Your Delta Dental Individual and Family – Basic Family Plan

Plan Overview

Use this overview and your benefits book to make the most of your plan

About your plan

Your plan is a family plan. It offers two different sets of benefits in one plan – pediatric (kids) and adult.

Children through age 18 get pediatric benefits. After they turn 19, they get adult benefits, even though they can still be your dependent on this plan up to age 26.

Understand your plan
This is your Plan Overview information page. It shows your costs for the plan. It also shows the types of treatments that are covered by your plan – like preventive services or oral surgery. And it lists the percentage we pay for each of the treatment types.

But this only tells you part of the story.
While this Plan Overview shows you the types of treatment we cover, it doesn't list specific procedures. For that, you need to look in your benefits book. That's where you'll see which procedures are covered and which are not.

As always, if you have any questions, we are just a web visit or phone call away.

DeltaDentalWA.com
800-526-8323

This Plan Overview is issued and delivered in the state of Washington and is governed by Washington State laws. It sets out the information of the Delta Dental Individual and Family – Basic Family Plan which provides dental benefits subject to the terms set forth in the contract.

DELTA DENTAL®

Delta Dental of Washington

- **PREVENTIVE CARE IS COVERED AT 100% - with no deductible**
- **SAVE MONEY WITH DELTA DENTAL IN-NETWORK DENTISTS**
  You can go to any dentist. But your costs may be lower if you go to a dentist in either of our networks – Delta Dental PPO℠ and Delta Dental Premier©
  – *but you'll usually save the most when you see a dentist in our Delta Dental PPO℠ network.*
  Find an in-network dentist on our website, DeltaDentalWA.com or call us at 800-526-8323

Contract term When you enroll in a dental plan, you've entered into a contract. This means that you're responsible to pay your premiums and follow the rules of the plan. It means that we're responsible to pay for covered services listed in your benefits book at the percentages below. And we have to follow the plan's rules, too. This Plan Overview application and your benefits book are our contract.	Your contract with Delta Dental of Washington starts at 12:01 a.m. Pacific Time on the first day of August 2018, at Seattle, Washington. The contract term is August 1, 2018 through December 31, 2018.
Benefit period This is when your coverage begins and ends.	Your benefit period is Aug. 1, 2018 through Dec. 31 2018.
Maximum amount A maximum amount is the total your plan will pay each year for dental services.	Pediatric maximum: none Adult maximum for each covered person: $1,250 annually for dental treatments $1,000 annually for TMJ-related treatments $5,000 lifetime for TMJ-related treatments
Plan deductible Before your plan begins paying for covered services, you must meet your plan deductible.	Your pediatric deductible is $85. The adult deductible is $50.
Out-of-pocket maximum For some services, we may pay only part of the cost. In those cases, you're responsible for paying what's left. That's called an out-of-pocket expense. After you meet your pediatric out-of-pocket maximum, you won't have any more out-of-pocket costs for your children. But you will continue to pay them for your adult benefits. NOTE: payments to dentists not in Delta Dental networks don't go toward your out-of-pocket maximum.	Pediatric: annually per child $350, up to $700 for families with 2 or more children. Adults: none
Premium This is the amount you pay each month to be enrolled in this plan. Premiums are due on the first of the month.	Single $41.13 Single + Spouse $82.27 Single + Child(ren) $91.47 Family $145.45

Percent your plan pays for these dental treatment areas

PEDIATRIC BENEFITS

COVERED TREATMENT AREA	MAXIMUM AMOUNT PAID BY YOUR PLAN
Diagnostic and preventive services and accidental injury	100 percent - without having to meet your deductible
Adjunctive and restorative services, oral surgery, periodontics, endodontics	70 percent - after meeting your deductible
Crowns, prosthodontics, implants	50 percent - after meeting your deductible
Medically necessary orthodontia	50 percent - without having to meet your deductible

ADULT BENEFITS

COVERED TREATMENT AREA	MAXIMUM AMOUNT PAID BY YOUR PLAN
Class I: Diagnostic and preventive services and accidental injury	100 percent - without having to meet your deductible
Class II: Adjunctive and restorative services, oral surgery, sedation, palliative treatment, periodontics, endodontics, TMJ treatment	50 percent - after meeting your deductible
Class III: Crowns, periodontics, restorative prosthodontics	50 percent - after meeting your deductible

DELTA DENTAL®

Delta Dental of Washington

You have 10 days to decide if you want keep this plan

If you're not satisfied with this plan after reading through this booklet and your Plan Overview page, you can cancel it anytime within 10 days of the date you received these materials. We'll void the policy and refund your money, less any payment we made for your dentist bills.

If we don't refund your money within 30 days after you cancel, we'll pay you an additional 10% of the refunded amount.

Delta Dental Individual and Family – Basic Family Plan

Benefit Booklet

Your all-in-one guide to making the most out of your family's dental benefits

Delta Dental of Washington

Welcome to your Delta Dental Individual and Family – Basic Family Plan

Thank you for choosing our Delta Dental Individual and Family - Basic Family plan for your family. This plan includes two different sets of benefits in one plan – pediatric (kids) benefits and adult benefits.

Children through age 18 qualify for pediatric benefits. After they turn 19, they get adult benefits, even though they can still be your dependent on this plan up to age 26.

We hope you'll take a few minutes to read through this benefit booklet. We set it up so you'll have all the information you need right at your fingertips. But if you ever need help beyond this booklet, call us at 800-526-8323. Or, visit our website, DeltaDentalWA.com. It's full of helpful information, available 24/7.

Smile, you're covered.

Where to find things in this policy

Table of Contents

You might be wondering...

If my plan is easy to use, why is the benefit booklet so big?

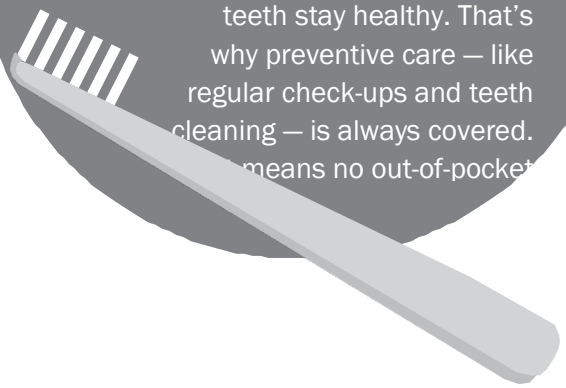
Don’t worry, we’ll cut it down to size!

Learn how to use this booklet and get the most out of your benefits:

FIVE EASY STEPS

1 Take advantage of preventive care

At Delta Dental, we're big believers in making sure your family's teeth stay healthy. That's why preventive care — like regular check-ups and teeth cleaning — is always covered. means no out-of-pocket



2

Call us or visit our website

800-526-8323
DeltaDentalWA.com

Need a copy of your family's ID card?
Looking for help finding a network dentist?
Not sure if your plan covers crowns?
Interested in dental health tips?

Call us or visit our website for all this and more.

3 Look for this graphic

words TO KNOW

It's important that you understand your dental plan. But some of the words and terms can be technical and may not be familiar to you. Not to worry! Just look for this words to know graphic. That's where you'll find easy-to-understand explanations to help you make the most of your dental

4

Use these icons to find information that you need

When you have a question about your plan, use this page to figure out where to find answers. We've divided this book into three sections and we've paired each section up with it's own icon so it's easy to find the type of answers you need.

SECTION 1

What benefits do I get with this plan?

Let's say you want to know if your plan covers having a cavity filled (it does). Or a night guard for grinding teeth (it does). Or a root canal (it does). Look for the tooth icon to learn more about the dental services your plan covers.

Diagnostic - Exams & check ups
Preventive - Cleanings & maintenance
Adjunctive/Sedation - Help with pain
Restorative - Fillings
Crowns - Tooth coverings
Oral surgery - Removing teeth & repairs
Periodontics - Gum treatments
Endodontics - Care for the inside of teeth
Prosthodontics – Dentures
Injury - Accidents
Orthodontia (Pediatric Only) - Teeth and jaw realignment

SECTION 2

How does my plan work?

Let's say you have a question about which dentists you can see. Or how much you'll pay for oral surgery. Or what to do if a claim is denied. Look for the calculator icon to learn more about how to get your dental visits paid.

Your Plan Overview page
Saving with in-network dentists
Your dentist bills
Estimating costs
Appeals
Enrolling, renewing, and making changes to your plan

SECTION 3

What else do I need to know?

Let's say you have a question about how to add a new child to your plan. Or how to get plan information in another language. Or what if you have more than one dental plan? Look for the light bulb icon to learn more about plan specifics.

Who's covered
Contacting us
If you're not happy with your plan
Coordination of benefits (When you're covered by more than one plan)
Privacy Odds & ends

5 STEP FIVE NEXT PAGE

5

Get ready to visit your dentist

Here are three examples of how to work with your dentist to make the best use of this plan.

PREVENTIVE CARE

Preventive care is covered 100% with no deductible. That way you can keep your family's smile clean and healthy. For Jayden, it's time for a routine exam and teeth cleaning.

- Find a dentist
  - use our website or ask your family and friends who they use
- Call to make an appointment
  - ask if they're a Delta Dental in-network dentist
- Go to the dentist's office
  - let your dentist know you're covered by Delta Dental of Washington
  - schedule check ups for six months later
- Watch for paperwork in the mail
  - an explanation of benefits will tell you what the dentist billed, what Delta Dental of Washington paid, and how much (if any) you owe

URGENT CARE

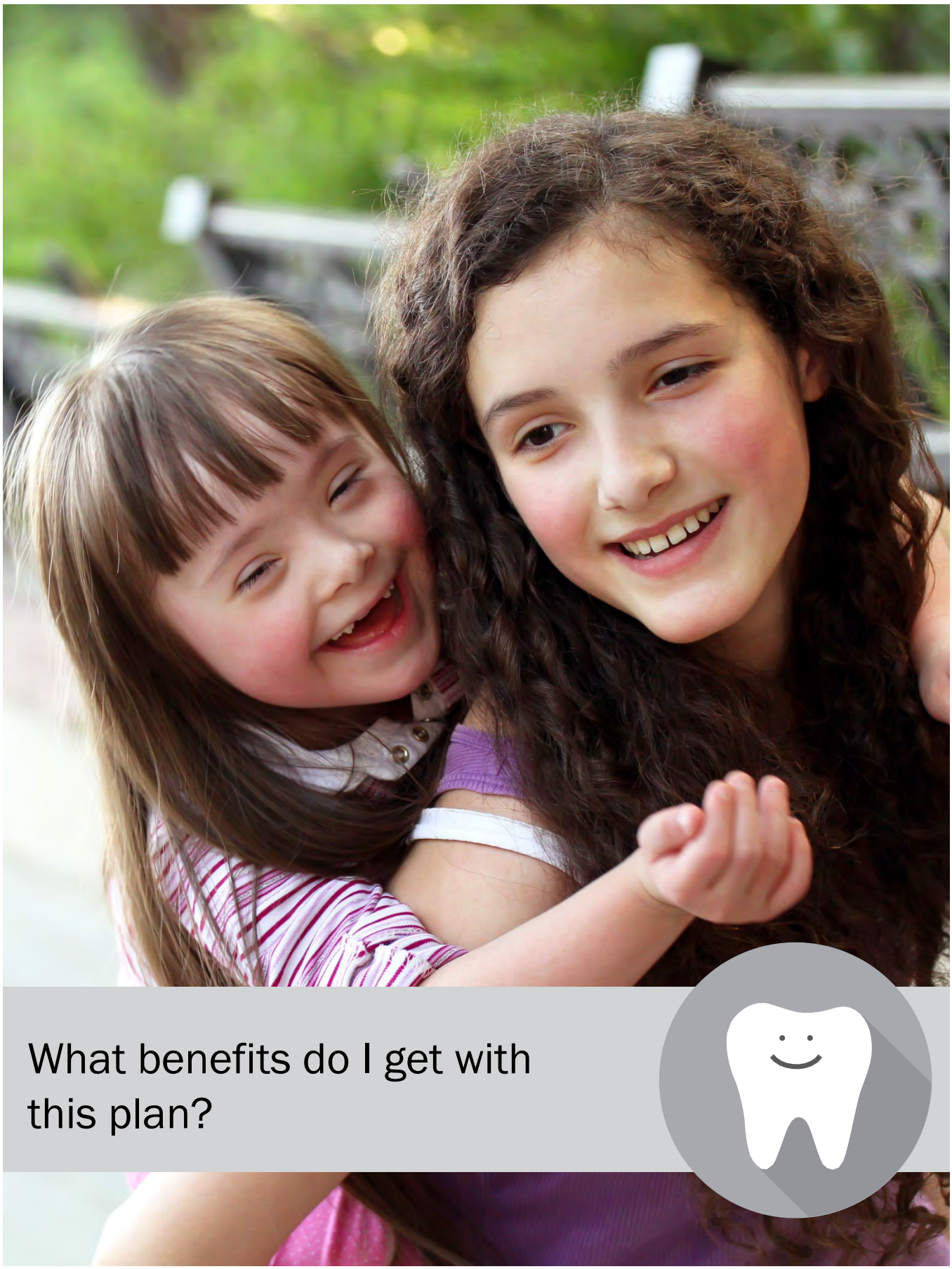
Your dental plan gives you peace of mind when your family has an urgent need. You have s a painful toothache and need to see the dentist right away.

