Delta Dental PPO℠

DENTAL PLAN

Plan No. 03873 - Option 2

Effective January 1, 2018

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

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

Your 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 for your reference.

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 Department

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.

Dial 711 (the statewide telephone relay number) or 800-833-6384 to connect with a Washington Relay Service communications assistant. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. They will then relay the conversation between you and our customer service representatives.

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

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Section A – Summary of Benefits

Reimbursement Levels for Allowable Benefits

In Network – Delta Dental PPO Dentists

Class I	70-100%
Class II	70-100%
Class III	Constant 50%
TMJ procedures	Constant 50%
Annual Deductible per Person	$0
Annual Deductible — Family Maximum	$0

Out-of-Network – Non-Delta Dental PPO

Class I	70-100%
Class II	70-100%
Class III	Constant 50%
TMJ procedures	Constant 50%
Annual Deductible per Person	$50
Annual Deductible — Family Maximum	$150

Plan Maximum

Class I Annual Plan Maximum per Person	Unlimited
Class II and Class III Annual Plan Maximum per Person	$2,000
Lifetime TMJ Maximum	$5,000
Annual TMJ Maximum	$1,000

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III Covered Dental Benefits and temporomandibular joint (TMJ) benefits.

The annual deductible is waived for:

- ◊ Class I Covered Dental Benefits

Quick Answers

- Your dental plan is provided through your employer's group plan with Associated Industries Management Services.
- The carrier for the group plan is Delta Dental of Washington.
- Your plan number is 03873.
- Your plan is a group incentive payment PPO plan.
- Your dental benefits are based on a calendar year and begin on January 1 of each year.
- Your plan provides coverage for eligible employees and eligible dependents.
- Your annual plan maximum is $2,000 per covered person.
- Your annual plan individual deductible is $50; family deductible is $150 for Out-of-Network and Out-of-Service, waived on Class I benefits.
- If you have any questions, call your personnel department Associated Industries Management Services at (509) 326-6892.

How to use your Plan

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

Consult your provider regarding any charges that may be your responsibility before treatment begins.

Coinsurance

DDWA will pay a percentage of the cost of your treatment and you are responsible for paying the allowable balance. The part you pay is called the coinsurance. You are responsible for the coinsurance even after a deductible is met.

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

Benefit Period

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

Plan Maximum

For your plan, the maximum amount payable by DDWA for Class II and III Covered Dental Benefits per Enrolled Person is $2,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed, also known as the seat date. Amounts paid for such procedures will be applied to the Plan maximum based on the incurred date. Class I Covered Dental Benefits do not accrue toward the Annual Plan Maximum.

The lifetime maximum amount payable by DDWA for TMJ benefits is $5,000 per Enrolled Person, with a calendar year maximum of $1,000 per Enrolled Person.

Plan Deductible

This Plan does not have an In Network or Out of Service Area deductible. For Out–of-Network deductibles, your Plan has a $50 deductible per Enrolled Person each benefit period. This means that from the first payment or payments DDWA makes for Covered Dental Benefits, a deduction of $50 is taken. This deduction is owed to the provider by you. Once and Enrolled Person has satisfied the deductible during the benefit period, no further deduction will be taken for that Enrolled Person until the next benefit period. The maximum deductible for all members of a family (Enrolled

employee and one or more enrolled Dependents) each benefit period is three times the individual deductible. This means that the maximum amount that will be deducted for all members of a family during a benefit period will not exceed $150. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

The deductible does not apply to:

- ◊ Class I Covered Dental Benefits

Reimbursement Levels

Your Plan is a Group based incentive Plan. It is designed to encourage prevention by rewarding you for receiving preventive care and other dental services during each incentive period. An incentive period consists of this 12-month period:

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

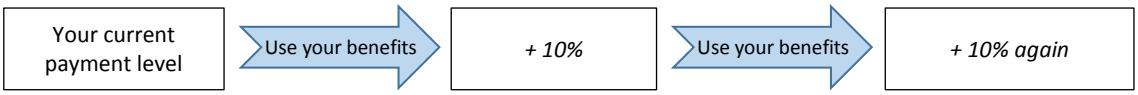
Your dental Plan offers three classes of covered treatment. Each class also specifies limitations and exclusions for a summary of reimbursement levels for your plan, see the "Summary of Benefits" section in the front of this benefit booklet.

