WEA
WASHINGTON EDUCATION ASSOCIATION
SELECT

DeltaCare®
Managed Care Dental Network

Benefits Booklet

The benefits included in this booklet are effective November 1, 2015.

Your benefits are being paid based on the benefit year beginning November 1 and ending on October 31.

A benefit booklet insert, effective November 1, 2018 through October 31, 2019, has been incorporated into this booklet.

DELTA DENTAL

Delta Dental of Washington

Delta Dental of Washington

DeltaCare®
Administered by Delta Dental of Washington

Benefit Booklet Insert

Washington Education Association

Delta Dental of Washington, a Delta Dental Plan

Plan No. 00188

Plan Changes Effective: November 1, 2018

This insert supplements your Dental Care Service Contract with Delta Dental of Washington.

This notice forms part of and must be read together with your Benefits Booklet.

Your Benefit Booklet wording is amended as detailed on the following page(s). All other terms and conditions remain unchanged.

Benefit Booklet Insert

Group Number: 00188
Group Name: Washington Education Association

The revisions to your Benefit Booklet outlined below represent changes to your benefits and/or changes to how your plan is administered. Additional text revisions have been made to provide additional information, for clarity or to ensure accuracy with how your Plan is administered.

New language is underlined and deleted language is shown with a ~~strike through it~~, unless otherwise noted.

Benefit Changes

None

Plan Administration Changes

Benefit Period

Most dental benefits are calculated within a "benefit period." ~~which is typically for one year~~. For this Plan, this is the 14 month period beginning November 1, 2018 and ending December 31, 2019.

Schedule of Benefits and Co-Payments

The CDT Codes within the Schedule of Benefits and Co-Payments have been updated as follows:

Revision	Code	Procedure Description	Patient Co-Pay
New Code	D5511	Repair broken complete denture base, mandibular	$26
New Code	D5512	Repair broken complete denture base, maxillary	$26
New Code	D5611	Repair resin partial denture base, mandibular	$37
New Code	D5612	Repair resin partial denture base, maxillary	$37
New Code	D9222	Deep sedation/general anesthesia – first 15 minutes	$0
New Code	D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$0
Terminated Code	~~D5510~~	~~Repair complete denture~~	~~$26~~
Terminated Code	~~D5610~~	~~Repair resin saddle or base~~	~~$37~~
Terminated Code	~~D5620~~	~~Repair cast framework~~	~~$47~~
Nomenclature Change	D7111	Coronal remnants – primary ~~deciduous~~ tooth (removal)	$0
Nomenclature Change	D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit ~~once in a three-year period~~	$0
Nomenclature Change	D3421	Apicoectomy ~~bicuspid~~ premolar, first root	$0
Nomenclature Change	D3347	Retreatment of previous root canal therapy – ~~bicuspid~~ premolar	$0

Text Revisions for Clarity and Accuracy – Plan Administration

Changing Plans

Please note, the WEA has contracted with DDWA to offer several different dental coverage plans to school districts/bargaining units. Different school districts or bargaining units may choose to offer different plans. If you are changing school districts or bargaining units, please be aware that your benefits may be different. Please contact your benefits administrator for information regarding any potential changes to your benefits.

Nondiscrimination and Language Assistance Services

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

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

Delta Dental of Washington:

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

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

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

- Qualified interpreters
- Information written in other languages

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

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

Language	Tagline	Nondiscrimination Statement
Amharic	እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአሰተርጓሚ 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። የጤና ሽፋንዎን ለመጠበቅና በአከፋል እርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለ ምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። 1(800)554-1907 ይደውሉ።
Arabic	إن كان لديك أو لدى أي شخص تساعده أسئلة بخصوص تغطيتك الصحية لدى Delta Dental of Washington، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع المترجم اتصل بـ 1(800) 554-1907.	يحوي هذا الإشعار معلومات هامة بخصوص طلبك للحصول على تغطية من خلال Delta Dental of Washington. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة. اتصل بـ 1(800) 554-1907.

Language	Tagline	Nondiscrimination Statement
Cambodian (Mon-Khmer)	ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានសំណួរអំពីធានារ៉ាប់រងរបស់អ្នកជាមួយ Delta Dental of Washington អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាននៅក្នុងភាសារបស់អ្នកដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1(800) 554-1907។	សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់អំពីពាក្យសុំ ឬធានារ៉ាប់រងរបស់អ្នកតាមរយៈ Delta Dental of Washington។ សូមយកចិត្តទុកដាក់លើកាលបរិច្ឆេទណាមួយដែលមានក្តង សេចក្តីជូនដំណឹងនេះ។ អ្នកអាចត្រូវចាត់វិធានការមួយចំនួនមុនថ្ងៃកំណត់ជាក់លាក់ ដើម្បីរក្សាទុកធានារ៉ាប់រងរបស់អ្នក ឬទទួលជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាននេះនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយ។ សូមទូរស័ព្ទមកលេខ 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。請留意本通知中包含的日期。您可能需要在截止日期之前採行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話[在此插入數字 1(800)554-1907。
Cushite (Oromo)	Isin yookan namni biraa isin deeggartan Delta Dental of Washington irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1(800)554-1907 tiin bilbilaa.	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Delta Dental of Washington tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1(800)554-1907 tii bilbilaa.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Washington haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1(800)554-1907 an.	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Delta Dental of Washington. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1(800)554-1907.
Japanese	ご本人様、またはお客様の身の回りの方でもDelta Dental of Washingtonについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合1(800)554-1907までお電話ください。	この通知には重要な情報が含まれています。この通知にはDelta Dental of Washingtonの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます1(800)554-1907までお電話ください。