- Call your dentist to make an appointment
  - tell the dentist what the problem is
  - See your Plan Overview page to find out how much your plan covers
- Go to the dentist's office
  - let your dentist know you're covered by Delta Dental of Washington
- Watch for paperwork in the mail
  - an explanation of benefits will tell you what the dentist billed, what Delta Dental of Washington paid, and how much (if any) you owe

BRACES (Pediatric only)

Your regular dentist will tell you if your child needs braces. Abby had a medically necessary reason for needing braces, so her treatment was covered

- During a routine dental visit, ask your dentist about braces
  - if your dentist thinks your child needs braces, they'll refer you to an orthodontist
- Call the orthodontist and make an appointment
  - see if they're a Delta Dental in-network provider
- Go to the orthodontist's office
  - let your dentist know you're covered by Delta Dental of Washington
  - If the orthodontist thinks your child needs braces, they have to show us that it's medically necessary
- If we approve orthodontia treatment, your orthodontist can start treatment



What benefits do I get with this plan?

What benefits do I get with this plan?

In this section find

answers

about

Dental services your plan covers:

Diagnostic
Exams & check ups

Preventive
Cleanings & maintenance

Adjunctive/Sedation
Help with pain & anxiety

Restorative
Fillings

Crowns
Tooth coverings

Oral surgery
Removing teeth & repairs

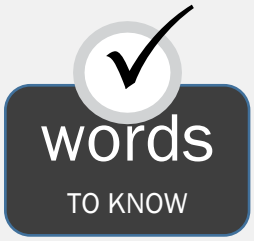
Periodontics
Gum treatments

Endodontics
Care for the inside of teeth

Prosthodontics
Dentures

Injury
Accidents

Pediatric Orthodontia
Teeth and jaw realignment



When you see the word **limitations**, it means that your plan will pay for certain dental services — within limits. For example, in the case of panoramic x-rays, your plan limits them to once every three years. If your family needs them more than once every three years, you would have to pay for them out-of-pocket.

Exclusions are dental services or procedures your plan doesn't cover.

A **licensed professional** has special training and a license that allows them to perform specific services. In the dental world, licensed professionals include dentists, dental hygienists, denturists, registered nurses and nurse practitioners. 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.

Overt pathology means there's something wrong in your mouth, like an injury, disease or decay, and it must be treated for your health and safety.

When you go to a dentist with a problem, they ask questions, run tests and examine you to find out what's the matter. That's how they **diagnose** what's wrong and decide what treatment you need.

Primary teeth = baby teeth. **Permanent teeth** = adult teeth.

Molars are the teeth in the back of your mouth.

A **cavity** is a hole in a tooth caused by decay. A filling does just that– it fills the cavity to stop decay from spreading.

Dentists think of your mouth as having four sections, called **quadrants**: the top left and right sides, and the bottom left and right sides of your mouth.

Second Opinions are when you request another dentist to review the treatment diagnosis or treatment plan of your dentist before treatment is done. A second opinion is paid as a limited oral evaluation however, there are no limitations on the number of second opinions you can have.

What benefits do I get with this plan?

Pediatric (kids) Benefits

The benefits listed below are covered for children through age 18 who are enrolled in this plan. These benefits are available only if they are performed by an individual legally authorized to perform services and when dentally appropriate as determined by the standards of generally accepted dental practice. See the Adult benefit section for information about coverage for adults age 19 an older.

Pediatric (kids) - Diagnostic services

Diagnostic services help your dentist diagnose — or know — what's happening inside your mouth.

Your plan covers 100%

(without having to meet your deductible)

- Routine diagnostic oral exams
- Comprehensive oral exams
- Limited or problem-focused oral exams
- Emergency exams
- X-rays

Keep these limitations in mind

- *Comprehensive and routine oral exams*
  Comprehensive oral exams happen the first time your child visits a new dentist. These visits are meant to help your dentist get a general idea about your child's overall health. They'll ask about your child's dental and medical history and any medications they're taking.

  Your dentist will examine the areas inside and outside of your child's mouth — including their head, neck, teeth, tongue and gums.

  Routine exams are not as in-depth as a complete oral exam.

- *Routine and comprehensive oral exams*
  Your child is covered for 2 routine or comprehensive exams per benefit period.

- *Limited oral exams*
  Limited oral exams are visits for:
  - Dental problems or oral health complaints
  - Dental emergencies
  - Referrals for other treatment

Your plan covers x-rays, films and tests – WITH THESE LIMITATIONS

- Complete series or **panoramic x-rays** capture all of your child's teeth. They're covered once every 3 years (from treatment date). If you have multiple x-rays on the same day, and the fee for those x-rays is more than a complete series, then only a complete series will be allowed.
- **Periapical x-rays** show the entire tooth, from the chewing surface to below the gums to the tip of the root. They're covered when medically necessary. NOTE: If these x-rays are taken as part of a complete series of x-rays for a procedure, they won't be covered again if used for a different procedure.
- **Occlusal intraoral x-rays** show how teeth are growing in and where they are in the mouth. They're covered once every 2 years (from treatment date).
- **Bitewing x-rays** look at your child's back teeth, called premolars and molars. Your child can have one bitewing x-ray for each quadrant every 12 months.
- **Cephalometric x-rays** show the entire side of your child's head. They're covered once every 2 years (from treatment date).
- Oral and facial **photographic images** are covered, but only if they're needed to get a clear picture of the growth and development of your child's teeth, jaws and face.
- **Pulp vitality tests** check the health of your child's dental pulp — the material inside each tooth. Your plan covers pulp vitality tests only when they're done during a limited oral exam, and only one test is covered per visit. These tests are for diagnosis only. Your dentist must show that the test is medically necessary.
- **Diagnostic casts** are models of your child's actual teeth. They're covered for orthodontic case studies on a case-by-case basis.

What's not covered — exclusions

- Consultations to evaluate slides taken by another provider aren't covered.
- Diagnostic services and x-rays related to treatment temporomandibular joints (the hinge part of your jaw) aren't covered.

What benefits do I get with this plan?

Pediatric (kids) - Preventive services

Preventive services help keep your child's teeth healthy in order to prevent things like tooth decay and gum disease. Good preventive practices — such as visiting the dentist twice a year, brushing twice a day and flossing — can mean fewer serious dental problems.

Your plan covers 100%

(without having to meet your deductible)

We want your child to have strong, healthy teeth. That's why a wide range of preventive services are covered under your plan. These include:

- Prophylaxis (cleaning)
- Periodontal (gum) maintenance
- Fluoride treatments like fluoride rinse, foam and gel, as well as fluoride varnishes and disposable fluoride trays
- Oral hygiene instruction that shows your child the correct way to brush and floss their teeth and the best way to use toothpaste and mouth rinses
- Space maintainers, including removing and re-cementing
- Sealants cover molars with a plastic coating to keep food and bacteria from getting into tiny grooves and causing decay
- Preventive resin restorations fills in areas of shallow decay (cavities in the outer enamel layer of teeth)

Keep these limitations in mind

- Prophylaxis (cleaning) is covered twice in a benefit period
- Periodontal (gum) maintenance is covered once in a benefit period
- Sealants are covered on molars (back teeth) and bicuspids that have no fillings, once per tooth every 2 years
- Preventive resin restorations are covered only on molars with no fillings on the biting surface, once per tooth every 2 years (from treatment date). These restorations are not covered for 2 years after a sealant or filing on the same tooth.
- Fluoride treatments are covered up to 3 times in a benefit period for children 6 and younger. They're covered twice in a benefit period for children over
- 6. During orthodontic treatment, they're covered up to 3 times every 12 months. Additional fluoride treatments are covered when dentally appropriate.
- Oral hygiene instruction is covered twice in a benefit period for children eight-years-old and younger. To be covered, the instruction can't be given during the same visit as a cleaning. Also, it must be done by a licensed dentist or hygienist at a place that's not a dental office or clinic — such as a school screening
- Space maintainers (fixed unilateral or fixed bilateral) are covered once during the time your child is enrolled in this plan for each of the 4 sections of the mouth, called quadrants. Replacement of space maintainers are covered when dentally necessary

What benefits do I get with this plan?

Pediatric (kids) – Adjunctive services

Adjunctive services play a supporting role in your child's treatment. For example, getting local anesthesia (often called novocaine) to numb your child's mouth so they won't feel any pain is a type of adjunctive service.

Your plan covers 70%
(after you meet your deductible)

Several different types of adjunctive services are covered. These include:

- Emergency treatment for dental pain
- Controlling pain during treatments with local anesthesia (blocking pain in a specific area) or general anesthesia (like being asleep)
- Sedative drugs to make your child feel calm or sleep during treatment (called sedation)
- Dentist visits to nursing homes, hospitals and emergency rooms
- Behavior management (helping your child feel safe and relaxed when they can't stay calm during treatment)
- Follow-up treatment for complications after surgery
- Night guards to protect teeth during sleep from grinding and clenching

Keep these limitations in mind

- General anesthesia is only covered for certain endodontic, periodontic and oral surgery procedures that are covered by your plan. It's also covered for children 8 and younger or for physically or developmentally disabled children when medically necessary for services covered by your plan
- For patients 9 through age 18, deep sedation or general anesthesia services are covered on a case-by-case basis and need preauthorization — except for oral surgery. For oral surgery, sedation and general anesthesia services don't need preauthorization
- Intravenous sedation is covered when you're having endodontic, periodontic and oral surgery services that are covered by your plan
- Nitrous oxide can be used for sedation, but only once per day
- If your child has a procedure that allows for anesthesia, they are covered for either general anesthesia or intravenous sedation, but not both on the same day.
- Your child's dentist can visit your home or an extended care facility twice for each place while your child is enrolled in this plan
- Your child's dentist(s) can make 1 visit per day to a hospital to care for them. This includes seeing your child in the emergency room
- Services needed after oral surgery, called post-operative care and treatment, are considered part of the surgery. Treatment for complications after surgery are also considered part of the surgery if they're given within 30 days

What's not covered — exclusions

- General anesthesia or intravenous sedation aren't covered for routine procedures needed after an operation

What benefits do I get with this plan?