Refer to the "Benefits Covered by Your Plan" section of this benefit booklet for specific covered dental benefits under this Plan.

Reimbursement Levels for Class I and Class II Procedures

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

Minimum Payment Level 70%	Maximum Payment Level 100%



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

Each Enrolled Person establishes his or her own payment levels through utilization during incentive periods.

Reimbursement Levels for Class III Procedures

The payment level for covered and allowable Class III (major) procedures is 50 percent. The incentive provision described above does not apply to Class III procedures.

Reimbursement Levels for Other Procedures

The payment level for covered and allowable TMJ procedures is 50 percent.

Section B – Your Benefits

Benefits Covered By Your Plan

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

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

The amounts payable by DDWA for Covered Dental Benefits are described on your Summary of Benefits section of this benefit booklet.

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

- Comprehensive, or detailed and extensive oral evaluation
- Diagnostic evaluation for routine or emergency purposes
- X-rays

Limitations

- Comprehensive, or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same dentist are paid as a periodic oral evaluation.
- 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.
- Bitewing X-rays are covered twice in a benefit period.
- A complete series or panoramic X-ray is covered once in a three-year period from the date of service.
    - ◊ Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.

Exclusions

- Consultations – diagnostic service provided by a dentist other than the requesting dentist
- Study models
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a Class I paid Covered Dental Benefit.

Please also see:

- "Temporomandibular Joint Benefits" section for information on X-rays related to temporomandibular joint benefits.

Class I Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)

- Periodontal maintenance
- Topical application of fluoride including fluoridated varnishes
- Sealants
- 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 dentist determines the patient meets periodontal Case Type III or IV (Pocket depth readings of 5mm or greater).*
- Topical application of fluoride is limited to two covered procedures in a benefit period.
- The application of a sealant is a Covered Dental Benefit once in a three-year period per tooth from the date of service.
    - Available for children through the age 14
    - Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
    - If eruption of permanent molars is delayed, sealants will be allowed if applied within 12-months of eruption with documentation from the attending Dentist.
- Space maintainers are covered once in a patient's lifetime through age 17 for the same missing tooth or teeth.
- The application of a preventive resin restoration is a covered dental benefit once in a three-year period per tooth from the date of service.
    - Available for children through age 14
    - If eruption of permanent molars is delayed, preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
    - Payment for preventive resin restorations will be for permanent molars with no restorations on the occlusal (biting) surface.
    - The application of a preventive resin restoration is not a Covered Dental Benefit for three years after a sealant or preventive resin restoration on the same tooth.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

Exclusions

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

Class II Benefits

Class II Sedation

Covered Dental Benefits

- General Anesthesia

- Intravenous Sedation

Limitations

- General Anesthesia or Intravenous Sedation are Covered Dental Benefits 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 six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III or TMJ Covered Dental Benefits.*
- 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.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section" for additional information.

Exclusions

- General Anesthesia or Intravenous Sedation for routine post-operative procedures is not a paid Covered Dental Benefit except as described above for children through the age of six 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 two-year period from the date of service
- Restorations are covered for the following reasons:
    - ◊ Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
    - ◊ Fracture resulting in significant loss of tooth structure (missing cusp)

- ◊ Fracture resulting in significant damage to an existing restoration

- 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 will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Stainless steel crowns are covered once in a two-year period from the seat date.

Exclusions

- Overhang removal
- Copings
- Re-contouring or polishing of a restoration
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion

Please also see:

- Refer to "Class III Restorative" for more information regarding coverage for crowns (other than stainless steel), inlays, 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
- Orthognathic surgery or treatment
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Please also see:

- "Class II Sedation "section for additional information.

Class II Periodontics

Covered Dental Benefits

- Nonsurgical procedures for treatment of the tissues supporting the teeth
- Periodontal scaling/root planing
- Limited adjustments to occlusion (eight teeth or fewer)
- Localized delivery of antimicrobial agents*

Limitations

- Periodontal scaling/root planing is covered once in a 36-month 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 five mm (or greater) pocket depth readings.*

- ◊ When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two 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 six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.

*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost "section for additional information.

