WEA
WASHINGTON
EDUCATION
ASSOCIATION

SELECT

Dental Care Program

PLAN A

Benefits Booklet

The benefits included in this booklet are
effective November 1, 2016.

DELTA DENTAL

Delta Dental of Washington

Delta Dental PPO℠

Benefit Booklet Insert

Washington Education Association

Delta Dental of Washington, a Delta Dental Plan

Plan No. 00186, 00187

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.

DELTA DENTAL®

Delta Dental of Washington

Benefit Booklet Insert

Group Number: #00186, 00187
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

All Groups

Annual Plan Maximum, The Plan Maximum section within the text has been replaced in its entirety with the following:

Plan Maximum

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

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

Class 1 Diagnostic, Limitations

- Supplementary bitewing X-rays are covered ~~twice~~ three times in a benefit period.
- Routine evaluation is covered ~~twice~~ three times in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered ~~twice~~ three times in a benefit period.

Class I Preventive, Limitations

- Any combination of prophylaxis and periodontal maintenance is covered ~~twice~~ three times in a benefit period.
  - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) *may be* covered up to a total of ~~four~~ five times in a benefit period.
- Topical application of fluoride is limited to ~~two~~ three covered procedures in a benefit period.

Healthy Start for Kids, this benefit has been added to all plans. The Healthy Start for Kids section has been added to the Summary of Benefits section. Additionally, the current Summary of Benefits information has been re-labeled to apply to "All Other Members":

Benefits for Members through Age 14

Healthy Start for Kids Benefit

Your plan includes the Healthy Start for Kids benefit, which covers all Class I, II, and III services at 100% for children through age 14. This benefit covers your child through the end of the month in which he or she turns 15. On the first day of the following month, the child receives the standard benefits listed for "All Other Members".

All Providers

Class I	100%
Class II	100%
Class III	100%
TMJ procedures	50%
Annual Deductible per Child	No Deductible

Plan Maximum

Annual Plan Maximum (for Class I, II, and III)	Unlimited
Lifetime TMJ Maximum	$5,000
Annual TMJ Maximum	$1,000

Please note - The Summary of Benefit section in the current benefit booklet remains unchanged, and now applies only to members age 15 and over. The information provided above has been included in addition to the existing information and applies specifically to members 14 and under.

Group specific changes for Group 00186

Annual Plan Maximum: The Summary of Benefits section for "All Other Members" has been revised to reflect an increased Annual Plan Maximum:

Plan Maximum
The Plan maximum for Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists will not be paid as two separate annual maximums.

Annual Plan Maximum per Person – Delta Dental PPO Dentists	~~$2,000~~ $2,300
Annual Plan Maximum per Person – Non-Delta Dental PPO Dentists	~~$1,750~~ $2,000

Group specific changes for Group 00187

Annual Plan Maximum: The Summary of Benefits section for "All Other Members" has been revised to reflect an increased Annual Plan Maximum:

Plan Maximum
The Plan maximum for Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists will not be paid as two separate annual maximums.

Annual Plan Maximum per Person ..... ~~$1,750~~ $2,000

Plan Administration Changes

All Groups

Benefit Period, Glossary Section

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.

Text Revisions for Clarity and Accuracy – Plan Administration

All Groups

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።

DELTA DENTAL®

Delta Dental of Washington

Language	Tagline	Nondiscrimination Statement
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.
Cambodian (Mon-Khmer)	ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានសំណួរអំពីជានារ៉ាប់រងរបស់អ្នកជាមួយ Delta Dental of Washington អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាននៅក្នុងភាសារបស់អ្នកដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1(800) 554-1907។	សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់អំពីពាក្យសុំ ឬជានារ៉ាប់រងរបស់អ្នកតាមរយៈ Delta Dental of Washington។ សូមយកចិត្តទុកដាក់លើកាលបរិច្ឆេទណាមួយដែលមានក្នុង សេចក្តីជូនដំណឹងនេះ។ អ្នកអាចត្រូវចាត់វិធានការមួយចំនួនមុនថ្ងៃកំណត់ជាក់លាក់ ដើម្បីរក្សាទុកជានារ៉ាប់រងរបស់អ្នក 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.

