DELTA DENTAL® Delta Dental of Washington

Plan Overview

Delta Dental Individual and Family – Basic Family Plan

This Plan Overview page is issued and delivered in the state of Washington and is governed by Washington State laws. It tells you important information about this Plan, which provides dental benefits to you and your dependents, and is subject to the terms set forth in the policy.

Understand your plan

This is your Plan Overview Page. It shows your costs for this plan, and how much we pay for your treatment. ***But this only tells you part of the story****. While this plan overview shows you the types of treatment we cover, it does not list specific procedures. For that, you need to look in your benefits book. That is where you will see which procedures are covered and which are not.*

Plan Information	
Contract Term:	The effective date of this policy is 12:01 a.m. Pacific Time on the first day of December, 2021 at Seattle, Washington and it runs through December 31, 2021.
Benefit Period:	This is when your coverage begins and ends. Your benefit period is December 2021 – December 31, 2021.

	Pediatric Members Members 18 years of age and under	Adult Members Members 19 years of age and older
Maximum Benefit:	No Annual Maximum	$1,250 Annual Plan Maximum $1,000 Annual TMJ Maximum $5,000 Lifetime TMJ Maximum
Plan Deductible:	$85 per child per year	$50 per adult per year
Out of Pocket Maximum:*	$350 per child per year to a maximum of $700 per year for families with 2 or more children	NA
Premium:	Single $45.51 Single + Spouse $91.04 Single + Child(ren) $101.22 Family $160.96	

Adult Benefits	
Covered Dental Benefits	**Amount of Maximum Allowable Fee DDWA Pays:****
Class I: Diagnostic and Preventive Services	100% - without having to meet your deductible
Class II: Sedation and Palliative Treatment, Restorative Services, Oral Surgery, Periodontics and Endodontics	50% - after meeting your deductible
Class III: Restorative Services (Crowns), Periodontics, Prosthodontics, Implants and Temporomandibular Joint Benefits	50% - after meeting your deductible
Accidental Injury	100% - without having to meet your deductible

Pediatric Benefits	
Covered Dental Benefits	**Amount of Maximum Allowable Fee DDWA Pays:****
Diagnostic and Preventive Services, and Accidental Injury	100% - without having to meet your deductible
Adjunctive and Restorative Services, Oral Surgery, Periodontics, and Endodontics	70% - after meeting your deductible
Crowns and Prosthodontics	50% - after meeting your deductible
Medically Necessary Orthodontia	50% - without having to meet your deductible

* Only fees paid to a Delta Dental PPO or a Delta Dental Premier Dentist accrue to the annual out-of-pocket maximum

** DDWA has no control over the charges or billing practices of dentists who do not contract with Delta Dental. Our payments for services performed by these dentists will be based on actual charges or DDWA's maximum allowable fees for non-participating dentists, whichever is less. You will be responsible for any balance remaining.

DELTA DENTAL

Delta Dental of Washington

Delta Dental Individual and Family – Basic Family Plan

Benefit Booklet

Your all-in-one-guide to making the most out of your dental benefits.



You have 10 days to decide if you want to keep this plan. If you are not satisfied with this plan after reading through this booklet and your plan Overview Page, you can cancel it anytime within 10 days of the date you received these materials by notifying us at 800-526-8323, or returning your Policy to Delta Dental of Washington or your Producer. We will void the policy and refund your money, less any payment we made for your dentist bills. If we do not refund your money within 30 days after you cancel, we will pay you an additional 10% of the refunded amount.

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Bright Ideas

Regular dental care, from cleanings to crowns, are essential to your smile's health. Fortunately, you have a great service plan—your dental coverage. This section highlights key features built into your coverage and helpful tips to make your dental visits easy - and more affordable.

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Important Details

Remember that your plan is a contract between you and us. This section gives you more information about our obligations to you, and your obligations to us.

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Who We Are

Delta Dental of Washington (referenced here simply as DDWA) is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from DDWA, you join more than 80 million people across the nation who have discovered the value of our coverage.

This document is your policy, which is a contract, and includes the Plan Overview Page. Please hold onto this document, it has answers to many questions about your dental coverage including eligibility, enrollment, changes to enrollment, benefits and claims administration.

The application you filled out is also part of this policy. If any part of the application is wrong, please notify DDWA. Wrong information may affect your family's coverage. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind this policy. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits.

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

Thank you for choosing our Delta Dental Individual and Family – Basic Family Plan for your family. We hope you will take a few minutes to get familiar with this benefit booklet. We set it up so you will have all the information you need right at your fingertips. If you ever need help beyond this booklet, call us at 800-526-8323, or visit our website www.DeltaDentalWA.com.

This is a family plan. This plan includes two different sets of benefits in one plan – adult benefits and pediatric (kids) benefits. Children through age 18 qualify for pediatric benefits. After your child turns 19, they will move to the adult benefits. They can be your dependent on this plan up to age 26.

Pediatric Benefits



Children 0-18 years of age

Adult Benefits



Adults 19 years of age and up

Smile, you are covered.

Covered Dental Benefits



Adult Benefits

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

Adult - Class I Diagnostic Services — Covered at 100%

Diagnostic services help your dentist determine the health of your mouth. We pay 100% of the allowable expense for these services and you do not have to pay your deductible before we pay.

- Routine diagnostic oral exams
  - Enrolled family members are covered for two routine exams per benefit period. Routine exams are not as in-depth as comprehensive oral exams.
- Comprehensive oral exams
  - You are covered for only one comprehensive oral exam per dentist for the entire time you are on this plan. If you change dentists, you are covered for a new comprehensive oral exam. After that, if your dentist wants to do more comprehensive oral exams, we will cover additional exams at the same rate as a routine check-up, and you would be responsible for any additional costs.
- Second opinions
  - Second opinions are when you request another dentist to review the treatment diagnosis or treatment plan of your dentist before treatment is done.
  - A second opinion is paid as a limited oral evaluation however, there are no limitations on the number of second opinions you can have.
- Limited or problem-focused oral exams
  - Limited exams are covered two times per benefit period. They cannot be part of any other oral exam, and must be performed by a licensed dentist or dental hygienist.
- Emergency exams
- X-rays
  - One bitewing x-ray for each quadrant per benefit period.
  - Complete series or panoramic x-ray are covered once every five years.
  - If x-rays are taken as part of a complete series of x-rays for a procedure, a complete series will not be covered again for a different procedure until the five-year period has passed.

These diagnostic services are not covered

- Diagnostic services and x-rays related to treatment of temporomandibular joints (the hinge part of your jaw). See the "Adult Temporomandibular Joint Benefits" section for information on this benefit.
- Consultations by a dentist other than the requesting dentist.
- Study models.

Covered Dental Benefits

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

Limited oral exams are visits for dental problems or oral health complaints; dental emergencies; or referrals for other treatment.

Adult Class I Preventive Services — Covered at 100%

Preventive services help keep your teeth healthy by preventing tooth decay and gum disease. Good preventive practices — such as visiting the dentist twice a year, brushing twice a day and flossing — can mean fewer serious dental problems. We pay 100% of the allowable expense for these services and you do not have to pay your deductible before we pay.

- **Prophylaxis (cleaning)**
  - Any combination of prophylaxis or periodontal maintenance is covered twice in a benefit period.
  - Additional prophylaxis or periodontal maintenance is covered (up to four treatments combined) if your gums have pocket depth readings of 5mm or greater.
- **Periodontal (gum) maintenance**
  - Periodontal (gum) maintenance is covered only if you have completed active periodontal treatment.
  - Any combination of prophylaxis or periodontal maintenance is covered twice in a benefit period.
  - Additional prophylaxis or periodontal maintenance is covered (up to four treatments combined) if your gums have pocket depth readings of 5mm or greater.
- **Sealants**
  - Covered for posterior teeth that have no restorations (includes preventive resin restorations) on the biting surface.
  - Covered every two years (from treatment date) per tooth.
- **Topical application of fluoride**
  - Fluoride treatments including fluoridated varnish.
  - Fluoride treatments are covered two times in a benefit period.
- **Preventive resin restoration**
  - Preventive resin restorations are covered only on permanent molars with no restorations on the biting surface.
  - Preventive resin restorations are not covered for two years after a sealant or preventive resin restoration is put on the same tooth.
- **Prescription-strength fluoride toothpaste**
  - Covered following periodontal surgery or other covered periodontal procedures.
  - Must be provided by the dental office.

