Delta Dental of Washington

Delta Dental PPO℠

Delta Dental of Washington, a member of the Delta Dental Plans Association

Delta Dental PPO℠ Plan

Welcome to your Delta Dental PPO℠ plan, administered by Delta Dental of Washington, a founding member of the nationwide Delta Dental Plans Association.

Our mission is to support your overall health by providing excellent dental benefits and the advantages of access to care within the largest network of dentists in Washington and nationwide. Supporting healthy smiles has been our focus for over 60 years.

Your PPO 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 as a reference for later on.

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

Questions Regarding Your Plan

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

Delta Dental of Washington Customer Service
800-554-1907

Written inquiries may be sent to:

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

You can also email us at CService@DeltaDentalWA.com.

For the most current listing 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, Deaf-Blind or Speech-disabled

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

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

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

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

Table of Contents

Section A. Summary of Benefits

This section explains the terms you will find on your *"Summary of Benefits Insert".* Please look at that document for specific, detailed information about your coverage.

Coinsurance

DDWA will pay a percentage of the cost of your treatment and you are responsible for paying the allowable balance (see "*Reimbursement Levels for Allowable Benefits"* in the *"Summary of Benefits Insert")*. The part you pay is called the coinsurance. You are responsible for the coinsurance even after a deductible (if applicable) is met.

Please refer to your *"Summary of Benefits Insert"* for details on deductibles required by your plan.

Benefit Period

Benefit period is the period of time shown on the *"Summary of Benefits Insert"* to which benefit time limitations refer.

Plan Maximum

The plan maximum is the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period. You are personally responsible for paying costs above the annual maximum. Please see your *"Summary of Benefits Insert"* for your plan maximum.

Plan Deductible (For Plans with a Deductible)

Your deductible amount, if any, can be found on your *"Summary of Benefits Insert".* If your Plan has a deductible, it is taken from the first payment or payments made by each Enrolled Person for certain Covered Dental Benefits provided. Once each Enrolled Person has satisfied the deductible during the benefit period, no further deduction will apply to that Enrolled Person until the next benefit period. You are not required to pay a deductible for Class I Covered Dental Benefits.

Reimbursement Levels

Your dental plan offers different classes of covered treatment. Each class also specifies limitations and exclusions. For a summary of reimbursement levels for your plan, see *"Summary of Benefits Insert"* for your plan.

You may choose any dentist to provide services under this plan; however, if you choose a Delta Dental PPO Dentist your costs may be lower than if you were to choose a dentist who is not a Delta Dental PPO Dentist.

See the *"Benefits Covered by Your Plan"* section for specific Covered Dental Benefits under this plan.

Section B. Your Benefits

Benefits Covered By Your Plan

The following are the dental benefits covered under this plan and are subject to all the limitations and exclusions contained in this booklet. Such benefits 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.

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

The coinsurance amounts payable by DDWA for Covered Dental Benefits are detailed on your *"Summary of Benefits Insert"*.

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

- Diagnostic evaluation for routine or emergency purposes
- X-rays

Limitations

- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as periodic oral evaluation.
- Supplementary bitewing X-rays are covered once in a benefit period.
- A complete series or a panoramic X-rays is covered once in a 5-year period from the date of service.
- Any number or combination of X-rays billed for same date of service that equals or exceeds the allowed fee for a complete series will be paid as a complete series.

Exclusions

- Consultations – diagnostic service provided by a dentists other than the requesting dentist
- Study models (unless performed for orthodontic purposes, refer to the *"Orthodontic Benefits"* section)
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a Class I paid covered benefit. Please see *"Temporomandibular Joint Benefits"* section for information on this benefit.

