Delta Dental of Washington

Benefit Booklet

Your all-in-one guide to making the most out of your dental benefits.

Northwest Financial Associations' Employee Benefit Trust

Delta Dental PPO™

Plan Number – 00955 Plan A

Effective Date – January 1, 2027

Welcome to your dental Plan, administered by Delta Dental of Washington (DDWA), a founding member of the nationwide Delta Dental Plans Association.

We believe everyone can enjoy good oral and overall health, with no one left behind. It drives everything we do and has been our sole focus for over 60 years.

Your Plan is a resource to make it easy for you to care for your smile. This benefit booklet summarizes your coverage and describes how your benefits may be used. Understanding your benefits is the first step to getting the most from your dental Plan. Review this booklet before you visit your Dentist and keep it for your reference.

You deserve a healthy smile. We're happy to help you protect it.

Questions Regarding Your Plan

If you have questions about your dental benefits, contact our Customer Service Department at:

Phone: 800-554-1907

Text: 833-604-1246

Online Chat: www.DeltaDentalWA.com

Email: CService@DeltaDentalWA.com

Written inquiries may be sent to:

Delta Dental of Washington

Customer Service Department

P.O. Box 75983

Seattle, WA 98175-0983

For the most up to date of Delta Dental Participating Dentists, visit our online directory at www.DeltaDentalWA.com or call us at 800-554-1907.

Communication Access for Individuals who are Deaf, Hard of Hearing, DeafBlind or Speech-Disabled

Communication with Delta Dental of Washington is available through Washington Relay Service, a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

This service allows individuals who are Deaf, Hard of Hearing, DeafBlind, or speech disabled to communicate with Delta Dental of Washington through specially trained communications assistants using a variety of relay methods.

To access the relay service, dial 711 (statewide) or 800-833-6384. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. The assistant will then relay the conversation between you and our representatives.

The Washington Relay Service is available 24 hours a day, 7 days a week, at no cost to users. All relay calls are confidential.

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Section A – Summary of Benefits

Reimbursement Levels for Allowable Benefits

In-Network – Delta Dental PPO™ Dentists

Class I 70-100%

Class II 70-100%

Class III 50%*

TMJ procedures 50%

Annual Deductible per person ..... No Deductible

Annual Deductible — Family maximum ..... No Deductible

Out-of-Network – Non-Delta Dental PPO Dentists

Class I 70-100%

Class II 70-100%

Class III 50%*

TMJ procedures 50%

Annual Deductible per person $50

Annual Deductible — Family maximum $150

**There is a 12-month waiting period for Class III benefits for all new enrollees. The waiting period does not apply to new financial institutions with existing dental coverage coming into The Trust.*

Note: Please see the "Choosing a Dentist" section for more information on Dentist networks and the network for your Plan.

Plan Maximum

Annual Plan Maximum per person $2,000

Lifetime TMJ Maximum per person..... $5,000

Annual TMJ Maximum per person $1,000

The Payment Level for covered dental expenses arising as a direct result of an accidental injury is 100 percent, up to the unused Plan Maximum.

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III Covered Dental Benefits, Temporomandibular Joint Benefits (TMJ), and Accidental Injury Benefits.

The annual Deductible is waived for:

- ◊ Class I Covered Dental Benefits.
- ◊ Accidental Injury Benefits.

How to use your Plan

The best way to take full advantage of your dental Plan is to know its features. You can learn them by reading this benefit booklet before you go to the Dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions. If you have questions or do not understand something, please give us a call at 800-554-1907. We're more than happy to help.

Consult your provider regarding any charges that may be your responsibility before treatment begins. For a more detailed estimate specific to your treatment plan, please refer to the "Pre-Treatment Cost Estimate" section.

Coinsurance

DDWA will pay a percentage of the cost of your treatment, and you are responsible for paying the allowable balance. The part you pay is called the Coinsurance and the part we pay is referred to as the Reimbursement. If your Plan has a Deductible, you are responsible for the Coinsurance even after a Deductible is met.

Please see your "Reimbursement Levels for Allowable Benefits" under the "Summary of Benefits" section for details on the Coinsurance required by your Plan.

Benefit Period

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

Plan Maximum

The Plan Maximum is the maximum dollar amount DDWA will pay toward the cost of dental care within a specific Benefit Period. The maximum amount payable for Covered Dental Benefits in each Benefit Period is listed in the "Summary of Benefits" section.

Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed, also known as the Seat Date. Amounts paid for such procedures will be applied to the Plan Maximum based on the incurred date.

Plan Deductible – In-Network

This Plan does not have an In-Network Deductible requirement.

Plan Deductible – Out-of-Network

Your Plan has a Deductible, which can be found in the "Summary of Benefits" section. This means that from the first payment or payments DDWA makes for Covered Dental Benefits, a deduction is taken. This deduction is owed to the provider by you. Once an Enrolled Person has satisfied the Deductible during the Benefit Period, no further deduction will be taken for that Enrolled Person until the next Benefit Period.

Your family Deductible is also listed in the "Summary of Benefits" section. Once a family has satisfied the maximum Deductible amount during the Benefit Period, no further deduction will apply to any member of that family until the next Benefit Period.

Reimbursement Levels

Your Plan is a Group based incentive Plan. It is designed to encourage prevention by rewarding you for receiving preventive care and other dental services during each incentive period.

The incentive period consists of the following 12-month period:

Your Group's Incentive Period
First day of January through the last day of December

Your dental Plan offers different classes of covered treatment. Each class also specifies Limitations and Exclusions. For more information about reimbursement levels for your plan, see the "Summary of Benefits" section.

Refer to the "Benefits Covered by Your Plan" section for specific Covered Dental Benefits under this Plan.

Reimbursement Levels for Class I and Class II Procedures

The original Payment Level for covered and allowable Class I (diagnostic and preventive) and Class II (basic) procedures for the first incentive period is set by your employer at the minimum Payment Level. This Payment Level increases 10 percentage points each successive incentive period in which the covered person uses the benefits under this Plan up to the maximum Payment Level. Once you reach your maximum level, the Plan will stay at the maximum level if you use your benefit during each consecutive incentive period.

Minimum Payment Level 70%	Maximum Payment Level 100%

If a covered person fails to use benefits during an incentive period, the Payment Level will be decreased by 10 percentage points from the level you were at when you last used your benefits. An additional 10 percentage point decrease will happen for each successive incentive period during which benefits are not used until you reach the minimum Payment Level set by your employer.

Each Enrolled Person establishes their own Payment Levels through utilization during incentive periods.

Reimbursement Levels for All Other Procedures

Please see the "Summary of Benefits" section for more information about reimbursement levels for all other procedures.

Section B – Your Benefits

Benefits Covered by Your Plan

The following section summarizes the Covered Dental Benefits under this Plan, which are subject to the Limitations and Exclusions (refer also to "General Exclusions" section) contained in this benefit booklet. Such benefits (as defined) are available only when provided by a licensed Dentist or other Licensed Professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

Your Dentist may recommend treatments that are not covered by this Plan.

DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your Dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Pre-Treatment Cost Estimate" section.