- Proof of a periodontal procedure must accompany the claim or the patient's history with DDWA must show a periodontal procedure within the previous 180 days.

➢ Prescription-strength antimicrobial rinses
- Covered following periodontal surgery or other covered periodontal procedures.
- Proof of a periodontal procedure must accompany the claim or the patient's history with DDWA must show a periodontal procedure within the previous 180 days.
- Antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

These preventive services are not covered

➢ Plaque control program which include oral hygiene instruction, dietary instruction and home fluoride kits.

Adult Class II Sedation and Palliative Treatment — Covered at 50%

Sedation plays a supporting role in your treatment, and palliative treatment is treatment to lessen pain from an oral condition. We pay 50% of the allowable expense for these services after you pay your deductible.

➢ Intravenous moderate sedation
- Covered when you are having endodontic, periodontic and oral surgery services that are covered by your plan.
- Sedation, which is either General Anesthesia or Intravenous Sedation, is a Covered Dental Benefit only once per day.

➢ General anesthesia
- Covered for certain endodontic, periodontic, oral surgery, and implant surgery procedures that are covered by your plan when medically necessary.
- Covered for physically or developmentally disabled persons when medically necessary for services covered by your plan.

➢ Pain relief
- Services needed after oral surgery, called post-operative care and treatment, are considered part of the surgery and not covered separately.
- Treatment for complications after surgery are considered part of the surgery and are included in the cost of surgery charged by your provider. Additional costs for this treatment are not billable separately by your provider if done within 30 days of the surgery.

These sedation and palliative services are not covered

➢ General anesthesia or intravenous sedation for routine procedures except as stated above.

Adult Class II Restorative Services — Covered at 50%

Fillings and treatment for cavities. We pay 50% of the allowable expense for these services after you pay your deductible.

➢ Fillings

- The same surface on the same tooth once every two years, in the following cases:
  - decay is visible on the tooth,
  - a fracture (crack) has caused the loss of a significant part of a tooth cusp, or, a fracture causes significant damage to an existing filing.
- Fillings for anything other than decay or fracture are not covered.

➢ Stainless steel crowns
- Once per tooth every two years.

These restorative services are not covered

➢ Recontouring or polishing fillings.

➢ Overhang removal.

➢ Copings.

Adult Class II Oral Surgery — Covered at 50%

Oral surgery includes many common procedures that happen at the dentist's office such as removing teeth and treating diseases. We pay 50% of the allowable expense for these services after you pay your deductible.

➢ Removal of teeth

➢ Preparing the mouth for the insertion of dentures

➢ Treating traumatic injuries or diseases in the mouth

➢ Bone grafts
- Covered only when done with treatment for periodontal disease.

These oral surgery services are not covered

➢ Bone replacement grafting for ridge preservation.

➢ Bone grafts of any kind to the upper or lower jaws, except when done with treatment for periodontal disease.

➢ Tooth transplants (re-implanting or relocating a tooth in the jaw).

➢ Placing materials in a hole in the jawbone to regrow bone (generate osseous filling) after a tooth or implant is removed.

Adult Class II Periodontics — Covered at 50%

Periodontics is the part of dentistry that deals with the structures surrounding and supporting the teeth. In other words, it means things as simple as removing plaque or as complicated as surgical gum treatments. We pay 50% of the allowable expense for these services after you pay your deductible.

➢ Surgical and nonsurgical treatment of tissues supporting the teeth (gums)
- Soft tissue grafts (per site) are covered once every three years.

➢ Occlusion - Fixing how teeth bite together
- Covered for eight teeth or fewer once in a 12-month period.

- Treating gum disease with nonsurgical periodontal scaling and root planing
  - Covered every three years from the date of service.
- Periodontal surgery
  - Periodontal surgery (per site) is covered once every three years (from treatment date).
  - You must have had scaling and root planing done six weeks - six months before the surgery, or you must be in active supportive periodontal therapy.
- Localized delivery of antimicrobial agents
  - Localized delivery of antimicrobial agents is covered when your gums have pocket depth readings of 5mm or greater.
  - Limited to two teeth per quadrant up to two times (per tooth) per benefit period.
  - Must have had scaling and root planing done six weeks - six months before the treatment, or you must be in active supportive periodontal therapy.

Adult Class II Endodontics — Covered at 50%

Endodontic services focus on the insides of teeth. These services work to save damaged or decayed teeth by repairing or replacing the soft inner tissue, called the pulp. Endodontics also help maintain the health of the roots of teeth and the "canals" they run through. We pay 50% of the allowable expense for these services after you pay your deductible.

- Procedures for pulpal and root canal treatment including:
  - Pulp exposure treatment.
  - Pulpotomy.
  - Apicoectomy (root end surgery).
  - Root canal treatment on the same tooth is covered only once every two years (from treatment date).
  - Re-treatment of the same tooth is covered only when done by a different dentist in a different dental office.

These endodontic services are not covered

- Internal bleaching of teeth.

Adult Class III Periodontics — Covered at 50%

Periodontics is the part of dentistry that deals with the structures surrounding and supporting the teeth. In other words, it means things as simple as removing plaque or as complicated as surgical gum treatments. We pay 50% of the allowable expense for these services after you pay your deductible.

- Nightguard (occlusal guard)
  - Covered once every three years from the date of service.
- Repair or reline of nightguard
  - Covered when done more than six months from the initial date of service.
- Complete occlusal equilibration
  - Covered once for the entire time you are on this plan.

Adult Class III Restorative Services (Crowns) — Covered at 50%

Crowns can have two meanings in dentistry. Dentists call the part of your teeth you can see when you smile the crown. But most people think of a crown as an artificial covering that gets cemented into your mouth over a tooth. Artificial crowns cover teeth that have been severely damaged. In this section, we are talking about the second type of crown — the artificial covering. We pay 50% of the allowable expense for these services after you pay your deductible.

- Crowns, veneers and onlays
  - A crown, veneer or onlay on the same tooth is covered once every seven years from the seat date.
  - Crowns, veneers or onlays are covered benefit for treatment of cavities (visible decay) or fracture resulting in significant loss of tooth structure (missing cusp) when teeth cannot reasonably be restored with a filling.
  - An inlay as a single tooth restoration, will be considered as elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being your responsibility.
  - An implant-supported crown on the same tooth is covered once every seven years from the seat date.
  - Crowns that support removable partial dentures are not covered unless the supporting tooth is so decayed it needs a crown anyway.
- Crown buildups
  - Crown buildups are covered once on each tooth in a seven-year period from the date of service.
  - Not covered within two years of a restoration on the same tooth from the date of service.
  - Covered for a posterior (back) tooth when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
  - Covered for an anterior (front) tooth when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
  - Covered in an endodontically treated tooth only if the above criteria are met.
  - A core buildup is not billable with placement of an onlay, 3/4 crown, inlay or veneer.
- Post and core on endodontically-treated teeth
  - Post and core are not covered within seven years (from treatment date) of a restoration on the same tooth.

These restorative services are not covered

- Copings.
- A crown or onlay used to repair a microfracture when there are no symptoms, or when there is an existing restoration and no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations.
- Restorations necessary to correct vertical dimension or restore the occlusion.

Adult Class III Prosthodontics — Covered at 50%



Covered Dental Benefits

Prosthodontics involves making and fitting artificial teeth, also known as dentures or prosthetic appliances. We pay 50% of the allowable expense for these services after you pay your deductible.

- Dentures
  - Payment is based on seat date.
  - Replacement of an existing prosthetic appliance is covered once every seven years (from the seat date) and only when it cannot be repaired.
  - We cover the cost for a full, immediate, or overdenture treatments; however any costs associated with personalization or specialization are not covered, and are the responsibility of the patient.
- Fixed partial dentures (fixed bridges)
  - Payment is based on seat date.
  - Replacement of an existing fixed partial denture is covered once every seven years (from the seat date) and only when it cannot be repaired.
- Removable partial dentures
  - Payment is based on seat date.
  - Replacement of an existing removable partial denture is covered once every seven years (from the seat date) and only when it cannot be repaired.
- Inlays
  - Only when used as a retainer for a fixed partial denture (fixed bridge).
- Adjustment or repair of an existing prosthetic appliance
  - Cost of a reline will be allowed towards the cost of a temporary partial or full denture.
  - After the permanent denture is placed, initial relines will be covered after six months.
  - Denture adjustments and relines are covered when done six months after the initial placement. Additional relines or rebases (but not both) will be covered once a year (from the date of service).
- Surgical placement or removal of implants or attachments to implants
  - Implants and superstructures are covered once every seven years (from the treatment date).