Language	Tagline	Nondiscrimination Statement
Japanese	ご本人様、またはお客様の身の回りの方でもDelta Dental of Washingtonについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 1(800)554-1907までお電話ください。	この通知には重要な情報が含まれています。この通知にはDelta Dental of Washingtonの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます 1(800)554-1907までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of 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 ຄົນທີທ່ານກຳລັງຊ່ວຍເຫຼືອ, 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. ທ່ານອາດຈະເປັນຕ້ອງໃຊ້ເວລາດຳເນີນການໂດຍກຳນົດ ເວລາທີ່ແນ່ນອນຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວ ສານນີ້ ແລະ ການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1(800)554-1907.

Language	Tagline	Nondiscrimination Statement
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।
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Washington, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1(800)554-1907.	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Delta Dental of Washington. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1(800)554-1907.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1(800)554-1907.	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Delta Dental of Washington. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1(800)554-1907.
Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Delta Dental of Washington, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1(800)554-1907.	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Delta Dental of Washington. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1(800)554-1907.

Language	Tagline	Nondiscrimination Statement
Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Delta Dental of Washington, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1(800)554-1907.	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через Delta Dental of Washington. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1(800)554-1907.
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Washington, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1(800)554-1907.	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Delta Dental of Washington. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1(800)554-1907.

Introduction

Your WEA Select Dental Plan was designed specifically for school district employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Hewitt (Employee Benefits Consultant), and Delta Dental of Washington (Dental Plan Underwriter).

The WEA is the policyholder for this Plan of dental benefits. The WEA retains full and exclusive authority, at its discretion, to determine the availability of this Plan. The Plan is not guaranteed to continue indefinitely. The Plan may be altered or terminated at any time.

All Plan Benefits and Limitations are reviewed by the WEA Benefits Services Advisory Board and approved by the WEA Board of Directors. Your suggestions for Plan improvements are always welcome and may be forwarded to the WEA or Aon Hewitt.

In order to understand how your benefits are paid, it is suggested that you review this booklet at the time of enrollment. As dental expenses are incurred, you may wish to review the section that applies to those specific types of expenses.

Questions Regarding Your Plan

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

Delta Dental of Washington Customer Service
(800) 554-1907

Written inquiries may be sent to:

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

You can also reach us by e-mail at **info@DeltaDentalWA.com.**

For the most current listing of Delta Dental participating dentists, visit our online directory at www.DeltaDentalWA.com or by calling us at 1-800-554-1907.

Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

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

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

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) *or* 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial Delta Dental of Washington Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the Delta Dental of Washington customer service representative.

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

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Summary of Benefits

Reimbursement Levels for Allowable Benefits

Delta Dental PPO Dentists

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

Non-Delta Dental PPO Dentists

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

Plan Maximum

The Plan maximum for Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists will not be paid as two separate annual maximums.

Annual Plan Maximum per Person – Delta Dental PPO Dentists	$2,000
Annual Plan Maximum per Person – Non-Delta Dental PPO Dentists	$1,750
Lifetime TMJ Maximum	$5,000
Annual TMJ Maximum	$1,000

The payment level for covered dental expenses arising as a direct result of an accidental bodily injury is 100 percent, up to the unused Plan maximum.

All enrolled employees and enrolled dependents are eligible for Class I, Class II, Class III covered dental benefits, temporomandibular joint (TMJ) benefits and dental accident benefits.

Introduction
Welcome to the Delta Dental PPO 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. 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 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 (800) 554-1907. Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.

Choosing a Dentist
With DDWA, you may select any licensed dentist; however, your benefits may be paid at a higher level and your out-of-pocket expenses may be lower if you choose a participating Delta Dental dentist. Tell your dentist that you are covered by a DDWA dental Plan and provide your identification number, the Plan name and the group number.