The amounts payable by DDWA for Covered Dental Benefits are described in the "Summary of Benefits" section.

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

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

- Comprehensive, or detailed and extensive oral evaluation.
- Diagnostic evaluation for routine or emergency purposes (dental exam).
- 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 evaluations from the same Dentist are paid as a Periodic Oral Evaluation.
- Routine evaluation is covered twice in a Benefit Period. For purposes of this limitation, routine evaluation include all evaluations, but limited problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a Benefit Period.
- A set of Bitewing X-rays (two or more images) is covered once in a Benefit Period.
    - A single Bitewing X-ray is covered, there are no Limitations on the number of single Bitewing X-rays a patient can have.
- A Comprehensive Series or Panoramic X-ray is covered once in a five-year period from the date of service.
    - Any number or combination of x-rays, with the exception of a Panoramic X-ray, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a Comprehensive Series, will be considered a Comprehensive Series for payment and benefit limitation purposes.

Exclusions

- Consultations – diagnostic services provided by a Dentist other than the requesting Dentist.

- Study models.
- Diagnostic services and x-rays related to Temporomandibular Joints (jaw joints).

Please also see:

- "Temporomandibular Joint Benefits (TMJ)" section for information on x-rays related to Temporomandibular Joint benefits.

Class I Preventive

Covered Dental Benefits

- Prophylaxis (cleaning).
- Periodontal maintenance.
- Topical Fluoride: full-mouth application of medicament, including fluoridated varnishes.
- Sealants.
- Space maintainers.
- Application of Caries arresting or primary prevention medicament without surgical intervention.

Limitations

- Any combination of Prophylaxis (cleaning), periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation is covered twice in a Benefit Period.
    - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- For any combination of adult Prophylaxis (cleaning), periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation, third and fourth occurrences may be covered if your gums have Pocket Depth readings of 5mm or greater.
- Topical Fluoride is limited to two covered procedures in a Benefit Period.
- The application of a Sealant is covered once in a two-year period per tooth from the date of service.
    - Benefit coverage for application of Sealants is limited to permanent molars that have no restorations on the occlusal (biting) surface.
- Space maintainers are covered once in a patient's lifetime through age 17 for the same quadrant.
- The application of Caries arresting or primary prevention medicament without surgical intervention is covered twice per Benefit Period per tooth.

Exclusions

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

Please also see:

- "Class II Periodontics" section for scaling in presence of generalized moderate or severe gingival inflammation.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a **Pre-Treatment Cost Estimate** request to determine if the treatment is a Covered Dental Benefit. A **Pre-Treatment Cost Estimate** is not a guarantee of payment. See the "**Pre-Treatment Cost Estimate**" section for additional information.

Class I Periodontics

Covered Dental Benefits

- Prescription-strength Fluoride toothpaste.
- Prescription-strength antimicrobial rinses.

Limitations

- Prescription-strength Fluoride toothpaste and prescription-strength antimicrobial rinse is covered following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's history with DDWA must show a periodontal procedure within the previous 180 days.
- Prescription-strength antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- Prescription-strength Fluoride toothpaste and prescription-strength antimicrobial rinse is available during pregnancy without any periodontal procedure.

Class II Benefits

Class II Sedation

Covered Dental Benefits

- General Anesthesia.
- Intravenous moderate sedation.

Limitations

- General Anesthesia is covered only in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with Class I, II, III, or TMJ Covered Dental Benefits.
- Intravenous moderate sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.
- Sedation, which is either General Anesthesia or intravenous moderate sedation, is covered only once per day.
- General Anesthesia or intravenous moderate sedation for routine post-operative procedures is covered only for children through the age of six, or a physically or developmentally disabled person.

Exclusions

- General Anesthesia or intravenous moderate sedation for routine post-operative procedures for children over the age of seven or for persons who are not physically or developmentally disabled.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a **Pre-Treatment Cost Estimate** request to determine if the treatment is a Covered Dental Benefit. A **Pre-Treatment Cost Estimate** is not a guarantee of payment. See the "**Pre-Treatment Cost Estimate**" section for additional information.

Class II Palliative Treatment

Covered Dental Benefits

- Palliative Treatment for pain.

Limitations

- Post-operative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Class II Restorative

Covered Dental Benefits

- Restorations (fillings).
- Stainless steel Crowns or prefabricated Crowns.
- Implant-supported Crowns.
- Posterior composites.
- Crowns, Veneers, or Onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in a significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- Crown buildups.
- Post and core on endodontically-treated teeth.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- Restorations are covered for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).
  - Fracture resulting in significant loss of tooth structure (missing cusp).
  - Fracture resulting in significant damage to an existing restoration.
- Stainless steel Crowns or prefabricated Crowns are covered on all primary and permanent teeth once in a two-year period from the date of service.
- A Crown, Veneer or Onlay on the same tooth is covered once in a seven-year period from the original Seat Date.
- An Implant-supported Crown on the same tooth is covered once in a five-year period from the original Seat Date of a previous Crown on the same tooth.
- Payment for a Crown, Veneer, Inlay, or Onlay shall be paid based upon the date that the treatment or procedure is completed.
- An Inlay (as a single tooth restoration) will be considered as an elective treatment and an Amalgam allowance will be made, with any difference in cost being the responsibility of the Enrolled Person, once in a two-year period from the Seat Date.
- A Crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a Restorative Crown.
- A Crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a Restorative Crown.

- A Crown buildup is covered once in a two-year period on the same tooth from the date of service.
- A post and core is covered once in a seven-year period on the same tooth from the date of service.
- Crown buildups or post and cores are Not a Paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.
- A Crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial Denture is Not a Paid Covered Dental Benefit unless the tooth is decayed to the extent that a Crown would be required to restore the tooth, whether or not a removable partial Denture is part of the treatment.

Exclusions

- Overhang removal.
- Copings.
- A core buildup with placement of an Onlay, 3/4 Crown, or Veneer.
- Re-contouring or polishing of a restoration.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion.
- A Crown or Onlay placed because of weakened cusps, when used to repair micro-fractures (cracks) of tooth structure when the tooth is asymptomatic (displays no symptoms), or there is an existing restoration with no evidence of decay, fractured (broken) off tooth structure, or other significant pathology.

Note: A crown may be recommended by your Dentist for a variety of clinical reasons; however, only those meeting the clinical criteria outlined within the provisions of this Plan are eligible for coverage.

It is strongly recommended that you have your Dentist submit a **Pre-Treatment Cost Estimate** request to determine if the treatment is a Covered Dental Benefit. A **Pre-Treatment Cost Estimate** is not a guarantee of payment. See the "**Pre-Treatment Cost Estimate**" section for additional information.

Class II Oral Surgery

Covered Dental Benefits

- Removal of teeth.
- Preparation of the mouth for insertion of Dentures.
- Treatment of pathological conditions and traumatic injuries of the mouth.

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.
- Orthognathic surgery or treatment.
- Tooth transplants.
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

Please also see:

- "Class II Sedation "section for additional information.