Pediatric (kids) – Restorative services

In other words, filling a cavity.

Your plan covers 70%
(after you meet your deductible)

- Amalgam (often called silver) and resin (white) fillings for primary (baby) and permanent (adult) teeth

Keep these limitations in mind

- You're covered for fillings in the same surface of the same tooth once every two years (from treatment date), but only in these cases:
  - When decay is visible in the tooth
  - When a fracture (crack) has caused the loss of a significant part of a tooth (missing cusp)
  - When a fracture causes significant damage to an existing filling
- 2 fillings to the biting surface of your child's top molars are covered — but only if the fillings don't touch each other and have healthy tooth structure between them
- Permanent back teeth can have fillings on a maximum of 5 surfaces per tooth. Upper molars are the exception — they can have fillings on a maximum of 6 surface per tooth
- Permanent front teeth can have resin fillings on a maximum of 6 surfaces. Making sure your child's bite is correct and comfortable after getting a filling is part of the treatment and is also covered
- If your child gets a filling within 6 months of having preparation for a crown, and the filling is done by the same dentist, then it will be covered as part of the crown treatment

What's not covered — exclusions

- Fillings for anything other than decay or fracture aren't covered
- Polishing or reshaping fillings isn't covered
- Overhang removal

Pediatric (kids) - Oral surgery

When you think of surgery, you usually think of hospitals. But in dentistry, oral surgery includes many common procedures that happen at the dentist's office — such as removing teeth and treating diseases.

Your plan covers 70%
(after you meet your deductible)

- Uncomplicated oral surgery is covered with preauthorization. This includes extraction (pulling teeth), making incisions and helping with drainage
- Complex oral surgery is covered with preauthorization. This includes extraction of impacted teeth (teeth that don't break through the gum), alveoloplasty and vestibuloplasty (surgeries to repair and reshape the jaw) and root removal
- Treating traumatic injuries or diseases in the mouth
- Surgically incision including frenectomy or frenuloplasty (treating how the tongue moves)
- Preparing the mouth for the insertion of dentures

What's not covered — exclusions

- Filling in a hole in the jawbone after a tooth or implant is removed (called bone replacement grafting) for ridge preservation isn't covered
- Bone grafts of any kind to the upper or lower jaws
- – unless they're needed to treat periodontal (gum) disease aren't covered
- Tooth transplants (re-implanting or relocating a tooth in the jaw) aren't covered
- Placing materials in a hole in the jawbone to regrow bone (generate osseous filling) after a tooth or implant is removed isn't covered

What benefits do I get with this plan?

Pediatric (kids) – Crowns

Crowns can have two meanings in dentistry. Dentists call the part of your teeth you can see when you smile the crown. But most people think of a crown as an artificial covering that gets cemented into your mouth over a tooth. Artificial crowns cover teeth that have been severely damaged. In this section, we're talking about the second type of crown — the artificial covering.

Your plan covers 50%
(after you meet your deductible)
Your plan covers a variety of things related to crowns. This includes:

- Stainless steel crowns for primary (baby) teeth and permanent (adult) teeth, except for wisdom teeth
- Permanent crowns – with preauthorization
- Re-cementing permanent crowns
- Core build-ups
- Dental implant crown and abutment procedures
- Repair of a crown, implant supported prosthesis, or abutment

Core buildups
Your plan covers services that make the tooth more stable for a crown — such as building up the core of the tooth or inserting a pin to hold the crown in place. But there are limitations and they're pretty technical. Bring this book and ask you dentist if your child's buildup meets these requirements:

Core buildups, including pins, are covered only on permanent teeth when performed in conjunction with a crown cast post and core or prefabricated post and core when performed in conjunction with a crown dental implant crown and abutment related procedures.

Crown buildups
Crown buildups are covered — but when and how gets very technical. Bring this book with you to ask your dentist if your child's buildup meets BOTH of these requirements:

- At least 50% of the visible coronal natural tooth structure is decayed or broken off and missing
- There's less than 2mm of vertical height remaining for 180 degrees or more of the tooth's circumference and there is decay and overt pathology

NOTE: crown buildups or post and core aren't covered within two years (from treatment date) of a restoration on the same tooth.

Keep these limitations in mind
We pay for crowns based on the date they're put in your child's mouth — called the seat date. If the seat date falls on a day before you're enrolled in the plan, the crown won't be covered.

- Buildup or a post and core are covered every 5 years from the date of service on the same tooth
- Implant crowns and bridges are covered once per tooth every 7 years from the seat date
- Stainless steel crowns are covered once per tooth every 2 years from the seat date
- Permanent crowns are covered on front teeth for children 12 through 18 once per tooth every 5 years from the seat date
- Crowns used to keep removable partial dentures in place aren't covered unless the tooth qualifies for a crown on its own
- Crown repairs are covered once per tooth while your child is enrolled in this plan
- Repair of an implant-supported prosthesis of abutment (bridge) limited to one per tooth, while on this plan

What's not covered — exclusions

- Crowns aren't covered when there is no sign of decay or overt pathology
- Crowns for weakened cusps, or for fractures with no decay or pain aren't covered
- Copings (thin coverings that fit over teeth to hold other dental restorations — like fillings — in place) aren't covered
- Inlays, onlays, and veneers (laminates on the front of your teeth) aren't covered

What benefits do I get with this plan?

Pediatric (kids) - Periodontics

Periodontics is the part of dentistry that deals with the structures surrounding and supporting the teeth. In other words, it means things as simple as removing plaque or as complicated as surgical gum treatments.

Your plan covers 70%

(after you meet your deductible)

- Periodontal (gum) maintenance
- Surgical and nonsurgical treatment of tissues supporting the teeth (gums)
- Osseous surgery (including flap entry and closure)
- Mucogingivoplastic surgery
- Full mouth debridement (removing plaque and tartar)
- Surgically removing gum tissue (gingivectomy
- Surgically reshaping gums (gingivoplasty)
- Treating gum disease with nonsurgical periodontal scaling and root planning
- Fixing how teeth bite together, called occlusion (limited adjustments to eight teeth or fewer)
- Localized delivery of antimicrobial agents

Keep these limitations in mind

- Your plan covers complex periodontal procedures once per each section of your child's mouth (called quadrants) every 3 years (from treatment date)
- Your plan covers extreme removal of plaque and calculus buildup (full mouth debridement) once every 3 years (from treatment date),
- Gingivectomy and gingivoplasty are covered once per quadrant every 3 years (from treatment date)
- Periodontal maintenance is limited to once per quadrant every 12 months (from treatment date) for children 13 and older
- Your plan covers nonsurgical periodontal scaling and root planing only when x-rays show bone loss. They're covered once per quadrant every 2 years (from treatment date) for children 13 and older

Pediatric (kids) - Endodontics

Endodontic services focus on the insides of teeth. These services work to save damaged or decayed teeth by repairing or replacing the soft inner tissue, called the pulp. Endodontics also help maintain the health of the roots of teeth and the "canals" they run through.

Your plan covers 70%

(after you meet your deductible)

Procedures for pulpal and root canal treatment including:

- Pulp exposure treatment
- Therapeutic pulpotomy on primary (baby) teeth and pulpal debridement on permanent (adult) teeth
- Apicoectomy (root end surgery) and retrograde filling for anterior (front) teeth
- Apexification for apical closures of anterior permanent teeth
- Removal of post, pin, old root canal filing material and all procedures needed to prepare the canal for new filing material
- Treatment with resorbable material for primary upper incisor teeth, if the entire root is present at treatment
- Treatment for permanent anterior, bicuspid and molar teeth (except wisdom teeth)

Keep these limitations in mind

- Pulp capping is covered as part of the restoration

What's not covered — exclusions

- Bleaching of teeth isn't covered

What benefits do I get with this plan?

Pediatric (kids) - Prosthodontics

Prosthodontics involves making and fitting artificial removable teeth, also known as dentures.

Your plan covers 50%

(after you meet your deductible) Full and partial dentures including:

- Complete upper and lower dentures
- Replacement dentures
- Resin-based partial dentures
- Denture adjustments (rebase) and relines

Keep these limitations in mind

- Delta Dental of Washington pays for dentures based on the date they're put in your child's mouth — called the seat date. If the seat date falls on any day before or after you're enrolled in the plan, the dentures won't be covered
- Your plan covers adjusting and repairing (relines) of dentures and bridges once per arch every 3 years (from treatment date) — but only if done at least 6 months from the day they were put in your child's mouth (seat date)
- Your plan covers one complete upper and lower denture and one replacement denture during the time your child is enrolled in this plan, if performed at least five years from the seat date.
- Your plan covers 1 resin-based partial denture every three years (from treatment date)

What's not covered — exclusions

- Crowns in conjunction with overdentures aren't covered
- Surgical placement or removal of implants or attachments to implants isn't covered
- Implant maintenance procedures aren't covered, including:
  - Removing of prosthesis
  - Cleaning of prosthesis and abutments
  - Reinserting of prosthesis
- Maintenance or cleaning of a prosthetic appliance
- Personalized dentures
- Duplicate dentures aren't covered

Pediatric (kids) - Accidental Injury

Let's say your child falls off her bike and chips a tooth or gets hit in the face with a basketball and a permanent tooth is loose — and you need to get to the dentist right away.

Your plan covers 100%

(without having to meet your deductible)

- Accidental injury
- 100% for covered services needed to treat accidental bodily injuries when done by an in-network dentist
- Services done by out-of-network dentists (up to our maximum allowable amount. You'll pay out-of-pocket for any remaining costs)

Keep these limitations in mind

- Your child needs to be treated within 180 days after the accident and the treatment must meet generally accepted dental practices

What's not covered — exclusions

- When teeth get broken or damaged while chewing or biting on foreign objects isn't covered

What benefits do I get with this plan?

Pediatric (kids) - Medically necessary orthodontia

More commonly called “braces,” orthodontic services work to position teeth to improve your child’s bite or smile. Your plan only covers medically necessary orthodontia — services your child needs so they can use their mouth in a normal way. Under this plan, orthodontia is not covered for cosmetic reasons, like teeth straightening for a more attractive smile.

To be covered, you must preauthorize all orthodontic services before you start treatment.

Your plan covers 50%

(without having to meet your deductible)

- Repositioning teeth and jaws so your child can use their mouth in a normal way
- Orthodontic records and exams (initial, periodic, comprehensive, detailed)
- X-rays (intraoral, extraoral, diagnostic radiographs, panoramic)
- Diagnostic photographs and casts (study models) or cephalometric films

Keep these limitations in mind

- Orthodontics often takes more than a year. So if you start your child’s orthodontic treatment while you’re enrolled, but you are no longer enrolled when the treatment is finished, we only cover the only the service you get while you’re enrolled
- Also, if you stop treatment before it’s complete, your plan won’t pay for any services if you restart treatment later
- Orthodontia services that began before you enrolled will be prorated. In other words, if you paid a down payment for services before you enrolled, your plan will reimburse you for any prepaid services you get after you enroll
- Your plan will pay your orthodontist each month for the length of the treatment, but only if the treatment is medically necessary

DID YOU KNOW? Most people think an overbite is when someone has “buck teeth.” It’s actually a little more complicated than that.

Your overbite is how far up or down your upper teeth land in relation to your lower teeth when you close your mouth. Overjet is how far back or forward they land when you close your mouth. If either one of these is too extreme, it can cause real problems that might need orthodontic treatment

What’s not covered — exclusions

- Replacing or repair of orthodontic retainers or appliances used to treat harmful habits (like thumb sucking) isn’t covered

How we define medically necessary orthodontia

We use the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score (how’s that for a mouthful?) to judge if your child’s orthodontic services are medically necessary. If your child’s case score is 25 or higher, treatment is covered. But even if their score is less than 25, we still review each file to see if treatment might be medically necessary.