Class I Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Sealants
- Topical application of fluoride including fluoridated varnishes
- Space maintainers
- Preventive resin restoration

Limitations

- Any combination of prophylaxis and periodontal maintenance 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 and periodontal maintenance, third and fourth occurrences may be covered if the patient meets periodontal Case Type III or IV.
- Topical application of fluoride is limited to 2 covered procedures in a benefit period.
- Benefit coverage for application of sealants is limited to posterior teeth that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- The application of a sealant is a Covered Dental Benefit once in a 2-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime through age 17 for the same missing tooth or teeth.
- Benefit coverage for preventive resin restorations is limited to permanent molars with no restorations on the occlusal (biting) surface.
- The application of preventive resin restoration is not a Covered Dental Benefit for 2 years after a sealant or preventive resin restoration on the same tooth.

Exclusions

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

Class I Periodontics

Covered Dental Benefits

- Prescription-strength fluoride toothpaste
- Antimicrobial rinse dispensed by the dental office

Limitations

- Prescription-strength fluoride toothpaste and antimicrobial rinse are Covered Dental Benefits 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.
- Antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

Class II Benefits

Class II Sedation

Covered Dental Benefits

- General Anesthesia
- Intravenous Sedation

Limitations

- General anesthesia or intravenous sedation are Covered Dental Benefit only when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- General anesthesia is a Covered Dental Benefit only in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II, III, TMJ or optional Orthodontic Covered Dental Benefits. Please see your "*Summary of Benefits Insert*" for coverage information.
- Intravenous 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 sedation, is a Covered Dental Benefit only once per day.

Exclusions

- General anesthesia or intravenous sedation for routine post-operative procedures is not a paid covered benefit except as described above for children through the age of 6 or a physically or developmentally disabled person.

Class II Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain

Limitations

- Postoperative 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

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a 2-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 are covered once in a 2-year period from the seat date.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it may be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient. Please refer to your *"Summary of Benefits Insert"* to confirm whether or not your group has Posterior Composite coverage.

Exclusions

- Overhang removal
- Copings
- Re-contouring or polishing of restoration
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.

Please also see:

- "*Class III Restorative*" section for information regarding crowns, veneers or onlays.

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

- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Please also see:

- "*Class II Sedation*" and "*Accidental Injury*" sections for additional information.

Class II Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Periodontal scaling/root planing
- Periodontal surgery
- Limited adjustments to occlusion (8 teeth or fewer)
- Localized delivery of antimicrobial agents

Limitations

- Periodontal scaling/root planing is covered once in a 3-year period from the date of service.
- Periodontal surgery (per site) is covered once in a 3-year period from the date of service.
    - ◊ Periodontal surgery must be preceded by scaling and root planing done a minimum of 6 weeks and a maximum of 6 months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- Soft tissue grafts (per site) are covered once in a 3-year period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions of oral health such as periodontal Case Type III or IV, and 5mm (or greater) pocket depth readings.
- When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to 2 times (per tooth) in a benefit period.
- When covered, localized delivery of antimicrobial agents must be preceded by scaling and root planing done a minimum of 6 weeks and a maximum of 6 months prior to treatment, or the patient must have been in active supportive periodontal therapy.

Please also see:

- "*Class I Preventive*" section for periodontal maintenance benefits.
- "*Class III Periodontics*" section for complete occlusal equilibration or occlusal guard.
- *"Class II Sedation"* 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 2-year period from the date of service.
- Re-treatment of the same tooth is allowed only when performed by a dentist other than the dentist who performed the original treatment and only if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions

- Bleaching of teeth

Please also see:

- "*Class III Prosthodontics*" for root canals placed in conjunction with a prosthetic appliance.
- "*Class II Sedation*" for additional information.

Class III Benefits

Class III Periodontics

These benefits are available for patients with periodontal case type III or IV only, as determined by your dentist. It is strongly recommended that prior to treatment you have your dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

- Occlusal guard (nightguard)
- Repair and relines of occlusal guard
- Complete occlusal equilibration

Limitations

- Occlusal guard (nightguard) is covered once in a 3-year period from the date of service.
- Repair and relines done more than 6 months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Exclusions

- Appliances necessary to correct vertical dimension or to restore the occlusion

Class III Restorative

Covered Dental Benefits

- Crowns, veneers, and onlays
- Crown buildups
- Post and core on endodontically-treated teeth

Limitations

- A crown, veneer or onlay on the same tooth is covered once in a 7-year period from the seat date.