Delta Dental Participating Dentists
If you select a dentist who is a Delta Dental participating provider, that dentist has agreed to provide treatment for Enrollees covered by DDWA plans. You will not have to hassle with sending in claim forms. Participating dentists complete claim forms and submit them directly to DDWA. Payment will be based on the pre-approved fees your dentist has filed with the local Delta Dental plan and will be sent directly to the dentist from DDWA. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan maximum and for any elective care you choose to receive outside the covered dental benefits. You will not be charged more than the participating dentist's approved fee or the fee that the Delta Dental dentist has filed with us.

Delta Dental Premier® Dentists (non-PPO)
The Premier network is Delta Dental's largest network of dentists. More than 87% of dentists in Washington are part of the Premier network (based on analysis of Delta Dental of Washington claims data as of February, 2015).

Delta Dental PPO Dentists
PPO dentists must be Delta Dental Premier® dentists in order to participate in the PPO network. Typically, PPO dentists have lower filed fees, thereby lowering your out-of-pocket costs. Also, by using a PPO dentist you will receive a higher annual plan maximum (see the "plan maximum" section for more details).

Nonparticipating Dentists
If you select a dentist who is not a Delta Dental participating dentist, you are responsible for having your dentist complete and sign an appropriate claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You may also download a claim form from our website at www.DeltaDentalWA.com/WEA. It is up to you to ensure that the claim is sent to DDWA. Payment by DDWA to nonparticipating dentist for services will be based on the dentist's actual charges or DDWA's maximum allowable fees for nonparticipating dentists in the state in which the services are performed, whichever is less. You will be responsible for any balance remaining. Please be aware that DDWA has no control over nonparticipating dentists' charges or billing practices.

Finding a Dentist
You can find the most current listing of participating dentists within the state of Washington by going online to the Delta Dental of Washington website at www.DeltaDentalWA.com. Click on the *Patients* tab and enter your information in the *Find a Dentist* fields and select *Find Dentists* to begin your search. Be sure to click on the *Delta Dental PPO Plan* to filter your search results.

Claim Forms
American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our website at www.DeltaDentalWA.com.

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

Information Needed For Claim Submission
1. Employee's Identification Number
2. Patient's name and birthdate
3. Name of Plan (WEA Plan #186)
4. Name of Employer (School District)

Note: Possession of this booklet is not proof of eligibility. Terms and conditions are set forth in a contract between the Washington Education Association and Delta Dental of Washington which is on file with the WEA Benefit Services Division.

Estimate Request
If you would like an estimate of your benefits and costs before treatment, you may ask your dentist to complete and submit a request for an estimate, 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.

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

Limitations and Exclusions
Dental plans typically include limitations and exclusions, meaning that the plans do not cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this benefit booklet under the sections called "Benefits Covered by Your Plan", "General Limitations" and "General Exclusions." They warrant careful reading.

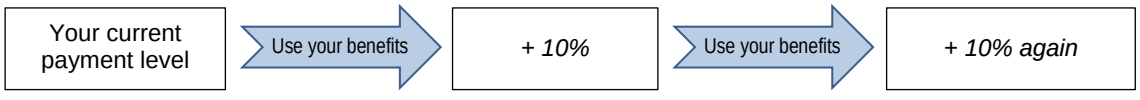
Plan Deductible
This Plan does not have a deductible requirement.

Coinsurance
DDWA will pay a predetermined percentage of the cost of your treatment (see "Reimbursement Levels" below) and you are responsible for paying the balance. What you pay is called the coinsurance.

Reimbursement Levels
Your Plan is an incentive plan. It is designed to encourage prevention by rewarding you for receiving preventive care and other dental services during each incentive period. An incentive period consists of this 12-month period beginning on the first day of November and ending on the last day of October each year.

Your dental Plan offers three classes of covered treatment: Class I – Diagnostic and Preventive; Class II – Basic; Class III – Major.

Reimbursement Levels for Class I and Class II Procedures
The original payment level for covered and allowable Class I (diagnostic and preventive) and Class II (basic) procedures for the first incentive period is set at the minimum payment level, 70%. This payment level increases 10 percentage points each successive incentive period in which you receive dental care, up to the maximum incentive level, 100%. Once you reach your maximum level, the plan will stay at the maximum level if you receive dental care during each consecutive incentive period.