Please also see:

- ♦ "Class I Preventive" section for periodontal maintenance benefits.
- ♦ "Class III Periodontics" section for complete occlusal equilibration or occlusal guard.

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 two-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 II Sedation" section 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

- ♦ Surgical procedures for treatment of the tissues supporting the teeth
- ♦ Gingivectomy
- ♦ Occlusal guard (nightguard)
- ♦ Repair and relines of occlusal guard
- ♦ Complete occlusal equilibration

Limitations

- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
    - ◊ Periodontal surgery must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- Soft tissue grafts (per site) for implants and natural teeth are covered once in a three-year period from the date of service.
- Occlusal guard is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Please also see:

- "Class II Sedation" section for additional information.

Class III Restorative

Covered Dental Benefits

- Crowns, veneers, and onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- Crown buildups
- Post and core on endodontically-treated teeth
- Implant Supported Crown

Limitations

- A crown, veneer, or onlay on the same tooth is covered once in a five-year period from the seat date.
- An implant-supported crown on the same tooth is covered once in a five-year period from the seat date of a previous crown on that same tooth.
- 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 Enrolled Person, once in a two-year period from the seat date.
- Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- 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 two mm 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 is covered once in a two-year period on the same tooth from the date of service.
- A post and core is covered once in a five-year period on the same tooth from the date of service.
- Crown buildups or a post and core are not a paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid Covered Dental Benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.

Exclusions

- Copings

- A crown or onlay is not a paid Covered Dental 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

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 five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/delivery date.
- Implants and superstructures are covered once every five years.
- **Temporary Denture -** DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Denture adjustments and relines –** Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

- Crowns in conjunction with overdentures
- Duplicate dentures
- Personalized dentures
- Copings
- Maintenance or cleaning of a prosthetic appliance

Other Benefits

Temporomandibular Joint Benefits

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:

1) Appropriate, for the treatment of a disorder of the temporomandibular joint;
2) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;

3) Recognized as effective, according to the professional standards of good dental practice; and

4) Not experimental or primarily for cosmetic purposes.

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

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

The annual maximum amount payable by DDWA for covered procedures related to the treatment of TMJ disorders is $1,000, with a lifetime maximum amount payable of $5,000, for each covered person. The amounts payable for TMJ benefits during the benefit period shall not be applied to the covered person's annual Plan maximum.

It is strongly suggested that a TMJ treatment Plan be submitted to, and a Confirmation of Treatment and Cost request be completed prior to commencement of treatment. A confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information. If you have any questions about your Covered Dental Benefits or plan maximums please see the "Questions Regarding Your Plan" section on how to contact Customer Service.

Well Baby Checkups

For your infant child (three years of age and under), Delta Dental of Washington offers coverage for an oral evaluation and fluoride treatment 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, DDWA will reimburse the physician as a Non-Participating Provider, on your behalf for Oral Evaluation and Topical Application of Fluoride services performed. Reimbursement will be based on 100 percent of the applicable Non-Participating 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.

General Exclusions

The benefits covered under this plan are subject to limitations and exclusions listed in the benefits sections above which affect the type or frequency of procedures which will be covered. Additionally, this Plan does not cover every aspect of dental care. There are exclusions to the type of services that are covered, which are detailed in this "General Exclusions" section. All limitations and exclusions warrant careful reading. These items are not paid Covered Dental Benefits under this Plan.

1) Dentistry for cosmetic reasons.

2) Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
3) Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4) Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5) Experimental services or supplies
    a) This includes:
        i) Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
            (1) The services are in general use in the dental community in the state of Washington;
            (2) The services are under continued scientific testing and research;
            (3) The services show a demonstrable benefit for a particular dental condition; and
            (4) They are proven to be safe and effective.
    b) Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
    c) Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.
    d) Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.
6) 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.
7) Prescription drugs.
8) Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
9) Charges for missed appointments.
10) Behavior management.
11) Completing claim forms.
12) Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), does not include Occlusal Guard, see "Class III Periodontics" for benefit information.
13) Orthodontic services or supplies are not covered unless Optional Orthodontic coverage has been selected.
14) Accidental Injury Benefits
15) This Plan does not provid.e benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

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

Confirmation of Treatment and Cost

A Confirmation of Treatment and Cost is a request made by your dentist to DDWA to determine your benefits for a particular service. This Confirmation of Treatment and Cost will provide you and your dentist with general coverage information regarding your benefits and your 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 Benefit 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 the receipt of the request and all supporting documentation. When practical, DDWA may provide notice of the determination orally with written or electronic confirmation to follow within 72 hours.

