DENTAL

For Students Only

These Dental Benefits are underwritten by Delta Dental of Washington (DDWA), Seattle, Washington. Please see dental claims and customer service information at the end of this section.

Most dentists in Washington and Idaho are Delta Dental Participating Dentists. For best benefits please verify that yours is a Delta Dental Participating Dentist before receiving care. Listings of participating dentists are available from the WSU Health and Wellness Services Office or DDWA upon request.

ELIGIBILITY, COVERAGE DATES AND TERMINATION

Those eligible to enroll in this Plan are WSU Graduate Student Assistants who are enrolled for 10 or more credit hours; who have an Assistantship stipend of at least 50%; for an academic semester or more and full-time Graduate Research Fellows/Trainees who are paid a stipend of at least $800.00 per month; who are engaged in research similar to that of a Research Assistant.

Each Eligible Graduate Student Assistant or Graduate Research Fellow/Trainee will be advised of automatic enrollment by the Health and Wellness Services Office.

Eligible Graduate Student Assistants and Graduate Research Fellows/Trainees will be insured during these policy periods:

- Fall — Coverage begins 12:01 a.m., August 16, 2015 and ends at 12:01 a.m., January 1, 2016
- Spring/Summer — Coverage begins 12:01 a.m., January 1, 2016 and ends at 12:01 a.m., August 16, 2016

Coverage will terminate for a Covered Student (a) upon expiration of the policy term; (b) upon the date of entry into an armed service on active duty; and (c) for a Student whose appointment as a Graduate Student Assistant or Graduate Research Fellow/Trainee terminates, at the end of the policy period during which the appointment terminated.

CLAIMS PROCEDURE

With DDWA, you may select any licensed dentist; however, your benefits may be paid at a higher level and your out-of-pocket expenses may be lower if you choose a participating DDWA dentist. Tell your dentist you are covered by the WSU/GSA Dental Plan through DDWA Group No. 00681 and give your member identification number.

Delta Dental Participating Dentists

If you select a dentist who is a Delta Dental participating provider, that dentist has agreed to provide treatment for enrolled persons covered by DDWA plans. You will not have to hassle with sending in claim forms. Participating dentists complete claim forms and submit them directly to DDWA. They receive payment directly from DDWA. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan maximum and for any elective care you choose to receive outside the covered dental benefits. You will not be charged more than the participating dentist’s approved fee or the fee that the Delta Dental dentist has filed with us.

Delta Dental PPO Dentists

PPO dentists must be Delta Dental Premier® dentists in order to participate in the PPO network. PPO dentists receive payment based on their PPO filed fees at the percentage levels listed on your Plan for PPO dentists. Patients are responsible only for percentage coinsurance up to the PPO filed fees. PPO is a point-of-service plan, meaning that you can choose any dentist — in or out of the PPO network — at the time you need treatment. However, if you select a dentist who is a PPO dentist, your benefits will likely be paid at a higher level and your out-of-pocket expenses may be lower.
Delta Dental/ Premier® Dentists (non-PPO)
Premier dentists also have contracts with DDWA, but they are not part of the PPO network. Premier dentists will submit claim forms for you and receive payment directly from DDWA.

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

Out-of-State Dentists
If you receive treatment from a dentist outside Washington State, other than a Delta Dental participating dentist, you may be responsible for having the dentist complete and sign a claim form. It may be up to you to ensure that the claim is sent to DDWA. Payment will be based upon the lesser of either the actual charges or the allowed fees, at the percentage levels listed for PPO network dentists.

You will receive a Notice of Payment showing the amount paid on your claim and the amount that is your responsibility.

You may obtain claim forms from WSU Health & Wellness Services Office, Washington Building, (509) 335-3575 or DDWA.

COORDINATION OF BENEFITS

If an enrolled person is entitled to benefits under two or more group dental plans, the amount payable under this Plan will be coordinated with any other plan. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as DDWA would have paid if it was the primary plan.

The benefits of any plan that does not have a coordination of benefits (COB) provision will be primary. The benefits of a plan that covers the enrolled person will be used before those of a plan that provides coverage as a dependent.