Your child automatically qualifies for orthodontic services if:

- They have a cleft palate deformity. If the cleft palate can’t be seen on diagnostic casts, then you must ask a credentialed specialist to send us a letter proving that your child has a deformity with your preauthorization request.
- They have head or facial bone deformities (craniofacial anomalies) such as hemifacial microsomia, craniosynostosis syndromes, arthrogryposis or Marfan syndrome. You must ask a credentialed specialist to send us a letter proving that your child has a deformity with your preauthorization request.
- They have a serious overbite where lower teeth are causing severe damage to the roof of the mouth.
- Their bite doesn’t line up (cross bite) and one or more of their teeth is causing severe damage to soft tissue in the mouth.
- They have an extreme overjet — either greater than 9 mm or a reverse overjet greater than 3.5 mm.
- They’ve had a traumatic facial/mouth injury caused by an accident, burn or disease. You must ask a credentialed specialist to send us a letter proving that your child had a traumatic injury with your preauthorization request.

What benefits do I get with this plan?

Pediatric (kids) - Dental services not covered by your plan

There are a handful of miscellaneous things that aren't covered by this plan. These include:

Counseling

- Tobacco counseling for control and prevention of oral disease isn't covered
- Nutritional or diet counseling isn't covered

Miscellaneous services, treatments, therapies and devices that aren't covered:

- Cosmetic services or supplies, including cosmetic work done on dentures
- Any treatments done to fix the height or width of teeth
- Injuries or conditions covered under Workers' Compensation or Employer's Liability laws
- Services provided by any government agency
- Services or supplies that are provided free
- Prescription drugs
- Lab tests or exams
- Temporomandibular joint (TMJ) services or supplies
- Devices to break habits like thumb sucking and tongue thrusting
- General anesthesia and/or intravenous (deep) sedation except when this policy says otherwise
- Replacement of a lost, missing, or stolen denture, bridge, or other prosthetic appliance
- Duplicate dentures or bridges, or any other duplicate appliance
- Repair or replacement of orthodontic appliance
- Expenses for myofunctional therapy

Certain charges and fees that aren't covered:

- Hospital fees
- Consultations
- Charges for missed appointments
- Charges for completing claims forms
- Anything that is not medically necessary
- Claims from out-of-network dentists that aren't sent to us within 12 months from the date of service
- Claims for dental services provided to anyone under this plan while they are active duty in the Armed Forces.

Coverage when you weren't on this plan

- Any dental services completed before you enrolled in this plan aren't covered
- Any dental services you get after you're no longer enrolled in this plan aren't covered

What benefits do I get with this plan?

Adult Benefits

The benefits listed below are covered for adults (age 19 and over) who are enrolled in this plan. These benefits are available only if they are performed by an individual legally authorized to perform services and when dentally appropriate as determined by the standards of generally accepted dental practice. See the Pediatric (Kids) benefit section for information about coverage for children through age 18.

Adult - Class I Diagnostic Services

Diagnostic services help your dentist diagnose (know) what's happening inside your mouth

Your plan covers 100%

(without having to meet your deductible)

- Routine diagnostic oral exams
- Comprehensive oral exams
- Limited or problem-focused oral exams
- Emergency exams
- X-rays

Keep these limitations in mind

- Comprehensive oral exams
  Comprehensive oral exams happen the first time you visit a new dentist. These visits are meant to help your dentist get a general idea about your overall health. They'll ask about dental and medical history and any medications you're taking. Your dentist will examine the areas inside and outside of the mouth including head, neck, teeth, tongue and gums.

- You are covered for only 1 comprehensive oral exam per dentist in a lifetime. If you change dentists, you are covered for a new comprehensive oral exam. After that, if your dentist wants to do more comprehensive oral exams, you be covered at the same rate as a routine check-up, and you'd be responsible for any out-of-pocket costs.

- *Routine diagnostic exams*
  Enrolled family members are covered for 2 routine exams per benefit period. Routine exams are not as in-depth as comprehensive oral exams.

- *Limited oral exams*
  Limited oral exams are visits for:
  - Dental problems or oral health complaints
  - Dental emergencies
  - Referrals for other treatment

  Limited exams are covered 2 times per benefit period. They can't be part of any other oral exam, and must be performed by a licensed dentist or dental hygienist.

- *Covered x-rays, films and tests*
  - Bitewing x-rays look at back teeth, called molars. Adults can have one bite-wing x-ray for each quadrant per benefit period.
  - Complete series or panoramic x-rays capture all of your teeth. They're covered once every 5 years (from treatment date).

NOTE: If x-rays are taken as part of a complete series of x-rays for a procedure, they won't be covered again if used for a different procedure.

What's not covered — exclusions

- Diagnostic services and x-rays related to treatment of temporomandibular joints (the hinge part of your jaw) aren't covered. Please see "Adult Temporomandibular Joint Benefits" section for information on this benefit.
- Consultations by a dentist other than the requesting dentist
- Study models

Adult Class I Preventive Services

Preventive services help keep your teeth healthy in order to prevent things like tooth decay and gum disease. Good preventive practices — such as visiting the dentist twice a year, brushing twice a day and flossing — can mean fewer serious dental problems.

Your plan covers 100%

(without having to meet your deductible)

We want your family to have strong, healthy teeth.
That's why a wide range of preventive services are covered under your plan. These include:

- Prophylaxis (cleaning)
- Periodontal (gum) maintenance
- Sealants
- Fluoride treatments including fluoridated varnish
- Preventive resin restoration
- Prescription-strength fluoride toothpaste
- Antimicrobial rinses given during a dental visit

What benefits do I get with this plan?

Keep these limitations in mind

- Any combination of prophylaxis (cleaning) or periodontal maintenance is covered twice in a benefit period
- Periodontal (gum) maintenance is covered once in a benefit period only if you've completed active periodontal treatment. Additional periodontal maintenance is covered (up to 4 treatments) if your gums have pocket depth readings of 5mm or greater, which is called Case Type 3 or 4.
- Additional prophylaxis maintenance is covered (up to 4 treatments) if your gums have pocket depth readings of 5mm or greater
- Fluoride treatments are covered 2 times in a benefit period.
- Sealants are covered for posterior teeth that have no restorations (includes preventive resin restorations) on the biting surface. They are covered every 2 years (from treatment date) per tooth
- Preventive resin restorations are covered only on permanent molars with no restorations on the biting surface.
- Preventive resin restorations is not a Covered Dental Benefit for 2 years after a sealant or preventive resin restoration on the same tooth.
- Prescription-strength fluoride toothpaste and antimicrobial rinse are covered following periodontal surgery or other covered periodontal procedures. They must be given during a dental visit. Also, you need to show proof that you had a periodontal procedure, or our records need to show that you had a periodontal procedure within 180 days before.
- Antimicrobial rinse is covered only once during periodontal treatment, even when the treatment requires more than one visit.
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

What's not covered — exclusions

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

Adult Class II Sedation

Sedation play a supporting role in your treatment. For example, getting local anesthesia (often called novocaine) to numb your mouth so you won't feel any pain is a type of adjunctive service.

Your plan covers 50%

(after you meet your deductible)

- Controlling pain during treatments with intravenous anesthesia or general anesthesia (like being asleep)

Keep these limitations in mind

- General anesthesia or intravenous sedation are covered only when given by a licensed dentist or other licensed professional who meets Washington State credentialing guidelines or those of the state where the services are provided
- General anesthesia is only covered for certain endodontic, periodontic and oral surgery procedures that are covered by your plan when medically necessary. It's also covered for children 6 and younger or for physically or developmentally disabled persons when medically necessary for services covered by your plan.
- Intravenous sedation is covered when you're having endodontic, periodontic and oral surgery services that are covered by your plan.

What's not covered — exclusions

- General anesthesia or intravenous sedation aren't covered for routine procedures except as stated above.

Adult Class II Palliative Treatment

Your plan covers 50%

(after you meet your deductible)

- Pain relief

Keep these limitations in mind

- Services needed after oral surgery, called post-operative care and treatment, are considered part of the surgery and are covered. Treatment for complications after surgery are also considered part of the surgery and are covered as long as they're given within 30 days

What benefits do I get with this plan?

Adult Class II Restorative Services

In other words, filling a cavity.

Your plan covers 50%
(after you meet your deductible)

- Fillings
- Stainless steel crowns

Keep these limitations in mind

- You're covered for fillings in the same surface on the same tooth once every two years (from treatment date), but only in these cases:
  - When decay is visible in the tooth
  - When a fracture (crack) has caused the loss of a significant part of a tooth (missing cusp)
  - When a fracture causes significant damage to an existing filling
- Stainless steel crowns are covered once per tooth every 2 years from the seat date
- If a resin based composite or a glass ionomer (tooth colored) restoration is placed in a back tooth, except those placed in the facial surface of bicuspids, it will be considered an elective procedure and we will pay the amount for an amalgam (silver) with any difference in cost being your responsibility.

What's not covered — exclusions

- Fillings for anything other than decay or fracture aren't covered
- Recontouring or polishing fillings aren't covered
- Overhang removal aren't covered
- Copings aren't covered

Adult Class II Oral Surgery

When you think of surgery, you usually think of hospitals. But in dentistry, oral surgery includes many common procedures that happen at the dentist's office — such as removing teeth and treating diseases.

Your plan covers 50%
(after you meet your deductible)

- Removal of teeth
- Preparing the mouth for the insertion of dentures
- Treating traumatic injuries or diseases in the mouth

What's not covered — exclusions

- Filling in a hole in the jawbone after a tooth or implant is removed (called bone replacement grafting) for ridge preservation isn't covered
- Bone grafts of any kind to the upper or lower jaws – unless they're needed to treat periodontal (gum) disease aren't covered
- Tooth transplants (re-implanting or relocating a tooth in the jaw) aren't covered
- Placing materials in a hole in the jawbone to regrow bone (generate osseous filling) after a tooth or implant is removed isn't covered

Adult Class II Periodontics

Periodontics is the part of dentistry that deals with the structures surrounding and supporting the teeth. In other words, it means things as simple as removing plaque or as complicated as surgical gum treatments.

Your plan covers 50%
(after you meet your deductible)

- Periodontal (gum) maintenance
- Surgical and nonsurgical treatment of tissues supporting the teeth (gums)
- Fixing how teeth bite together, called occlusion (limited adjustments to eight teeth or fewer)
- Treating gum disease with nonsurgical periodontal scaling and root planning
- Localized delivery of antimicrobial agents
- Periodontal surgery

Keep these limitations in mind

- Periodontal scaling/root planing is covered every 3 years (from treatment date)
- Periodontal surgery (per site) is covered once every 3 years (from treatment date). You must have had scaling and root planing done 6 weeks - 6 months before the surgery. Or you must have been in active supportive periodontal therapy.
- Soft tissue grafts (per site) are covered once every 3 years (from treatment date)
- Limited occlusal adjustments are covered once in a 12-month period
- Localized delivery of antimicrobial agents is covered when your gums have pocket depth readings of 5mm or greater, which is called Case Type 3 or 4. It's limited to 2 teeth per quadrant up to 2 times (per tooth) per benefit period. Also you must have had scaling and root planing done 6 weeks - 6 months before the treatment. Or you must have been in active supportive periodontal therapy.

What benefits do I get with this plan?

Adult Class II Endodontics

Endodontic services focus on the insides of teeth. These services work to save damaged or decayed teeth by repairing or replacing the soft inner tissue, called the pulp. Endodontics also help maintain the health of the roots of teeth and the "canals" they run through.