Language	Tagline	Nondiscrimination Statement
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Washington에 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 Washington을 통한 커버리지에 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)554-1907로 전화하십시오.
Laotian	ຖ້າທ່ານ, ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳ ຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍ ເຫຼືອ ແລະ ຂໍ້ມູນຂ່າວສານນີ້ເປັນພາສາຂອງທ່ານ ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ ໂທຫາ 1(800)554-1907.	ການແຈ້ງນີ້ມີຂໍ້ມູນສຳຄັນ. ການແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນກ່ຽວ ກັບຄຳຮ້ອງສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Delta Dental of Washington. ເບິ່ງສຳລັບກຳນົດທີ່ສຳຄັນໃນແຈ້ງ ການນີ້. ທ່ານອາດຈະເປັນຕ້ອງໃຊ້ເວລາດຳເນີນການໂດຍກຳນົ ດ ເວລາທີ່ແນ່ນອນຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອ ງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວ ສານນີ້ ແລະ ການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1(800)554-1907.
Punjabi	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਜਿਸ ਵਿਅਕਤੀ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Delta Dental of Washington ਦੇ ਨਾਲ ਬੀਮਾ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹੁੰਦੇ ਹਨ, ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1(800)554-1907 'ਤੇ ਕਾਲ ਕਰੋ।	ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੀ ਐਪਲੀਕੇਸ਼ਨ ਜਾਂ Delta Dental of Washington ਦੇ ਦੁਆਰਾ ਕਵਰੇਜ ਬਾਰੇ ਮਹੱਤਵਪੂਰਣ ਜਾਣਕਾਰੀ ਸ਼ਾਮਲ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਸ਼ਾਮਲ ਕਿਸੇ ਮਿਤੀਆਂ ਵੱਲ ਖਾਸ ਧਿਆਨ ਦਿਓ। ਤੁਹਾਨੂੰ ਆਪਣੇ ਬੀਮਾ ਕਵਰੇਜ ਨੂੰ ਕਾਇਮ ਰੱਖਣ ਲਈ ਜਾਂ ਲਾਗਤਾਂ ਦੇ ਨਾਲ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਨਿਸ਼ਚਿਤ ਮਿਤੀਆਂ ਤੋਂ ਪਹਿਲਾਂ ਕੁਝ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ। ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। 1(800)554-1907 'ਤੇ ਕਾਲ ਕਰੋ।

Language	Tagline	Nondiscrimination Statement
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.
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.

Language	Tagline	Nondiscrimination Statement
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.

Table of Contents

This booklet sets forth in summary form an explanation of the coverage available under your dental plan.

Introduction

Welcome to the DeltaCare® Dental Plan, which is administered by Delta Dental of Washington (DDWA), the state's largest and most experienced dental benefits carrier. DDWA is a member of the nationwide Delta Dental Plans Association. With a Delta Dental Plan from DDWA, you join more than 50 million people across the nation who have discovered the value of our coverage.

Delta Dental of Washington (DDWA) is a not-for-profit dental service corporation. DDWA developed the WEA Select Managed Dental Care Plan to address rising dental care costs. The WEA Select Managed Dental Care Plan offers the employee and family an economical choice for quality dental care. WEA Select Managed Dental Care Plan was founded on the principle of prevention - treating dental conditions before they become more serious and costly. The way DDWA has done this is to contract with a select network of dentists that have agreed to meet quality standards and to deliver care at an economical cost.

This benefit booklet is your Certificate of Coverage and sets forth, in summary form, an explanation of the coverage available under your dental plan.

How to Use Your Plan

The best way to take full advantage of your dental benefits plan is to understand its features. You can do this most easily by reading this benefit booklet *before* you go to the dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this benefit booklet does not answer all of your questions, or if you do not understand something, call a DDWA customer service representative at 1-800-650-1583. ***Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.***

Choosing a Primary Care Dentist (PCP)

When you enroll in the DeltaCare Dental Plan, you must complete the enrollment process and may indicate your PCP choices at that time. New enrollees have 60 days to select and notify us of your preferred Primary Care Provider (PCP). A PCP is a Washington state General Practitioner that has chosen to participate in the DeltaCare Network.

If you do not select a PCP within 60 days, we will assign you to a provider near your home. The choice of PCP can be changed with proper notice to DDWA. Please contact us at 1-800-650-1583 for more information on selecting or changing your PCP or to notify us of your selection.

Your selected dental office is now the center for all of your dental needs. The PCP will perform most dental services. For specialty care, the PCP may elect to refer treatment to a DeltaCare Dental Plan Specialist.

After you have enrolled, you will receive a membership card and letter. The letter will include the address and telephone number of your PCP.

If your PCPs participation in the DeltaCare Network is terminated, you will receive written notification. This notification will explain your option to: 1) automatically be assigned to another PCP; or 2) select another PCP from the directory of open PCPs. If your PCP is to be absent for an extended period of time, you may transfer to another PCP dentist during the period of the absence.

Appointments

To receive dental care, simply call your PCP to make an appointment. Routine, non-emergency appointments will be scheduled within three weeks of the date of the request. Dental services which are not performed by your PCP or properly referred to a DeltaCare Dental Plan Specialist will not be covered by the DeltaCare Dental Plan.

Specialty Services

Your PCP is responsible for coordinating all specialty care and will either perform the specialty treatment or refer you to a DeltaCare Dental Plan Specialist. In some unique cases the PCP may refer you to a non-DeltaCare Dental Plan Specialist, but prior authorization from DDWA is required.

Urgent Care

The PCP shall provide urgent dental care for a covered procedure within 24 hours of being contacted. If an Enrollee requires urgent dental care and is not able to be seen by their PCP within 24 hours or is not within a reasonable distance of their PCP's office, the enrollee may receive treatment from another dentist. Such treatment is limited to the treatment that is necessary to evaluate and stabilize the enrollee until they can obtain further treatment from their PCP.

The Plan shall reimburse the Enrollee for the cost of such urgent dental care which exceeds the enrollee's Co-payment up to a $100 maximum per calendar year. In cases where immediate additional care beyond stabilization and palliative treatment is medically required, DDWA will carefully review and consider additional reimbursable coverage beyond the $100 maximum according to the standard list of covered benefits under the plan.

Emergency Care

DeltaCare Network dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, 365 days a year. Treatment of a dental emergency, those rare dental health instances that may be life threatening or cause severe bodily injury, shall not require a predetermination if a prudent layperson acting reasonably would believe that such an emergency condition exists. The Plan would encourage the enrollee to seek a predetermination from the Plan for such emergency care if at all practical, but would not require predetermination if the treatment is a listed procedure under the terms of coverage. The Enrollee should notify DeltaCare after receiving emergency dental care within 15 days, or when practical, as to the extent of such emergency dental treatment.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this plan, the benefit period is the 12-month period starting the first day of the calendar month, November 1 and ending the last day of the calendar month, October 31 of each year.

Estimate Request (Predetermination of Benefits)

If you are receiving treatment from a provider who is not your assigned PCP, you may request an estimate of your costs and benefits before treatment by asking your dentist to complete and submit a request for an estimate. This estimate is also known as a "predetermination of benefits". This will allow you to know in advance which procedures may be covered, the amount DDWA may pay towards those procedures, and your expected financial responsibility.

Covered dental benefits which are provided by your Primary Care Provider which are listed in the "*Schedule of Co-Payments and Benefits"* and in the DeltaCare Provider Manual are covered and do not require predetermination.

Please see the "Predetermination of Benefits" Section under Claim Review and Appeals for more information.

Who is Eligible?

Employee

Eligible Employees are all active full-time employees for whom the District makes timely payment of the monthly dues.

Employees hired after the Plan is in effect become eligible on the first day of the month for which the District makes payment of the monthly dues.

All Eligible Employees must participate in this Plan, regardless of any coverage under any other Plan. However, an employee may only be enrolled as a Subscriber in the WEA Select Dental Plan at one school district.