If you fail to receive dental care during an incentive period, the payment level will be decreased by 10 percentage points from the level you were at when you last used your benefits. An additional 10 percentage point decrease will happen for each successive incentive period during which you did not receive dental care until you reach the minimum payment level.

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

Reimbursement Levels for Class III Procedures

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

Reimbursement Levels for Other Procedures

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

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

Plan Maximum

For your plan, the maximum amount payable by DDWA for Class I, II and III covered dental benefits (including Accidental Injury benefits) per Enrollee each benefit period is based on the provider's participation with Delta Dental. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the Plan maximum based on the incurred date.

Delta Dental PPO Dentists.....$2,000.00

Non-Delta Dental PPO Dentists $1,750.00

The Plan maximum for Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists will not be paid as two separate annual maximums. The applicable plan maximum will be determined based on the provider's participation with Delta Dental when claims are processed.

The lifetime maximum amount payable by DDWA for TMJ benefits is $5,000 per eligible person, with a benefit period maximum of $1,000 per eligible person.

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, incentive level (if transferring from one incentive Plan to another), maximum and deductible information for you and your dependents will continue, since your coverage is under the WEA/DDWA 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, and your incentive level will begin at 70%. You and your dependents will be subject to all Plan maximums and deductibles, if applicable.

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

Your 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.

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.”

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.

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

A child will be considered an Eligible Dependent as an adopted child if the following conditions are met: 1) the child has been placed with the Eligible Employee for the purpose of adoption under the laws of the state in which they reside; and 2) the Eligible Employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. If premium is required, notification of placement of a child for adoption and payment of any additional required monthly dues must be furnished to DDWA within 60 days from the date of placement.

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 must have been awarded in accordance with the laws of the state in which the guardianship/non-parental custody is 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.
- The guardian/person with non-parental custody must be either the subscriber or the subscriber's spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same Plan.
- The child must be under age 26.

A child eligible under a court order award is no longer eligible at the expiration or termination of the court order.

When the enrollment process for an eligible child covered under legal guardianship (legal wards) or under a legal non-parental custody decree is completed within 60 days of the date of the decree, coverage required under the decree will be effective on the date of the decree. If enrollment is not completed within 60 days, the child may not be enrolled until the next open enrollment period, with the exception of conditions described under “Loss of Other Coverage” below.

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 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 Employer Unit’s other plan may transfer to this plan during the Participating Employer Unit’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.

Extension of Benefits

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) 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) 554-1907. 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 1 (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.

Self-Payment Provisions

Labor Dispute

If compensation is suspended directly or indirectly as a result of strike, or lockout or other labor dispute, subscription charges may be paid for yourself and your Eligible Dependents directly to the employer for up to six months. This period of coverage will not extend any other period of continued coverage provided by your Plan.

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

Continuation 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 COBRA (see below). 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 Enrolled 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 Units 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.

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.

Continuation of Coverage — "COBRA"

For Participating Employer Unit 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 Unit 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 Unit must fulfill all of the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the Participating Employer Unit, 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 this 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 this 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

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 Unit 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 Unit 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 Unit 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 Unit 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 Unitno 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 Unit.

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 Unit 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.

The Participating Employer Unit ceases to offer this WEA Select Dental Plan. However, you should contact your Participating Employer Unit 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.

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

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

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

Order of Benefit Determination Rules: When you are covered by 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: The Company has the right to recover excess payment whenever it has paid *Allowable Expense*s in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plan*s.

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.

MySmile® Personal Benefits Center

The MySmile® personal benefits center, available on Delta Dental of Washington's website at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your Plan network, review your recent dental activity, check details of your Plan coverage, view and print your ID card, check the status of current claims, and more.

For your convenience, your DDWA dental benefits ID card can be found — and printed — directly from the middle of your MySmile personal benefits center portal page.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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 dates 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.