Class II Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- Scaling in presence of generalized moderate or severe gingival inflammation.
- Periodontal scaling/Root Planing.
- Periodontal surgery.
- Limited Occlusal Adjustments (eight teeth or fewer).
- Gingivectomy.

Limitations

- Periodontal scaling/Root Planing is covered once per quadrant in a three-year period from the date of service.
- Limited Occlusal Adjustments are covered once in a 12-month period from the date of service.
- Any combination of Prophylaxis (cleaning), periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation is covered twice in a Benefit Period.
    - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- For any combination of adult Prophylaxis (cleaning), periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation, third and fourth occurrences may be covered if your gums have Pocket Depth readings of 5mm or greater.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
    - Periodontal surgery must be preceded by scaling and Root Planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- Soft tissue grafts (two teeth per quadrant) are covered once in a three-year period from the date of service.

Exclusions

- Localized Delivery of Antimicrobial Agents.

Please also see:

- "Class I Preventive" section for Prophylaxis (cleaning) and periodontal maintenance.
- "Class II Sedation" section for additional information.
- "Class III Periodontics" section for complete Occlusal Adjustment or Occlusal Guard.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a **Pre-Treatment Cost Estimate** request to determine if the treatment is a Covered Dental Benefit. A **Pre-Treatment Cost Estimate** is not a guarantee of payment. See the "**Pre-Treatment Cost Estimate**" section for additional information.

Class II Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, including pulp exposure treatment, Pulpotomy, and Apicoectomy.

Limitations

- Root canal treatment on the same tooth is covered once in a lifetime.
- Re-treatment of the same tooth is Not a Paid Covered Dental Benefit when performed within two years of the previous root canal treatment.

Exclusions

- Bleaching of teeth.

Please also see:

- "Class II Sedation" section for additional information.

Class III Benefits

There is a 12-month waiting period for Class III benefits for all new enrollees. The waiting period does not apply to new financial institutions with existing dental coverage coming into The Trust.

Class III Periodontics

It is strongly recommended that prior to treatment you have your Dentist submit a Pre-Treatment Cost Estimate to determine if the planned treatment is a Covered Dental Benefit. A Pre-Treatment Cost Estimate is not a guarantee of payment.

Covered Dental Benefits

- Occlusal Guard (Nightguard).
- Repair and relines of Occlusal Guard.
- Complete Occlusal Adjustment (more than eight teeth).

Limitations

- Occlusal Guard is covered once in a three-year period from the date of service.
- Occlusal Guard repair and relines done more than six months after the date of initial placement are covered.
- Complete Occlusal Adjustment is covered once in a lifetime.

Class III Prosthodontics

Covered Dental Benefits

- Dentures.
- Fixed Partial Dentures (fixed Bridges).
- Inlays when used as a retainer for a Fixed Partial Denture (fixed Bridge).
- Removable partial Dentures.
- Adjustment or repair of an existing prosthetic appliance.
- Surgical placement or removal of Implants or attachments to Implants.

Limitations

- Replacement of an existing fixed or removable partial Denture is covered once every five years from the Delivery Date and only then if it is unserviceable and cannot be made serviceable.
- Payment for Dentures, Fixed Partial Dentures (fixed Bridges), Inlays (only when used as a retainer for a fixed Bridge), and removable partial Dentures shall be paid upon the Seat/Delivery Date.
- Implants and superstructures are covered once every five years.
- **Interim (temporary) Denture -** DDWA will allow the amount of a reline toward the cost of an interim partial or full Denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Denture adjustments and relines -** Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

- Crowns in conjunction with Overdentures.
- Duplicate Dentures.
- Personalized Dentures.
- Copings.
- Implant Maintenance.
- Maintenance or cleaning of a prosthetic appliance.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a **Pre-Treatment Cost Estimate** request to determine if the treatment is a Covered Dental Benefit. A **Pre-Treatment Cost Estimate** is not a guarantee of payment. See the "**Pre-Treatment Cost Estimate**" section for additional information.

Other Benefits

TotalHealth Wellness Program

Members with certain qualifying medical conditions are eligible for additional cleaning benefits. If you are diagnosed as having one or more qualifying medical conditions that fall within the categories listed below, you are eligible to receive additional cleaning benefits under this Plan. Please refer to the benefit sections above to determine the class of coverage for each cleaning.

Qualifying Medical Conditions

- Pregnancy
- Alzheimer's
- Cancer
- Oral Cancer
- Chronic Kidney Disease
- Diabetes
- Dementia
- Heart disease
- Huntington's disease
- Joint Replacement
- Sjögren's syndrome
- Stroke
- Amyotrophic lateral sclerosis (ALS)
- Lupus
- Opioid misuse and addiction
- Parkinson's disease
- Rheumatoid arthritis
- Periodontal disease
- Other neurological diseases
- Other auto immune diseases

Note: In order to receive the additional benefits, you must notify us through your MySmile® account at www.DeltaDentalWA.com or by calling us at 800-554-1907.

Covered Dental Benefits

- Additional Prophylaxis or,
- Additional periodontal maintenance or,
- Additional scaling in presence of generalized moderate or severe gingival inflammation.

Limitations

- Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Additional cleanings for pregnancy will be available in the current Benefit Period after you notify us of your pregnancy and for one Benefit Period thereafter.
    - For all other qualifying conditions besides pregnancy, additional cleanings are available in the current Benefit Period and for each Benefit Period thereafter, as long as you continue to have one or more qualifying medical conditions.
- A maximum of up to four cleanings are allowed in a Benefit Period.

Temporomandibular Joint Benefits (TMJ)

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

"Dental Services" are those that are:

1) Appropriate 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; and
4) Not experimental or primarily for cosmetic purposes.

Both surgical and non-surgical procedures are covered. Non-surgical procedures include, but are not limited to:

- TMJ examination.
- X-rays (including TMJ film and arthrogram).
- Temporary repositioning splint.
- Occlusal orthotic device.
- Removable metal overlay stabilizing appliance.
- Fixed stabilizing appliance.
- Occlusal Adjustment.
- Arthrocentesis.
- Manipulation under anesthesia.

The annual maximum amount payable by DDWA for covered dental services related to the treatment of TMJ disorders is $1,000, with a Lifetime Maximum amount payable of $5,000, for each covered person, after you have satisfied your

Deductible (if applicable). The amounts payable for TMJ benefits during the Benefit Period shall not be applied to the covered person's annual Plan Maximum.

Note: It is strongly recommended that you have your Dentist submit a **Pre-Treatment Cost Estimate,** including your TMJ treatment plan, be submitted to DDWA prior to the commencement of treatment. A **Pre-Treatment Cost Estimate** is not a guarantee of payment. See the "**Pre-Treatment Cost Estimate**" section for additional information.

Accidental Injury

DDWA will pay 100 percent of the Filed Fee or the Maximum Allowable Fee for Class I, Class II, and Class III 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 Exclusions

This Plan may not cover every part of the dental care you might need. The benefits covered under this Plan are subject to Limitations listed above which affect the type or frequency of procedures which will be reimbursed. Additionally, there are Exclusions to the type of services covered. These Limitations and Exclusions are detailed with the specific benefits listed above and in this "General Exclusion" section. Please read this section carefully.