These prosthodontic services are not covered

- Crowns in conjunction with overdentures.
- Duplicate dentures.
- Personalized dentures.
- Copings.
- Appliances that correct vertical dimension or restore the occlusion (the position of your teeth when your jaw is closed, or more simply, your bite).

Adult Temporomandibular Joint Benefits — Covered at 50%

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. We pay 50% of the allowable expense for these services after you pay your deductible.

- Dental services for the treatment of disorders associated with the TMJ
  - Procedures for the treatment of a documented and diagnosed temporomandibular joint dysfunction.
  - Effective for the control or elimination of one or more of the following issues which are caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
  - Recognized as effective, according to the professional standards of good dental practice; and
  - Not experimental or primarily for cosmetic purposes.
- Surgical treatment
- Non-surgical treatment including but not limited to:
  - TMJ examination,
  - X-rays (including TMJ film and arthrogram),
  - temporary repositioning splint,
  - occlusal orthotic device,
  - removable metal overlay stabilizing appliance,
  - fixed stabilizing appliance,
  - occlusal equilibration,
  - arthrocentesis,
  - and manipulation under anesthesia.

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

Any procedures which are defined as a TMJ service above, but which are also covered under your plan in a different class of service, will be covered under that other class of service and not under this TMJ benefit.

It is strongly recommended that you have your dentists submit a request for a Confirmation of Treatment and Cost prior to TMJ treatment. A Confirmation of Treatment and Cost is not a guarantee of payment, but may help you and your dentist understand which treatment is covered under this plan.

Adult Accidental Injury — Covered at 100%

DDWA will pay 100 percent of the filed fee or the Maximum Allowable Fee, whichever is less, for Class I, Class II and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused plan maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the

benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

Adult General Exclusions

This Plan does not cover every part of the dental care you may need. The benefits under this plan are subject to limitations listed above which affect the benefits you receive or how often some procedures will be covered. Additionally, there are exclusions to the type of services covered. These limitations and exclusions are detailed with the specific benefits listed above and in this Adult General Exclusion section. These limitations and exclusions warrant careful reading.

1. Dentistry for cosmetic reasons.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Procedures include: restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.
3. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5. Experimental services or supplies, which include:
    a. Procedures, services or supplies for which the use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
        i. The services are in general use in the dental community in the state of Washington;
        ii. The services are under continued scientific testing and research;
        iii. The services show a demonstrable benefit for a particular dental condition; and
        iv. They are proven to be safe and effective.
    b. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
    c. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the eligible person.
    d. Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review.
6. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
7. Prescription drugs.

8. Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
9. Broken appointments.
10. Behavior management.
11. Completing claim forms.
12. Habit-breaking appliances which are fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), does not include Occlusal Guard, see “Adult Periodontics” for benefit information.
13. Orthodontic services or supplies.
14. 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.

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

Pediatric (Kids) Benefits

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

Pediatric Diagnostic Services — Covered at 100%

Diagnostic services help your dentist determine what is happening inside your mouth. We pay 100% of the allowable expense for these services and you do not have to pay your deductible before we pay.

- Routine diagnostic oral exams
  - Children are covered for two routine exams per benefit period.
  - Routine exams are not as in-depth as comprehensive oral exams.
- Comprehensive oral exams
  - Children are covered for only one comprehensive oral exam per dentist for the entire time you are on this plan.
  - If they change dentists, they are covered for a new comprehensive oral exam.
  - If your dentist wants to do more comprehensive oral exams, we will cover additional exams at the same rate as a routine check-up, and you would be responsible for any additional costs.
- Limited or problem-focused oral exams
  - Limited exams.
  - They cannot be part of any other oral exam, and must be performed by a licensed dentist or dental hygienist.
- Second opinions
  - Second opinions are when you request another dentist to review the treatment diagnosis or treatment plan of your dentist before treatment is done.
  - A second opinion is paid as a limited oral evaluation however, there are no limitations on the number of second opinions you can have.
- Emergency exams
- X-rays - bitewing
  - Bitewing x-rays look at your child's back teeth, called premolars and molars. Your child can have one bitewing x-ray for each quadrant every 12 months.
- X-rays – complete series
  - Complete series or panoramic x-rays capture all of your child's teeth.
  - These are covered once every three years from treatment date.
  - If your child has multiple x-rays on the same day, and the fee for those x-rays is more than a complete series, then the complete series will be allowed.
- X-rays - periapical
  - Periapical x-rays show the entire tooth, from the chewing surface to below the gums to the tip of the root.

- These are covered when dentally appropriate.

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

- X-rays - occlusal intraoral
  - Occlusal intraoral x-rays show how teeth are growing in and where they are in the mouth.
  - These are covered once every two years from treatment date.
- X-rays - cephalometric
  - Cephalometric x-rays show the entire side of your child's head.
  - These are covered once every two years from treatment date.
- Photographic images
  - Oral and facial photographic images are covered, but only if needed to get a clear picture of the growth and development of your child's teeth, jaws and face.
- Pulp vitality test
  - Pulp vitality tests check the health of your child's dental pulp — the material inside each tooth.
  - These tests are for diagnosis only.
  - Your dentist must show that the test is medically necessary.
- Diagnostic casts
  - Diagnostic casts are models of your child's actual teeth.
  - They are covered for orthodontic case studies on a case-by-case basis.

These diagnostic services are not covered

- Consultations to evaluate slides taken by another provider.
- Diagnostic services and x-rays related to treatment for temporomandibular joints (the hinge part of your jaw).

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

Limited oral exams are visits for dental problems or oral health complaints; dental emergencies; or referrals for other treatment.

Pediatric Preventive Services — Covered at 100%

Preventive services help keep your child's teeth healthy in order to prevent things like tooth decay and gum disease. Good preventive practices — such as visiting the dentist twice a year, brushing twice a day and flossing — can mean fewer serious dental problems. We pay 100% of the allowable expense for these services and you do not have to pay your deductible before we pay.

- Prophylaxis (cleaning)

- This treatment is covered twice in a benefit period.

➢ Periodontal (gum) maintenance
- Covered once per quadrant every 12 months.

➢ Topical fluoride
- Fluoride rinse, foam, and gel, as well as fluoride varnishes and disposable fluoride trays.
- Covered up to three times in a benefit period for children six years old and younger.
- Covered twice in a benefit period for children over six years old.
- During orthodontic treatment topical fluoride is covered up to three times every 12 months.
- Additional fluoride treatments are covered when dentally appropriate.

➢ Oral hygiene instruction
- This shows your child the correct way to brush and floss their teeth and the best way to use toothpaste and mouth rinses.
- Covered twice in a benefit period for children eight years old and younger.
- This is not covered if given during the same visit as a cleaning.
- The instruction must be given by a licensed dentist or hygienist at a place that is not a dental office or clinic — such as a school screening.

➢ Space maintainers
- Fixed unilateral or fixed bilateral.
- Covered one time for each of the four sections (quadrants) of your child's mouth.
- Replacement of space maintainers are covered when dentally necessary.
- Includes removing and re-cementing.

➢ Sealants
- Sealants cover molars with a plastic coating to keep food and bacteria from getting into tiny grooves and causing decay.
- This treatment is covered on molars and bicuspids that have no fillings on the biting surface.
- Covered once per tooth every two years.

➢ Preventive resin restorations
- This type of treatment fills in areas of shallow decay (cavities in the outer enamel layer of teeth).
- Allowed only on molars with no fillings on the biting surface.
- Covered once per tooth every two years from treatment date.
- These restorations are not covered for two years after a sealant or filing on the same tooth.

Pediatric Adjunctive Services — Covered at 70%

Adjunctive services play a supporting role in your child's treatment. For example, getting local anesthesia (often called Novocain) to numb your child's mouth so they will not feel any pain is a type of adjunctive service. We pay 70% of the allowable expense for these services after you pay your deductible.

➢ Local anesthesia
- Blocking pain in a specific area as a stand-alone procedure.

➢ General anesthesia and intravenous moderate sedation

- Like being sleepy or asleep.
- Covered for certain endodontic, periodontic, and oral surgery procedures that are covered by your plan.
- Covered for children 8 years of age and younger, or for physically or developmentally disabled children, when medically necessary for services covered by your plan.
- For children from 9-18 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis.
- Nitrous oxide can be used for sedation once per day.
- If your child has a procedure that allows for anesthesia, they are covered for either general anesthesia or intravenous sedation, but not both on the same day.