Your plan covers 50%
(after you meet your deductible)

Procedures for pulpal and root canal treatment including:

- Pulp exposure treatment
- Pulpotomy
- Apicoectomy (root end surgery)

Keep these limitations in mind

- Root canal treatment on the same tooth is covered only once every 2 years (from treatment date)
- Re-treatment of the same tooth is covered only when done by a different dentist in a different dental office

What's not covered — exclusions

- Bleaching of teeth isn't covered

Adult Class III Periodontics

These benefits are available only to those patients who have a periodontal Case Type 3 or 4, which includes a pocket depth of 5mm or greater.

Your plan covers 50%
(after you meet your deductible)

- Nightguard (Occlusal Guard)
- Repair or reline of nightguard
- Complete occlusal equilibration

Keep these limitations in mind

- Nightguard is covered once in every 3 years from the date of service.
- Repair and relines are covered when done more than 6 months from the initial date of service
- Complete occlusal equilibration is covered once in lifetime

What's not covered — exclusions

Appliance necessary to correct vertical dimension or restore the occlusion

Adult Class III Restorative Services

Crowns can have two meanings in dentistry. Dentists call the part of your teeth you can see when you smile the crown. But most people think of a crown as an artificial covering that gets cemented into your mouth over a tooth. Artificial crowns cover teeth that have been severely damaged. In this section, we're talking about the second type of crown — the artificial covering.

Your plan covers 50%

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

Keep these limitations in mind

- A crown, veneer or onlay on the same tooth is covered once every 7 years from the seat date.
- Crowns, veneers or onlays are covered benefit for treatment of cavities (visible decay) or fracture resulting in significant loss of tooth structure (missing cusp) when teeth cannot reasonably be restored with a filling.
- An inlay as a single tooth restoration, will be considered as elective treatment and an amalgam allowance will be made once in a 2-year period, with any difference in cost being your responsibility.
- An implant-supported crown on the same tooth is covered once every 7 years from the seat date
- Crowns that support removable partial dentures aren't covered unless the supporting tooth is so decayed it needs a crown anyway.
- Crown buildups are covered once on each tooth in a 7 year period from the date of service.
- Crown buildups are covered when at least 50% of the visible coronal natural tooth structure is decayed or broken off and missing; and there's less than 2mm of vertical height remaining for 180 degrees or more of the tooth's circumference and there is decay and overt pathology.
- Crown buildups or post and core aren't covered within two years (from treatment date) of a restoration on the same tooth.

What's not covered — exclusions

- Copings
- A crown or onlay used to repair a microfracture when there are no symptoms, or when there is an existing restoration and no evidence of decay or other significant pathology is not covered.
- A crown or onlay placed because of weakended cusps or existing large restorations is not covered.

What benefits do I get with this plan?

Adult Class III Prosthodontics

Prosthodontics involves making and fitting artificial removable teeth, also known as dentures or prosthetic appliances.

Your plan covers 50%
(after you meet your deductible)

- Dentures
- Fixed partial dentures (fixed bridges)
- Removable partial dentures
- Inlays when used as a retainer for a fixed partial denture (fixed bridge)
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

Keep these limitations in mind

- Delta Dental of Washington pays for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge) and removable partial dentures based on the date they're put in your mouth — called the seat date. If the seat date falls on any day before or after you're enrolled in the plan, the dentures won't be covered.
- Replacement of an existing prosthetic appliance is covered once every 7 years (from the treatment date) and only when it can't be repaired
- Implants and superstructures are covered once every 7 years (from the treatment date)
- Costs for full, immediate or overdenture treatments made along with personalized restorations or specialized treatment is covered. But the cost of personalized restorations or specialized treatment isn't.
- Cost of a reline will be allowed towards the cost of a temporary partial or full denture. After the permanent denture is placed, initial relines will be covered after six months.
- Denture adjustments and relines are covered when done 6 months after the initial placement. Additional relines or rebases (but not both) will be covered once a year (from the date of service).

What's not covered — exclusions

- Crowns in conjunction with overdentures aren't covered
- Duplicate dentures aren't covered
- Personalized dentures aren't covered
- Copings aren't covered
- Appliances that correct vertical dimension or restore the occlusion aren't covered

Adult Temporomandibular Joint Benefits

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

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

"Dental Services" are those that are:

- Procedures for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- Recognized as effective, according to the professional standards of good dental practice; and
- Not experimental or primarily for cosmetic purposes.

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

- TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device, removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis, and manipulation under anesthesia.

- The amounts payable for TMJ benefits during the benefit year shall not be applied to the eligible person's annual plan maximum for Class I, Class II and Class III Covered Dental Benefits or orthodontic benefits. Refer to your "Plan Overview Page" for more information.

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

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

Adult Accidental Injury

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

Adult General Exclusions

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

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
3. Application of desensitizing agents (treatment for sensitivity or adhesive resin application)
4. Experimental services or supplies, which include:
   i. Procedures, services or supplies for which the use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. 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.
   ii. 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.
   iii. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the eligible person.
   iv. Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-4040(2).
5. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.

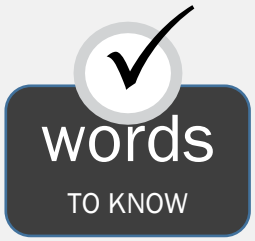
What benefits do I get with this plan?

6. Prescription drugs
7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment
8. Broken appointments
9. Behavior management
10. Completing claim forms
11. Habit-breaking appliances 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 “Adult Periodontics” for benefit information.
12. Orthodontic services or supplies.
13. This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this plan as Covered Dental Benefits.

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

How does my plan work?

How does my plan work?



Enroll means to sign up for something so you can be part of a group. When you sign up for a dental plan and pay for your first month's bill, you're **enrolled**.

When you enroll in the Delta Dental Family - Basic Family plan and start paying for it, your family has dental **coverage**. That means Delta Dental of Washington will pay for (or **cover**) some or all of your dental bills.

A **premium** is like a bill. It's the amount you pay each month to be enrolled in a health plan.

Qualifying for coverage means you meet the requirements of a plan.

Benefits are what you get from your health plan. For example, one of the benefits of this plan is that we pay 100% of your dentist bill for a check-up when you use a dentist in our network.

A **claim** is a request for payment from the dentist to us. Once the dentist performs a service – like filling a cavity – they send a claim to us for payment. It's a lot like a bill — from your dentist to us.

After we process a claim, we send you an **explanation of benefits** letter. It shows what your dentist's charges are, what we'll pay for, and what you might owe out-of-pocket.

In this section find

answers

about

How does my plan work?

Take a look at your Plan Overview page. It's a great starting place to learn more about how your plan works.

After you enrolled in this plan, we sent you this book and a Plan Overview page. That page has most of the information you need to understand the costs of your plan.

Here's what a typical Plan Overview page looks like:

Your Delta Dental Individual and Family – Basic Family Plan

Plan Overview

Use this overview and your benefits book to make the most of your plan

Your plan is a family plan. It offers two different sets of benefits in one plan – pediatric (kids) and adult.

Children through age 18 get pediatric benefits. After they turn 19, they get adult benefits, even though they can still be your dependent on this plan up to age 26.

Understand your plan
This is your Plan Overview information page. It shows your costs for the plan. It also shows the types of treatments that are covered by your plan – like preventive services or oral surgery. And it lists the percentage we pay for each of the treatment types.

But this only tells you part of the story.
While this Plan Overview shows you the types of treatment we cover, it doesn't list specific procedures. For that, you need to look in your benefits book. That's where you'll see which procedures are covered and which are not.

As always, if you have any questions, we are just a web visit or phone call away.

DeltaDentalWA.com
800-526-8323

This Plan Overview is issued and delivered in the state of Washington and is governed by Washington State laws. It sets out the information of the Delta Dental Individual and Family – Basic Family Plan, to provide dental benefits to dependent children and is subject to the terms set forth in the contract.

DELTA DENTAL

Delta Dental of Washington

About your plan

- **PREVENTIVE CARE IS COVERED AT 100% - with no deductible**
- **SAVE MONEY WITH DELTA DENTAL IN-NETWORK DENTISTS**
  You can go to any dentist. But your costs may be lower if you go to a dentist in either of our networks – Delta Dental PPO℠ and Delta Dental Premier®
  – *but you'll usually save the most when you see a dentist in our Delta Dental PPO℠ network.*

Find an in-network dentist on our website, DeltaDentalWA.com or call us at 800-526-8323

1 **Contract term** When you enroll in a dental plan, you've entered into a contract. This means that you're responsible to pay your premiums and follow the rules of the plan. It means that we're responsible to pay for covered services listed in your benefits book at the percentages below. And we have to follow the plan's rules, too. This Plan Overview, application, and your benefits book are our contract.	Your contract with Delta Dental of Washington starts at 12:01 a.m. Pacific Time on the first day of **January 1**, 2018, at Seattle, Washington. The contract terr is **January 1**, 2018 through December 31, 2018.
2 **Benefit period** This is when your coverage begins and ends.	Your benefit period is **Jan. 1, 2018** throu Dec. 31 2018.
3 **Maximum amount** A maximum amount is the total your plan will pay each year for dental services.	Pediatric maximum: none Adult maximum for each covered person: **$1,000** annually for dental treatments **$1,000** annually for TMJ-related treatme **$5,000** lifetime for TMJ-related treatmer
4 **Plan deductible** Before your plan begins paying for covered services, you must meet your plan deductible.	Your pediatric deductible is **$85.** The adult deductible is **$50.**
5 **Out-of-pocket maximum** For some services, we may pay only part of the cost. In those cases, you're responsible for paying what's left. That's called an out-of-pocket expense. After you meet your pediatric out-of-pocket maximum, you won't have any more out-of-pocket costs for your children. But you will continue to pay them for your adult benefits. NOTE: payments to dentists not in Delta Dental networks don't go toward your out-of-pocket maximum.	Pediatric: annually per child **$350**, up to **$700** for families with 2 or more children Adults: none
6 **Premium** This is the amount you pay each month to be enrolled in this plan. Premiums are due on the first of the month.	Pediatric per covered child: **$$** Adult per covered person: **$$**

7 Percent your plan pays for these dental treatment areas

PEDIATRIC BENEFITS

COVERED TREATMENT AREA	MAXIMUM AMOUNT PAID BY YOUR PLAN
Diagnostic and preventive services and accidental injury	100 percent - without having to meet your deductible
Adjunctive and restorative services, oral surgery, periodontics, endodontics	70 percent - after meeting your deductible
Crowns, prosthodontics, implants	50 percent - after meeting your deductible
Medically necessary orthodontia	50 percent - without having to meet your deductible

ADULT BENEFITS

COVERED TREATMENT AREA	MAXIMUM AMOUNT PAID BY YOUR PLAN
Class I: Diagnostic and preventive services and accidental injury	100 percent - without having to meet your deductible
Class II: Adjunctive and restorative services, oral surgery, sedation, palliative treatment, periodontics, endodontics, TMJ treatment	50 percent - after meeting your deductible
Class III: Crowns, periodontics, restorative, prosthodontics	50 percent - after meeting your deductible

What your plan costs

Understanding your Plan Overview page

Here are explanations of some of the things you'll find on your Plan Overview page:

1 Let's start with the **contract term** box. That shows you when your contract with Delta Dental of Washington began and how long it will last. This benefit booklet, your application, and Plan Overview are our contract. This is when your coverage begins.

When you enroll in a dental plan, you've entered into a contract. This means that you're responsible to pay your premiums and follow the rules of the plan.

We have responsibilities, too. We're responsible to pay for the covered services we've listed in this benefit booklet at the percentages shown on your Plan Overview page. Plus, we have to follow the plan's rules, too.

DID YOU KNOW? Signing up for a plan and paying your first premium is called enrolling. When you enroll in this plan, part if your contract is committing keeping it until the end of the calendar year.