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

Section C – Choosing a Dentist

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, or printed from www.DeltaDentalWA.com. 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 uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft. Please note that ID cards are not required to see your dentist, but are 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

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

If you select a Delta Dental Participating Dentist they will complete and submit claim forms, and receive payment directly from DDWA on your behalf. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurances, deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

Non-Participating Dentists

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

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

Out-of-State Dentists

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

Section D – Eligibility and Termination

Employee Eligibility and Enrollment

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

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

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

You must complete the enrollment process in order to receive benefits. DDWA must receive completed enrollment information within 60 days of employee's Eligibility Date. If the enrollment information is not received within 60 days, enrollment will not be accepted until the next Open Enrollment Period.

Employee Termination

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

In the event of a suspension or termination of compensation, directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may continue coverage by paying the applicable Premium directly to the employer for a period not to exceed six months. Payments of premiums must be made when due, or DDWA may terminate the coverage.

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

Dependent Eligibility and Enrollment

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

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

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

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

A child will be considered an Eligible Dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the eligible Enrolled Employee for the purpose of adoption under the laws of the state in which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in the claims processing. See the "Special Enrollment" section for additional information.

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

A new family member, with the exception of newborns, 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 or child placed in anticipation of adoption shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement.

When 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.

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 on the last day of the month of the Enrolled Employee’s employment, or when the dependent ceases to be eligible, whichever occurs first.

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

A Dependent may be enrolled or terminated from coverage under this Plan during Open Enrollment or during a Special Enrollment Period following 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 the Plan, the parent must enroll for coverage for both the parent and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Special Enrollment Periods

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

Loss of Other Coverage

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

- You declined enrollment in this Plan.
- You lose eligibility in another health Plan or your coverage is terminated due to the following:
    - ◊ Legal separation or divorce
    - ◊ Cessation of dependent status
    - ◊ Death of Employee
    - ◊ Termination of employment or employer contributions
    - ◊ Reduction in hours
    - ◊ Loss of individual or group market coverage because of move from Plan area or termination of benefit plan
    - ◊ Exhaustion of COBRA coverage
- Your application to enroll in this Plan must be received by DDWA within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

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

DDWA or Group may require confirmation that when initially offered coverage the Eligible Person submitted a written statement declining because the Eligible Person or Eligible Dependent has other coverage. DDWA requests that the application for coverage under this Plan must be made within 31 days of the termination of previous coverage. If an additional Premium for coverage is required and enrollment and payment is not completed within the 31 days, such Eligible Dependent may be enrolled during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

Marriage, Birth or Adoption

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

- Marriage or Domestic Partner Registration – DDWA requests the application for coverage be made within 31 days of the date of marriage/registration. If enrollment and payment are not completed within the 31 days, the Eligible Dependent may be enrolled during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

  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 benefit 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. DDWA requests the application for coverage be made within 90 days of the date of birth, if 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 or upon the occurrence of another valid qualifying election change event.
- 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 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 or upon the occurrence of another valid qualifying election change event.

Circumstances Which May Result in Ineligibility or Denial of Benefits

You or your dependents will become ineligible for benefits for any of the following reasons:

1. If your employment terminates or if you no longer work full-time as determined by your employer; or
2. If you otherwise fail to meet the eligibility requirements; or
3. If you do not elect continuation of coverage. See "Consolidated Omnibus Budget Reconciliation Act (COBRA)".

If you or your dependents are eligible, benefits may, nonetheless, be denied or reduced for any of the following reasons:

1. If you fail to list your Eligible Dependents on your enrollment form.
2. If you fail to file a claim for benefits within six months of the date of treatment.
3. If you did not file a complete and truthful application for benefits.
4. If the treatment is limited or excluded under this program. See Section B, "Your Benefits".
5. If charges for treatment for the Eligible Person exceed the Annual Plan Maximum allowed during any one benefit period (calendar year).