School Board members are not eligible for coverage unless they are paid employees of the school district and meet WEA eligibility requirements. School Board members who receive compensation for their services as board members are not considered employees for this purpose.

Dependent

Eligible Dependents are your legal spouse, registered domestic partner of any state or domestic partner who meets the requirements of and completes the "Declaration of Domestic Partnership", and children, including biological children, stepchildren and adopted children, from birth up to age 26. Spouses and children of your dependent children are not eligible for coverage under this Plan.

Wherever spouse is stated in this contract, an eligible domestic partner would also be included.

Verifying Dependents

The WEA verifies the eligibility of all dependents and reserves the right to request documents from subscribers that substantiate that the person(s) enrolled meet the criteria of the plan. Examples of documents that may be requested include, but are not limited to, government-issued marriage certificates, the Declaration of Domestic Partnership, government-issued birth certificates and legal guardianship papers. If documents are not provided that verify your dependents' eligibility, their coverage will be canceled and COBRA will not be offered. The WEA Select Dental Plan will not reenroll dependents for whom you are unable to provide acceptable documentation.

Please note that once enrolled, coverage for dependents may only be dropped at open enrollment or when there is a qualifying event as described under "Special Enrollment."

Child Developmental Disability

Coverage for a dependent child over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible person for support and maintenance, provided proof of incapacity and dependency is furnished to DDWA within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Marriage

You may enroll a newly acquired spouse and children within 60 days of marriage. When enrollment is completed within 60 days of the marriage, coverage will begin on the first day of the month following the date of the event. If you do not enroll your spouse/children within the specified time period, they may not be enrolled until the next open enrollment period, unless there is a qualifying event.

Natural Newborn Children

Children of you or your spouse born while you are covered under this plan are covered from date of birth if enrolled within 60 days of birth. If notification is not received within 60 days of the date of birth, coverage will become effective on the first of the month following the date of notification.

Adoptive Children

You may enroll your adoptive child within 60 days from date of placement. Coverage becomes effective for adoptive children on the date of placement with the subscriber. If notification is not received within 60 days of the date of placement, coverage will become effective on the first of the month following the date of notification.

Legal Guardianship/Non-Parental Custody

Children under legal guardianship (legal wards) or under a legal non-parental custody decree may be enrolled for coverage if the following conditions are met:

- The legal guardianship/non-parental custody was awarded in accordance with the laws of the state in which it was obtained. Documentation must be provided, including the court order and petition for guardianship/non-parental custody, stating the reason and authority of the guardianship/non-parental custody. When the court order terminates or expires, the child is no longer an eligible child.
- The guardian/person with non-parental custody is either you or your spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same plan.
- The child is under 26 years of age.

When you complete the enrollment process for an eligible child covered under legal guardianship (legal wards) or under a legal non-parental custody decree within 60 days of the date of that decree, coverage required under the decree will become effective on the date of the decree.

If enrollment is not completed within the 60-day time period for eligibility, the child may not be enrolled until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage."

Medical Child Support Orders

When a child is to be added to your coverage due to a medical child support order, you must provide a copy of the court order (or National Medical Support Notice, Part A or Part B) to the WEA Select Benefit Center. Once approved, coverage for the eligible child required under the order becomes effective on your coverage as of the date of the notice.

Change in Dependent Status

Please report any changes immediately. Eligibility will not be credited beyond 60 days prior to the date you report a change.

When a covered dependent is no longer eligible on your group dental plan, he or she may continue coverage through COBRA, see "Continuation of Group Coverage – COBRA."

Loss of Other Coverage

Your dependents may be enrolled on this plan outside the open enrollment period if they had other dental care coverage at the time this plan was offered, but later lost it. The loss of the other coverage must be due to one of the following events:

- Loss of eligibility for coverage for reasons including, but not limited to divorce, death, end of employment, retirement, or a reduction in the number of hours employed
- The employer terminates its contribution toward the coverage, or
- They were covered under COBRA and that COBRA coverage on a non-WEA Select Plan has been exhausted

If your dependents lose coverage for any other reason, you will have to wait until the next open enrollment period to enroll them.

When enrollment is completed within 60 days of the date the prior coverage ended, coverage on the plan will begin on the first of the month after the loss of other coverage.

Please also see "Special Enrollments."

Enrollment Periods

In addition to the criteria described in the sections above, the following enrollments may be available.

Open Enrollment

If the school district offers employees a choice of another dental care plan, subscribers and dependents enrolled on the participating employee group's other plan may transfer to this plan during the participating employee group's scheduled open enrollment period.

Enrollment at any other time will be allowed only as explained under "Loss Of Other Coverage," "Marriage," "Natural Newborn Children," "Adoptive Children," "Legal Guardianship/Non-parental Custody," "Medical Child Support Orders," or " Special Enrollment."

Special Enrollment

You may enroll your dependents on this plan outside the open enrollment period when you are enrolling a new dependent acquired through marriage, birth, adoption, assumption of legal guardianship, non-parental custody or due to a medical child support order as described earlier in this section.

For information on enrollment procedures and coverage effective dates, please see the appropriate benefit booklet section (Marriage, Natural Newborn Children, Adoptive Children, Legal Guardianship/Non-Parental Custody or Medical Child Support Orders.)

In addition to the above special enrollment rights, you also may be eligible to drop or add dependent coverage if you experience certain qualifying events. Qualifying events include a change in legal marital status, change in employment status of you or your enrolled dependent, change in dependent eligibility (such as reaching the limiting age) or a significant change in the cost of benefits for the dependent. Contact the WEA Select Benefits Center for more information.

Termination of Benefits

Coverage for you and your Eligible Dependents will terminate if you cease to be eligible as previously defined, or if the Plan is terminated.

An individual's dependent's coverage will terminate at the end of the month in which the dependent is no longer eligible as previously defined.

For the purpose of this Plan, termination of employment will be considered to occur on the last day of the calendar month for which premiums are paid from fringe benefit funds earned during active employment.

If you are terminating employment due to retirement, you may apply for the WEA sponsored DDWA Retiree Dental Plan. To be eligible you must receive monthly retirement benefits from the Washington State Retirement System (TRS or PERS). You must apply for Retiree Coverage while still covered as an Active Employee or covered under COBRA. Contact DDWA to receive application materials.

Self-Payment Provisions

Labor Dispute

In the event of a suspension or termination of compensation, directly or indirectly as a result of a strike, lockout, or other labor dispute, an eligible employee may remain enrolled by paying the applicable Premium directly to the employer for a period not to exceed six months. Payment of Premiums must be made when due, or DDWA may terminate the coverage.