Necessary vs. Not Covered Treatment

You and your provider should discuss which services may not be covered dental benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your plan. However, there are certain treatments that remain the responsibility of the patient.

Benefits Covered By Your Plan

The following are the covered dental benefits under this Plan and are subject to the limitations and exclusions (refer also to *"General Limitations and General 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. To determine Covered Dental Benefits for certain treatments, DDWA may require an Enrolled Person to obtain an independent examination from a DDWA-appointed Dentist. DDWA will pay all of the charges incurred for this examination.***

The amounts payable by DDWA for covered dental benefits are described on your Summary of Benefits section of this benefit booklet.

Class I Benefits

70-100% Incentive Level

Class I Diagnostic

Covered Dental Benefits

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

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- A complete series or a panoramic X-ray is covered once in a three-year period from the date of service.
  - Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.
- Supplementary bitewing X-rays are covered twice in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits. See *"Temporomandibular Joint Benefits"* section.

Exclusions

- Consultations
- Study models

Class I Preventive

Covered Dental Benefits

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

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period.
  - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) *may be* covered up to a total of four times in a benefit period.

Note: ***These 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. See "Predetermination of Benefits" for additional information.***

- Topical application of fluoride is limited to two covered procedures in a benefit period.
- Sealants:

- Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.

- Preventive resin restorations:
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 17.

Exclusions

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

Class I Periodontics

Covered Dental Benefits

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

Limitations

- Prescription-strength fluoride toothpaste and antimicrobial rinse are covered dental benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's DDWA history must show a periodontal procedure within the previous 180 days.
- Antimicrobial rinse may be dispensed once per course of periodontal treatment. (A course of treatment may include several visits).
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

Class II Benefits

70-100% Incentive Level

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

Class II Sedation

Covered Dental Benefits

- General anesthesia when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- Intravenous sedation when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III, TMJ or optional Orthodontic (please check with your district's benefits department for orthodontic coverage information) covered dental benefits.
- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- General anesthesia or intravenous sedation for routine postoperative procedures is not a paid covered benefit.

Class II Palliative Treatment

Covered Dental Benefits

- Palliative (emergency) treatment for pain

Limitations

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

Class II Restorative

Covered Dental Benefits

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

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being the responsibility of the covered person.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Stainless steel crowns are covered once in a two-year period from the seat date.
- If a tooth can be restored with a filling material such as Amalgam or resin-based composites, an allowance will be made for such a procedure towards the cost of any other type of restoration that may be provided.
- Payment for a crown, inlay, veneer or onlay shall be based upon the seat date.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing and there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- A crown buildup or a post and core are covered once in a two-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within two years of a restoration on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth, whether or not a removable partial denture is part of the treatment.
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations without overt pathology is not a paid covered benefit.

Exclusions

- Overhang removal
- Copings
- Re-contouring or polishing of restoration

Class II Oral Surgery

Covered Dental Benefits

- Major and minor oral surgery which includes the following general categories:
  - Removal of teeth
  - Preprosthetic surgery
  - Orthognathic surgery
  - Treatment of pathological conditions
  - Temporomandibular joint abnormalities
  - Traumatic facial injuries
  - Ridge extension for insertion of dentures (vestibuloplasty)
- Refer to "Class II Sedation" for Sedation information.

Exclusions

- Iliac crest or rib grafts to alveolar ridges
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling (e.g., bone grafts)

Class II 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
- Refer to *"Class I Preventive"* for periodontal maintenance benefits.
- Refer to *"Class II Sedation*" for Sedation information.
- Refer to *"Class III Periodontics"* for occlusal equilibration and occlusal guard.

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

Limitations

- Periodontal scaling/root planing is covered once in a three-year period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
  - Periodontal surgery must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Soft tissue grafts (per site) for implants and natural teeth are covered once in a three-year period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.

- Localized delivery of antimicrobial agents is a covered dental benefit under certain conditions of oral health.
  - Localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
  - Localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
  - Localized Delivery of Antimicrobial Agents is not a paid covered benefit when used for the purpose of maintaining non-covered dental procedures.