If the eligible person is covered on another group dental plan, please refer to "Coordination of Benefits".

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

Enrolled 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.

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 the 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)

Federal law requires that should certain qualifying events occur which would have previously terminated coverage, coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits for up to 18 months by self-paying the required Premium. This option to continue dental benefits terminates if you become eligible for coverage under another group dental plan.

If a dependent no longer meets the eligibility requirements due to the death or divorce of the employee, or does not meet the age requirement for children, coverage may continue up to three years by self-paying the required Premium. This option to continue dental benefits terminates if the dependent becomes eligible for coverage under another group dental plan.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

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 for which claim forms are not submitted within six months after the date of treatment or as soon as medically possible.

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

How to contact us

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

Authorized Representative

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

Informal Review

If your claim for dental benefits has been completely or partially denied, 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 the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and must include the following information:

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

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request a formal appeal. Your formal appeal will be reviewed by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or the previous review.

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

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

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulations.

How to Report Suspicion of Fraud

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

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

Your Rights and Responsibilities

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

You Have The Right To:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental Participating Dentist or Non-Participating Dentist), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.

- Contact 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 and have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

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

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

Your Rights Under ERISA

As a participant in this employee benefit health and welfare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated documents. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the documents governing this Plan for the rules governing your COBRA continuation of coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your right under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial all, within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that the Plan fiduciaries misused the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Summary Plan Description

Required By the Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act of 1974 requires that certain information be furnished to each participant (or eligible participant) in an employee benefit plan. This is your Summary Plan Description. The following is additional information required by the Act.

This plan is known as the Associated Industries Management Services Health & Welfare Plan.

Employer Identification Number (Ein):

91-6030840

Plan Number:

501

The trust fund through which this plan is provided is known as the Associated Industries Management Services Health & Welfare Trust.

Type of Plan

This plan can be described as a welfare plan which provides death benefits, disability income, health insurance benefits, and/or dental benefits for eligible employees and their dependents. Refer to this benefit booklet for information on the benefits available to you.

Administration of Plan

The Board of Trustees is the Plan Administrator. They administer the plan with the assistance of Associated Industries Management Services. Their address and telephone number are:

Board of Trustees

Associated Industries Management Services Health & Welfare Trust

c/o Associated Industries Management Services

1206 N. Lincoln St., Suite 200

Spokane, WA 99201-2559

Phone (509) 326-6892

The Trustees have the authorization and discretion to interpret the terms of the plan and requirements for participation in it. Information as to whether a particular employer is a sponsor of the plan and the employer's address may be obtained from the plan Administrator.

Important Information

This booklet describes the program selected by your employer and provides general information about your eligibility to participate in the plan, the benefits provided by the plan, the Exclusions and Limitations of the plan, and circumstances that may cause a loss or reduction of benefits. You should read carefully the information under the separate headings entitled ELIGIBILITY; BENEFITS; EXCLUSIONS and LIMITATIONS; and CIRCUMSTANCES THAT MAY CAUSE LOSS OR REDUCTION OF BENEFITS in this booklet.

Circumstances which may result in loss of eligibility or denial of benefits are:

1. The failure of the employer to remit any required premium contributions, or the employee to make any required self-payments.
2. Any circumstance that results in the employee or dependent no longer meeting the requirements for eligibility.
3. Termination of the plan.

Plan Year

The plan year for the plan ends on the last day of December of each year. Each 12-month period commencing on January 1 consists of an entire plan year for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

Sources of Contributions to the Plan

This plan is supported by the employer and/or employee contributions as established by individual participating firms. Contributions are received and held in Trust by the Board of Trustees pending payment to Medical Service Corporation, Delta Dental of Washington, and Standard Insurance Company. Addresses of Carriers are provided in each individual benefit booklet.

Agent for Service of Legal Process

The agent for legal process for this plan is Associated Industries Management Services, 1206 N. Lincoln St., Suite 200, Spokane, Washington 99201-2559. Service of legal process may be made on any member of the Board of Trustees, identified below, in its capacity as agent or in its capacity as Plan Administrator. Service of legal process may also be made on a Plan Trustee.