When the subscriber's compensation or wage is so suspended or terminated, the subscriber shall be notified immediately in writing by the Participating Employer Group. A notice will be mailed to the address last on record with the Participating Employer Group that the subscriber may pay subscription charges to the participating employer group as they are due as provided in this section.

Continuation of Coverage During Leave of Absence

Coverage for the subscriber and any enrolled dependents on an official leave of absence or sabbatical may be continued for up to 18 months. The leave of absence period must begin at the end of the last month of coverage paid from fringe benefit funds earned during active employment. If you do not elect continued coverage at this time or if you terminate coverage at any time during your leave of absence, you may not enroll on the plan until you return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during your leave of absence, you will immediately be eligible for "Continuation of Group Coverage—COBRA" (refer to the *Continuation of Coverage — "COBRA*" section). To be eligible for COBRA, you must elect coverage under COBRA within 60 days after coverage under the leave of absence provision terminates.

A district approved leave beyond 18 months does not entitle the subscriber (or enrolled dependents) to extend coverage under this leave of absence provision. If you do not return to work after your leave of absence or if another consecutive district-approved leave is granted without another period of active employment, you and your enrolled dependents may be eligible for an additional 18 months of COBRA continuation coverage. The maximum period of extended coverage under any circumstance is 36 months, i.e., up to 18 months of continued coverage under the leave of absence provisions and up to 18 months of COBRA continuation.

Additional coverage under this provision may be elected if you return to employment and are granted further official leaves of absence or sabbaticals.

Example:

- Employee is granted a leave of absence and is no longer actively at work as of March 20.
- Employee's active work results in fringe benefit dollars for March, which pay for April benefits.
- Employee will receive sick leave through the district leave-sharing program for 2 months.

In the above example, the 18-month leave of absence coverage period would officially begin on May 1, because April 1 is the last month of fringe benefit funds from active employment. The total extended coverage for sick leave and the leave of absence would be 18-months, at which time the district would need to provide the employee notice of access to COBRA continuation for 18 additional months (total 36-months). If the above leave of absence had been started prior to the March payroll cutoff for benefits, the leave period would begin April 1.

Employer-paid continuation of coverage may be available for up to 12 weeks in the event of leave covered under the Family and Medical Leave Act of 1993. Please check with your local payroll office for additional information.

Reduction in Force

For those participating employer groups who do not provide COBRA under this Plan, the following provision will apply:

Coverage for Reduction In Force (RIF) subscribers and their enrolled dependents may be continued on a self-paid basis through the group for up to 12 months from the date of lay-off.

Continuation of Group Coverage—COBRA

For participating employer groups with 20 or more employees (as described by COBRA)

When group coverage is lost because of a "qualifying event" shown below, federal law and regulations require that the participating employer group offer qualified enrollees an election to continue their group coverage for a limited time. (These laws and regulations are referred to in this Plan as "COBRA.") Continued coverage is not automatic. Under COBRA, a qualified enrollee must apply for continued coverage within a certain time period and may also have to pay the subscription charges for it.

If subscriber or any enrolled dependents do not elect COBRA coverage at this time, they may not enroll on the plan at a later date.

The participating employer group must fulfill all of the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the participating employer group, plan sponsor or administrator and to the "group health plan." DDWA is not the COBRA plan administrator, and our actions pertaining to COBRA continuation coverage under the Plan shall not be construed as relieving the participating employer of its responsibility under COBRA. We provide coverage only to the extent that enrollees are entitled to continued coverage under COBRA and only to the extent of the other terms and limitations of the Plan.

The following summary of continued coverage is taken from COBRA. Enrollees' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by the courts and federal regulatory agencies.

Qualifying Events and Length of Coverage

Please contact the participating employer group immediately when one of the qualifying events below occurs. The continuation periods listed extend from the date of the qualifying event.

- The participating employer group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of one of the two qualifying events:
- The subscriber's work hours are reduced.
- The subscriber's employment terminates, except for discharge due to actions defined by the participating employer group as gross misconduct.

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the participating employer group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

COBRA coverage can be extended if an enrollee who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (IASDI) or Title XVI (SSI) or the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination. To be eligible for the extended continuation period, you must give the Group a copy of the determination of disability during the 18-month continuation period and no later than 60 days after you receive the determination.

The participating employer group must offer the covered spouse or children an election to continue coverage for up to 36 months if their coverage is lost because of one of the four qualifying events:

- The subscriber dies.
- The subscriber and spouse divorce.
- The subscriber becomes entitled to Medicare.
- A child loses eligibility for dependent coverage.

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. The extended period will end no later than 36 months from the date of the first qualifying event.

A covered spouse or child is eligible for continued coverage due to a divorce, or a child's loss of dependent eligibility only if the participating employer group is notified no more than 60 days after either the qualifying event date or the date the dependent's coverage ends, whichever is later.

Conditions of Continued Coverage

For continued coverage to become effective, all of the requirements below must be met:

1. You must notify the participating employer group if the "qualifying event" is divorce, or a child's loss of eligibility for dependent coverage.

2. You must elect continued coverage no more than 60 days after either the date coverage was to end because of the qualifying event, or the date of the participating employer group notified you of your right to elect continued coverage, whichever is later.

3. You must send your first subscription charge payment to the participating employer group no more than 45 days after the date you elected continued coverage.

4. Subsequent subscription charges must be paid on a timely basis to the participating employer group.

When Continued Cobra Coverage Ends

Continued coverage will end on the last day for which subscriptions charges have been paid in the monthly period in which the first of the following occurs:

1. The applicable continuation period expires.

2. The next monthly subscription charge is not paid when due or within the grace period.

3. If you have extended COBRA coverage due to disability, it will end if Social Security determines that you are no longer disabled. In this case, coverage terminates at the end of the month that begins at least 30 days after Social Security's decision. For example, if Social Security decides on March 15 that you are not disabled, your coverage would end May 31. You must provide the participating employer group with a copy of the determination within 30 days after the date of the termination.

4. You become covered under another group dental Plan after the date you elect COBRA coverage. If, however, the new Plan contains an exclusion or limitation for your preexisting condition, coverage does not end for this reason until the exclusion or limitation no longer applies.

5. You become entitled to Medicare after the date you elect COBRA coverage.

6. The participating employer group ceases to offer this WEA Select Dental Plan. However, you should contact your participating employer group regarding participation in any other group dental plan offered to your bargaining unit/employee classification.

Coordination of Benefits

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

Note: This Plan will always be considered primary (the plan whose benefits are determined first), except under the following circumstances: 1) orthodontic benefits that are payable on a fee-for-service basis shall be based on the rules below; and 2) if both this Contract and the other Plan have provisions stating they are primary, then see the "Order of Benefit Determination Rules" below to establish the order of benefit payment under the Plans.