- Crowns, veneers, or onlays are a Covered Dental Benefit for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin-based composites.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the eligible person once in a 2-year period from the seat date.
- An implant-supported crown on the same tooth is covered once in a 7-year period from the seat date
- Payment for a crown, veneer or onlay shall be based upon the seat date.
- A crown buildup is a Covered Dental Benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- A crown buildup or a post and core are covered once in a 7-year period on the same tooth from the date of service.
- Crown buildups or a post and core are not a paid covered benefit within 2 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 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

- Copings
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations is not a paid covered benefit.

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 prosthetic appliance is covered once every 7 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 7 years.
- DDWA will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- 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 6 months.
- Denture adjustments and relines done more than 6 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
- Appliances necessary to correct vertical dimension or to restore the occlusion

Other Benefits

Temporomandibular Joint Benefits

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

For the purpose of this plan, 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:

- Procedures for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- 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;
- Recognized as effective, according to the professional standards of good dental practice; and

- Not experimental or primarily for cosmetic purposes.

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

- TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device, removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis, and manipulation under anesthesia.
- The amounts payable for TMJ benefits during the benefit year shall not be applied to the eligible person's annual plan maximum for Class I, Class II and Class III Covered Dental Benefits or optional orthodontic benefits. Refer to your *"Summary of Benefits Insert"* for more information.

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

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

Orthodontic Benefits

Optional – Orthodontic coverage is available to groups with 10 or more Enrolled Employees.

Please refer to your "*Summary of Benefits Insert*" for information regarding orthodontic benefit coverage.

Orthodontic treatment is defined as the necessary procedures of treatment of malalignment of teeth and/or jaws, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

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

Covered Dental Benefits

- Orthodontic records
- Exams (initial, periodic, comprehensive, detailed and extensive)
- X-rays (intraoral, extraoral, diagnostic radiographs, panoramic)
- Diagnostic photographs
- Cephalometric films
- Diagnostic casts (study models)
- Retainers
- Aligner Trays

Exclusions

- Replacement or repair of an appliance

Payment for Orthodontic Services

- For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- Payment for orthodontic benefits is made monthly based upon eligibility and services provided.
- Payment is only made for treatment received while a patient is eligible.

- If individuals become ineligible prior to the payment of all benefits, any subsequent payment due is not covered.
- If Treatment began prior to the start of coverage under this plan, payment will be prorated based on the balance remaining after the down payment and monthly charges which were due prior to the date of eligibility are deducted.

Well Baby Checkups

For your infant child, Delta Dental of Washington offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of service. When visiting a physician with your infant (age 0-3), DDWA will reimburse the physician, as a nonparticipating provider, on your behalf for Oral Evaluation and Topical Application of Fluoride services performed. Reimbursement will be based on 100 percent of the applicable nonparticipating provider fee for either Oral Evaluation or Topical Application of Fluoride, or both, depending on actual services provided.

Please see the *"Benefits Covered by Your Plan"* section of this booklet for any other limitations. Also, please be aware that Delta Dental of Washington has no control over the charges or billing practices of non-dentist providers which may affect the amount Delta Dental of Washington will pay and your financial responsibility.

If your provider has received training regarding Well Baby Checkups from DDWA they will have been provided instructions on how to submit a claim form. If your provider has not received training from DDWA, or if any provider has questions regarding how to file a claim they may contact us at 800-554-1907 for information on submitting a standard claim form for this service. If you have paid your provider directly and have a receipt for these services, please call us at 800-554-1907 for information on how to obtain reimbursement.

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.

Additional Information

General Exclusions

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, this Plan does not cover every aspect of dental care. 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 Exclusions"* section. These limitations and exclusions warrant careful reading.