These items are not paid Covered Dental Benefits under this Plan.

1) Dentistry for cosmetic reasons.
2) Cone beam CT imaging or scan.
3) Restorations or appliances, including crowns, necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
4) Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered 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.
5) Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
6) Experimental services or supplies.
    a) This includes:
        i) 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:
            (1) The services are in general use in the dental community in the state of Washington;
            (2) The services are under continued scientific testing and research;
            (3) The services show a demonstrable benefit for a particular dental condition; and
            (4) They are proven to be safe and effective.
    b) Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
    c) Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an 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 person.

d) 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 72 hours after receipt of the Appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.

7) Analgesics such as nitrous oxide, conscious sedation, and euphoric drugs.
8) Injections of anesthetic not in conjunction with a dental service.
9) Injection of any medication or drug not associated with the delivery of a covered dental service.
10) Prescription drugs.
11) Laboratory tests and laboratory exams.
12) Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
13) Charges for missed appointments.
14) Behavior management.
15) Completing claim forms.
16) Orthodontic services or supplies are not covered unless Optional Orthodontic coverage has been selected.
17) This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable 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.

DDWA shall determine whether services are Covered Dental Benefits in accordance with a standard dental practice and the Limitations and Exclusions shown in this benefit 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 benefit booklet and may seek judicial review of any denial of coverage of benefits.

Pre-Treatment Cost Estimate

A Pre-Treatment Cost Estimate, also known as a predetermination of benefits, is a request made by your Dentist to DDWA to determine your benefits for a particular service. This Pre-Treatment Cost Estimate will provide you and your Dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A Pre-Treatment Cost Estimate is not an authorization for services but a notification of Covered Dental Benefits available at the time the Pre-Treatment Cost Estimate is made and is not a guarantee of payment (please see the "Initial Benefit Determination" section regarding claims requirements).

A standard Pre-Treatment Cost Estimate 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 Pre-Treatment Cost Estimate. Once the additional information is available your Dentist should submit a new request for a Pre-Treatment Cost Estimate to DDWA.

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

Urgent Pre-Treatment Cost Estimate Requests

Should a Pre-Treatment Cost Estimate 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 the receipt of the request and all supporting documentation. When practical, DDWA may provide notice of the determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a Pre-Treatment Cost Estimate in an emergency situation subject to the Contract provisions.

Section C – Choosing a Dentist

Your Provider Network is: Delta Dental PPO Network.

You may select any licensed Dentist to provide services under this Plan; however, if you choose a Dentist outside of the Delta Dental PPO Network, your costs may be higher than if you were to choose a Delta Dental PPO Dentist. Dentists that do not participate in the Delta Dental PPO Network have not contracted with DDWA to charge our established PPO fees for covered services. As a result, your choice of Dentists could substantially impact your out-of-pocket costs.

Once you choose a Dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your Group and your member identification number. Your Group information can be found on your identification card which can be accessed by logging in to your MySmile® account at www.DeltaDentalWA.com. You may also obtain your Group information and your member identification number by calling our Customer Service Department at 800-554-1907.

DDWA uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft.

Please note that ID cards are not required to see your Dentist but are available for your convenience.

Delta Dental Participating Dentists

Dentists who have agreed to provide treatment to patients covered by a DDWA plan are called 'Participating' Dentists. For your Plan, Participating Dentists may be either Delta Dental Premier Dentists or Delta Dental PPO Dentists. You can find the most current listing of Participating Dentists by going online to the DDWA website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

Delta Dental Premier Dentists

Our Premier Dentists have agreed to provide services for their Filed Fee under our standard agreement.

Delta Dental PPO Dentists

Our PPO Dentists have agreed to provide services at a fee lower than their original Filed Fee. Because of this, selecting a PPO Dentist may be a more cost-effective option for you.

If you select a Delta Dental Participating Dentist, they will complete and submit claim forms and receive payment directly from DDWA on your behalf. You will not be charged more than the Participating Dentist's approved fee. 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.

Non-Participating Dentists

If you select a Dentist who is not a Delta Dental Participating Dentist, you are responsible for ensuring either you or your Dentist completes and submits a claim form. We accept any American Dental Association-approved claim form that you or your Dentist may provide. You can also download a claim form by logging on to your MySmile® account on our website at www.DeltaDentalWA.com or obtain a form by calling us at 800-554-1907.

Payment for services performed by a Non-Participating Dentist will be based on their actual charges or DDWA's Maximum Allowable Fees for Non-Participating Dentists, whichever is less. You will be responsible for paying any balance remaining to the Dentist. Please be aware that DDWA has no control over Non-Participating Dentist's charges or billing practices.

Out-of-State Dentists

If you receive treatment from a Non-Participating Dentist outside of the state of Washington, your Coinsurance amounts will be based on the Coinsurance percentage established for a Delta Dental PPO Dentist. Allowable amounts paid for covered services will be based on the Maximum Allowable Fee for a Participating Dentist in that state, or their actual fee, whichever is less.

Out-of-Country Coverage

Dentists who are located outside of the United States (this does not include US Territories – Guam, Puerto Rico, and the US Virgin Islands) are Non-Participating Dentists. If you receive treatment outside of the United States, you are responsible for ensuring either you or your Dentist completes and submits a claim form. We will accept an "Out of The Country Claim Form" which can be downloaded from our website at www.DeltaDentalWA.com or obtained by calling us at 800-554-1907. You may submit the claim by email at outofcountry@deltadentalwa.com, by mail at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983, or by fax at 509-685-6599. When submitting the claim, you must include a copy of the payment receipt showing treatment has been paid. For more information, please call us at 800-554-1907.

Section D – Eligibility and Termination

Employee Eligibility and Enrollment

An Eligible Employee is an employee who meets the qualifications for eligibility established by Group.

Eligible Employees become Enrolled Employees once they have fully completed the enrollment process and DDWA has received the employer contributions or eligibility information for their enrollment.

New employees are eligible to enroll in this Plan on the first day of the month after satisfying any waiting period established by the Participating Employer.

You must complete the enrollment process in order to receive benefits.

Employee Termination

Eligibility and Coverage terminates at the end of the month in which you cease to be an employee, or at the end of the month for which timely payment of monthly Premiums was made by Group on your behalf to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

In the event of a suspension or termination of compensation, directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may continue coverage by paying the applicable Premium directly to your employer for a period not to exceed six months. Payments of Premiums must be made when due, or DDWA may terminate the coverage. If continued coverage is needed after the six-month period, please see the "Conversion Option" section.

The benefits under your DDWA dental Plan may be continued provided you are eligible for Federal Family and Medical Leave Act (FMLA), or Washington State's Paid Family Medical Leave (PFML) and you are on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

Dependent Eligibility and Enrollment

Eligible Dependents are your spouse or domestic partner, and children of yours, your spouse, or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. A dependent child's spouse and/or child(ren) are not eligible for coverage under this Plan.