➢ Emergency treatment for dental pain

➢ Dentist out-of-office visits
- Professional visits to nursing homes, hospitals and emergency rooms.
- Your child's dentist can visit your home or an extended care facility twice for each location while your child is enrolled in this plan.
- Your child's dentist can make one visit per day to a hospital to care for them, inclusive of seeing your child in the emergency room.

➢ Behavior management
- To help your child feel safe and relaxed when they are not able to stay calm during treatment.

➢ Follow-up treatment
- Related to complications after covered surgery.
- Services needed after oral surgery, called post-operative care and treatment, are considered part of the surgery and not billable separately.
- Treatment for complications after surgery are also considered part of the surgery if given within 30 days of the surgery.

➢ Night guards
- To protect teeth during sleep from grinding and clenching.

These adjunctive services are not covered

➢ General anesthesia or intravenous sedation are not covered for routine procedures needed after an operation.

Pediatric Restorative Services — Covered at 70%

In other words, filling a cavity. We pay 70% of the allowable expense for these services after you pay your deductible.

➢ Restorations - fillings
- Amalgam (often called silver) and resin (tooth-colored) fillings for primary (baby) and permanent (adult) teeth.
- Same surface of the same tooth covered once every two years.
- Only covered when decay is visible, a fracture causes a loss of a significant part of the tooth (missing cusp), or a fracture causes significant damage to an existing filling.

- Two fillings to the biting surface of the top molars are covered only if the two fillings have healthy tooth structure between them.
- Permanent back teeth can have fillings on a maximum of five surfaces per tooth, except for upper molars which can have fillings on a maximum of six surfaces per tooth.
- Permanent front teeth can have resin-based fillings on a maximum of six surfaces.
- Making sure your child's bite is correct and comfortable after getting a filling is part of the treatment.
- If your child gets a filling within six months of having preparation for a crown, and the filling is done by the same dentist, then it will be covered as part of the crown treatment.

These restorative services are not covered

- Fillings for anything other than decay or fracture.
- Polishing or reshaping fillings.
- Overhang removal.

Pediatric Crowns — Covered at 50%

Crowns can have two meanings in dentistry. Dentists call the part of your teeth you can see when you smile the crown. But most people think of a crown as an artificial covering that gets cemented into your mouth over a tooth. Artificial crowns cover teeth that have been severely damaged. In this section, we are talking about the second type of crown — the artificial covering. We pay 50% of the allowable expense for these services after you pay your deductible.

- Stainless steel crowns
  - Covered for primary (baby) teeth and permanent (adult) teeth, except for wisdom teeth.
  - Covered once per tooth every two years.
- Permanent crowns
  - We pay for crowns based on the date they are put in your child's mouth — called the seat date.
  - If the seat date falls on a day before or after you are enrolled in the plan, the crown will not be covered.
  - Implant crowns and bridges are covered once per tooth every seven years from the seat date.
  - Permanent crowns are covered for children ages 12-18, and only once per tooth every five years from the seat date.
  - Crowns used to keep removable partial dentures in place are not covered unless the tooth qualifies for a crown on its own.
- Re-cementing permanent crowns
- Core buildups
  - Including pins, are covered only on permanent teeth when performed in conjunction with a crown cast post and core, or prefabricated post and core when performed in conjunction with a crown dental implant crown and abutment related procedures.
  - Covered every five years on the same tooth.
  - Not covered within two years from treatment date of a restoration on the same tooth.

- Covered for a posterior (back) tooth when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
- Covered for an anterior (front) tooth when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- Covered in an endodontically treated tooth only if the above criteria are met.
- A core buildup is not billable with placement of an onlay, 3/4 crown, inlay or veneer.

➢ Dental implant crown and abutment procedures
- Covered every seven years on the same tooth.

➢ Repair of a crown, implant-supported prosthesis, or abutment
- Crown repairs are covered once per tooth while your child is enrolled in this plan.
- Repair of an implant-supported prosthesis of abutment (bridge) limited to one per tooth, for the entire time you are on this plan.

These crown services are not covered

➢ Permanent crowns on front teeth of children under age 12.

➢ Crowns when there is no sign of decay or overt pathology.

➢ Crowns for weakened cusps, or for fractures with no decay or pain.

➢ Copings - thin coverings that fit over teeth to hold other dental restorations — like fillings — in place.

➢ Inlays.

Pediatric Oral Surgery — Covered at 70%

When you think of surgery, you usually think of hospitals. But in dentistry, oral surgery includes many common procedures that happen at the dentist's office — such as removing teeth and treating diseases. We pay 70% of the allowable expense for these services after you pay your deductible.

➢ Routine extractions
- Pulling teeth.

➢ Oral and maxillofacial surgical extractions
- Extraction of impacted teeth – teeth that have not broken through the gum.
- Alveoloplasty and vestibuloplasty – surgeries to repair and reshape the jaw.
- Root removal.

➢ Treating traumatic injuries or diseases in the mouth

➢ Surgical incision and drainage

➢ Frenectomy or frenuloplasty
- Treating how the tongue moves.

➢ Preparing the mouth for the insertion of dentures

These oral surgery services are not covered

- Filling in a hole in the jawbone after a tooth or implant is removed - called bone replacement grafting - for ridge preservation.
- Bone grafts of any kind to the upper or lower jaws unless they are needed to treat periodontal (gum) disease.
- Tooth transplants - re-implanting or relocating a tooth in the jaw.
- Generate osseous filling - placing materials in a hole in the jawbone to regrow bone after a tooth or implant is removed.

Pediatric Periodontics — Covered at 70%

Periodontics is the part of dentistry that deals with the structures surrounding and supporting the teeth. In other words, it means things as simple as removing plaque from your teeth or as complicated as surgical gum treatments. We pay 70% of the allowable expense for these services after you pay your deductible.

- Surgical and nonsurgical treatment of tissues supporting the teeth, for example osseous surgery including flap entry and closure or mucogingivoplastic surgery.
  - Complex periodontal procedures covered once per each section of your child's mouth - quadrants - every three years.
- Full mouth debridement
  - Removing plaque and tartar.
  - Covered once every three years.
- Gingivectomy
  - Surgically removing gum tissue.
  - Covered once per quadrant every three years.
- Gingivoplasty
  - Surgically reshaping gums.
  - Covered once per quadrant every three years.
- Nonsurgical periodontal scaling and root planing
  - Covered for children 13 years old and older.
  - Covered only when x-rays show bone loss.
  - Covered once per quadrant every two years.
- Limited occlusal adjustments
  - Fixing how teeth bite together.
  - Eight teeth or fewer.
- Localized delivery of antimicrobial agents
  - Localized delivery of antimicrobial agents is covered when your gums have pocket depth readings of 5mm or greater.
  - Limited to two teeth per quadrant up to two times (per tooth) per benefit period.
  - Must have had scaling and root planing done six weeks - six months before the treatment, or you must be in active supportive periodontal therapy.

Pediatric Endodontics — Covered at 70%

Endodontic services focus on the insides of teeth. These services work to save damaged or decayed teeth by repairing or replacing the soft inner tissue, called the pulp. Endodontics also help maintain the health of the roots of teeth and the "canals" they run through. We pay 70% of the allowable expense for these services after you pay your deductible.

- Procedures for pulpal and root canal treatment
  - For anterior, bicuspid and molar teeth (except wisdom teeth).
- Pulp exposure treatment
- Therapeutic pulpotomy
  - For primary (baby) and permanent (adult) teeth.
- Pulpal debridement
  - For primary (baby) and permanent (adult) teeth.
- Apicoectomy and retrograde filling
  - For anterior (front) teeth.
- Apexification
  - For apical closures of anterior permanent teeth.
- Procedures to prepare canal
  - Removal of post, pin, old root canal filing material.
- Treatment with resorbable material
  - Covered if the entire root is present at treatment.
- Direct pulp capping
  - Covered as part of a restoration, not covered as a separate treatment.

These endodontic services are not covered

- Internal bleaching of teeth.
- Indirect pulp capping.

Pediatric Prosthodontics — Covered at 50%

Prosthodontics involves making and fitting artificial removable teeth, also known as dentures. We pay 50% of the allowable expense for these services after you pay your deductible.

- Complete dentures
  - One complete upper and lower during the time your child is enrolled on this plan.
- Replacement dentures
  - One replacement during the time your child is enrolled on this plan.
  - Covered five-years after original seat date.
- Resin-based partial dentures
  - Covered once every three years.