---

2 Benefit Period

This is the period of time that relates to the frequencies, limitations, and cost-sharing under this plan. The **benefit period** may be different than your contract term. Please see your Plan Overview page for your specific benefit period

3 Maximum Amount

Some benefit plans set a maximum amount of money that they'll pay each year for your dental services. That's called a **maximum amount**. If you plan has a plan maximum, it will be shown on here.

4 Plan deductible

Every year, before your plan begins paying for your family's dental services, you have to meet your **plan deductible**. That's a set cost you need to pay. Your yearly deductible for the Delta Dental Family - Basic Family plan is shown here. That means the first time your child visits the dentist each year, you have to pay this amount before your benefits start. After that, your plan will begin to pay for your family's dental visits.

Your deductible period starts every year on the first day of your benefit period. You pay your deductible directly to your dentist. If your services cost more than your annual deductible, the dentist will send us a claim for the rest. **Some services are covered even if you haven't met your annual deductible**. These will be shown on your Plan Overview page.

5 Out-of-pocket maximum

You may have to pay part of the cost for dental services. That's called an **out-of-pocket expense**. Your plan sets a maximum amount you'll have to pay out-of-pocket each year. Once you meet that amount, you don't have to pay any more out-of-pocket costs.

You can only reach your out-of-pocket maximum by going to dentists in Delta Dental's network. If you go to an out-of-network dentist, you'll still have to pay out-of-pocket costs, even after you reach your maximum. Also, out-of-pocket costs paid to out-of-network dentists don't count toward your out-of-pocket maximum.

How does my plan work?

6 Premium

Your Plan Overview page shows the cost of your monthly premium. Premiums are due on the first of the month. When you pay your premium, you're paying in advance for the next month's coverage.

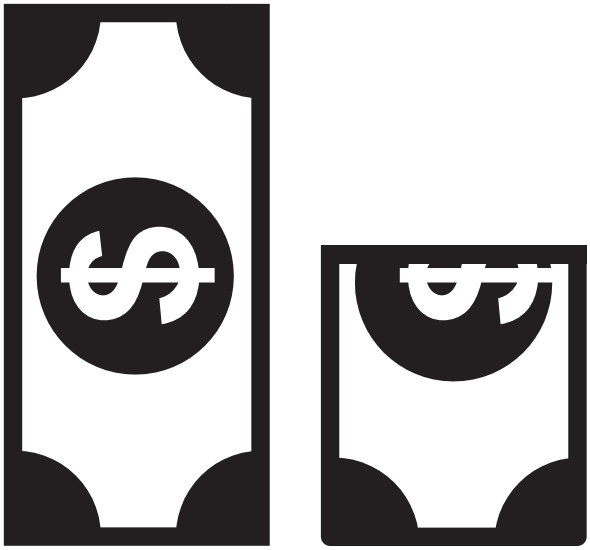
What happens if you miss a payment

If you miss a payment, we'll put a hold on paying your claims starting on the first day of the month after you miss a payment. Payment for your claims will stay on hold until your account is paid up. After 30 days, we may end this plan and anyone covered under this plan may lose coverage.

7 Percent paid for each dental type of treatment

This section of your Plan Overview page shows what percentage of the dentists charge for your treatment we cover based on the different types of treatment, like preventive services or oral surgery.

While the Plan Overview page shows you the treatment areas we cover, it doesn't show you the specific services within each area. For that, you need to go to the *What benefits do I get with this plan?* section of this book. Find the type of treatment, then see if the procedure you or your family member needs is listed as being covered. If it is covered, go back to the Plan Overview page to see what percentage of your dentist bill we'll pay.



How much we pay for different types of services

Your plan pays different amounts for different dental treatment areas. For example, we pay 100% for preventive services, like cleanings and fluoride treatment, and we pay 50% for new crowns.

Your Plan Overview page shows what percentage we pay for each treatment area.

Save money with **Delta Dental in-network dentists**

It's important that both you and your family members feel comfortable when you visit the dentist. You want someone you trust and who takes the time to answer your questions and explain what's happening during your visit.

Another thing to consider is cost. Dentists who are part of our networks will usually cost you less than out-of-network dentists.

Find a Delta Dental in-network dentist

Go to DeltaDentalWA.com
or call 800-526-8323

DID YOU KNOW You can find in-network dentists in both of our networks – Delta Dental PPO℠ and Delta Dental Premier.© Your plan lets you see dentists from both, but you'll usually save the most when you see a dentist in our Delta Dental PPOSM network.

In-network dentists have set fees.

There's a maximum amount – called a **maximum allowable fee** – that we believe each benefit should cost. In order to be part of our network, dentists agree to never charge more than the maximum allowable fee.

But let's say you go to an out-of-network dentist. We have no control over their charges and billing practices. They may charge more than our maximum allowable fee.

So, we'll pay them our maximum allowable fee, but you have to pay any difference. That's called an out-of-pocket cost.

The box below shows an example of how our maximum allowable fee can be higher for an in-network dentist – and how that can save you money.

This is an example of how you could save money getting a cleaning from an in-network dentist. This is just an example and doesn't show actual costs or Delta Dental of Washington fees.

	Dentist's charge for cleaning		Maximum allowable fee in-network		Your out-of-pocket costs
In-Network Dentist	$80	-	$80	=	$0
	Dentist's charge for cleaning		**Maximum allowable fee out-of-network**		**Your out-of-pocket costs**
Out-of-Network Dentist	$100	-	$70	=	$30

How to make sure your plan pays your dentist bills

Here are the steps:

1. Check if your family's dental service needs preauthorization
2. If you need preauthorization, ask your dentist to get one from us
3. Make sure a claim is sent to us
4. Watch for an explanation of benefits letter from us
5. Pay your dentist any out-of-pocket costs
6. Review your Explanation of Benefits form and call us if you have questions about it

1 Preauthorization

Preauthorization for Pediatric (kids) Benefits -
Some services for your child must be approved by us before you have them done. This is called preauthorization. If you don't get these services preauthorized, your plan won't pay for them.
Here are some services that need preauthorization in order for your child's bills to be paid:

- Crowns
- Medically necessary orthodontia
- Oral surgery

It's always a good idea to ask your dentist to check with us to see if a dental service needs preauthorization.

Preauthorization for Adult Benefits - There are no preauthorization requirements for the adult benefits.

You can also find the information you need in the "Benefits Covered by Your Plan" section of this book. You can also call us at 800-526-8323 or visit DeltaDentalWA.com.

2 How do I get a preauthorization

If your dentist decides that your child needs a treatment that needs preauthorization, they need to send us a plan for that treatment and ask us for a preauthorization. After we get the treatment plan, we'll let you and your dentist know if we approve the plan and if we agree to pay for it.

How long does it take to get a preauthorization?
Once we get all the information we need from your dentist, it usually it takes 15 days to get a preauthorization.

Sometimes we need more information from your dentist. While we're waiting for the missing information, your preauthorization goes on hold, or into what's called pending status. If we don't get all the information we need within 45 days, we'll cancel your preauthorization and your dentist will have to start the process over again.

What if it's an emergency and I need preauthorization?
It's possible that your child might need emergency dental work for services that need preauthorization. Examples of emergency dental services are:

- Your child is in severe pain
- Your child's life or health is threatened
- Your child might not be able to use their mouth in a normal way again

These are called urgent services that can't wait the usual 15 days to be approved. In these cases, your dentist needs to send us an urgent preauthorization request. If we get all the information we need, we'll let your dentist know within 72 hours if the treatment is approved.

Immediate treatment is allowed without preauthorization in an emergency situation consistent with this plan.

DID YOU KNOW? Preauthorization doesn't guarantee that your plan will pay for your child's treatment. If your dentist changes the treatment plan, performs other services, or if your eligibility changes, we might not pay your claim. If you want to know for sure what your plan will pay, call 800-526-8323.

REFERALS: Referrals are different from preauthorizations. We don't require a formal referral if your general dentist suggests that you visit a specialist for treatment like orthodontia or oral surgery. Please make sure you get your preauthorization when required.

3 Sending claim

In order for us to pay for your dentist bills, you or your dentist have to send us a **claim**. It's a lot like a bill — from your dentist to us. Usually your dentist will submit claims for you. But sometimes it will be up to you to make sure we get your claim.

What you need to do

When you check in at the dentist's office, let your dentist know you're covered by Delta Dental of Washington. Ask if your dentist will file the claim for you, or if you have to do it yourself.

Dentists in our networks automatically send in claims for you. But if your dentist isn't in one of our networks (out-of-network), you need to ask if they'll send in a claim for you. Whoever ends up filing it, we need to get it within 180 days after your family's visit.

We accept all American Dental Association-approved claim forms. Your dentist can download one from our website, DeltaDentalWA.com, or they can call us at 800-526-8323 to have one faxed or mailed.

How to file a claim yourself

You can download a claim form from our website, DeltaDentalWA.com. If you need help completing it, either ask your dentist or call us at 800-526-8323. We can also mail or fax a claim form to you if you call us at that number.

Timing is everything

When your claims get paid Your plan pays for covered dental services after they're all done. Sometimes, everything can be done in one visit. Other times, your family might have to make many visits to complete a treatment. Your dentist will send us a claim after your family's final visit.

Time limitations For some services, your plan will only pay for them once within a certain time frame. For example, your plan might say it will pay for your family's full-mouth x-rays once every 5 years. That means you have to wait five years after the day they get full-mouth x-rays before your plan will pay for them again

4 Explanation of benefits letters

Once we process a claim from either you or your dentist, we'll send you an **explanation of benefits**. These aren't bills. They explain what your dentist's charges are, what we'll pay for, and what you might owe out-of-pocket. You'll usually get an explanation of benefits within 30 days of seeing the dentist.

5 Paying out-of-pocket costs

If you still owe your dentist after we pay our share, your dentist will send a bill to you directly.

6 If your claim is denied

When we **deny** a claim it means we don't agree to pay for it. When that happens, we'll send you an explanation of benefits letter with the reason we denied your claim. Sometimes we just need more information from your dentist. If so, we'll tell you what we need and where to send it.

If you don't agree with our decision about your claim, you can file an **appeal**. See the next page, How to file an appeal, to learn how.

How to file an appeal

An appeal is when you ask us to take another look at a request for service, payment or coverage that we denied. You can ask us to take another look whenever you don't agree with our decision. Your explanation of benefits letter will have instructions on how to file an appeal.

Appeals have two parts: informal and formal reviews.

STEP 1: Informal review

If you feel we've made a mistake about your claim, or disagree with our decision, ask us for an **informal review**. You have 180 days from the date your claim was denied to ask.

We'll review your request and make a decision within 14 days after we get it. We'll send you written notice of our decision. If our decision isn't in your favor, we'll tell you what else you can do if you still think we made a mistake. Also, you can ask us to send you copies of the information we used to make our decision.

Sometimes we may need more than 14 days to make a decision. If that happens, we'll send you written notice that we need another 16 days. We'll also tell you what decision we expect to make and why we need the extra time.

If a delay in the appeals process would jeopardize your family's life or health, we'll fast-track your appeal to get you an answer within 72 hours.

STEP 2: Formal review

If you still feel that we made a mistake or disagree with our decision after the informal review, you can ask for a **formal review**. Formal reviews go to our appeals committee.

You need to ask for a formal review within 90 days of the post-marked date on the envelope that our informal review decision letter came in.

The appeals committee will review your request and make a decision within 14 days after we get it. We'll send you written notice of our decision. Also, you can ask us to send you copies of the information we used to make our decision.

Sometimes we may need more than 14 days to make a decision. If that happens we'll send you written notice that we need another 16 days. We'll tell you when we expect to have a decision and why we need the extra time.

Your appeals for informal and formal reviews must include:

- Your name
- Your family's name and ID number
- The claim number (from the explanation of benefits)
- Your dentist's name

You can also send any documents or other information that support your appeal.