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

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

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

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

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

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

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

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

"***Allowable Expense***" except as outlined below, means any health care expense including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary Plan would have paid if it was the primary plan. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the *plan*s is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by two or more *Plan*s that compute their benefit payments on the basis of a relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

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

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

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

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

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

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

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

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

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

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

c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
    I. The *Plan* covering the *Custodial Parent*, first;
    II. The *Plan* covering the spouse of the *Custodial Parent*, second;
    III. The *Plan* covering the non*custodial Parent*, third; and then
    IV. The *Plan* covering the spouse of the non*custodial Parent*, last

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

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

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

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

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

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

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

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

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each *plan* involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

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

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

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

If payments that should have been made under *This Plan* are made by another *Plan*, DDWA has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, DDWA is fully discharged from liability under *This Plan*.

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

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

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

Subrogation

Based on the following legal criteria, subrogation means that if you receive this Plan's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss any money recovered in excess of full compensation must be used to reimburse DDWA. DDWA will prorate any attorneys' fees against the amount owed.

To the extent of any amounts paid by DDWA for a covered person on account of services made necessary by an injury to or condition of his or her person, DDWA shall be subrogated to his or her rights against any third party liable for the injury or condition. DDWA shall, however, not be obligated to pay for such services unless and until the covered person, or someone legally qualified and authorized to act for him or her, agrees to:

- Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
- Repay DDWA those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;
- Cooperate fully with DDWA in asserting its rights under the contract, to supply DDWA with any and all information and execute any and all instruments DDWA reasonably needs for that purpose.

Provided the injured party is in compliance with the above, DDWA will prorate any attorneys' fees incurred in the recovery.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. The exception will be for the completion (within 30 days) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this Plan.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the DDWA hotline for Fraud & Abuse at (800) 211-0359 or (206) 985-5927. You may also want to alert any of the appropriate law enforcement authorities listed:

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

Transfer of Benefits

If you transfer from one school district to another, but maintain continuous coverage under a WEA Select Dental Plan (186/187 or 188), the claim history, maximum and deductible information for you and your dependents will continue, since your coverage is under the WEA/DDWA Plan.

If you transfer from this WEA Select DeltaCare Dental Plan to a WEA Select Dental Care Incentive plan, incentive credit will be given based on Plan utilization under this plan.

- If you transfer from a school district with a non-WEA Select Dental Plan, to a district with a WEA Select Dental Plan, you are a new enrollee on the WEA/DDWA Plan. You and your dependents will be subject to all plan maximums and deductibles, if applicable.

Right of Recovery

DDWA will have the right to recover overpayments or payments obtained through fraud, error, mistake or payments made in excess of the maximum amount necessary to satisfy the intent of the Coordination of Benefits provision of this Plan made to: the enrollee, the provider, other insurers, any service plans, any other organization, or on behalf of an enrollee, or someone who is not eligible to receive benefits.

If reimbursement is not made, such overpayments or payments will be deducted from future payments.

Health Insurance Portability and Accountability Act (HIPAA)

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

The Health Insurance Portability and Accountability Act (HIPAA) requires DDWA to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.deltadentalwa.com/WEA. You may also request a printed copy by calling the DDWA privacy hotline at (206) 985-5963.

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

Employees called to military service have the right to continue dental coverage for up to 24 months by paying the monthly premiums, even if they are employed by groups that are too small to comply with COBRA. USERRA contains other employment-related requirements, including (but not limited to) the employer having to hold the employee's position until he/she returns from service. For further information on this act, please contact your legal counsel or insurance producer.

Conversion Option

If your dental coverage stops because your employment or eligibility ends or the group policy ends, you may apply directly to DDWA to convert your coverage to an individual policy. You must apply within 31 days after termination of your group coverage. The benefits and premium costs may be different from those available under your current plan. There may be a gap in coverage between the date your coverage under your current plan ends and the date that coverage begins under an individual policy.

You may apply for coverage under a DDWA Individual Plan online at www.DeltaDentalWA.com/Individual or by calling (800) 286-1885 to have an application sent to you. Converted policies are subject to certain benefits and limits.

Benefits Covered By Your Plan

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

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

Diagnostic

Covered Dental Benefits

- Diagnostic evaluation for routine or emergency purposes
- X-rays (radiographic images)

Limitations

- Routine evaluation is covered twice in a Benefit Period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is as periodic oral evaluation.
- Limited problem-focused evaluations are covered twice in a Benefit Period.
- Full mouth or panoramic x-ray is limited to one every 3 years and for patients over 3 years of age;
- Bitewing x-rays limited to not more than twice in a Benefit Period;

Preventive

Covered Dental Benefits

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

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period. Additional periodontal maintenance procedures are the patient's responsibility;
    - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Topical application of fluoride is limited to two covered procedures in a benefit period.

- Space maintainers are covered for children through the age of 17.
- Sealants:
    - Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
    - The application of a sealant is a covered dental benefit once in a two-year period per tooth from the date of service.
- Preventive resin restorations:
    - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
    - The application of a preventive resin restoration is a covered dental benefit once in a two-year period per tooth from the date of service.
    - The application of preventive resin restoration is not a paid covered benefit for two years after a sealant or preventive resin restoration on the same tooth from the date of service.

Restorative

Covered Dental Benefits

- Restorations (fillings)
- Stainless steel crowns

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period;
- Crowns are covered once in a five-year period;
- Stainless steel crowns on primary teeth are covered once in a two-year period;
- Resin-based composite crowns on anterior teeth are covered once in a two year period.

Periodontics

Covered Dental Benefits

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

Limitations

- Root planing/subgingival curettage is covered once in a 12-month period;
- Gingival flap procedure - in conjunction with a bone replacement graft is covered once in a three year period.
- Limited occlusal adjustments are covered once in a 12-month period;

- Localized delivery of antimicrobial agents approved by DDWA is limited to two teeth per quadrant, twice per Benefit Period under certain conditions of oral health when performed at the suggested regimen for that therapy;
- Periodontal surgery is covered once in a three-year period;
- Two sites of soft tissue grafting are covered in the same quadrant in a three year period.
- Scaling and root planing must be done a minimum of six weeks and a maximum of six months prior to periodontal surgery or localized delivery of antimicrobial agents;
- One Periodontal Maintenance therapy treatment, specifically periodontal prophylaxis, is covered twice in a Benefit Period and is to be charged at the applicable copayment level. The cost of additional Periodontal Maintenance prophylaxis treatments over twice in a Benefit Period are your responsibility;
- Full mouth debridement is covered once in a three-year period;
- Crown lengthening - hard/soft tissue is covered once in a three year period.

Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period.
- Pulp Vitality Tests are limited to 1 per visit, including multiple teeth.