Names and Address of Trustees

Jim DeWalt
President
Associated Industries of the Inland Northwest
1206 N. Lincoln St., Suite 200
Spokane, WA 99201-2559
777-2652
Fax 328-6832
jdewalt@aiin.com

Robert G. Bakie
Associated Industries
1206 N. Lincoln St., Suite 200
Spokane, WA 99201-2559
777-2651
Fax 328-6832
bbakie@aiin.com

Jack Fallis
Global Credit Union
1520 West 3rd Avenue
PO Box 3200
Spokane, WA 99220
455-4770
Fax 624-9299

Future of the Plan and Trust Fund

The Board of Trustees has the authority to terminate the Trust Fund. In the event of termination of the Trust Fund, any and all monies and assets remaining in the Trust fund, after the payment of expenses, shall be used for the continuance of benefits by the then existing plans, until such monies and assets have been exhausted.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your dental health information in compliance with the Health Insurance Portability and Accountability Act. You can get our Notice of Privacy Practices by visiting www.DeltaDentalWA.com, or by calling DDWA at 800-554-1907.

Conversion Option

If your dental coverage stops because your employment or eligibility ends, the group policy ends, or there is an extended strike, lockout or labor dispute, you may apply directly to DDWA to convert your coverage to a Delta Dental Individual and Family plan. You must apply within 31 days of 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 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 for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. An exception will be made for the completion of procedures requiring multiple visits that were started while coverage was in effect, are completed within 21 days of the termination date, and are otherwise benefits under the terms of this Plan.

Coordination of Benefits

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

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

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

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has 2 parts and COB rules apply only to one of the 2, each of the parts is treated as a separate *Plan*.

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

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

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

"**Allowable Expense**" except as outlined below, means any health care expense including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering you. When coordinating benefits 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 *plan*s is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by 2 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*.
- If you are covered by 2 or more *Plan*s 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*.

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

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

Order of Benefit Determination Rules: When you are covered by 2 or more *Plan*s, the rules for determining the order of benefit payments are as follows:

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

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

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

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

"***Non-Dependent or Dependent***" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the 2 *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

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

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
   a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
   b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
   b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
   c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of point 1) above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;

d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of point 1) above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or

e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:

I. The *Plan* covering the *Custodial Parent*, first;
II. The *Plan* covering the spouse of the *Custodial Parent*, second;
III. The *Plan* covering the non*custodial Parent*, third; and then
IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of points 1) or 2) above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.
- We will determine our payment by subtracting the amount paid by the Primary Plan from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all 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 *Plan*s. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plan*s covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

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

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

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

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

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

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 about Your Dental Benefits

What is a Delta Dental "Participating Dentist"?

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

Can I choose my own dentist?

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

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

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

How can I get claim forms?

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

What is the mailing address for DDWA claim forms?

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

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

If you have questions about your dental benefits, call DDWA's Customer Service Department at 800-554-1907. Questions can also be addressed via e-mail at CService@DeltaDentalWA.com.

Does DDWA cover tooth colored filings on my back teeth?

It is your group's choice to cover posterior composite fillings (tooth colored fillings on your back teeth), or only allow posterior amalgam fillings (silver fillings on your back teeth). Please see the "Benefits Covered by Your Plan" section to determine which election your Group has made. You may also log on to 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 estimate will provide you with estimated cost for your procedure, but is not a guarantee of payment.

Who is Delta Dental?

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

Glossary

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

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

Apicoectomy
Surgery on the root of the tooth.

Appeal
An oral or written communication by a subscriber or their 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
Also known as a fixed partial denture. See “Fixed Partial Denture”.

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

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

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

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

Contract
This agreement between DDWA and Group. The Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding or negotiation between the parties.

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

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

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

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

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

Delta Dental
Delta Dental Plans Association, which is a nationwide nonprofit organization of health care service plans, which offers a range of group dental benefit plans.

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

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

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

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

Eligibility Date
The date on which an Eligible Person becomes eligible to enroll in the Plan.

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

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

Eligible Person
An Eligible Employee or an Eligible Dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Licensed Professional
An individual legally authorized to perform services as defined in his or her license. Licensed professionals include, but are not limited to, denturist, hygienist and radiology technician. Benefits under this Contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW.