- Denture adjustments, repairs, relines and rebase procedures
  - Dentures and bridges once per arch every three years after the initial six-months from the seat date.

These prosthodontic services are not covered

- Crowns in conjunction with overdentures.
- Surgical placement or removal of implants.
- Attachments to implants.
- Implant maintenance procedures including:
  - Removing of prosthesis.
  - Cleaning of prosthesis and abutments.
  - Reinserting of prosthesis.
- Maintenance or cleaning of a prosthetic appliance.
- Personalized dentures.
- Duplicate dentures.
- Treatment for teeth that are broken or damaged while chewing or biting on anything other than food.



Seat Date

Payment for dentures is based on the date they are put in your child's mouth — called the seat date. If the seat date falls on any day before or after you are enrolled in the plan, the dentures will not be covered.

Pediatric Accidental Injury — Covered at 100%

If your child falls off their bike and chips a tooth or gets hit in the face with a basketball and a permanent tooth is loose – that is an example of an accidental injury. We pay 100% of the allowable expense for these services and you do not have to pay your deductible before we pay.

- Accidental injury
  - 100% for covered services needed to treat accidental bodily injuries when done by an in-network dentist.
  - Services done by out-of-network dentists will be covered up to our maximum allowable amount and you will pay for any remaining costs.
  - Your child needs to be treated within 180 days after the accident.
  - Treatment must meet generally accepted dental practices.

Pediatric Medically-Necessary Orthodontia — Covered at 50%

More commonly called braces, orthodontic services work to position teeth to improve your child's bite or smile. Your plan only covers medically-necessary orthodontia — services your child needs so they can use their mouth in a normal way. Under this plan, orthodontia is not covered for cosmetic reasons, like teeth straightening for a more attractive smile. We pay 50% of the allowable expense for these services and you do not have to pay your deductible before we pay.

NOTE: To be covered all orthodontic services must be preauthorized before you start treatment.

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

These orthodontic services are not covered

- Replacing or repair of orthodontic retainers or appliances.

Payment Information

- Orthodontic treatment often takes more than a year to complete.
- Orthodontia treatment that began before your child is enrolled in this plan will be prorated.
- If orthodontic treatment started while your child is enrolled, but enrollment stops during treatment, we only cover the service done while you child is enrolled.
- If you stop treatment before it is complete, your plan will not pay for any services if your child restarts treatment later.
- Your plan will pay your orthodontist each month for the length of the treatment, but only if the treatment is medically necessary.

What is medically-necessary orthodontia?

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

Your child automatically qualifies for orthodontic services if:

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

Pediatric General Exclusions

Dental services not covered by your child's plan. Not all dental services are covered by this plan. In addition to the limitations and exclusions listed above, there are other items that are specifically not covered by this plan. **Please read this section carefully.**

Treatment, services, and supplies not covered include:

- **Counseling**
  - Tobacco counseling for control and prevention of oral disease.
  - Nutritional or diet counseling.
- **Miscellaneous services, treatments, therapies, and devices**
  - Cosmetic services or supplies, including cosmetic work done on dentures.
  - Any treatments done to fix the height or width of teeth.
  - Injuries or conditions covered under Workers' Compensation or Employer's Liability laws.
  - Services provided by any government agency.
  - Services or supplies that are provided to you for free.
  - Prescription drugs.
  - Lab tests or exams.
  - Temporomandibular joint (TMJ) services or supplies.
  - Devices to break habits like thumb sucking and tongue thrusting.
  - General anesthesia and/or intravenous (deep) sedation except when this policy says otherwise.
  - Replacement of a lost, missing, or stolen denture, bridge, or other prosthetic appliance.
  - Duplicate dentures or bridges, or any other duplicate appliance.
  - Repair or replacement of orthodontic appliance.
  - Expenses for myofunctional therapy.
- **Charges and fees**
  - Hospital fees.
  - Consultations.
  - Charges for missed appointments.
  - Charges for completing claims forms.
  - Anything that is not medically necessary.
  - Claims from out-of-network dentists that are not sent to us within 12 months from the date of service.
  - Claims for dental services provided to anyone under this plan while they are active duty in the Armed Forces.
- **Coverage when not enrolled**
  - Any dental services completed before your child is enrolled in this plan.
  - Any dental services you get after your child is no longer enrolled in this plan.

Enrollment and Using Your Benefits



Here are important rules and a few guidelines to follow as you manage your enrollment and use your dental care benefits. Please make sure you understand this information so you get the most out of your plan for you and your children.



Enrollment and Using Your Benefits

Enrollment Information

You have signed up for your dental coverage with a Delta Dental of Washington Plan. Please see below for information about enrollment for you and your family. If you have questions please visit our website at www.DeltaDentalWA.com, or call 800-526-8323.

Who can be covered by this plan?

- **Service area**
  This plan may be purchased by people who live in Washington State. If you need care while travelling outside of Washington State you can still get benefits for covered services, including services received while in another state or country.
- **Adults**
  For adult benefits, this plan covers Washington State residents ages 19 years and older, including:
  - Spouses and domestic partners.
  - Dependent children 19 to 26; when your child turns 19, they no longer qualify for pediatric benefits on this plan. They can stay on this plan as your dependent up until age 26 with adult benefits.
  - Anyone you include on your federal income tax return (even if they do not live with you).
- **Children**
  This plan covers children with pediatric benefits through age 18 who are dependents of Washington State residents.

How to enroll

You may enroll during open enrollment, or at the other times listed below. For more information, please see our website at www.DeltaDentalWA.com, or you can call us at 800-526-8323.

- **Open enrollment**
  You are allowed to enroll or make changes to your dental plan during open enrollment. If you do not enroll or make changes to your plan during this time, you must satisfy specific rules to enroll or make changes outside open enrollment.
- **Other enrollment opportunities**
  In specific situations, you can enroll, reinstate, or make changes to your plan outside of open enrollment. These cases are called qualifying events. If any of these things happen, you can enroll or make changes to your plan:
  - You add to your family.
    - You have a baby.
    - You adopt a child.
    - You foster a child.
  - There is a change in your status or that of your family.
    - You get married or start a domestic partnership.
    - You get divorced or end a domestic partnership.
    - You or your child moves in or out of the state.
    - Your child turns 19.
    - Your child no longer qualifies for their current plan.

- Your child becomes a U.S. citizen.

- Other qualifying changes.
  - You or your child's parent/guardian no longer get coverage through work.
  - You or your child's parent/guardian no longer get COBRA coverage.
  - You and your child now qualify for an Exchange tax credit (subsidy).
  - You and your child no longer qualify for an Exchange tax credit (subsidy).
  - Your child's coverage in an Exchange plan ends and the grace period for continuation of coverage has expired.
  - Your child's coverage ends for a plan offered through the Washington State Health Insurance Coverage Access Act.
  - Your child's plan violated the rules of the plan.
  - You or your child lost coverage because of mistakes made by health benefit exchange staff or the U.S. Department of Health and Human Services.
  - You or your child is Native American, as defined by Section 4 of the Indian Health Care Improvement Act. Native American children can change health plans one time per month, without the need for a qualifying event.

Adding or removing children

You can only add or remove children from this plan during open enrollment periods, unless they are a newborn baby, newly adopted or placed child. Otherwise, you must have a qualifying event to add or remove children from this plan outside of the open enrollment period.

➢ When you have a baby, adopt or foster a child

- Your newborn baby is covered at birth. Adopted and fostered children are covered on their adoption date, at the time of placement, or the date when you become legally responsible for their support.
- Dental coverage for newborns will include coverage for congenital anomalies from the moment of birth. Additional premium is required for your first child covered under this plan; there are no additional premiums for enrolling children beyond your first child. You can take up to 90 days to get your enrollment paperwork done and send in your initial payment if your new child is the first child on your plan. For any child, we encourage you to submit your paperwork as soon as possible to avoid delays in claims processing.

➢ If your new spouse or domestic partner has kids

- Getting married or entering a domestic partnership is a qualifying event. That means you can enroll your new partner's children in your plan. The same is true if you get divorced or end a domestic partnership.
- New dependents must be enrolled within 90 days of the qualifying event, except for a newborn. Enrollment for newborns may be completed any time before their 4th birthday. If enrollment is not received in the timeframe described here, you have to wait to enroll them during an open enrollment period.

Making changes

Once you and your child are enrolled on this plan, there are a few times that enrollment may change. Here are some of those times.