Non-registered domestic partnership is a relationship whereby two people:

1) Share the same regular and permanent residence;
2) Have a close personal committed relationship;
3) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
4) Are not married to anyone;
5) Are each 18 years of age or older;
6) Are not related by blood closer than would bar marriage in their state of residence;
7) Were mentally competent to consent to contract when the domestic partnership began; and
8) Are each other's sole domestic partner and are responsible for each other's common welfare.

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

A new family member, with the exception of newborns, adopted and foster children, will be enrolled on the first day of the month following the date they qualify as an Eligible Dependent.

A newborn shall be covered from and after the moment of birth, and an adopted child or child placed in anticipation of adoption shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement.

A child will be considered an Eligible Dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the eligible Enrolled Employee for the purpose of adoption under the laws of the state in

which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption.

When additional Premium is required for a newborn or adopted child or child placed in anticipation of adoption, enrollment must be received by DDWA within the timeframe listed under "Marriage, Birth or Adoption" section, which is no less than 60 days from the date of the qualifying event.

When additional Premium is not required for a newborn or adopted child or child placed in anticipation of adoption, we encourage enrollment as soon as possible to prevent delays in claims processing but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Enrolled employees who choose not to enroll an Eligible Dependent during the initial enrollment period of the dental Plan may enroll the Eligible Dependent only during an Open Enrollment Period, except under special enrollment. See the "Special Enrollment Periods" section for more information. An Enrolled Dependent is an Eligible Dependent that has completed the enrollment process.

Dependent Termination

Enrolled Dependent coverage terminates at the end of the month in which the Enrolled Employee's coverage terminates, or when the dependent ceases to be eligible, whichever occurs first.

Unless otherwise indicated, an Enrolled Dependent shall cease to be enrolled in this Plan on the last day of the month of the Enrolled Employee's employment, or when the person no longer meets the definition of an Eligible Dependent, or the end of the calendar month for which Group has made timely payment of the monthly Premiums on behalf of the Enrolled Employee to DDWA, or upon termination of Group's Contract with DDWA, whichever occur first.

A Dependent may be enrolled or terminated from coverage or reinstate coverage under this Plan during an Open Enrollment Period or during a Special Enrollment Period following a qualifying event as defined in the "Special Enrollment Periods" section.

Other Dependent Eligibility Topics

Coverage for an Enrolled Dependent child who attains the limiting age while covered under this Plan will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of developmental disability (attributable to intellectual disability or related conditions which include cerebral palsy, epilepsy, autism, or another neurological condition which is closely related to intellectual disability or which requires treatment similar to that required for intellectually disabled individuals) or physical disability; and 2) chiefly dependent upon the Enrolled Person for support and maintenance. Continued coverage requires that proof of incapacity and dependency be furnished to DDWA within 31 days of the dependent's attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the Plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. If the parent is not enrolled in the Plan, the parent must enroll for coverage for both the parent and the child. If the Plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the Plan.

Special Enrollment Periods

Enrollment or termination of you or your Eligible Dependent is allowed during an Open Enrollment Period, and during Special Enrollment Periods, which are triggered by the following situations:

Loss of Other Coverage

If you and/or your Eligible Dependents involuntarily lose coverage or are no longer eligible under another dental Plan, you may apply for coverage or make changes under this Plan if the following applies:

- You declined enrollment in this Plan.
- You lose eligibility in another health Plan, or your coverage is terminated due to the following:
  - Legal separation or divorce
  - Cessation of dependent status
  - Death of Employee
  - Termination of employment or employer contributions
  - Reduction in hours
  - Loss of individual or Group market coverage due to moving away from the Plan area or termination of benefit Plan
  - Exhaustion of COBRA coverage
- The enrollment process must be completed within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

If these conditions are not met, you must wait until the next Open Enrollment Period, or the occurrence of another valid qualifying election event, to apply for coverage.

Marriage, Birth or Adoption

If you declined enrollment in this Plan, you may apply for coverage for yourself and your Eligible Dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support or upon placement of a child(ren) in anticipation of adoption.

- Marriage or Domestic Partner Registration – The enrollment process must be completed within the timeframe established by the Group, but not less than 30 days. If enrollment and payment are not completed within the timeframe established, any changes to enrollment can be made during the next Open Enrollment Period or upon the occurrence of another valid qualifying election change event.

  DDWA treats domestic partnerships the same as marriages for purposes of eligibility and coverage, in accordance with applicable state and federal law. References to spouses or marriage in this Plan include registered domestic partners. References to dissolution of marriage will apply equally to the termination of a domestic partnership.
- Birth – A newborn shall be covered from and after the moment of birth. The enrollment process must be completed within 60 days of the date of birth. If additional Premium is required, and enrollment is not completed within the timeframe established, changes may only be made during the next Open Enrollment Period or upon the occurrence of another valid qualifying election change event.
- Adoption – The enrollment process must be completed within 60 days of the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. If additional Premium is required, and enrollment is not completed within the timeframe established, changes may only be made during the next Open Enrollment Period or upon the occurrence of another valid qualifying election change event.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Enrolled Employees who join a branch of military service have the right to continue dental coverage as established by Group by paying the monthly Premiums For further information on your rights under this act, please contact your legal counsel.

Family and Medical Leave Act (FMLA) and Paid Family and Medical Leave (PFML)

The benefits for an enrolled member under this DDWA dental Plan may be continued during a leave of absence that qualifies under the Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family and Medical Leave (PFML). Coverage will be maintained under the same terms as for active employees, including employer contributions, if applicable. For further information on these programs and any other employer approved leaves that may be available to you, contact your employer.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This section provides a general summary of continuation coverage rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA continuation coverage is administered by the Employer or their designee, and members should contact their Employer for specific information regarding eligibility, election, and administration of continuation coverage.

DDWA supports the Federal Health Benefit Continuation Provisions of The Consolidated Omnibus Budget Reconciliation Act known as "COBRA" which are applicable to this Plan.

An employee and any enrolled family members affected by the above law should be aware of the following terms, conditions and Limitations as they apply to temporary continuation of Group dental care coverage upon the occurrence of certain qualifying events.

An employee covered by this Group dental care Plan has a right to choose this continuation coverage if Group dental care coverage is lost because of reduced employment hours or terminated of employment for reasons other than gross misconduct on the part of the employee.

The dependents of an employee covered by a Group dental care Plan have the right to choose continuation coverage, if Group coverage under the Group dental care Plan is lost for any of the following five reasons:

1) The death of the employee;
2) A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
3) Divorce, legal separation, or dissolution of domestic partnership from the employee;
4) The employee becomes entitled to Medicare; or
5) The dependent ceases to be an "Eligible Dependent" under the Group dental care Plan.

Under the law, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, dissolution of domestic partnership or of a child losing dependent status under the Group dental care Plan.

COBRA coverage begins on the date that coverage would otherwise have ended due to a qualifying event. Coverage will end at the end of the maximum period as defined below.

When the employer is notified of a qualifying event, the employer in turn notifies the employee of their right to choose continuation coverage. The employee then has 60 days from the date they are furnished election notice, or the date that coverage would have ended, whichever is later, to inform the employer that continuation coverage has been chosen. The employer is required to notify the dental care Plan within 30 days of an employee's death, termination, reduction of hours or entitlement to Medicare.