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
3. Application of desensitizing agents (treatment for sensitivity or adhesive resin application)
4. Experimental services or supplies, which include procedures, services or supplies for which the use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation.
    a. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
        i. The services are in general use in the dental community in the state of Washington;
        ii. The services are under continued scientific testing and research;
        iii. The services show a demonstrable benefit for a particular dental condition; and
        iv. They are proven to be safe and effective.
    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 appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the eligible person.
    d. Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 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 under WAC 284-43-620(2).
5. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
6. Prescription drugs
7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment
8. Broken appointments
9. Behavior management
10. Completing claim forms
11. Habit-breaking appliances

12. Orthodontic services or supplies are not covered unless optional Orthodontic coverage has been selected. Please see your *"Summary of Benefits Insert"* for coverage details).
13. This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this plan as Covered Dental Benefits.

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

Necessary vs. Not Covered Treatment

Your dentist may recommend a treatment plan that includes services which may not be covered by this Plan. 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 *"Confirmation of Treatment and Cost"* section.

Additional Procedures

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the plan. In such instances, the plan will pay the proper percentage of the lowest fee. The balance of treatment cost remains the eligible person's responsibility.

Confirmation of Treatment and Cost (Formerly called Predeterminations)

It is recommended that prior to treatment you have your dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

A Confirmation of Treatment and Cost is an estimate of your benefits for a particular service. DDWA will provide this estimate to your dentist upon request, and will list the information about your general coverage, benefits, and potential out-of-pocket cost for services.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the Confirmation of Treatment and Cost is made and is not a guarantee of payment. Please refer to the *"Initial Benefits Determination"* section regarding claims requirements.

A standard Confirmation of Treatment and Cost 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 Confirmation of Treatment and Cost. Once the additional information is available your dentist should submit a new request for a Confirmation of Treatment and Cost to DDWA.

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

Urgent Confirmation of Treatment and Cost Requests

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

Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the contract provisions.

Section C. Choosing a Dentist

With DDWA, 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 the identification card document provided to you at enrollment. Additionally, you may obtain your group information and your member identification number by calling our customer service number at 800-554-1907 or through our website at www.DeltaDentalWA.com.

Delta Dental of Washington will be assigning a randomly selected identification number to ensure the privacy of your information and to address concerns about identify theft. Please note that ID cards are not required to see your dentists, but are provided 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, because they participate in our program of plans. 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 Delta Dental of Washington website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their filed fee under our standard agreement.

Delta Dental PPO Dentists

Some dentists also offer our patients a more value-added option by agreeing to provide services at a fee lower than their original filed fee. These are our PPO dentists.

If you select either a Delta Dental Premier Dentist or a Delta Dental PPO 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 your dentist complete and submit a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You can also download claim forms from our website at www.DeltaDentalWA.com or get them 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 to the dentist for any balance remaining. Please be aware that DDWA has no control over Non-Participating Dentist's charges or billing practices.

Section D. Eligibility and Termination

Employee Eligibility

The eligibility requirements of an employee to enroll in this Plan are defined by the Group. New employees are eligible for benefits on the first day of the month following completion of the waiting period established by the Group, and become enrolled when they have completed the enrollment process.

No person may be enrolled both as an employee and as a dependent on this Plan.

To enroll in this Plan, you must complete the enrollment process with within 60 days of your eligibility date. If the enrollment process is not received within 60 days, your enrollment will not be accepted until your Group's next open enrollment period. All of your Eligible Dependents must be included in the enrollment process in order to be enrolled.

Employee Termination

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

You may change or terminate plan coverage only coincident with an open enrollment period.

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 the employer for a period not to exceed six months. Payment of premiums must be made when due, or DDWA may terminate the coverage.

Dependent Eligibility

Eligible Dependents are your spouse or domestic partner, and children of you, your spouse or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. A dependent's spouse and/or child(ren) are not eligible for coverage under this plan. Dependent children who are and continue to be dependent beyond age 25 due to developmental disability or physical handicap are also eligible. Non-registered domestic partners are covered unless specifically excluded at the option of the group.

An enrolled dependent is an Eligible Dependent that has completed the enrollment process.

No person may be enrolled in this dental Plan both as an employee and as a dependent and no person will be considered as a dependent of more than one employee on this Plan.