Lifetime Maximum
The maximum amount DDWA will pay in the specified covered dental benefit class for an insured individual during the time that individual is on this Plan or any other Plan offered by this Employer.

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

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

Maximum Allowable Fees
The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Nightguard
See "Occlusal Guard."

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

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

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

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

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

Palliative Treatment
Services provided for emergency relief of dental pain.

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

Participating Plan
Delta Dental of Washington, and any other member of the Delta Dental Plans Association with which Delta Dental contracts to assist in administering the benefits described in this Benefits Booklet.

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

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

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

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

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

Prophylaxis
Cleaning and polishing of teeth.

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

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

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

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

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

Root Planing
A procedure done to smooth roughened root surfaces.

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

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

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

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

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

Nondiscrimination and Language Assistance Services

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

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

Delta Dental of Washington:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language and service to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 1(800)554-1907.

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Isaac Lenox, Compliance/Privacy Officer, PO Box 75983 Seattle, WA 98175, Ph: 1(800)554-1907, TTY: 1-800-833-6384, Fx: (206) 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Isaac Lenox, Compliance/Privacy Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language	Tagline	Nondiscrimination Statement
Amharic	እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1(800)554-1907 ይደውሉ።	ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Delta Dental of Washington ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። 1(800)554-1907 ይደውሉ።
Arabic	والمعلومات المساعدة على الحصول في الحق فلديك Delta Dental of Washington لديك كان إن بخصوص أسئلة تساعده شخص لدى أو اية دون من بلغتك الضرورية 1(800)554-1907 بـ اتصل مترجم مع للتحدث .تكلفة	Delta Dental of Washington معلومات الاشعار هذا يحوي للحصول طلبك بخصوص مهمة معلومات الاشعار هذا يحوي .هامة قد .الاشعار هذا في الهامة التواريخ عن ابحث خلال من التغطية على او الصحية تغطيتك على للحفاظ معينة تواريخ في اجراء لاتخاذ تحتاج في الحق لك .التكاليف 1(800)554-1907 دفع في للمساعدة بـ اتصل .تكلفة أي دون من بلغتك والمساعدة المعلومات على الحصور
Cambodian (Mon-Khmer)	្របសិនបេរើអ្នក ឬនរណាម្នក់ែដលអ្នកកំពុងែដជួយ ម្ននសំណួរអំពី Delta Dental of Washington េប, អ្នកម្ននសិេធិេេ្ួលជំនួយនិងព័ែ៌ម្នន ជៅកនុងភាសា រស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។	បសចកតីជូនែំណឹងបនេះ ម្នព័ែ៌ម្នយា៉ា ងសំខាន់ ។ បសចកតីជូនែំណឹងបនេះ ម្នព័ែ៌ម្នយា៉ា ងសំខាន់ អំពីេប្ង់ដររេ ឬការា៉ រ់រង រស់អ្នកតាមរយៈ Delta Dental of Washington ។ សូមដស្វងរកកាលររិបចេេសំខាន់ចាំច់ ជៅកនុងបសចកតីជូនែំណឹងបនេះ ។

	បែខើមបីនីយាយជាមួយអ្នកកដប្រ សូម 1(800)554-1907.។	អ្នកប្រដែលជាប្ខែូវការបចេញសកមមភាព ែលំ់ណែ់ថ្ងៃជាក់ចាស់នានា បែខើមបីនីងរកាេ១ុកការ៉ា រ់ងសុខភាពរស់អ្នក ឬបុ ាក់ជំនួយបចញថ្ងៃ។ អ្នកម្ននសិេធិេ១ែូលព័ែ៌ម្ននបនេះ និងជំនួយជៅកនុងភាសារស់អ្នកជោយមិនអ្ស់លុយ ប ខើយ។ សូមេ១រស័ពទ 1(800)554-1907.
Chinese	如果您，或是您正在協助的對象，有關於[插入項目的名稱 Delta Dental of Washington 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1(800)554-1907.	本通知有重要的訊息。本通知有關於您透過[插入項目的名稱 Delta Dental of Washington 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1(800)554-1907.
Cushite (Oromo)	Isin yookan namni biraa isin deeggartan Delta Dental of Washington irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1(800)554-1907 tiin bilbilaa.	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Delta Dental of Washington tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1(800)554-1907 tii bilbilaa.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Washington haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1(800)554-1907 an.	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Delta Dental of Washington. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1(800)554-1907.
Japanese	ご本人様、またはお客様の身の回りの方でも Delta Dental of Washington についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 1(800)554-1907 までお電話ください。	この通知には重要な情報が含まれています。この通知には Delta Dental of Washingtonの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます 1(800)554-1907 までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Delta