When your child turns 19

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

If we have already paid some pediatric benefits in the plan year when your child turns 19, those payments will not count toward your child's annual adult maximum. When your child moves from pediatric to adult benefits, you will be credited any deductible you have paid.

Dependent adult children over age 26

Children over age 26 who are unable to live independently may stay enrolled in this plan if they meet these qualifications:

- They are enrolled as a dependent on your plan when they turn 26 years of age;
- They are incapable of self-sustaining employment because of an intellectual disability (or related conditions which include cerebral palsy, epilepsy, autism, or another neurological condition which is closely related to intellectual disability or which requires treatment similar to that required for intellectually disabled individuals) or physical handicap; and
- They are chiefly dependent upon you for support and maintenance.

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

Canceling your plan

When you purchase or renew this policy, you are committing to keeping it until the end of the calendar year. To cancel your policy before the end of the calendar year, you must send a written request prior to the requested date of termination. We will terminate your policy at the end of the month in which we receive your written request.
If you terminate your policy prior to the end of the calendar year for any reason not listed below, you will not be allowed to purchase another Delta Dental of Washington Individual plan for 24 months.
If you terminate your dental coverage prior to the end of the calendar year, we will refund any premium paid for coverage after your termination date less any claims incurred after that termination date.

You can cancel your plan without penalty if:

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

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

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

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

When your plan ends

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

- If the premium has not been paid, the plan ends on the day following the last day of the grace period.
- If you ask us to end the plan, the plan will end on the last day of the month you requested.
- If you tell us you do not want to renew this plan, it will end on the last day of the contract term.
- If you die this plan will end on the last day of the month of your death.
- If someone covered under this plan dies, their coverage will end on the last day of the month of their death, but the plan will continue if there are other people covered by the plan.
- If you move out of Washington State, this plan will end on the last day of the contract term, including coverage for everyone on this plan.

Your Dentist and Our Networks

You may choose any dentist to provide services under this plan; however, if you choose a dentist outside of the Delta Dental PPO plus Premier™ Network, your costs may be higher than if you were to choose a Delta Dental PPO plus Premier Dentist.

Our networks

We have different networks, or groups, that our dentists join. Dentists who choose to not join one of our networks are called Non-Participating Dentists.

Non-Participating Dentists

If you prefer a dentist that does not participate in the Delta Dental Networks, we will pay the benefits for covered services up to the Maximum Allowable Fee for Non-Participating Dentists, or the actual charge, whichever is less. Dentists that do not participate in a Delta Dental Network have not contracted with DDWA to charge established fees for covered services; DDWA has no control over the prices they charge you or their billing practices.

As a result, your out-of-pocket costs may be substantially higher if you use a Non-Participating Dentist than with a Delta Dental PPO plus Premier Dentist. You will be responsible for payment of any balance remaining after the DDWA benefit is paid.

To learn more about Delta Dental Network Dentists and how to find one near you, check the next section of this booklet. To search for a network dentist now, visit our online directory at www.DeltaDentalWA.com or call 800-526-8323.

Estimating your costs

Your dentist can ask us for an estimate of how much we will cover for your family's dental work before the treatment is done. These cost estimates are called *Confirmation of Treatment and Cost*. For example, if your child visits the dentist for a routine cleaning and the dentist determines that they have a cracked tooth and needs a crown. You want to know how much it will cost. Ask your dentist to send us a treatment plan, along

with x-rays. After we look over the plan, we will send you and your dentist an estimate for how much we will pay and what your out-of-pocket costs might be. It usually takes 15 days after we get your dentist's request for us to make our estimate. We also have a tool on our website that can help you get an idea about how much your dental work will cost. You can use that at www.DeltaDentalWA.com, or you can call us at 800-526-8323.

Premiums and Renewal

Rates and financial obligations

The monthly premium payable during this policy period is shown on your Plan Overview Page. Payment must be made before your coverage starts and prior to each month following.

Missed payments

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

Renewal

This policy is valid starting with the policy's effective date as shown on your Plan Overview Page and ending at the end of the calendar year. After that, your policy will automatically renew at the beginning of the next calendar year, also known as the Renewal Date, if you or any dependent covered under this policy remains eligible, and if premiums are paid according to this policy. You will receive a notice from us before the Renewal Date with instructions on how to let us know if you do not want to renew your plan. You must contact us to stop your automatic renewal; otherwise you will be renewed for an additional 12 months.

DDWA may change the rates under this policy on this policy's Renewal Date. DDWA will send you written notice of a rate change at least 30 days before the Renewal Date. However, if we will be increasing your rate 25% or more DDWA will send you written notice of the new rate at least 60 days before the Renewal Date.

Legislative surcharge clause

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

Plan Details

Plan Overview Page

Your Plan Overview Page is part of this plan. It contains details about your plan, like the term of the policy, your maximums and our reimbursement amounts for your benefits. Please read over the Plan Overview Page carefully to fully understand your plan.

Benefit Period

Your plan is designed around a benefit period – the time period that your limitations, deductible, and maximums refer to. The benefit period starts when your policy starts and goes to the end of the calendar year. The specific benefit period for your plan is shown on your Plan Overview Page.

Deductible

This plan has an amount that you must pay directly to your dentist before some benefits will begin. The amount of your deductible for you and your children is shown on your Plan Overview Page. The deductible does not apply to Diagnostic Services, Preventive Services, Medically Necessary Orthodontia (pediatric members only), or Accidental Injury.

Waiting Period

There is no waiting period under this policy.

Maximum Benefit

There are limitations on how much we will pay for claims during your benefit period for adult members. The plan maximum is shown on your Plan Overview Page. You are responsible for paying costs above the annual maximum directly to your dentist.

There is no annual maximum for your children on the pediatric plan under this policy.

Out-of-Pocket Maximum

There is a maximum amount that you must pay for covered dental services under this plan during each benefit period. The out-of-pocket maximum for a single child and for all your children is shown on your Plan Overview Page. Once your out-of-pocket maximum has been reached, covered services provided by a Delta Dental PPO plus Premier Dentist are paid at 100% for the remainder of the Benefit Period.

The out-of-pocket limit only applies to covered procedures performed by a Delta Dental PPO plus Premier Dentist. Services performed by a Non-Participating Dentist do not accrue towards the out-of-pocket maximum, and are not limited by the out-of-pocket maximum.

There is no out-of-pocket maximum for members receiving adult benefits.

When We Pay

DDWA pays benefits for a covered service when the service is complete. Removable full and partial dentures are considered completed when they are placed in a patient's mouth. Crowns are considered completed when they are cemented. Root canals are completed on the date the canals are permanently filled. Please see the "Medically Necessary Orthodontia" section for more information regarding payments for orthodontia.

Time Limitations on Procedures

When we pay for a procedure that has a time limitation, the next time we will cover that procedure on that tooth or teeth will be after the time period has passed from the date the service was completed. For example, "full-mouth x-rays once every five years", means full-mouth x-rays once every five years from the date the x-rays were previously taken.

Bright Ideas



Regular dental care, from cleanings to crowns, are essential to your smile's health. Fortunately, you have a great service plan—your dental coverage. This section highlights key features built into your coverage and helpful tips to make your dental visits easy - and more affordable.



Bright Ideas

Visit a Participating Delta Dental Network dentist

To get the most from your benefits, we encourage you to see a Participating Dentist . These dentists contract with us to provide services at discounted rates and file all claims paperwork for you. Dentists who are part of our networks will not charge more than their approved fees and usually cost you less than out-of-network dentists.

You may select any licensed dentist to provide services under this Plan. However, if you go to an out-of-network dentist, we have no control over their charges and billing practices. We will pay based on their actual charges, or our Maximum Allowable Fee for Non-Participating Dentists, whichever is less. If they charge more than the maximums set for your plan, you are responsible to pay any difference. That is called balance billing.

Finding a Delta Dental network dentist

Visit www.DeltaDentalWA.com and use our Find a Dentist tool. Remember to select the Delta Dental PPO plus Premier Network.

Our on-line directory is easy to use anytime, at home or on your smartphone. You can search based on preferences that matter to you, including dentist name, specialty, location and language. You can even see endorsements from other Delta Dental patients for categories including extended office hours, friendly staff, kid-friendly and if they help ease anxiety.

You can also call us at 800-526-8323 for assistance finding a network dentist.