A new family member, with the exception of newborns and adopted and foster children, should be enrolled on the first day of the month following the date he or she qualifies as an Eligible Dependent.

A newborn shall be covered from and after the moment of birth, and an adopted child 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.

When an additional premium is required, enrollment must be received within 90 days of the date of birth; of placement for foster care or adoption; or of assumption of legal obligation for total or partial support in anticipation of adoption. When additional premium is not required, 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.

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 Enrolled Employee for the purpose of adoption under the laws of the state in which the employee resides; 2) the employee has assumed a legal obligation for total or partial support; or 3) upon placement of the child in anticipation of adoption.

When an additional premium is required, enrollment must be received within 90 days of the date of birth; of placement for foster care or adoption; or of assumption of legal obligation for total or partial support in anticipation of adoption. When additional premium is not required, DDWA encourages enrollment as soon as possible to prevent delays in claims processing (see "*Special Enrollment*").

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, except under special enrollment.

See the *"Special Enrollment"* section for more information.

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.

An enrolled dependent may terminate coverage at the renewal or extension of the dental plan or at open enrollment only. Once an enrolled dependent's coverage is terminated, the coverage cannot be reinstated unless there is a qualifying event as defined in the "*Special Enrollment"* 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 handicap; 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 this 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

Special enrollments are allowed under the following conditions:

Loss of Other Coverage

If you and/or your Eligible Dependents involuntarily lose coverage under another dental plan, you may apply for coverage under this Plan if the following applies:

- The loss of minimum essential benefits, including loss of employer sponsored insurance coverage, or of the coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's voluntary termination of employer sponsored coverage, the misrepresentation of a material fact affecting coverage or for fraud related to the terminated health coverage
- If you or your eligible dependent(s) lose eligibility for coverage under medicaid or a public program.
- Dissolution of a marriage or termination of a domestic partnership,
- A permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area
- If you or your eligible dependent(s) current plan no longer offers eligibility or benefits.
- Loss of individual or group coverage purchased on the health benefit exchange due to an error on the part of the exchange, the issuer or the U.S. Department of Health and Human Services
- Exhaustion of COBRA coverage due to failure of the employer to remit premium,
- Loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available,
- Loss of coverage as a dependent due to age limitations.
- Your application to enroll in this Plan is received by DDWA within 60 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 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 of a child(ren) or upon placement of the child(ren) in anticipation of adoption.

- Marriage or Domestic Partner Registration — DDWA requests the application for coverage be made within 60 days of the date of marriage/registration. If enrollment and payment are not completed within the 60 days, the Eligible Dependent may be enrolled during the next open enrollment.

  DDWA considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefits booklet will be considered as gender neutral and applicable to individuals in domestic

partnerships. DDWA and the group will follow all applicable state and federal requirements, including any applicable regulations.

- Birth — A newborn shall be covered from and after the moment of birth. If an additional Premium for coverage is required and enrollment is not completed within the 90 days, the newborn dependent will be covered from the effective date of enrollment. DDWA requests the application for coverage be made within 90 days of the date of birth. Enrollment may be completed at any time up to the fourth birthday. If enrollment is completed after 90 days, the enrollment becomes effective on the first day of the month in which enrollment occurs. Enrollment after the fourth birthday must be coincident with an Open Enrollment period.
- Adoption — DDWA requests the application for coverage be made within 90 days of the date of assumption of a legal obligation for total or partial support of the child or upon placement of the child in anticipation of adoption. If an additional Premium for coverage is required and enrollment and payment is not completed within the 90 days, the Eligible Dependent may be enrolled during the next open enrollment.

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

Employees who join a branch of military service have the right to continue dental coverage for up to 24 months by paying the monthly premiums, even if they are employed by groups that are too small to comply with COBRA. For further information on your rights under this act, please contact your legal counsel.

Continuation of Coverage

Family and Medical Leave Act (FMLA)

The benefits for an enrolled member under this DDWA dental Plan may be continued provided the employee is eligible for Federal Family and Medical Leave Act ("FMLA") and is on a leave of absence that meets the FMLA criteria. For further information, contact your employer.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This Section Applies To Groups of 20 or More.