	Washington 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1(800)554-1907로 전화하십시오.	Dental of Washington 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1(800)554-1907 로 전화하십시오.
Laotian	ຖາ ່ທານ, ືູຫ ິ ນີ່ທ ່ທານໍກາ ັລງ ່ຊວຍເືູຫອ, ີມໍຄາຖາມ ່ກຽວ ັກບ Delta Dental of Washington, ່ທານີມີສດິ່ທຈະໄ ້ດ ັຮບການ ່ຊວຍເືູຫອແລະໍ່ ້ຂ ູມນ ່ຂາວສານິີທເັປນພາສາຂອງ ່ທານໍ່ບີມ ່ຄາໃ ້ຊ ່ຈາຍ. ການໂ ້ອ ິລມ ັກບນາຍພາສາ, ໃ ້ຫໂທຫາ 1(800)554-1907.	ການແ ້ຈງການີ ້ນີມໍ້ຂ ູມນໍສາ ັຄນ. ການແ ້ຈງການີ ້ນີມໍ້ຂ ູມນີ່ທໍສາ ັຄນ ່ກຽວ ັກບໍຄາ ້ຮອງສະ ຫັມ ກືູຫການ ຸ້ຄມຄອງຂອງ ່ທານໂດຍ ່ຜານ Delta Dental of Washington ເິ່ບງໍສາ ັລບໍກາ ິນດ ັວນີ່ທໍສາ ັຄນໃນແ ້ຈງການີ ້ນ. ່ທານອາດໍຈາເັປນ ້ຕອງໃ ້ຊເວລາໍດາເິນນການໂດຍໍກາ ິນດເວລາິ່ທແ ່ນນອນ ຈະ ັຮກສາການ ຸ້ຄມຄອງ ຸສຂະພາບຂອງ ່ທານີູຫການ ່ຊວຍເືູຫອີທີ່ມ ່ຄາໃ ້ຊ ່ຈາຍ. ່ທານີມີສດິ່ທຈະໄ ້ດ ັຮບໍ້ຂ ູມນ ່ຂາວສານີ ້ນແລະການ ່ຊວຍເືູຫອໃນພາສາຂອງ ່ທານີ່ທໍ່ບີມ ່ຄາໃ ້ຊ ່ຈາຍ. ໂທ 1(800)554-1907.
Punjabi	ਜੇ ਤੁਹਾਨੰ ੂ , ਜਾਂ ਤੁਸੀ ਜਜਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ , Delta Dental of Washington ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਜਿਨਾ ਜਕਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ . ਦੁਭਾਸੀਏ ਨਾਲ ਗਿੱਲ ਕਰਨ ਲਈ, 1(800)554-1907 ਤੇ ਕਾਲ ਕਰ	ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੇ ਜਿਸ ਜਵਚ [Delta Dental of Washington ਵਲੋ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੱਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁਿੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੂੰਤਮ ਤਾਜਰਖ਼ ਤੋਂ ਪਜਹਲਾਂ ਕੁਿੱਝ ਖਾਸ ਕਦਮ ਚੁਿੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ 1(800)554-1907.
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Washington, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Delta Dental of Washington. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно,

	переводчиком позвоните по телефону 1(800)554-1907.	потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1(800)554-1907.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1(800)554-1907.	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Delta Dental of Washington. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1(800)554-1907.
Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Delta Dental of Washington, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1(800)554-1907.	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Delta Dental of Washington. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1(800)554-1907.
Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Delta Dental of Washington, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1(800)554-1907.	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через Delta Dental of Washington. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1(800)554-1907.
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Washington, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1(800)554-1907.	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Delta Dental of Washington. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và

		được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1(800)554-1907.

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

Here are our top tips for a healthy smile:

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

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

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

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

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