Prosthodontics

Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Adjustment or repair of an existing prosthetic appliance

Limitations

- Full upper and/or lower dentures and partial upper and/or lower dentures are not to exceed one each in any five-year period and only then if it is unserviceable and cannot be made serviceable;
- Rebase of full upper and/or lower dentures and partial upper and/or lower dentures are not to exceed one each in a 12 month period following initial placement;
- Denture relines are limited to one per denture during any 12 consecutive months except in the case of an immediate denture then a reline is a benefit six months after the initial placement;
- Upper Tissue Conditioning is limited to twice per 3 year period.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that *you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

General Dental Exclusions

1. General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures;
2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;
3. Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the Enrollee by any federal or state or provincial government agency or provided without cost to the Enrollee by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act;
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth;
5. Application of desensitizing agents;
6. Experimental procedures, services or supplies, which include:
   a. Procedures, services or supplies whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
      i) The services are in general use in the dental community in the state of Washington;
      ii) The services are under continued scientific testing and research;
      iii) The services show a demonstrable benefit for a particular dental condition; and
      iv) They are proven to be safe and effective.

      Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
   b. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. 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 Enrollee.
   c. Whenever DDWA makes an adverse determination and delay would jeopardize the Enrollee's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the Enrollee's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).
7. Dental services performed in a hospital and related hospital fees;
8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);
9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;
10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility;
11. Cysts and malignancies;
12. Laboratory examination of tissue specimen;
13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;

14. Accidental injury. 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;
15. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;
16. Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
17. Prophylactic removal of impactions (asymptomatic, nonpathological);
18. Specialist consultations for non-covered benefits;
19. Implant placement or removal, appliance placed on or services associated with implants;
20. Orthodontic treatment which involves therapy for myofunctional problems, TMJ, dysfunctions, or hormonal imbalances causing growth and developmental abnormalities;
21. All other services not specifically included on the patient's Schedule of Benefits and Co-payments;
22. Treatment of fractures and dislocations to the jaw;
23. Dental services received from any dentist other than the assigned PCP, unless expressly authorized in writing by DDWA or as cited under the "Emergency *or Urgent Care*." Section.

Schedule of Benefits and Co-Payments

The services covered under the DeltaCare Dental Plan are listed in the following schedule and are effective January 1, 2015. These co-payments are your total price, including lab work. All coverage is subject to the exclusions and limitations set forth in the benefit descriptions and exclusions.

Code	Procedure	Patient Co-Pay
	Diagnostic & Preventive	
D0120	Periodic oral examination – established patient	$ 0
D0140	Limited oral evaluation, problem focused	$ 15
D0145	Oral evaluation for patient under age 3 & counseling w/ primary caregiver	$ 0
D0150	Comprehensive oral evaluation -– new or established patient	$ 0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$ 0
D0170	Re-evaluation limited, problem focused	$ 0
D0180	Comprehensive periodontal evaluation – new or established patient	$ 0
D0210	Intraoral-complete series (including bitewings)	$ 0
D0220	Intraoral - periapical-first radiographic image	$ 0
D0230	Intraoral – periapical each additional radiographic image	$ 0
D0240	Intraoral – occlusal radiographic image	$ 0
D0270	Bitewing – single radiographic image	$ 0
D0272	Bitewings-two radiographic images	$ 0
D0273	Bitewings-three radiographic images	$ 0
D0274	Bitewings-four radiographic images	$ 0
D0330	Panoramic radiographic image	$ 0
D0460	Pulp vitality tests	$ 0
D1110	Prophylaxis-adult	$ 0
D1120	Prophylaxis-child	$ 0
D1206	Topical application of fluoride varnish	$ 0
D1208	Topical application of fluoride – excluding varnish	$ 0
D1330	Oral hygiene instruction	$ 0
D1351	Sealant-per tooth	$ 5
D1352	Preventive Resin Restoration – per tooth	$ 5
D1353	Sealant Repair – per tooth	$ 5
D1510	Space maintainer-fixed-unilateral	$ 24
D1515	Space maintainer-fixed-bilateral	$ 34
D1520	Space maintainer-removable-unilateral	$ 25
D1525	Space maintainer-removable-bilateral	$ 32
D1550	Recement or rebond of space maintainer	$ 0
D1555	Removal of fixed space maintainer	$ 0
	Restorative	
D2140	Amalgam-one surface, primary or permanent	$ 0
D2150	Amalgam-two surfaces, primary or permanent	$ 0
D2160	Amalgam-three surfaces, primary or permanent	$ 0
D2161	Amalgam-four or more surfaces, primary or permanent	$ 0

Code	Procedure	Patient Co-Pay
D2330	Resin-one surface, anterior	$ 0
D2331	Resin-two surfaces, anterior	$ 0
D2332	Resin-three surfaces, anterior	$ 0
D2335	Resin-four or more surfaces or involving incisal angle (anterior)	$ 0
	Crowns	
D2750	Crown-porcelain fused to high noble metal	$ 238
D2751	Crown-porcelain fused to predominantly base metal	$ 212
D2752	Crown-porcelain fused to noble metal	$ 229
D2790	Crown-full cast high noble metal	$ 235
D2791	Crown-full cast predominantly base metal	$ 206
D2792	Crown-full cast noble metal	$ 224
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations	$ 25
D2920	Rcement or rebond crown	$ 17
D2930	Prefabricated stainless steel crown-primary tooth	$ 47
D2931	Prefabricated stainless steel crown – permanent tooth	$ 47
D2932	Prefabricated resin crown	$ 47
D2940	Sedative filling	$ 0
D2950	Core build-up, including any pins, when required	$ 0
D2951	Pin - per tooth	$ 0
D2952	Post and core in addition to crown, indirectly fabricated	$ 49
D2953	Each additional indirectly fabricated post – same tooth	$ 49
D2954	Prefabricated post & core in addition to crown	$ 0
D2957	Each additional prefabricated post – same tooth	$ 0
D2970	Temporary crown (fractured tooth)	$ 0
	Endodontics	
D3110	Pulp cap-direct (excluding final restoration)	$ 0
D3120	Pulp cap-indirect (excluding final restoration)	$ 0
D3220	Therapeutic pulpotomy (excluding final restoration)	$ 0
D3310	Anterior root canal (excluding final restoration)	$ 0
D3320	Bicuspid root canal (excluding final restoration)	$ 0
D3330	Molar root canal (excluding final restoration)	$ 0
D3346	Retreatment of previous root canal therapy - anterior	$ 0
D3347	Retreatment of previous root canal therapy – bicuspid	$ 0
D3348	Retreatment of previous root canal therapy – molar	$ 0
D3410	Apicoectomy - anterior	$ 0
D3421	Apicoectomy bicuspid, first root	$ 0
D3425	Apicoectomy molar, first root	$ 0
D3426	Apicoectomy each additional root	$ 0
D3427	Periradicular surgery without apicoectomy	$ 0
D3428	Bone graft in conjunction with Periradicular surgery – per tooth; first surgical site	$ 0
D3429	Bone graft in conjunction with Periradicular surgery – each additional contiguous tooth in the same surgical site	$ 0