DDWA supports the Federal Health Benefit Continuation Provisions applicable to this group health care plan which are part of The Consolidated Omnibus Budget Reconciliation Act known as “COBRA” Public Law 99-272 and as Amended by Public Law 104-191.

An employee employed by a group 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 health care coverage upon the occurrence of certain qualifying events.

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

The dependents of an employee covered by a group health care plan have the right to choose continuation coverage, if group coverage under the group health 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 or legal separation from the employee;

4) The employee becomes entitled to Medicare; or

5) The dependent ceases to be an Eligible Dependent under the group health care plan.

Under the law, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the group health care plan.

COBRA coverage begins on the date that coverage would otherwise have been lost due to a qualifying event. Coverage will end at the end of the maximum period.

When the employer is notified of a qualifying event, the employer in turn notifies the employee of his or her right to choose continuation coverage. The employee then has at least 60 days starting on the later of the date you are furnished the election notice or the date that you would lose coverage, to inform the employer that continuation coverage has been chosen. The employer is required to notify the health 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 health 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 of 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 or dependent's eligibility under this contract ends when he or she becomes entitled to Medicare benefits, then coverage may not be continued for the employee. However, coverage may be continued for any dependents 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 either 36 months from the covered employee's Medicare entitlement date or 18 months from the date the insured person's employment ended, whichever is later.

Employees or dependents who are disabled at the time they become eligible for coverage under COBRA, 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.

COBRA payments are due within 45 days from the date of application. Payments must be made retroactively from the date of COBRA eligibility up through the current month of eligibility.

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 health 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 become covered under another group health 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 health 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 claim forms from our website at www.DeltaDentalWA.com or call us at 800-554-1907 to have forms sent to you.

DDWA is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 12 months after the date the treatment is provided. Optional orthodontic claims must be submitted within 12 months of the initial banding date, which is the date the appliance is placed.

Please refer to your *"Summary of Benefits Insert"* to see if your group has orthodontic benefits.

Initial Benefit Determinations

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

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

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

Appeals of Denied or Modified Claims

How to contact us

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

Authorized Representative

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

Informal Review

If your claim for dental benefits has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an appeal. Your first step in the appeal process is to request an informal review of the decision. Either you, or your authorized representative (see above), must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and must include the following information:

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

DDWA will review your request and make a determination within 14 days of receiving your request. If needed, we may take up to an additional 16 days if we provide you notice, for a total of 30 days. DDWA will send you a written notification of the review decision and 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 further appeal in writing. Your appeal will be reviewed formally by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or previous reviews.

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

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

Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 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 regulation.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer, or individual may 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 360-725-7263 or go to www.insurance.wa.gov for more information.

Your Rights and Responsibilities

At DDWA our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of Participating Dentists in the state of Washington. We view our benefit packages as a partnership between 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 of Participating 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 DDWA customer service personnel 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. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

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

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

Conversion Option

If your dental coverage stops because your employment or eligibility ends, the group policy ends, in instances of an extended strike, or lockout or labor dispute; you may apply directly to DDWA to convert your coverage to Delta Dental Individual and Family plan. You must apply within 31 days after termination of your group coverage or 31 days after you receive notice of termination of coverage, whichever is later. The benefits and premium costs of a Delta Dental Individual and Family plan may be different from those available under your current plan. You may learn about our Individual and Family Plans and/or apply for coverage online at DeltaDentalCoversMe.com or by calling 888-899-3734.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. The exception will be for the completion (within 3 weeks) of procedures requiring multiple visits to complete the work which was started while coverage was in effect and which are otherwise benefits under this plan.

Coordination of Benefits

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

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

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

A. 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 and similar coverage that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care

policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state plan under Medicaid; A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under the above sections 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 you have dental coverage under more than one Plan.

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

D. "Allowable Expense" is health care expense including deductibles, coinsurance or copayments, which is covered at least in part by any plan covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

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

(1) If you are covered by two or more Plans that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan's negotiated fee is not an Allowable Expense.