If the above order does not establish the primary plan, then the plan that has covered that enrolled person for the longest period of time is the primary plan.

If the enrolled person is covered by more than one health plan, they or their provider should file all claims with each plan at the same time.

If payments that should have been made under this Plan are made by another plan, DDWA has the right, at its discretion, to remit to the other plan the amount it determines appropriate. DDWA is fully discharged from liability under this Plan up to and including the amount of such payment.

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

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

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.
Note: All dental plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary dental 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 dental plan, you or your provider will need to submit your claim to the secondary dental plan within its claim filing time limit to prevent a denial of the claim.

SUMMARY OF DENTAL BENEFITS

POLICY YEAR DEDUCTIBLE PER PERSON - $50 Waived on Class I
Applies to Out-of-Network – Delta Dental Premier Dentists and Nonparticipating Dentists in Washington State Only

Reimbursement Levels
Class I................................................................. 90%
Class II............................................................... 75%
Policy Year Maximum per Person.................................. $1,000

The payment level for covered dental expenses arising as a direct result of an accidental bodily injury is 100%, up to the unused policy year maximum (deductible is waived).

COVERED TREATMENT
CLASS I

DIAGNOSTIC
Covered Treatment
• Diagnostic evaluation for routine or emergency purposes.
• X-rays.

Limitations
• Comprehensive or detailed and extensive oral evaluation is covered once in the patient’s lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
• Routine evaluation is covered twice in a Policy Year. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
• Limited problem-focused evaluations are covered twice in a Policy Year.
• A complete series or a panoramic X-ray is covered once in a three-year period from the date of service.
  o Any number or combination of x-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.
• Supplementary bitewing X-rays are covered once in a Policy Year.
• Diagnostic services and X-rays related to temporomandibular joints jaw joints are not a paid covered benefit under Class I covered dental benefits.

Exclusions
• Consultations.
• Study models.

PREVENTIVE
Covered Treatment
• Prophylaxis (cleaning).
• Periodontal maintenance.
• Space maintainers.

Limitations
• Any combination of prophylaxis and periodontal maintenance is covered twice in a Policy Year.
  o Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
• Space maintainers are covered once in a patient’s lifetime for the same missing tooth or teeth through age 17.
Exclusions
• Plaque control program (oral hygiene instruction, dietary, instruction and home fluoride kits).
• Sealants.
• Preventive resin restorations
• Topical application of fluoride.

CLASS II

You should consult the provider as to any charges that may be your responsibility before treatment begins.

SEDATION
Covered Treatment
• General anesthesia when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
• Intravenous sedation when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

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

PALLIATIVE TREATMENT
Covered Treatment
• Palliative treatment for pain.

RESTORATIVE
Covered Treatment
• Restorations (fillings)
• Stainless steel crowns.

Limitations
• Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service for the following reasons:
  o Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  o Fracture resulting in significant loss of tooth structure (missing cusp)
  o Fracture resulting in significant damage to an existing restoration
• If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicusps), it will be considered as elective procedure and an amalgam allowance will be made. The difference in cost is your responsibility.
• Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
• Stainless steel crowns are covered once in a two-year period from the seat date.

Exclusions
• Overhang removal, copings, re-contouring or polishing of restoration.
ORAL SURGERY  
Covered Treatment  
• Removal of teeth.  
• Preparation of the mouth for insertion of dentures.  
• Treatment of pathological conditions and traumatic injuries of the mouth.

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

PERIODONTICS  
Covered Treatment  
• Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.  
• Services covered include:  
  o Periodontal scaling/root planing  
  o Gingivectomy  
  o Limited adjustments to occlusion (eight teeth or fewer)

Note: Some benefits are available only under certain conditions of oral health. It is recommended that you ask your dentist to submit a predetermination of benefits to DDWA.

Limitations  
• Periodontal scaling/root planing is covered once in a Policy Year.  
• Limited occlusal adjustments are covered once in a Policy Year.