Using your MySmile personal benefits center account at www.DeltaDentalWA.com

MySmile is a secure, personalized toolbox to help you every step of the way as you plan and use your dental benefits. You have 24/7 access to MySmile and registration is easy. Once registered, you will have easy access to:

- ✓ View your coverage.
- ✓ Find a high-quality dentist in your plan's network, based on your preferences.
- ✓ Print your ID card.
- ✓ Get instant, personalized out-of-pocket cost estimates for treatments, based on your benefits and selection of in-network dentists.
- ✓ Check your claims and claims activity, including current and past Explanation of Benefits (EOB).
- ✓ And more!

MySmile accounts are available for subscribers and their dependents who are 18 years of age or older.

Tips for when you visit the dentist

- ✓ Tell your dentist that you are covered by Delta Dental of Washington
- ✓ Provide information on other dental coverage you may have.
  - o If you are covered by more than one dental plan, your dentist's office will help coordinate your coverage. Your dentist and dental plans will work together to make sure you get the most out of your dental benefits.
  - o Tell your dentist's office about both plans.
- ✓ Request a Confirmation of Treatment and Cost when your dentist recommends treatment. This is a pre-treatment estimate, which is different from preauthorization, which is described in the section on enrollment and using your benefits.

- For expensive, extensive treatment, get a precise estimate by asking your dentist to submit a request. Once submitted, you will receive a Confirmation of Treatment and Costs from us.
- A confirmation details your dentist's specific treatment plan, what your benefits pay, and gives you an accurate out-of-pocket estimate. Many dentists are able to get confirmations in real-time. If not, you can view your confirmation through your MySmile account or wait for a paper version via standard mail.

✓ Talk about your health.
- A healthy smile is an important part of your overall health. Research shows there's a link between your oral and overall health. Telling your dentist about your health helps them provide better care to your smile.

✓ Talk to your dentist about:
- Cancer; many treatments cause dry mouth and painful gums.
- Diabetes; gum disease makes it harder to control blood sugar.
- Heart disease; people with unhealthy gums are twice as likely to have heart disease.
- Medications; many can cause dry mouth which can cause bad breath and cavities.
- Pregnancy; moms can pass cavity-causing bacteria to their babies.
- Tobacco use; increases your risk of tooth decay, gum disease, tooth loss and oral cancer.

Tips for after your dental care visit

Review your EOB

After your visit, sign in to MySmile and click "My dental activity" to review your Explanation of Benefits (EOB). If you haven't registered for your MySmile account, you will receive a paper copy via standard mail.

Your EOB is not a bill. This useful document shows you how much of your benefits were applied towards your treatment, how much you have left – and the amount, if any, you need to pay out-of-pocket for your care. Here's what you will find on your EOB:

✓ Treatments billed by your dentist.
Treatments listed should match the ones you received and were billed for. If you notice any inconsistencies, talk to your dentist's office. If you are not satisfied that your EOB is correct, let us know.

✓ Your benefit maximums and deductibles.
This is helpful if you need more treatments. Use it to work with your dentist on scheduling so you do not exceed your maximums for the year.

✓ Other dental overage (if applicable).
Use this information to compare to your other plan's EOB and dentist's bill. If you have other coverage that is primary and this is blank, talk to your dentist office. If there is a number here and you do not think it is right, give us a call.

✓ How your benefits were applied - here is the math behind your cost share:

$ Total Billed by Your Dentist
- Network Savings
- Deductible
- Other Insurance (if applicable)
- Amount Paid by Your Dental Plan

= $ Your Share



Bright Ideas

Reasons to save your EOB's

1. Use them to itemize your deduction on your taxes.
2. Proof of a qualified medical expense.
3. HSA, FSA, and HRA reimbursement.

Sending Claims

In order for us to pay for your dentist bills, you or your dentist have to send us a claim. It is a lot like a bill — from your dentist to us. Claims must be submitted to us within 180 days after your family's dental visit.

Usually your dentist will submit claims for you. Sometimes it will be up to you to make sure we get your claim.

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

We process all claims within 30 days, unless special circumstances require more time. Once we have processed your claim, we will send you a notice to tell you what we paid - called an Explanation of Benefits (EOB). The EOB will tell you what we have paid on your claim. If we deny a claim because we need more information, the EOB will show what additional information we need.

If your claim is denied

When we deny a claim it means we do not believe it is covered under your plan and have not paid the claim. When that happens, we will send you an explanation of benefits with the reason we denied your claim. If your claim is denied or modified, you may file an appeal to ask us to reconsider our decision. See the section on Appeals for more information.

How to file a claim yourself

If you get care from a dentist who does not participate in a Delta Dental network, you may need to file a claim yourself. You can download a claim form from our website, www.DeltaDentalWA.com. If you need help completing it, either ask your dentist or call us at 800-526-8323. We can also mail or fax a claim form to you if you call us at that number.

Paying out-of-pocket costs

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

How to make sure your plan pays your dentist bills

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

Important Details



Remember that your plan is a contract between you and us. This section gives you more information about our obligations to you, and your obligations to us.

Preauthorization

Preauthorization for Adult Benefits

There are no preauthorization requirements for the adult benefits.

Preauthorization for Pediatric Benefits

Medically Necessary Orthodontic services your child gets must be approved by us before you have them done. This is called preauthorization. **If you do not get a preauthorization for these benefits for services before treatment, your plan will not pay for them.**

It is always a good idea to ask your dentist to check with us to see if a dental service needs preauthorization. For this plan, preauthorization is needed in order for medically necessary orthodontia to be covered for your child:

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

Requesting a Preauthorization

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

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

Sometimes we need more information from your dentist. While we are waiting for the information, your preauthorization goes on hold, or into a pending status. If we do not get all the information we need within 45 days, your dentist will have to start the process over again.

Referrals

A referral is different from a preauthorization. If your general dentist suggests you visit a specialist for orthodontia treatment, this is a referral. If you visit a specialist for care, please make sure they get a preauthorization before treatment is performed, as this is still required.

Emergency Treatment and Preauthorization

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

Examples of dental emergencies are:

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

Urgent Preauthorizations

If your dentist determines that there is an urgent need to provide treatment quickly, they may ask for an urgent preauthorization request. Once we get all the information we need, we will let your dentist know within 72 hours if the benefit is covered.

Appeals

How to file an appeal

An appeal is when you ask us to reconsider a claim or a preauthorization request that has been denied or modified. You can ask us to reconsider whenever you do not agree with our decision. Your explanation of benefits letter will have instructions on how to file an appeal.

Your appeals request must include:

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

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

You, your dentist, your child or an authorized representative can submit appeals. An authorized representative is someone you have chosen to make your appeal for you. You must send us a letter signed by you letting us know that you want us to allow this person to speak for you or your child. **If we do not get a signed letter from you for an appeal submitted by someone else, your appeal will be closed.**

Please send your appeal requests to:

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

Or, call us at: 800-526-8323

Appeals have two parts: informal and formal reviews.

Step 1: Informal Review

If you disagree with our decision, ask us for an informal review. You have 180 days from the date your claim was processed to ask for this.

We will review your request and make a decision within 14 days after we get it. We will send you written notice of our decision as soon as it is complete. If our decision is not in your favor, we will tell you what else you can do to appeal our decision. You can ask us to send you copies of the information we used to make our decision.

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

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

Step 2: Formal review

If you disagree with our decision after the informal review, you can ask for a formal review. Formal reviews go to our appeals committee.

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

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

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

Making the appeals process fair

Different people review your case during each step of the appeal process. That means that the people who reviewed your claim the first time are not the same people who look at it during the informal review. If you have a formal review of your appeal, that is done by people who were not involved with the previous reviews. We designed our systems in that way to show you we are giving each appeal a fair hearing.

Other actions you can take

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

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

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

Fax: 360-586-2018

More Important Stuff

Notices

Information sent to you will be sent to your last known physical address or email address. Please let us know right away if you move or change email addresses.

Any notice sent to DDWA must be sent by you or your authorized representative in writing (either electronically or by U.S. Postal Service). Your notice to us is considered delivered when sent to us at the email address shown below; when given in person; or when sent registered or certified United States mail, return receipt requested, proper postage prepaid, and properly addressed to:

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

Email: CService@DeltaDentalWA.com

You may also contact us by phone or fax for questions, to provide us with general information, or to provide us notice of an urgent care request or appeal.

Phone: 800-526-8323

Fax: 206-985-4783

See the "Appeals " section for more detailed information on sending an appeal request.

Delta Dental of Washington's Responsibility

We are responsible for providing administrative services including paying claims for services properly received under this policy.