Send your requests to:

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

Or, call us at:

800-526-8323

DID YOU KNOW? Appeals can be submitted by you, your dentist, your child or an authorized representative. That's someone you've chosen to make your appeal for you. You must send us a letter signed by you saying it's OK for this person to speak for you or your child. If we don't get a signed letter, your appeal will be closed.

For more information about appeals, call 800-526-8323.

Making the appeals process fair

Different people review your case during each step of the appeal process. That means that the people who denied your claim in the first place aren't the same people who look at it during the informal review. And a whole new group of people will review your appeal if it gets to the formal review stage. That way you can be sure we're doing our best to give your appeal a fair hearing.

Other actions you can take

The decision of the appeals committee is final. If you still disagree with us, there are other actions you can take.
Start by contacting the Office of the Insurance Commissioner. This is the state agency that oversees Washington State insurance companies and producers. You can contact them at:

Washington State Office of the Insurance Commissioner
P.O. Box 40256
Olympia, WA 98504-0256

Phone: 800-562-6900
or 360-725-7080

Fax: 360-586-2018

Estimating your costs

Your dentist can ask us for an estimate of how much we'll pay for your family's dental work. These cost estimates are called **confirmations of treatment and cost.**

For example, let's say your child visits the dentist for a routine cleaning and it's discovered that they have a cracked tooth and need a crown. You want to know how much it will cost.

Ask your dentist to send us a treatment plan, along with x-rays. After we look over the plan, we'll send you and your dentist an estimate for how much we'll pay and what your out-of-pocket costs might be. It usually takes 15 days after we get your dentist's request for us to make our estimate.

We have a tool on our website that can help you get an idea about how much your dental work will cost. Visit DeltaDentalWA.com. Or you can call us at 800-526-8323.

Renewing, enrolling and making changes to your plan

Your plan automatically renews (restarts) when it expires. But only if your family still qualifies for the plan and you're up-to-date with your payments.

If you don't want to renew this plan, or you want to take one of your family members off the plan, you need to let us know 30 days before it renews.

You have to let us know in writing if your not renewing.

You can email us at CService@DeltaDentalWA.com or send a letter to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983.

Your benefits and the cost of your plan can change when you renew

Many things go into deciding what gets covered in a dental plan and how much the coverage costs. We have to consider things like government policies or new methods in dentistry. That's why we take a look at our plans every year to see if they need to change. And sometimes we have to adjust the price you pay or change what benefits get covered.

But don't worry, we'll let you know if your bill is going up at least 30 days before your plan renews.

If your bill goes up 25% or more, we'll let you know 60 days before you're your plan renews. We'll also give you 60 days notice if we change any benefits covered by your plan.

Sometimes we decide not to offer a plan any more. If that happens, we'll let you know in writing at least 60 days before your plan renews.

If we don't hear from you after we let you know about changes to your plan, and you still qualify for coverage, we'll automatically renew your policy with the new rates and/or benefits.

Making changes to your plan

You're allowed to enroll or make changes to your dental plan during **open enrollment**. If you don't enroll or make changes to your plan during this time, **you won't have another chance until the next open enrollment**.

DID YOU KNOW? In some cases you can enroll, renew or make changes to your plan outside of open enrollment. These cases are called **qualifying events**.
Qualifying events let you enroll, make changes or cancel your plan during what's called **special enrollment periods.**

Special enrollment qualifying events

If any of these things happen, you can enroll or make changes to your plan even if it isn't during the open enrollment period:

You add to your family

- You have a baby
- You adopt a child
- You foster a child

There's a change in your status

- You get married or start a domestic partnership
- You get divorced or end a domestic partnership
- You or your child moves in or out of the state
- Your child turns 19
- Your child no longer qualifies for their current plan
- Your child becomes a U.S. citizen

There are qualifying changes

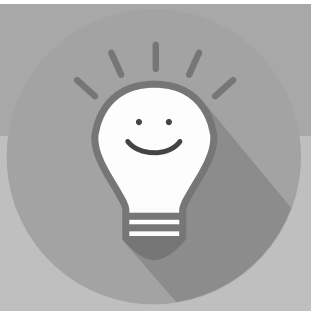
- You or your child's parent/guardian no longer get coverage through work
- You or your child's parent/guardian no longer get COBRA coverage
- You and your child now qualify for an Exchange tax credit (subsidy)
- You and your child no longer qualify for an Exchange tax credit (subsidy)
- Your child's coverage in an Exchange plan ends and the grace period for continuation of coverage has expired
- Your child's coverage ends for a plan offered through the Washington State Health Insurance Coverage Access Act
- Your child's plan violated the rules of the plan

Other special situations

- Your child lost coverage because of mistakes made by health benefit exchange staff or the U.S. Department of Health and Human Services
- Your child is Native American, as defined by Section 4 of the Indian Health Care Improvement Act. Native American children can change health plans one time per month, without the need for a qualifying event

What else do I need to know?

What else do I need to know?



In this section find

answers

about

Here are a few guidelines to follow to make sure you keep your coverage and make the most of your benefits.

Who can be covered by this plan

People who live in Washington State can purchase this plan.

For pediatric benefits, it covers children through age 18 who are dependents of Washington State residents.

For adult benefits, it covers Washington State residents over 19 years old, including:

- Spouses and domestic partners
- Dependent children 19 to 26
- Anyone you include on your federal income tax return (even if they don't live with you)

Children age 19 to 26
When your child turns 19, they no longer qualify for pediatric benefits on this plan. But they can stay on this plan as your dependent up until age 26.

On the first day of the month following your child's 19th birthday, they will automatically switch over to the plan's adult benefits.

If we've already paid for some pediatric benefits before your child turns 19, those payments won't count toward your child's annual adult maximum. Also, when your child moves from pediatric to adult benefits, you'll be credited any deductible you've paid.

Dependent adult children over age 26
Children over age 26 who are unable to live independently can stay enrolled in this plan. If your child is enrolled in this plan when they turn 26, and they are:

- incapable of self-sustaining employment because of an 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
- chiefly dependent upon you for support and maintenance.

Continued coverage requires that proof of incapacity and dependency be sent to DDWA within 31 days of the child turning 26 years of age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years

What else do I need to know?

Having a baby, adopting or fostering a child

Your newborn baby is covered at birth. Adopted and fostered children are covered on their adoption date, at the time of placement, or the date when you become legally responsible for their support. Dental coverage for newborns will include coverage for congenital anomalies from the moment of birth.

Additional premium is required for your first baby, adopted or fostered child added to this plan. Coverage for any newly added child begins the first day of the month of their birth, adoption, placement, or when you become legally responsible for them, but you can take up to 90 days to get your enrollment paper-work done and send in your first payment. If you already have a child enrolled, your premium does not change when additional child(ren) are added. We encourage you to submit your paperwork as soon as possible to avoid delays in claims processing.

Adding children to the plan or taking them off

You can only add or remove children from this plan during open enrollment periods, unless they're a newborn baby or a newly adopted child. There are some cases where you're allowed to add or take children off this plan. See How your qualified dental plan works, to learn about special enrollment periods.

If your new spouse or domestic partner has kids

Getting married or entering a domestic partnership is a qualifying event. That means you can enroll your new partner's children in your plan. The same is true if you get divorced or end a domestic partnership. If your kids were covered through your spouse or partner, you can enroll them in a new plan

New dependents must be enrolled within 90 days of the qualifying event, except for a newborns. Enrollment for newborns may be completed any time before their 4th birthday. If enrollment is not received in the timeframe described here, you have to wait to enroll them during an open enrollment period.

is up. However, there are a few exceptions to this. If you meet the circumstance listed below, you may cancel this plan early. If your plan is canceled for any other reason, you'll have to wait 24 months (2 years) before you can enroll in one of our individual plans again.

You can cancel your plan if:

- Your child dies
- You die. If that happens, this plan will end, however coverage for anyone under this plan may be continued under a separate plan.
- You or another parent or guardian enters full-time United States military service
- Your child gets covered by a group plan offered through work or a public program. In that case, you can take them off this plan starting the first day of the month after they start their new plan. But you'll need to let us know right away. If you don't let us know, we'll continue to bill you for this plan. You can't cancel this plan if you move your child to a different individual plan.

You need to tell us in writing within 30 days after one of these events happens. You also need to send us proof of the event. We'll refund any unused part of your premium.

We can cancel your plan before your contract term ends if:

- You don't pay your premiums within your missed-payment grace period
- You or your dependent commit fraud (cheat or lie to get benefits) for this or any other plan.

Canceling your plan

When you enroll in this plan, you're committing to keep it until the end of your contract term. You may choose to not renew this plan after the contract term

What else do I need to know?

When your plan ends

Your dependents coverage for benefits stops on the date this plan ends. That date is the earliest of the following:

- If the premium hasn't been paid, the plan ends on the day following the last day of the grace period.
- If you ask us to end the plan, the plan will end on the last day of the month you requested.
- If you tell us you don't want to renew this plan, it will end on the last day of the contract term.
- If you die this plan will end on the last day of the month of your death.
- If someone covered under this plan dies, their coverage will end on the last day of the month after their death, but the plan will continue if there are other people covered by the plan.

If you move out of Washington State, this plan will end on the last day of the contract term, including coverage for everyone on this plan.

Contacting us

We'll send anything you need to know to the last mailing or email address we have on file for you. So please let us know right away if you move or change your mailing or email address.

You contact us by sending a letter, email, calling or faxing.

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

Email: CService@DeltaDentalWA.com Phone: 800-526-8323
Fax: 206-985-4783

If you're not happy with this plan

If you have problems with Delta Dental of Washington, or any other concern about your benefits, please contact us.

If you prefer, you can speak with the *Office of the Insurance Commissioner*. This is the state agency that oversees Washington State health and dental plans.

Mail:
Washington State Office of the Insurance Commissioner
P.O. Box 40256
Olympia, WA 98504-0256
Phone: 800-562-6900 or 360-725-7080
Fax: 360-586-2018

DID YOU KNOW? If you need dental care when you're traveling outside of Washington, you're covered — even if you're treated in another state or country.

When you're covered by more than one plan:
Coordination of benefits

What happens when a member of your family is covered by more than one dental plan? This can happen in many ways. One parent may have dental coverage through her job, but decide to get another plan for services not covered by her work plan. Or parents could be separated or divorced and have their own plans.

Dual coverage

When a member of your family has coverage from more than one plan, it's called dual coverage. If a member of your family has dual coverage, you need to let each plan know you're covered by more than one plan. That way the companies can work together to "coordinate" your benefits. It will also help avoid any delays in paying your claims.

Who pays what?

Your dental plans determines which plan is the "primary" payer and which is the "secondary" payer. The primary plan always pays first when you have a claim. It also acts like you don't have another plan. In other words, if it says it pays 50 percent for fillings, it must pay that amount.

Coordination of benefits can get pretty complicated. To decide who's the primary payer, dental plans have to follow special guidelines. Plans use things like which birthday comes earliest in the year or for children, who has custody of the child if you're divorced, to decide which plan is the primary payer.

To make sure that your claims get paid and your plans cover their share, contact the plans directly and ask to speak with a coordination of benefits specialist.

Coordination of benefits at Delta Dental of Washington

This is the model coordination of benefits language provided by Washington State. These are the rules that govern how we coordinate your benefits with other carriers when you have more than one plan. If you'd like any of it explained or need help with your coordination of benefits, call 800-526-8323.

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

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its 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 Plans do not exceed 100 percent of the total Allowable Expense.

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

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

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

(2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a

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-dentist primary care practice as defined by law or coverage under other federal governmental Plans, unless permitted by law.

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

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

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

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

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

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

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

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

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

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

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

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

B. A Plan that does not contain a coordination of benefits provision that is consistent with applicable regulation is always primary unless the provisions of both Plans state that the complying Plan is primary, 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.