Class II Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy
- Refer to “Class II Sedation” for Sedation information.

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a dentist other than the dentist who performed the original treatment and if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions

- Bleaching of teeth
- Pulp Cap

Class III Benefits

50% Payment Level

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

Class III Periodontics

Covered Dental Benefits

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

  Note: ***Complete occlusal equilibration is 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. See “Predetermination of Benefits” for additional information.***

Limitations

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

Class III Prosthodontics

Covered Dental Benefits

- Full and immediate dentures
- Removable and fixed partial dentures
- Inlays when used as a retainer for a fixed partial denture

- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing prosthetic appliance is covered once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Fixed prosthodontics for children less than 16 years of age are not a paid covered benefit.
- Payment for dentures, fixed partial dentures; inlays (only when used as a retainer for a fixed partial denture) and removable partial dentures shall be paid upon the delivery date.
- Replacement of implants is covered only after five years have elapsed from any prior provision of the Implant.
- Crowns in conjunction with overdentures are not a paid covered benefit.
- **Temporary dentures** — DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
    - Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.
- **Full and immediate dentures** — DDWA will allow the appropriate amount for a full or immediate denture toward the cost of an elective procedure such as a personalized restoration, or a specialized treatment.
- **Denture adjustments and relines —** Denture adjustments, relines, repairs and rebases done more than six months after the initial placement are covered.
    - Subsequent adjustments and repairs are covered.
    - Subsequent relines or rebases will be covered once in a 12-month period
    - An adjustment or reline performed more than 6 months after a rebase will be covered.

Exclusions

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance
- Copings
- Crowns in conjunction with overdentures are not a paid covered benefit.
- Porcelain and resin inlay bridges

Temporomandibular Joint Benefits

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

“Dental Services” are those that are:

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

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

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

The maximum amount payable by DDWA for dental services related to the treatment of TMJ disorders shall be $1,000 per Enrollee in any benefit period, after the application of deductibles, if applicable and coinsurance, and a lifetime maximum benefit of $5,000 per Enrollee. The amounts payable for TMJ benefits during the benefit period shall not be applied to the Enrollee's annual Plan maximum.

It is strongly suggested that a TMJ treatment Plan be submitted to, and a predetermination be made by, DDWA prior to commencement of treatment. A predetermination is not a guarantee of payment. See "Predetermination of Benefits" for additional information.

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

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

Well Baby Checkups

For your infant child, Delta Dental of Washington offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental Plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of services. When visiting a participating physician with your infant (age 0-3), DDWA will reimburse the physician on your behalf for specific services performed, up to the amount listed below:

- Oral Evaluation: Reimbursed up to $43
- Topical application of fluoride: Reimbursed up to $36

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

Accidental Injury

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II and Class III covered dental benefit expenses arising as a direct result of an accidental injury. However, payment for accidental injury claims will not exceed the unused Plan maximum. The accidental bodily injury must have occurred while the Enrollee was covered under this Plan. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

General Limitations

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.

General Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal or state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
2. Application of desensitizing agents

3. Experimental services or supplies, which include:
    a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
        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 covered person.
    c. Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).
4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections
5. Prescription drugs
6. In the event a covered person fails to obtain a required examination from a DDWA -appointed independent dentist for certain treatments, no benefits shall be provided for such treatment.
7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment
8. Broken appointments
9. Behavior management
10. Completing claim forms
11. Habit-breaking appliances
12. Orthodontic services or supplies (unless offered by your district)
13. This Plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this Plan as covered dental benefits.

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

Frequently Asked Questions about Your Dental Benefits

What is a Delta Dental “participating dentist”?

A Delta Dental participating dentist is a dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to subscribers and their dependents covered by DDWA’s group dental care plans. Delta Dental participating dentists submit claims directly to DDWA for their patients, and cannot charge more than their filed fees with DDWA.

Can I choose my own dentist?