Code	Procedure	Patient Co-Pay
D3430	Retrograde filling – per root	$ 0
D3450	Root amputation-per root	$ 0
D3910	Surgical procedure for isolation of tooth with rubber dam	$ 0
D3920	Hemisection, including root removal	$ 0
	Periodontics	
D4210	Gingivectomy or gingivoplasty - Four or more contiguous teeth or bounded teeth per quadrant	$ 0
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	$ 0
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$ 0
D4240	Gingival flap procedure, including root planing - Four or more contiguous teeth or bounded teeth	$ 0
D4241	Gingival flap procedure, , including root planing - one to three teeth per quadrant	$ 0
D4249	Crown Lengthening	$ 0
D4260	Osseous surgery (including elevation of a full thickness flap entry and closure)-Four or more contiguous teeth or bounded teeth	$ 0
D4261	Osseous surgery (including elevation of a full thickness flap entry and closure)-one to three teeth per quadrant	$ 0
D4263	Bone replacement graft – first site in quadrant,(for use with covered procedure D4240, D4241, D4260, D4261)	$ 0
D4264	Bone replacement graft – each additional site in quadrant, (for use with covered procedure D4240, D4241, D4260, D4261)	$ 0
D4270	Pedicle soft tissue graft procedure	$ 0
		$ 0
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$ 0
D4278	free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$ 0
D4341	Periodontal scaling - Four or more contiguous teeth or bounded teeth per quadrant	$ 0
D4342	Periodontal scaling - one to three teeth per quadrant	$ 0
D4355	Full mouth debridement once in a three-year period	$ 0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$ 0
D4910	Periodontal maintenance procedures (following active therapy)	$ 0
	Prosthodontics, removable	
D5110	Complete upper denture	$ 305
D5120	Complete lower denture	$ 305
D5130	Immediate upper denture	$ 530
D5140	Immediate lower denture	$ 530
D5213	Upper partial-cast metal base with resin saddles (including any conventional clasps, rests, and teeth)	$ 331
D5214	Lower partial-cast metal base with resin saddles (including any conventional clasps, rests, and teeth)	$ 331
D5410	Adjust complete denture – upper	$ 0

Code	Procedure	Patient Co-Pay
D5411	Adjust complete denture – lower	$ 0
D5421	Adjust partial denture – upper	$ 0
D5422	Adjust partial denture – lower	$ 0
D5510	Repair complete denture	$ 26
D5520	Repair teeth complete denture	$ 24
D5610	Repair resin saddle or base	$ 37
D5620	Repair cast framework	$ 47
D5630	Repair or replace broken clasp	$ 47
D5640	Repair broken teeth-per tooth	$ 32
D5650	Add tooth to existing partial denture	$ 42
D5660	Add clasp to existing partial denture	$ 47
D5710	Rebase complete upper denture	$ 121
D5711	Rebase complete lower denture	$ 121
D5720	Rebase maxillary partial denture	$ 121
D5721	Rebase mandibular partial denture	$ 121
D5730	Reline complete upper denture (chairside)	$ 57
D5731	Reline complete lower denture (chairside)	$ 57
D5740	Reline upper partial denture (chairside)	$ 55
D5741	Reline lower partial denture (chairside)	$ 55
D5750	Reline complete upper denture (laboratory)	$ 100
D5751	Reline complete lower denture (laboratory)	$ 100
D5760	Reline upper partial denture (laboratory)	$ 96
D5761	Reline lower partial denture (laboratory)	$ 96
D5850	Tissue conditioning, upper-per denture unit	$ 0
D5851	Tissue conditioning, lower-per denture unit	$ 0
	Prosthodontics, Fixed	
D6210	Pontic-cast high noble metal	$ 231
D6211	Pontic-cast predominantly base metal	$ 202
D6212	Pontic-cast noble metal	$ 222
D6240	Pontic-porcelain fused to high noble metal	$ 233
D6241	Pontic-porcelain fused to predominantly base metal	$ 212
D6242	Pontic-porcelain fused to noble metal	$ 225
D6750	Crown-porcelain fused to high noble metal	$ 238
D6751	Crown-porcelain fused to predominantly base metal	$ 213
D6752	Crown-porcelain fused to noble metal	$ 229
D6930	Recement or rebond fixed partial denture	$ 27
D6940	Stressbreaker	$ 61
D6980	Fixed partial denture repair necessitated by restorative material failure	$ 49
	Oral Surgery	
D7111	Coronal remnants – deciduous tooth (removal)	$ 0
D7140	Extraction, erupted tooth or exposed root	$ 0
D7210	Surgical removal of erupted tooth	$ 0

Code	Procedure	Patient Co-Pay
D7220	Removal of impacted tooth-soft tissue	$ 0
D7230	Removal of impacted tooth-partially bony	$ 0
D7240	Removal of impacted tooth-completely bony	$ 0
D7241	Removal of impacted tooth-completely bony w/complications	$ 0
D7250	Surgical removal of residual tooth	$ 0
D7251	Coronectomy – intentional partial tooth removal	$ 0
D7280	Surgical access of an unerupted tooth	$ 0
D7281	Surgical exposure of tooth to aid eruption	$ 0
D7285	Incisional biopsy of oral tissue-hard	$ 0
D7286	Incisional biopsy of oral tissue-soft	$ 0
D7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces per quadrant	$ 0
D7320	Alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces-per quadrant	$ 0
D7340	Vestibuloplasty	$ 0
D7350	Vestibuloplasty-ridge extension	$ 0
D7471	Removal of lateral exostosis	$ 0
D7472	Removal of torus palantinus	$ 0
D7473	Removal of torus mandibularis	$ 0
D7510	Incision and drainage of abscess-intraoral soft tissue	$ 0
D7960	Frenulectomy	$ 0
D7970	Excision of hyperplastic tissue	$ 0
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain-minor procedures	$ 0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$ 0
D9211	Regional block anesthesia	$ 0
D9212	Trigeminal block anesthesia	$ 0
D9215	Local anesthesia	$ 0
D9310	Consultation – diagnostic service provided by dentist or physician other than practitioner providing treatment.	$ 0
D9440	Office visit after hours	$ 0
D9951	Occlusal adjustment – limited	$ 0
D0125	Failed appointment – per 15 minutes of time	$ 10
	Specialty Services	
00190	Specialist examination	$ 0
D3330	Molar root canal (excluding final restoration)	$ 0
D3410	Apicoectomy/Periradicular surgery-anterior	$ 0
D3421	Apicoectomy bicuspid, first root	$ 0
D3425	Apicoectomy molar, first root	$ 0
D3426	Apicoectomy each additional root	$ 0
D3430	Retrograde filling – per root	$ 0
D3450	Root amputation-per root	$ 0
D3920	Hemisection, including root removal	$ 0