If continuation coverage is not chosen, the Group dental care coverage will end.

Covered employees are eligible to continue coverage for 18 months when coverage is lost due to termination of employment or from reduction in hours. If continuation of coverage is chosen, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

If the covered employee's eligibility under this Contract ends when they become entitled to Medicare benefits, then COBRA coverage may not be continued for that employee. If a dependent is actively participating in COBRA and the covered employee becomes entitled to Medicare benefits, then coverage may not be continued for the employee; however, COBRA coverage may be continued for any dependent's for up to 36 months from the covered employee's

Medicare entitlement date. If the covered employee's eligibility under the Contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement, then any dependents may continue coverage for up to 1) 36 months from the covered employee's Medicare entitlement date, or 2) 18 months from the date the insured person's employment ended, whichever is later.

Employees or dependents who are disabled at the time the employee terminates employment or reduces hours or if they become disabled at any time during the first 60 days of COBRA coverage, are eligible for an additional 11 months of continued coverage from the date of the qualifying event. The total continued coverage period will not exceed 29 months from the date of the qualifying event. The individual must be determined as disabled by the Social Security Administration and must notify Group within 60 days of Social Security's determination date.

If the covered employee has a child or adopts a child during the period of COBRA coverage, such employee may elect to cover that child.

Generally, COBRA participants lose coverage when they become eligible under another Group plan. However, if the new Plan has pre-existing Limitations or Exclusions, affected individuals may continue coverage under the former Plan until the pre-existing condition(s) is no longer limited or the continuation coverage period ends, whichever is earlier.

Initial premium payment must be made within **45 days of the COBRA election**. Ongoing premium payments are due monthly and are subject to appliable grace periods as required by law.

Dependents experiencing second qualifying events while under COBRA may extend coverage for an additional 18 months.

Continuation coverage may be ended for any of the following reasons:

1) The employer no longer provides Group dental care coverage to any of its employees;
2) The Premium for continuation coverage is not paid, or not paid on time, as provided by law;
3) You became covered under another Group dental care Plan after the date you elect COBRA coverage. If, however, the new Plan contains an exclusion or limitation for a pre-existing condition (as explained above), coverage does not end for this reason until the exclusion or limitation no longer applies;
4) You become entitled to Medicare after the date you elect COBRA coverage, or
5) The spouse is divorced from a covered employee and subsequently remarries and is covered under any Group dental care Plan unless a pre-existing condition described above takes precedence.

Proof of insurability is not required to choose continuation coverage. However, the employee may have to pay all or part of the Premium for the continuation coverage.

Section E – Claim Review

Claim Forms

American Dental Association-approved claim forms may be obtained from your Dentist. You may also download a claim form by logging on to your MySmile® account on our website at www.DeltaDentalWA.com or by calling us at 800-554-1907 to have forms sent to you.

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than 12 months after the date of such treatment.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment modification or denial of payment. 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, we will send you an 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

If your claim or Pre-Treatment Cost Estimate has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an Appeal. An appeal is a request for DDWA to reconsider the prior determination, and your opportunity to provide us with any additional comments or information you would like us to consider. The Appeals process includes two levels of review, informal and formal. An informal review of your Appeal is when DDWA staff evaluates the claim and the terms of your Plan to determine if the claim processed consistently with the terms of your Plan. A formal review of your Appeal is when our Appeals Committee evaluates your claim, the terms of your Plan, any existing or new information, all correspondence and communications between you and DDWA, and any clinical considerations in order to determine if a claim processed consistently with the terms of your plan.

How to contact us

We will accept notice of an Appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us via email at memberappeals@deltadentalwa.com, by mail at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may also contact us by telephone at 800-554-1907 for assistance submitting an Appeal, or for more information. When submitting an Appeal, you may include any written comments, documents, or other information that you believe supports your claim.

Authorized Representative

You may authorize another person to represent you or your dependent and receive communications from DDWA regarding you or your dependent's 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, or appropriate written authorization in another format, 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

Your first step in the Appeal process is to request an informal review of the decision. Either you, or your authorized representative (see the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your EOB form). A request for a review may be made orally or in writing and must include the following information:

- Your name, the patient's name (if different) and ID number
- The claim number (from your EOB)
- The name of the Dentist

DDWA will review your request 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 request a formal review for your Appeal. Your formal Appeal will be reviewed by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or the previous review.

Your request for a formal review by the Appeals Committee must be made within 90 days of the 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 72 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 regulations.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer, or an individual might be committing insurance fraud, please contact DDWA at 800-554-1907. You may also want to alert any of the appropriate law enforcement authorities including:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at 800-835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC). You can reach the OIC at 800-562-6900 or go to www.insurance.wa.gov for more information.

Your Rights and Responsibilities

We view our benefit packages as a partnership between DDWA, our subscribers, and our Participating Dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have the Right To:

- Seek care from any licensed Dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental Participating Dentist or Non-Participating Dentist), but you can receive care from any Dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to Specialists when services are required to complete a treatment, diagnosis or when your primary care Dentist makes a specific referral for specialty care.
- Contact the DDWA Customer Service Department during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at www.DeltaDentalWA.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage and have these issues resolved in a timely, professional, and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational, or religious background.

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

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24-hour 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 healthcare providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign and request further information about items you do not understand.
- Follow instructions given by your Dentist or their staff concerning daily oral health improvement or post service care.
- Send requested documentation to DDWA to assist with the processing of claims, Pre-Treatment Cost Estimates, or Appeals.
- If applicable, pay the dental office any appropriate Coinsurance or Deductible amounts at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- Inform your Dentist and your employer promptly of any change to your, or a family member's address, telephone, or family status.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

You may obtain a copy of our Notice of Privacy Practices, which describes how your information may be used and disclosed and how you can access your information, by visiting www.DeltaDentalWA.com, or by calling Customer Service at 800-554-1907.

Conversion Option

If your dental coverage stops because your employment or eligibility ends or the Group Contract ends, you may apply directly to DDWA to obtain coverage under a Delta Dental Individual and Family plan. The benefits and Premium costs

of a Delta Dental Individual and Family plan may be different from those available under your current plan. To avoid any potential waiting periods, your new coverage must be effective within 63 days of any prior coverage. You may learn about our Individual and Family plans and apply for coverage online at www.DeltaDentalCoversMe.com or by calling 888-899-3734.

Extension of Benefits

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. An exception will be made for the completion of procedures requiring multiple visits that were started while coverage was in effect, are completed within 21 days of the termination date and are otherwise benefits under the terms of this Plan.

Coordination of Benefits

When you have dental coverage under more than one plan, those plans work together to provide you the benefit of that additional coverage. That is called coordination of benefits.

General Information

The rules regarding coordination of benefits are very detailed. The full information is contained below, but here is some general information that can help you get the most out of your plan.