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

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 without regard to any temporary visitation.

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

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

B. A Plan purchased from the Washington State Health Benefit Exchange (HBE) which includes pediatric dental benefits as part of the essential health benefits will always pay secondary to this Plan if the child covered under the pediatric dental portion of the HBE Plan is also covered under this Plan.

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

D. 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.

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

(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 claims 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 section (a)above (for dependent child(ren) 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 section (a) above (for dependent child(ren) 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:

- The Plan covering the Custodial Parent, first;
- The Plan covering the spouse of the Custodial Parent, second;
- The Plan covering the noncustodial Parent, third; and then
- 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 of section (a) and (b) above (for dependent child(ren) whose parents are married or are living together or for dependent child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee: The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the 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 your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the 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 you as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

(6) 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 do not exceed 100 percent of the total Allowable Expense for that claim. Total Allowable Expense is the Allowable Expense of the Primary Plan or the Secondary Plan up to this plan's allowable expense. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

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

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

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

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

Right to Receive and Release Needed Information:

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other 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 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.

Notice to Covered Persons

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

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

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

Subrogation

If we pay benefits under this policy, 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

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, or you may download claim forms from our website at www.DeltaDentalWA.com. You may also obtain a claim form by calling our Customer Service Number at 800-554-1907.

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 call if I have questions about my dental plan benefits?

If you have questions about your dental benefits, call DDWA's customer service department at 800-554-1907. Questions can also be addressed via email at CService@DeltaDentalWA.com.

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

It is your groups' choice to cover posterior composite filling (tooth-colored fillings on your back teeth), or only allow posterior amalgam fillings (silver filling on your back teeth). Please see your *"Summary of Benefits Insert"* to determine which election your group has made. You may also log on to the "MySmile® Personal Benefits Center" on our website, www.DeltaDentalWA.com, or call us at 800-554-1907 for assistance in determining whether or not 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 "Confirmation of Treatment and Cost." The estimates provided do not represent a guarantee of payment, but they provide you with estimated costs and benefits for your procedure.

What 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.

Is this plan a qualified dental plan?

No, this plan has not been certified to meet the state and federal pediatric dental benefits (Essential Health Benefits) requirements for dental plans.

Glossary

Amalgam: Mostly silver filling often used to restore decayed teeth.

Apicoectomy: Surgery on the root of a tooth.

Appeal: An oral or written communication by a subscriber or an authorized representative requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits.

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

Bridge: See *"Fixed Partial Denture"* below.

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

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

Covered Dental Benefits: Those dental services that are covered under this Contract, subject to the limitations set forth in Benefits Covered by Your Plan.

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

DDWA: Delta Dental of Washington, a non-profit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

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

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

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

Employee: Any employee of Group who is enrolled on this Plan or has a dependent enrolled on this Plan.

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

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

Filed Fees: Approved fees that participating Delta Dental 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.

Fluoridated 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.

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

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

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

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

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

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

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

Limitations: Those dental services that are subject to restricting conditions set forth in Benefits Covered by Your Plan.

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"* below.

Not a Paid Covered Benefit: Any dental procedure that, under some circumstances, would be covered by DDWA, but is not covered under other conditions. Examples are listed in Benefits Covered by Your Plan.

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

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

Open Enrollment Period: Is the month preceding the Group's contract renewal date, or at some other mutually agreeable time but at least annually, during which Eligible Employees may select benefits plans and add or delete Eligible Dependents. Coverage changes made during the open enrollment period will be effective as of the renewal date.

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.

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

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

Prophylaxis: Cleaning and polishing of teeth.

Prosthodontics: The replacement of missing teeth by artificial means such as bridges and dentures.

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

Qualified Medical Child Support Order (QMCSO): An order issued by a court under which an employee must provide medical coverage for a dependent child. QMCSO'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.

Resin Filling: Tooth-colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

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

Root Planing: A procedure done to smooth roughened root surfaces.

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

Seat Date: The date a crown, veneer, inlay or onlay is permanently cemented into place on the tooth.

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.