Yes, this plan will pay for covered dental benefits by any licensed dental provider. However, your out-of-pocket costs may be lower if you receive benefits from a Delta Dental participating dentist. Please see "Choosing a Dentist" for more information.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your dentist. You can also obtain a copy of the approved claim form from our website at www.DeltaDentalWa.com. **Note**: If your dentist is a Delta Dental participating provider, he or she will complete and submit claim forms for you.

What is the mailing address for DDWA claim forms?

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

Who do I call if I have questions about my dental Plan benefits?

If you have questions about your dental benefits, call DDWA's customer service department toll-free at (800) 554-1907. Questions can also be addressed via e-mail at cservice@DeltaDentalWa.com.

Does DDWA pay less for tooth-colored fillings on my back teeth?

Tooth-colored fillings, or fillings made of resin-based composite, are considered to be cosmetic. Dental amalgams, or what we normally think of as silver fillings, are less expensive and clinically equivalent to resin-based composite. Because of this, your Plan reimburses your dentist for amalgam fillings in back (posterior) teeth. DDWA does cover composite filings in the front (anterior) teeth. If you have questions about this, feel free to discuss them with your dentist.

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

You are not required to get an estimate, called a "predetermination of benefits", in order for services to be covered. However, it is highly recommended that you do so for any extensive procedures. The estimates provided do not represent a guarantee of payment, but they will let you know if the planned procedure is a covered benefit and what your estimated out-of-pocket expenses will be.

What is Delta Dental?

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

Claim Review and Appeal

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. It 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 Grievance or Appeal if made by you, your covered dependent, or an authorized representative of your covered dependent orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 1-800-554-1907.

Authorized Representative

You may authorize another person to represent you or your child and receive communications from DDWA regarding your specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, 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 make a written request 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 submitted with your informal review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

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

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

If You Have a Question Regarding Your Claim:

You may call the DDWA Customer Service Department at 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.

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.

Your Rights and Responsibilities

At DDWA our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between DDWA, our subscribers and our participating 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/nonmember), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact DDWA customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at DeltaDentalWA.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

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

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 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 that you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to DDWA to assist with the processing of claims, 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 that projects from the upper and lower jaw and supports the roots of the teeth.

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

Apicoectomy — Surgery on the root of a tooth.

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.

Benefit Period — Most dental benefits are calculated within a "benefit period," which is typically for one year. For this Plan, this is the period beginning November 1 and ending October 31.

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

Bridge — Also known as a fixed partial denture. See Fixed Partial Denture.

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

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

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

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

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

Covered Dental Benefits — Those dental services that are covered under this 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.

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

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

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

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

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

Dentist — A licensed dentist legally authorized to practice dentistry at the time and in the place services are performed. This Contract provides for covered services only if those services are performed by or under direction of a licensed Dentist or other DDWA-approved Licensed Professional. A Dentist does not mean a dental mechanic or any other type of dental technician.

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

Eligible Dependent — Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in the “Who is Eligible” section.

Eligible Employee — Any employee who meets the conditions of eligibility set forth in the “Who is Eligible” section.

Eligible Person — An Eligible Employee or an Eligible Dependent.

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

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

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

Enrolled Dependent, Enrolled Employee, Enrollee — Any Eligible Dependent, or Eligible Employee, as applicable, who has completed the enrollment process and for whom the Participating Employer Unit has submitted the monthly Premium to DDWA.

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

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

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

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

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

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

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

Group –The Washington Education Association (WEA), which has entered into a Contract with DDWA for the purpose of making this prepaid dental care program available to its members and other Eligible Employees of Participating Employer Units as defined in the Contract.

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

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

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

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

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

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

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

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

Nightguard — See “Occlusal Guard.”

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

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

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

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

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

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

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

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

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

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

Participating Employer Unit — A bargaining unit or other bona fide employee classification of an Eligible Employer or school district which has elected to offer the WEA Select Dental Plans to all of its Eligible Employees.

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

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

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

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

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

Premium — The monthly amount payable to DDWA by the Participating Employer Unit.

Prophylaxis — Cleaning and polishing of teeth.

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

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

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

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

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

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

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

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

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

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

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

Delta Dental of Washington, 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 website at www.DeltaDentalWA.com.

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