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

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

(1) "Non-Dependent or Dependent:" The Plan that covers your family other than as a Dependent, for example as

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

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

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

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

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

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

(i) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claims determination periods commencing after the Plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the Plan of the parent assuming financial responsibility is primary;

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

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of D.2.(a) above (for Dependent child(ren) whose parents are married or are living together) determine the order of benefits; or

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

- The Plan covering the Custodial Parent, first;
- The Plan covering the spouse of the Custodial Parent, second;
- The Plan covering the noncustodial Parent, third; and then
- The Plan covering the spouse of the noncustodial Parent, last

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

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

(4) "COBRA or State Continuation Coverage:" If your family's 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 or your child as an employee, member, subscriber or retiree or covering yourchild as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

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

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

Effect on the Benefits of This Plan:

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the Total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim 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 the Primary Plan. The Primary Plan, and we as your family's Secondary Plan, may ask you and/or your family's dentist for information in order to make payment. To expedite payment, be sure that you and/or your child's dentist 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 child's dentist, you and/or your child's dentist may submit your claim for us to make payment as if we were your Primary Plan. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your Primary Plan has not paid. This provision does not apply if Medicare is the Primary Plan. We may recover from the Primary Plan any excess amount paid under the "right of recovery" provision in our contract.

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

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

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

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

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

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

CAUTION: All health Plans have timely claim filing requirements. If you, or your child's dentist, 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 child's dentist will need to submit your claim to the secondary health Plan within its claim filing time limit to prevent a denial of the claim.

What else do I need to know?

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

Civil rights complaints

If you believe that Delta Dental of Washington has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. Send it to:

Isaac Lenox, Compliance/Privacy Officer Email: Compliance@DeltaDentalWA.com Mail: PO Box 75983, Seattle, WA 98175 Phone: 800-554-1907 TTY: 800-833-6384,
Fax: 206-729-5512

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
Mail: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington DC 20201
Phone: 1-800-868-1019
TDD: 800-537-7697

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html

Your privacy - HIPAA

Health Insurance Portability and Accountability Act
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 (HIPAA). You can get our Notice of Privacy Practices by visiting www.DeltaDentalWA.com, or by calling us at 800-554-1907

What else do I need to know?

Odds & Ends

Delta Dental of Washington's responsibility
We're responsible for providing the administrative services and for paying claims for services properly received under this policy.

Compliance with laws and regulations
This policy complies with all pertinent federal and state laws and regulations, including (but not limited to) the health care privacy and disclosure provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If any part of this policy is not in compliance with any pertinent federal or state law or regulation, then Delta Dental of Washington will revise the policy to correct the noncompliance.

Rights of recovery (Subrogation)
If we pay benefits under this policy, and you are paid by someone else for the same procedures, 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 prorated 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.

Legislative surcharge clause
If a government unit imposes a new tax or assessment or increases the rate of a current tax or assessment that affects any of your payments to Delta Dental of Washington, then we're authorized to increase your monthly premium by the amount of the new tax, assessment or increase.

Governing law
This policy is issued and delivered in the State of Washington and obeys its laws and regulations. On the effective date of this policy, any term, condition or provision conflicting with Washington State laws and regulations applying to this policy will automatically conform to the minimum requirements of such laws and regulations.

Non-waiver and severability
If we don't exercise any remedy or right under this policy, that doesn't affect our ability to exercise any remedy or right at any time in the future.

Entire contract; changes
The entire contract between you and us consists of this policy, which includes the Plan Overview page, this benefit booklet which includes limitations and co-payments, any and all endorsements or riders, and the application. This policy may only be amended by Delta Dental of Washington for changes in state or federal law and may not be amended by the policyholder. No oral statements by anyone can change or affect any aspect of this policy.

Notice of legal action
No legal action can be brought against us until at least 60 days after proof of loss has been furnished, or that proof of loss has been waived by Delta Dental of Washington, or we have denied payment, whichever comes earlier

What else do I need to know?

Translation and accessibility services

Getting the help you need, no matter who you are

At Delta Dental of Washington, we believe that everyone deserves to have a healthy, beautiful smile. We follow all Federal civil rights laws and don't discriminate or exclude on the basis of race, color, national origin, age, disability or sex.

If you have a disability

We provide free aids and services to anyone with disabilities so they can better understand their plan and communicate with us. This includes:

- Qualified sign language interpreters
- Written information in other formats, such as large print, audio and accessible electronic formats

If your first language isn't English

We provide free language services to anyone whose primary language is not English so they can better understand their plan and communicate with us. This includes:

- 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.

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 .تفلكة	Delta Dental of Washington معلومات الاشعار هذا يحوي للحصول طلبك بخصوص مهمة معلومات الاشعار هذا يحوي .هامة الاشعار هذا في الهامة التواريخ عن ابحث خلال من التغطية على الصحية تغطيتك على للحفاظ تنيعم تواريخ في اجراء لاتخاذ تحتاج في الحق لك .التكاليف 1(800)554-1907 دفع في للمساعدة او اتصل .تفلكة أي دون من بلغتك والمساعدة المعلومات على الحصور بـ

Language	Tagline	Nondiscrimination Statement
Cambodian (Mon-Khmer)	្រសិនបើអ្នក ឬនរណាម្នក់ដែលអ្នកកំពុងដែជួយ មួនសំណួរអ្ំពី Delta Dental of Washington បេ, អ្នកមួនសិេធិេេួលជំនួយនិងព័ែ៌មួន ចៅកនុងភាសា ររស់អ្នក ចោយមិនអ្ស់ប្ាក់ ។ បែើមបីនិយាយជាមួយអ្នករកដប្រសូម 1(800)554-1907.។	បសចកតីជូនែំណឹងបនេះ មួនព័ែ៌មួនយា៉ាងសំខាន់ ។ បសចកតីជូនែំណឹងបនេះ មួនព័ែ៌មួនយា៉ាង សំខាន់ អ្ំពីេបេង់ដររេ ឬ ការរ៉ា រ់រង ររស់អ្នកតាមរយៈ Delta Dental of Washington ។ សូមដសែងរកកាលរិបចេេសំខាន់ចាំច ចៅកនុងបសចកតីជូនែំណឹងបនេះ ។ អ្នកប្រដែលជាប្ែូវការរបចេញសកមមភាព ែ៌ល់កំណ៌ែថ្ងៃជាក់ចាស់នានា បែើមបីនឹងរកាេុកការ៉ា រ់រងសុខភាពររស់អ្នក ឬប្ាក់ជំនួយបចញថ្ងៃ ។ អ្នកមួនសិេធិេេួលព័ែ៌មួនបនេះ និងជំនួយចៅកនុងភាសាររស់អ្នកចោយមិនអ្ស់លុយប ើយ ។ សូមេូរស័ពទ 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□ □ □ □ □ □ 。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.

Language	Tagline	Nondiscrimination Statement
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 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.	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Delta 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	ຖ້າ ່ທ່ານ, ຶ ຼ ຫ ິ ນ ິ ທ ່ ທ ່ ານ ໍ ກ ່ ານ ັ ວ ໆ ່ ຊ ່ ວ ຍ ເ ຶ ຼ ອ ຫ ອ, ີ ມ ໍ ່ ຄ ່ ານ ຖ ່ ານ ່ ກ ໆ ວ ັ ກ ັ ບ Delta Dental of Washington, ່ ທ ່ ານ ິ ມ ິ ສ ດ ີ ທ ່ ຈ ະ ໄ ້ ດ ັ ຮ ັ ບ ກ ່ ານ ່ ຊ ່ ວ ຍ ເ ຶ ຼ ອ ຫ ອ ເ ຈ ່ ະ ່ ໍ ້ ຂ ູ ມ ນ ່ ຂ ່ າ ວ ສ ່ ານ ິ ທ ເ ັ ປ ນ ພ ່ າ ສ ່ າ ຂ ອ ໆ ່ ທ ່ ານ ່ ໍ ບ ິ ມ ່ ຄ ່ ານ ໃ ້ ຊ ່ ່ ຈ ່ ່ ຍ. ກ ່ ານ ໄ ້ ອ ິ ວ ມ ັ ກ ັ ບ ນ ່ ຍ ພ ່ າ ສ ່ າ, ໃ ້ ຫ ໂ ທ ຫ ່ ່ ານ 1(800)554-1907.	ກ ່ ານ ເ ້ ຈ ໆ ກ ່ ານ ີ ້ ນ ິ ມ ໍ ້ ຂ ູ ມ ນ ໍ ່ ສ ່ ານ ັ ຄ ນ. ກ ່ ານ ເ ້ ຈ ໆ ກ ່ ານ ີ ້ ນ ິ ມ ໍ ້ ຂ ູ ມ ນ ີ ທ ໍ ່ ສ ່ ານ ັ ຄ ນ ່ ກ ໆ ວ ັ ກ ັ ບ ໍ ຄ ່ ານ ້ ຮ ອ ໆ ສ ະ ໜ ັ ກ ື ຼ ຫ ກ ່ ານ ຸ ໍ ້ ຄ ມ ຄ ອ ໆ ຂ ອ ໆ ່ ທ ່ ານ ໂ ດ ຍ ່ ຜ ່ ານ Delta Dental of Washington ເ ີ ່ ບ ງ ໍ ່ ສ ່ ານ ັ ລ ບ ໍ ກ ່ ານ ິ ນ ດ ັ ອ ນ ີ ທ ໍ ່ ສ ່ ານ ັ ຄ ນ ໃ ນ ເ ້ ຈ ໆ ກ ່ ານ ີ ້ ນ. ່ ທ ່ ານ ອ ່ ານ ດ ໍ ່ ຈ ່ ານ ເ ັ ປ ນ ້ ຕ ອ ໆ ໃ ້ ຊ ເ ອ ່ ານ ໍ ດ ່ ານ ເ ີ ນ ນ ກ ່ ານ ໂ ດ ຍ ໍ ກ ່ ານ ິ ນ ດ ເ ອ ່ ານ ີ ່ ທ ເ ່ ່ ນ ນ ອ ນ ຈ ະ ັ ຮ ກ ສ ່ ານ ກ ່ ານ ຸ ໍ ້ ຄ ມ ຄ ອ ໆ ຸ ສ ຂ ະ ພ ່ າ ບ ຂ ອ ໆ ່ ທ ່ ານ ີ ຼ ຫ ກ ່ ານ ່ ຊ ່ ວ ຍ ເ ຶ ຼ ອ ຫ ອ ີ ທ ິ ມ ່ ຄ ່ ານ ໃ ້ ຊ ່ ່ ຈ ່ ່ ຍ. ່ ທ ່ ານ ິ ມ ິ ສ ດ ີ ທ ່ ຈ ະ ໄ ້ ດ ັ ຮ ບ ໍ ້ ຂ ູ ມ ນ ່ ຂ ່ າ ວ ສ ່ ານ ິ ້ ນ ເ ຈ ່ ະ ກ ່ ານ ່ ຊ ່ ວ ຍ ເ ຶ ຼ ອ ຫ ໃ ນ ພ ່ າ ສ ່ າ ຂ ອ ໆ ່ ທ ່ ານ ິ ທ ່ ໍ ບ ິ ມ ່ ຄ ່ ານ ໃ ້ ຊ ່ ່ ຈ ່ ່ ຍ. ໂ ທ 1(800)554-1907.

Language	Tagline	Nondiscrimination Statement
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 ਅੰਤਮ 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 переводчиком позвоните по телефону 1(800)554-1907.	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, 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.

Language	Tagline	Nondiscrimination Statement
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.

Notes

Thank you for choosing
Delta Dental Individual and Family – Basic Family
plan for the health of your family's smile.

Delta Dental of Washington

DeltaDentalWA.com
800-526-8323