- If someone covered under your plan has more than one plan covering them, you should let both plans know so that they can coordinate benefits.
- The benefit of having coverage under more than one plan is to help you with payment of your out-of-pocket costs. Each dental benefit plan does not pay less when you have more than one plan. Your Dentist does not get more money.
- Based on the rules set out by the State of Washington, the plans determine which plan pays first, and which pays second.
- The plan that pays first will pay as if there is no other plan. The plan that pays second will pay any amounts that the other plan did not pay, up to the amount it would pay if it was the first plan.
- Once your claim is paid in full, including all your out-of-pocket cost, if the plan that pays second does not need to pay as much as it would have if it were first, that amount of credit will be set aside for your use later. This is called COB Savings.

If you have any questions about payment of claims when you have more than one plan, contact us or the other plan directly and ask to speak with a customer service specialist.

Notice to Covered Persons

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

CAUTION: All dental plans have timely claim filing requirements. If you, or your Dentist, fail 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 Dentist will need to submit your claim to the secondary dental 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 Dentists and plans any changes in your coverage.

Full Coordination of Benefits Information

Coordination of this Contract's Benefits with other Benefits: The coordination of benefits (COB) provision applies when a person has dental coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its contract terms without regard

to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total Allowable Expense.

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

A. 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.

   (1) Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

   (2) 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 type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under the above 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.

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

C. The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has 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 plans for the claim equal 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, totals 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 the covered person. 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.

D. **"Allowable Expense"** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. 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 that is not covered by any plan covering the person is not an allowable expense.

   The following are examples of expenses that are not Allowable Expenses:

   (1) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method, or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   (2) If a person is covered by two or more plans 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.

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

F. **"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 excluding any temporary visitation.

Order of Benefit Determination Rules: When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits as if the secondary plan or plans does not exist.

B. (1) Except as provided in subsection (2), a plan that does not contain a coordination of benefits provision that is consistent with applicable regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) 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.

C. 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.

D. Each plan determines its order of benefits using the first of the following rules that apply:

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

(2) **"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:

(a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) 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 claim determination periods commencing after the plan is given notice of the court decree;

(ii) 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;

(iii) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of D.2.(a) above *(For a Dependent child whose parents are married or are living together)* determine the order of benefits;

(iv) 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

D.2.(a) above *(For a Dependent child whose parents are married or are living together)* determine the order of benefits; or

(v) 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:

(a) The plan covering the Custodial Parent, first;

(b) The plan covering the spouse of the Custodial Parent, second;

(c) The plan covering the noncustodial parent, third; and then

(d) The plan covering the spouse of the noncustodial parent, last

(c) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions above (D.2.(a) *For a Dependent child whose parents are married or are living together* or D.2.(b) *For a Dependent child 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.

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

(4) **"COBRA or State Continuation Coverage:"** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent or Dependent* provision above can determine the order of benefits.

(5) **"Longer or Shorter Length of Coverage:"** The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

E. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 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.

Right to Receive and Release Needed Information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. DDWA may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. DDWA need not tell, or get the consent of, any person to do this. To claim benefits under this Plan you or your Dependents must give DDWA 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, DDWA has the right, at its discretion, to remit to the other plan the amount DDWA 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, DDWA is fully discharged from liability under this Plan.

Right of Recovery

DDWA has the right to recover excess payment whenever it has paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. DDWA may recover excess payment from any person to whom or for whom payment was made or any other company or plans.

Subrogation

If we pay benefits under this Plan, and you are paid by someone else for the same procedures we pay for, we have the right to recover what we paid from the excess received by you, after full compensation for your loss is received. Any legal fees for recovery will be pro-rated between the parties based on the percentage of the recovery received. You have to sign and deliver to us any documents relating to the recovery that we reasonably request.

Section F - Resources

Frequently Asked Questions about Your Dental Benefits

What is a Delta Dental "Participating Dentist"?

A Delta Dental Participating Dentist is a Dentist who has signed an agreement with Delta Dental stipulating that they will provide dental treatment to subscribers and their dependents who are covered by DDWA's Group dental care plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients.

Can I choose my own Dentist?

See the "Choosing a Dentist" section for more information.

How can I obtain a list of Delta Dental Participating Dentists?

You can obtain a current list of Delta Dental Participating Dentists by going to our website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your Dentist. You can also obtain a copy of the approved claim form by logging on to your MySmile® account on our website at www.DeltaDentalWA.com or by calling our Customer Service Number at 800-554-1907. Note: If your Dentist is a Delta Dental Participating Dentist, they will complete and submit claim forms for you.

What is the mailing address for DDWA claim forms?

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

Who do I reach out to if I have questions about my dental Plan?

If you have questions about your dental benefits, you can call, text, chat, or email DDWA's Customer Service Department at the following: Call: 800-554-1907, Text: 833-604-1246, Online Chat: www.DeltaDentalWA.com, Email: CService@DeltaDentalWA.com

Does DDWA cover tooth-colored filings on my back teeth?

It is your Group's choice to cover posterior composite fillings (tooth-colored fillings on your back teeth) or only allow posterior Amalgam fillings (silver fillings on your back teeth). Please see the "Benefits Covered by Your Plan" section to determine which election your Group has made. You may also log on to your MySmile® account on our website, www.DeltaDentalWA.com or call us at 800-554-1907 for assistance in determining whether your Plan covers posterior composite fillings.

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

You are not required to get an estimate before having treatment, but you may wish to do so. You may ask your Dentist to complete and submit a request for an estimate, called a Pre-Treatment Cost Estimate. The estimate will provide you with an estimated cost for your procedure but is not a guarantee of payment.

Who is Delta Dental?

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

Glossary

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

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

Apicoectomy
Surgery on the root of the tooth.

Appeal
A written or verbal request for consideration submitted by or on behalf of a subscriber or patient regarding the denial, modification, reduction, or termination of payment, coverage, authorization, or provision of health care services or benefits.

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

Bridge
Also known as a Fixed Partial Denture. See “Fixed Partial Denture”.

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

Certificate of Coverage
The benefit booklet which describes in summary form the essential features of the Contract coverage, and to or for whom the benefits hereunder are payable.

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

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

Contract
This agreement between DDWA and Group, including the Declaration Page, Certificates of Coverage, Group application and enrollment forms, and any and all appendices and amendments. This Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding, or negotiation between the parties.

Coping
A thin thimble of a Crown with no anatomic features. It is placed on teeth prior to the placement of either an Overdenture or a large span Bridge. The purpose of a Coping is to allow the removal and modification of the Bridge without requiring a major remake of the bridgework if the tooth is lost.

Covered Dental Benefits
Those dental services that are covered under this Contract, subject to the Limitations set forth in “Benefits Covered by Your Plan” section.

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

DDWA
Delta Dental of Washington, a nonprofit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

Deductible
The Deductible is the dollar amount you must pay to the provider for Covered Dental Benefits before your Plan begins paying the designated Coinsurance. The Deductible will need to be met each Benefit Period. See the "Summary of Benefits" section to see if your Plan has a Deductible.

Delivery Date
The date a prosthetic appliance is permanently cemented into place.

Delta Dental
Delta Dental Plans Association, which is a nationwide not-for-profit organization of health care service plans, which offers a range of Group dental benefit plans.

