DeltaCare shall be subrogated to his or her rights against any third party liable for the injury or condition. DeltaCare 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 DeltaCare in asserting its rights under the Contract, to supply DeltaCare with any and all information and execute any and all instruments DeltaCare reasonably needs for that purpose.

Provided the injured party is in compliance with the above, DeltaCare will prorate any attorneys' fees incurred in the recovery. What this means to you is 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.

Uninsured or Underinsured Motorist Coverage

This DeltaCare 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.

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 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
P.O. Box 75983
Seattle, WA 98175-0983

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

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

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

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

Appeals Committee

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

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

The 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 this 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.

When the Enrollee Has Other Medical Coverage

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

Note: This Plan will always be considered primary (the plan whose benefits are determined first), except under the following circumstances: 1) orthodontic benefits that are payable on a fee-for-service basis shall be based on the rules below; and 2) if both this Contract and the other Plan have provisions stating they are primary, then see the "*Order of Benefit Determination Rules*" below to establish the order of benefit payment under the Plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
    a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
    b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
    b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
    c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
    d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
    e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
        I. The *Plan* covering the *Custodial Parent*, first;
        II. The *Plan* covering the spouse of the *Custodial Parent*, second;
        III. The *Plan* covering the non*custodial Parent*, third; and then
        IV. The *Plan* covering the spouse of the non*custodial Parent*, last
3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

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

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

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the *Primary Plan*, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.

- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each *plan* involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

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

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

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

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

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

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

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

Washington Dental Service DeltaCare

Subscriber Rights and Responsibilities

At Washington Dental Service our mission is to provide quality dental benefit coverage to employers and employees throughout Washington. We view our benefit packages as a partnership between Washington Dental Service, our subscribers and our participating member 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.

The enrollee or dependent has the right to:

- 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 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 the enrollee or dependents 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 his or her 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 copayments 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 number, or family status.

HIPAA Disclosure Policy

Washington Dental Service maintains a Compliance Program which includes an element involving maintaining privacy of information as it relates to the HIPAA Privacy & Security Rule and the Gram-Leach Bliley Act. As such we maintain a HIPAA Privacy member helpline for reporting of suspected privacy disclosures, provide members a copy of our privacy notice, track any unintended disclosures, and ensure the member rights are protected as identified by the Privacy Rule.

Policies and procedures are maintained and communicated to WDS employees with reminders to maintain the privacy of our member's information. We also require all employees to participate in HIPAA Privacy & Security training through on-line education classes, email communications, and periodic auditing.

DELTA DENTAL®
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

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