Code	Procedure	Patient Co-Pay
D4240	Gingival flap procedure,(for use with covered procedure D4263, D4264)- Four or more contiguous teeth or bounded teeth	$ 0
D4241	Gingival flap procedure,(for use with covered procedure D4263, D4264)- one to three teeth per quadrant	$ 0
D4249	Crown Lengthening	$ 0
D4260	Osseous surgery (including flap entry and closure)- Four or more contiguous teeth or bounded teeth	$ 0
D4261	Osseous surgery (including flap entry and closure)- one to three teeth per quadrant	$ 0
D4263	Bone replacement graft – first site in quadrant	$ 0
D4264	Bone replacement graft – each additional site in quadrant	$ 0
D4270	Pedicle soft tissue graft procedure	$ 0
D4271	Free soft tissue graft procedure (including donor site)	$ 0
D7220	Removal of impacted tooth-soft tissue	$ 0
D7230	Removal of impacted tooth-partially bony	$ 0
D7240	Removal of impacted tooth-completely bony	$ 0
D7241	Removal of impacted tooth-completely bony w/complications	$ 0
D7250	Surgical removal of residual tooth	$ 0
D7251	Coronectomy – intentional partial tooth removal	$ 0
D7280	Surgical access of an unerupted tooth	$ 0
D7281	Surgical exposure of tooth to aid eruption	$ 0
D7285	Biopsy of oral tissue-hard	$ 0
D7286	Biopsy of oral tissue-soft	$ 0
D7340	Vestibuloplasty	$ 0
D7350	Vestibuloplasty-ridge extension	$ 0
D7471	Removal of lateral exostosis	$ 0
D7472	Removal of torus palantinus	$ 0
D7473	Removal of torus mandibularis	$ 0
D7510	Incision and drainage of abscess-intraoral soft tissue	$ 0
D7960	Frenulectomy	$ 0
D7970	Excision of hyperplastic tissue	$ 0

Claim Review and Appeal

Predetermination of Benefits

Covered dental benefits which are prepaid to your Primary Care Provider are documented in the DeltaCare provider manual and the member's benefit booklet. These procedures do not require predetermination and are considered covered. If the treatment will be provided by a provider other than the assigned PCP, DDWA recommends, and will accept a request for a predetermination of benefits.

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

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

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

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

Urgent Predetermination Requests

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

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the plan provisions.

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

How to contact us

We will accept notice of an Urgent Care Request or Appeal if made by you, your covered dependent, or an authorized representative orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 1-800-650-1583.

Authorized Representative

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

Informal Review

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

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

DDWA will review your claim and make a determination within 30 days of receiving your request. DDWA will send you a written notification of the review decision and information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

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

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

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

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

The decision of the Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action including, but not limited to, civil remedies and review by regulatory agencies. If so, these will be provided to you in the final decision letter.

If You Have a Question Regarding Your Claim:

You may call the DDWA Customer Service Department at (206) 522-2300 or 1-800-554-1907.

WEA Claim Review

In the event the claim appeal is denied, the letter shall also include notice of the WEA claim review process noted below. In addition to the above review by the Appeals Committee, at any point in time after a claim for services rendered has been denied, the patient can appeal the denied claim to the WEA Benefit Services Advisory Board.

The Board shall conduct a hearing at which the participant shall be entitled to present his or her position and any evidence in support thereof, and the Board will determine if additional benefits should be provided, to the extent there are WEA funds available to cover such additional benefits. Thereafter, the Board shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Hewitt at (206) 467-4646.

Furthermore, any costs incurred in connection with claim appeals such as attorney's fees, travel expenses and so forth are not covered, nor will the Board have access to dental information without the written permission of the enrollee.

If after review the matter has not been resolved to the satisfaction of all parties, any person aggrieved thereby may submit the matter to nonbinding mediation conducted pursuant to mediation rules of the American Arbitration Association or the Judicial Arbitration and Mediation Service, or other such organization, as agreed to by both parties. If no agreement is reached between both parties on the desired mediation rules within 15 days, then DDWA will choose from the above services.

Subscriber Rights and Responsibilities

At Delta Dental of Washington our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between Delta Dental of Washington, our subscribers and our participating member dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You have the right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental member / non-member), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your PCP makes a specific referral for specialty care.
- Contact Delta Dental of Washington customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com
- Appeal orally or in writing, decisions or requests regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.

- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To receive the best oral health care possible, it is your responsibility to:

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

Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

Glossary

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

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

Bitewing X-ray — An x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.

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

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

Covered Dental Benefit - Those dental services which are covered under this plan, subject to the limitations set forth in Benefits Covered By Your Plan.

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

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

Emergency Examination — Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

Endodontics — That branch of dentistry which deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

Exclusions — Dental services which are not a contract benefit set forth in Benefit Covered By Your Plan and all other services not specifically included as a Covered Dental Benefit set forth in Benefit Covered By Your Plan.

Fluoride — A substance when topically applied or applied to drinking water is effective in resisting tooth decay.

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

Implant — A graft or insert set firmly onto or deeply into the alveolar area prepared for its insertion. It may support a crown or crowns, a bridge abutment, a partial denture or a complete denture.

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

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

Licensed Professional — means an individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to, denturist, hygienist and radiology technician.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured. Dental services which are subject to restricting conditions set forth in Benefits Covered By Your Plan.

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

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

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

Open Enrollment Period — The annual period in which subscribers can select benefits plans and add or delete eligible dependents.

Palliative Treatment — Services provided for emergency relief of dental pain.

Panorex X-ray — An x-ray system using two points of rotation to obtain a panoramic view of the dental arches.

Periodontics — That branch of dentistry which deals with the prevention and treatment of diseases of the bone and soft tissues surrounding the teeth.

Primary Care Dentist or Primary Care Provider (PCP)— The primary care dentist selected upon enrollment in the DeltaCare Dental Plan provides all necessary dental care and referrals.

Prophylaxis — The control of dental and oral diseases by preventive measures, especially the mechanical cleansing of the teeth.

Prosthodontics — That branch of dentistry which deals with the replacement of missing teeth or oral tissues by artificial means, such as crowns, bridges and dentures.

Restorative — A process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, crown, bridge or denture designed to restore proper dental function.

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

Sealants — A resinous material designed for application to the surfaces of posterior teeth in order to seal the surface irregularities and prevent tooth decay.

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

DDWA, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today we cover more than 50 million people nationwide through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Advancing better oral health — that is what we are all about!

To learn more about DDWA and your benefits, visit our Web site at www.DeltaDentalWA.com/WEA .

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