Exclusions  
• Occlusal guard (nightguard)  
• Major (complete) occlusal adjustment.

ENDODONTICS  
Covered Treatment  
• Procedures for pulpal and root canal treatment, services covered include:  
  o Pulp exposure treatment  
  o Pulpotomy  
  o Apicoectomy

Limitations  
• Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.  
• Re-treatment of the same tooth is allowed when performed by a dentist other than the dentist who performed the original treatment and if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions  
• Bleaching of teeth.
ACCIDENTAL INJURY

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I and Class II covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused Plan maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

GENERAL LIMITATIONS (Dental)

- Dentistry for cosmetic reasons is not a paid covered benefit.
- 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 and restorations for malalignment of teeth are not a paid covered benefit.

GENERAL EXCLUSIONS (Dental)

This Plan does NOT cover the following:

- Services for injuries or conditions which are compensable under Worker’s Compensation or Employer’s Liability laws, services which are provided to the covered Student by any federal, state or provincial government agency or provided without cost to the covered Student 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.
- Application of desensitizing agents.
- Experimental services or supplies, which include:
  a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
     i) The services are in general use in the dental community in the state of Washington;
     ii) The services are under continued scientific testing and research;
     iii) The services show a demonstrable benefit for a particular dental condition; and
     iv) They are proven to be safe and effective.
    Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
  b. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. By law, DDWA must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered Student.
  c. Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).
- Analgesics such as nitrous oxide, conscious sedation, or euphoric drugs or injections.
- Prescription drugs.
- In the event a covered Student fails to obtain a required examination from a DDWA-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
• Dental services started prior to the date the Student became covered for services under this program.
• Broken appointments, patient management problems, and completing claim forms.
• Habit breaking appliances, including nightguards, except as specifically provided herein.
• Orthodontic services or supplies.
• Services or supplies for temporomandibular joint dysfunction.
• This Plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner’s policy, or other similar type of coverage.
• In the event a student ceases to be covered, DDWA shall not pay for services beyond the termination date, except for the completion of single procedures prepared prior to termination but completed within three weeks of termination.
• Expense incurred which is recoverable under any other insurance policy or service contract, and expense incurred as a result of acts of some other person and payable by that person.
• All other services not specifically included in this plan as covered dental benefits.

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

CLAIM REVIEW AND APPEAL

Predetermination of Benefits
A predetermination is a request made by your dentist to DDWA to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A predetermination is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made. It is not a guarantee of payment (please refer to the “Initial Benefits Determination” section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete DDWA will notify you and your Dentist in writing that additional information is required in order to process the predetermination. Once the additional information is available your Dentist should submit a new request for a predetermination to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the predetermination is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

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

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

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

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

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

Appeals of Denied Claims

How to contact us

We will accept notice of an Urgent Care Grievance or Appeal if made by you, your covered dependent, or an authorized representative of your covered dependent orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 1-800-554-1907.

Authorized Representative

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

Informal Review

If your claim for dental benefits has been completely or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see above), 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 include the following information:

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

DDWA will review your claim and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. 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.
**Formal Review**

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

Your request for a review by the 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 submitted with your informal review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim within 30 days of receiving your request. Upon completion of their review, the Appeals Committee will send you written notification of their decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person’s life or materially jeopardize the covered person’s health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person’s health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulation.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

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

The Health Insurance Portability and Accountability Act (HIPAA) requires DDWA to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.DeltaDentalWA.com. You may also request a printed copy by calling the DDWA privacy hotline at (800) 554-1907.

**MYSMILE® PERSONAL BENEFITS CENTER**

The MySmile® personal benefits center, available on Delta Dental of Washington’s Web site at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your plan network, review your recent dental activity, check details of your plan coverage, view and print your ID card, check the status of current claims, and more.

**DENTAL CLAIMS QUESTIONS**

**DDWA Group No. 00681**

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

Delta Dental of Washington Customer Service
(800) 554-1907

Written inquiries may be sent to:

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

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

For the most current listing of Delta Dental participating dentists, visit our online directory at Website: www.DeltaDentalWA.com