Delta Dental Participating Dentist
A licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental provider agreement, which includes looking solely to Delta Dental for payment for covered services. Delta Dental Participating Dentists include Delta Dental PPO Dentists, Delta Dental Premier Dentists, and Delta Dental PPO plus Premier Dentists.

Delta Dental PPO Dentist
A Delta Dental Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO agreement, which includes looking solely to Delta Dental for payment for covered services.

Delta Dental Premier Dentist
A Delta Dental Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental provider agreement, which includes looking solely to Delta Dental for payment for covered services.

Dentist
A licensed Dentist legally authorized to practice dentistry at the time and in the place, services are performed. This Plan provides for covered services only if those services are performed by or under direction of a licensed Dentist or other Licensed Professional operating within the scope of their license.

Denture
A removable prosthesis that replaces missing teeth. A complete (or "full") Denture replaces all of the upper or lower teeth. A partial Denture replaces one to several missing upper or lower teeth.

Eligible Dependent
Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in "Dependent Eligibility and Enrollment" section.

Eligible Employee
Any employee who meets the conditions of eligibility set forth in "Employee Eligibility and Enrollment" section.

Eligible Person
An Eligible Employee or an Eligible Dependent.

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

Emergency Examination
Also known as a "limited oral evaluation – problem focused." Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

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

Enrolled Dependent, Enrolled Employee, Enrolled Person
Any Eligible Dependent, Eligible Employee or Eligible Person, as applicable, who has completed the enrollment process and for whom Group has submitted eligibility records or the monthly Premium to DDWA.

Exclusions
Those dental services that are not Contract benefits set forth in your "Benefits Covered by Your Plan" section and all other services not specifically included as a Covered Dental Benefit set forth in "Benefits Covered by Your Plan" section.

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

Fixed Partial Denture
A replacement for a missing tooth or teeth. The Fixed Partial Denture consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). They are cemented (fixed) in place and therefore are not removable.

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

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

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

Group
The employer or entity that is contracting for the dental benefits described in this benefit booklet for its employees.

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

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

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

Intravenous (I.V.) Sedation
A form of sedation whereby the patient experiences a lowered level of consciousness but is still awake and can respond.

Licensed Professional
An individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to a denturist, hygienist, and radiology technician. Benefits under this Contract will not be denied for any health care service performed by a registered nurse or nurse practitioner licensed to practice under chapter 18.88 RCW, if the service performed was within the lawful scope of the nurse's license, and the Contract would have provided benefits if such service had been performed by a Doctor of Medicine licensed to practice under chapter 18.71 RCW.

Lifetime Maximum
The maximum amount DDWA will pay in the specified Covered Dental Benefit class for an insured individual during the time that individual is enrolled in this Plan or any other Plan offered by this Employer.

Limitations
An exception or condition of coverage for a particular Covered Dental Benefit.

Localized Delivery of Antimicrobial Agents
Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees
The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a Covered Dental Benefit.

Nightguard
See "Occlusal Guard."

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

Not a Paid Covered Dental Benefit
Any dental procedure that is covered under this Plan however, is not payable based on specific conditions, such as clinical criteria.

Occlusal Adjustment
Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the Temporomandibular Joints and the structure supporting the teeth.

Occlusal Guard – (Nightguard)
A removable dental appliance – sometimes called a Nightguard – that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An Occlusal Guard is typically used at night.

Onlay
A restoration of the contact surface of the tooth that covers the entire surface.

Open Enrollment Period
The annual period in which subscribers can select benefits plans and add or delete Eligible Dependents.

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

Overdenture
A removable Denture constructed over existing natural teeth or implanted studs.

Palliative Treatment
Services provided for emergency relief of dental pain.

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

Payment Level
The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the "Summary of Benefits" and "Reimbursement Levels" sections of this benefit booklet.

Periodic Oral Evaluation – (Routine Examination)
An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics
The diagnosis, prevention, and treatment of diseases of gums and the bone that supports teeth.

Plan
The dental benefits as provided and described in this benefit booklet and its accompanying Contract. Any other booklet or Contract that provides dental benefits and meets the definition of a "Plan" in the "Coordination of Benefits" section of the Certificate of Coverage is a Plan for the purpose of coordination of benefits.

Pocket Depth
An internal measurement from the top of the gum tissue to its attachment on the root of a tooth.

Premium
The monthly amount payable to DDWA by Group, and/or by an Enrolled Employee to Group, as designated in the Contract.

Prophylaxis
Cleaning and polishing of teeth.

Prosthodontics
The replacement of missing teeth by artificial means such as Bridges and Dentures.

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

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

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

Restorative
Replacing portions of lost or diseased tooth structures with a filling or Crown to restore proper dental function.

Root Planing
A procedure done to smooth roughened root surfaces.

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

Seat Date
The date a Crown, Veneer, Inlay, or Onlay is permanently cemented into place on the tooth.

Specialist
A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

Temporomandibular Joint
The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Veneer
A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

Nondiscrimination and Language Assistance Services

Delta Dental of Washington complies with applicable Federal and Washington State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Delta Dental of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

We will provide free auxiliary aids and services to people with disabilities to assist in communicating effectively with DDWA staff, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We will provide free language assistance services to assist in communicating effectively with DDWA staff for people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 800-554-1907. If you need translation or interpreter assistance at your dental provider's office, please contact their staff. The cost for translations and interpreter services for communication between you and your provider are not covered by DDWA.

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our Compliance and Privacy Officer/1557 Coordinator who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Notice of Availability of Language Services
Amharic እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።
Arabic إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.
Cambodian (Mon-Khmer) ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 800-554-1907។
Chinese 如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。
Cushite (Oromo) Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.
French Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.
German Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.
Japanese ご本人様、またはお客様の身寄りの方でも Delta Dental of Washington についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907 までお電話ください。
Korean 귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington 에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907 로 전화하십시오.
Laotian ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.
Persian (Farsi) اگر شما، یا شخصی که به وی کمک می‌کنید، سؤالی درباره‌ی Delta Dental of Washington دارد، این حق را دارید که اطلاعات مورد نیازتان را تماس بگیرید. 800-554-1907 جهت صحبت با یک مترجم شفاهی، با شماره به زبان خود و بدون هیچ هزینه‌ای دریافت کنید.
Punjabi ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.
Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.
Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.
Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.
Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye keƀƀugo wallende be matinolji be wolde moƒon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.
Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.
Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.
Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.

Your smile is part of an incredible, complex system – your body. Research shows your smile's health influences your body's health the same way an engine effects how a car performs. Taking care of your smile now helps prevent painful, expensive problems down the road.

Here are our top tips for a healthy smile:

- Brush for two minutes, twice a day with fluoride toothpaste
- Floss at least once a day
- Eat a well-balanced diet
- Drink fluoridated water
- Visit your Dentist at least once a year

Remember, your smile has a great service plan – your dental coverage. It makes dental visits easy and affordable.

So, why wait? Call your Dentist and schedule your next visit today. If you're looking for a Dentist, visit www.DeltaDentalWA.com to find one near you.

Follow us online for fun, helpful tips to keep your smile healthy and get the most from your dental benefits.

BLOG