Compliance with Laws and Regulations

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

Rights of Recovery (Subrogation)

If we pay benefits under this policy, and you are paid by someone else for the same procedures, we have the right to recover what we paid from the excess received by you, after full compensation for your loss is received. Any legal fees for recovery will be prorated between the parties based on the percentage of the recovery received. You have to sign and deliver to us any documents relating to the recovery that we reasonably request.

Governing Law

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

Non-Waiver and Severability

If we do not use any remedy or right under this policy, that does not affect our ability to use any remedy or right at any time in the future.

Entire Contract; Changes

The entire contract between you and us consists of this policy, which includes the Plan Overview Page, this benefit booklet, any and all endorsements or riders, and the application. This policy may only be changed by Delta Dental of Washington for changes in state or federal law and may not be amended by the policyholder.

Nothing said by anyone can change or affect any part of this policy.

Notice of Legal Action

You cannot bring legal action against us until you provide proof of loss and give us 60 days to review all the information. If we have denied payment for the loss, or waived the 60-day period, you can bring legal action sooner.

Coordination of Benefits

When you have dental coverage under more than one plan, those plans work together to provide you the benefit of that additional coverage. That is called coordination of benefits.

General Information

The rules regarding coordination of benefits are very detailed. The full information is contained below, but here is some general information that can help you get the most out of your plan.

- If someone covered under your plan has more than one plan covering them, you should let both plans know so that they can coordinate benefits.
- The benefit of having coverage under more than one plan is to help you with payment of your out-of-pocket costs. Each dental benefit plan does not pay less when you have more than one plan. Your dentist does not get more money.
- Based on the rules set out by the State of Washington, the plans determine which plan pays first, and which pays second.
- The plan that pays first will pay as if there is no other plan. The plan who pays second will pay any amounts that the other plan did not pay, up to the amount they would pay if they were the first plan.
- Once your claim is paid in full, including all of your out-of-pocket cost, if the plan who pays second does not need to pay as much as they would have if they were first, they will set aside that amount of credit for your use later. This is called COB Savings.

If you have any questions about payment of claims when you have more than one plan, contact us or the other plan directly and ask to speak with a coordination of benefits specialist.

Full Coordination of Benefits Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent, first;

(b) The Plan covering the spouse of the Custodial Parent, second;

(c) The Plan covering the noncustodial Parent, third; and then

(d) The Plan covering the spouse of the noncustodial Parent, last

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

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

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

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

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

Effect on the Benefits of This Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the Total Allowable Expenses. In determining the

amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed 100 percent of the total Allowable Expense for that claim. Total Allowable Expense is the Allowable Expense of the Primary Plan or the Secondary Plan up to this plan's allowable expense. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Notice to Covered Persons

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

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

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

Definitions

These are some of the terms we use in this policy that you should understand. If you are not sure what they mean or how they impact your plan, please call our customer service team at 800-526-8323.

Accidental Injury

An injury or damage caused as a direct result of an accidental bodily injury. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects.

Adult Member/Adult Benefits

An adult member is a member who is age 19 or over. The adult benefits are the benefits that are available to an adult member.

Benefit Period

The period of time from which your policy starts and continues until the end of the calendar year as documented on the Plan Overview Page.

Calendar Year

January through December.

Cavity

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

Completion Date

The date a covered dental procedure is considered completed. Benefits for dental procedures are payable on the completion date. Removable dentures are considered completed when placed in the patient's mouth, crowns once they are cemented, and root canals on the date the canals are permanently filled.

Contract

See "Policy" below.

Contract Term

When you enroll in a dental plan, you have entered into a contract. This means that you are responsible to pay your premiums and follow the rules of the plan. It means that we're responsible to pay for covered services listed in your benefit booklet at the reimbursement levels listed on your Plan Overview Page. And we have to follow the plan's rules, too. This Plan Overview and your benefit booklet are our contract.

Covered Dental Benefit

Dental services that are covered under this Policy, subject to the limitations set forth.

Deductible

Every year, before your plan begins paying for your family's dental services, you have to meet your plan deductible. That is a set cost you need to pay. Your yearly deductible is shown on your Plan Overview Page. The amount of money that you must pay toward the cost of dental treatment before the benefits of the plan go into effect. The deductible applies to a Benefit Period.

Dentist

A licensed dentist legally authorized to practice dentistry at the time and in the place services are

performed. This Policy provides for covered services only if those services are performed by or under direction of a licensed Dentist or other Licensed Professional operating within scope of their license.

Dependent

Your spouse or domestic partner (registered or non-registered), and children, up to the age of 26, of you or of your spouse or domestic partner. Children include stepchildren, adopted children, foster children and any children of you or your spouse or domestic partner.

Enrollee

An eligible person who is enrolled in this plan.

Exclusions

Dental services or procedures your plan does not cover.

Explanation of Benefits (EOB)

Once we process a claim from either you or your dentist, we will send you an explanation of benefits. These are not bills. They explain what your dentist's charges are, what we have paid to your dentist, and what you might owe out-of-pocket.

Filed Fee

The approved fee accepted by DDWA for a specific dental procedure performed by a Participating Dentist or Licensed Professional.

Licensed Professional

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

Limitations

Your plan will pay for certain dental services - within limits. These limits are often referred to as limitations. For example, in the case of panoramic x-rays, your plan limits them to once every three years. If your family needs them more than once every three years, you would have to pay for them out-of-pocket.

Maximum Allowable Fee

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

Maximum amount

The total your plan will pay each year for dental services.

Medically Necessary

A dental procedure which as determined by the standards of generally accepted dental practice and

DDWA is to be necessary. Please see the “Medically Necessary Orthodontia” section for more information.

Molars

Teeth in the back of your mouth.

Network

A group of dentists that contractually agree to provide treatment according to administrative guidelines for a certain plan, including limits to the fees they will accept as payment in full. Dentists in the Delta Dental PPO plus Premier Network have agreed to participate in this plan. They have also agreed to provide treatment according to certain administrative guidelines and to accept their contracted fees as payment in full. Different plans are served by distinct dentist Networks. Dentists who are part of our networks will usually cost you less than out-of-network dentists.

Non-Participating Dentist

A licensed Dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental provider agreement.

Out-of-Pocket Maximum

The maximum cost per child that you will be responsible for paying, if you see a Delta Dental PPO plus Premier Dentist.

Premium

This is the amount you pay each month to be enrolled in this plan. Premiums are due on the first of the month.

Participating Dentist or Participating Provider

A licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental provider agreement.

Pediatric Member/Pediatric Benefits

A pediatric member is a member who is under age 19. The pediatric benefits are the benefits that are available to a pediatric member.

Permanent Teeth

Adult teeth that come in after your baby teeth fall out.

Plan Overview

The summary of coverage, deductible and co-insurance amounts, annual out-of-pocket maximum, premium, and benefit period of this Policy. The Plan Overview Page is incorporated into this policy by this reference.

Pocket Depth

An internal measurement from the top of the gum tissue to its attachment on the root of a tooth.

Policy

This agreement between you and DDWA, including all attachments or amendments thereof. This Policy

constitutes the entire contract between the parties and supersedes any prior agreement, or understanding between the parties.

Primary Teeth

The original baby teeth that come in first. Your primary teeth are temporary and fall out.

Quadrants

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

Renewal Date

The beginning of the calendar year following the current enrollment year.

Seat Date

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

Service Area

Washington State, the geographic area in which DDWA will issue this policy. Benefits are provided for covered services received outside of Washington State.

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: 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 our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 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, our 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, 800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Taglines
Amharic እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላቸሁ፣ በራሳቸሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።
Arabic إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.
Cambodian (Mon-Khmer) ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 800-554-1907។
Chinese 如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。

Cushite (Oromo) Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.
French Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.
German Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.
Japanese ご本人様、またはお客様の身寄りの方でも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 800-554-1907までお電話ください。
Korean 귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907로 전화하십시오.
Laotian ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.
Persian (Farsi) اگر شما، یا شخصی که به وی کمک می کنید، سؤالی درباره‌ی Delta Dental of Washington دارد، این حق را دارید که اطلاعات مورد نیازتان را به جهت صحبت با یک مترجم شفاهی، با شماره زبان خود و بدون هیچ هزینه‌ای دریافت کنید. 800-554-1907 تماس بگیرید.
Punjabi ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.
Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.
Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.

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 800-554-1907.
Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde modon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.
Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.
Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.
Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.