THE BOEING COMPANY
PREPAID PROVIDER PLAN – UNION HOURLY EMPLOYEES

Delta Dental of Washington
Program No. 04100

January 1, 2014
Questions Regarding Your Program

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

Delta Dental of Washington
DeltaCare Customer Service
(206) 517-6329
(800) 650-1583

You can also reach us through Internet e-mail at DeltaCare@DeltaDentalWA.com.

Written inquiries may be sent to:
DeltaCare
Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

For the most current listing of Delta Dental of Washington participating dentists, visit our online directory at www.DeltaDentalWA.com.
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Specialty Care Covered Dental Benefits

The terms and conditions of this coverage are set forth in a contract between your employer and Delta Dental of Washington.

1. The Summary Plan Description for this Plan is The Boeing Company Health and Welfare Plans booklet for the eligible population, any applicable provider directory and this coverage-specific brochure issued by Delta Dental of Washington.

2. For detailed information concerning employee and dependent eligibility, enrollment, contributions, coverage terminations, leave of absence provisions, eligibility review and appeals, Qualified Medical Child Support Order (QMCSO), ERISA Special Disclosures and other general plan information, refer to The Boeing Health and Welfare Plans Summary Plan Description, which supersedes any eligibility information contained in this document, or contact the plan administrator.

3. The health plan benefit description is incorporated as part of the Boeing Summary Plan Description.
Welcome to your Boeing Prepaid Dental Plan #4100
The Boeing Prepaid Dental Plan is an innovative dental plan administered by Delta Dental of Washington.
The Boeing Prepaid Dental Plan provides you with comprehensive dental care at a significantly lower cost than the more traditional plans you may be accustomed to. It is unique in its emphasis on preventive care. Moreover, because there are no deductibles or annual maximums when you use a prepaid dentist, you can get the care you need when you need it.

The health plan benefit description is incorporated as part of the Boeing Summary Plan Description.
This summary plan description for this Plan is the combination of:
- The Boeing Company Health & Welfare Plans booklet for the eligible population
- Any applicable provider directory
- This coverage-specific brochure issued by Delta Dental of Washington

Boeing Service Center for Health and Welfare Plans
For detailed information concerning employee and dependent eligibility or enrollment, contributions, coverage terminations, leaves of absence provisions, eligibility reviews and appeal, Qualified Medical Child Support Orders (QMCSO), ERISA Special Disclosures and other general plan information, refer to The Boeing Health and Welfare Plans Summary Plan Description, (which supersedes any eligibility information contained in this document), or contact the plan administrator at:
Automated Phone System Seven days a week, 24 hours a day
1-888-747-2016
1-800-855-8220 (hearing impaired)
847-883-0746 (if calling from overseas)

Boeing Service Center Representatives – Available through the above numbers, Monday through Friday
9 a.m. to 8 p.m. Eastern time,
8 a.m. to 7 p.m. Central time,
7 a.m. to 6 p.m. Mountain Time and
6 a.m. to 5 p.m. Pacific Time

Your password is needed whenever you use the Boeing Service Center automated phone system.

Eligible Employee Groups:
Activites: Union Hourly- 04100

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New Enrollees & Late Enrollment
Eligibility to participate in the plan is effective as determined by your employer. If you decline enrollment when first eligible and later wish to enroll yourself or dependents as a result of marriage, birth or adoption or other qualified change in status, your request for enrollment must be submitted to your employer within 30 days, or the timeframe established by your employer, if your employer allows more than 30 days for this type of change.

An Excellent Network of Quality Providers
As a DeltaCare member, you will choose a primary care dentist from the DeltaCare network. He or she will coordinate your dental care. DeltaCare dentists meet both the strict credentialing standards of the National Committee for Quality Assurance (NCQA) and Delta Dental of Washington’s criteria for practice management.
Low Out-of-pocket Costs

The majority of required dental services are provided at no cost to you under the Boeing Prepaid Dental Plan. However, there are limitations and exclusions that will define your benefits. If you elect to upgrade your treatment, you will be responsible for the cost differential and will pay the difference directly to your dentist.

No Annual Maximums or Network Deductibles

Unlike most traditional dental plans, there are no annual maximums or deductibles when you receive care from your selected primary care dentist.

The Boeing Prepaid Dental Plan Is Easy to Use

Simply contact your primary care dentist and receive treatment. There are never any claim forms for you to complete when you visit your primary care dentist or a specialist to whom your primary care dentist refers you.

No services will be covered unless obtained from an assigned primary care dentist or designated referral dentist.

Plan Information

Provider Selection

The employee must select a participating provider at the time of enrollment or during the open-enrollment period for each family member using up to 3 different providers. Thereafter, all covered dental services except orthodontia will be provided to the employee and each of his or her eligible dependents by the providers selected. If you are a new enrollee, we have made every attempt to assign you to your dentist of choice.

If the dentist/dental office on your card is not the dentist you have selected, you may contact the DeltaCare unit at 1(800) 650-1583 to verify that we received the original information or discuss additional options.

Identification Cards

Each newly eligible member receives an identification card that lists the subscriber’s name and group number, as well as the DeltaCare dentist's name, address and telephone number.

The patient should show this card upon arrival for an appointment. However, please note that eligibility is not based exclusively on the presentation or lack of an identification card. Your dental office should check its most recent list to verify eligibility. If a member’s name does not appear on the most recent eligibility list, the dental office may contact the DeltaCare unit for eligibility confirmation.

New identification cards will be issued when the eligible member contacts DeltaCare and selects a new dentist. You may also contact DeltaCare at 1 (800) 650-1583 for replacement of lost ID cards.

Changing Dentists

To obtain a list of current providers, please contact the DeltaCare unit at 1-(800)-650-1583. The choice of “primary care” dental office can be changed with proper notice to Delta Dental of Washington. The DeltaCare customer service representative will confirm the effective date.

Dentist Deletion

Delta Dental of Washington contracts with private dental offices to participate in the DeltaCare program. For various reasons, these contracts are sometimes terminated. In that event, DeltaCare will attempt to contract with another dentist in the same area. You will be notified of the change in dentists, along with an effective date and current list of open providers. You will have the option to remain with the dentist we select or select another DeltaCare dentist.

Necessary vs. Not Covered Treatment

The DeltaCare dentist will inform the patient of services that are covered benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are provided at no cost to the patient under the DeltaCare Plan. However, there are certain treatments that, according to the contract between The Boeing Company and Delta Dental of Washington, remain the responsibility of the patient. Patients may contact the DeltaCare unit at Delta Dental of Washington at (206) 517-6329 or toll free at 1- (800) 650-1583 with questions.
Elective Care

In all cases where there are alternative methods considered equally effective for the treatment of a condition, this plan shall cover the procedure that is least expensive. If the eligible person elects the more costly service, the dentist may charge the patient for the cost difference between the two procedures.

Referral Process

Specific procedures may be referred to a plan specialist. Your primary care dentist will determine the need for the referral and refer you to a plan specialist in your area.

Urgent Care

The Panel Dentist shall provide urgent dental care for a covered procedure that is required if an enrollee is within 35 miles of the office of the Panel Dentist. If an enrollee requires urgent dental care and is more than 35 miles from the office of the Panel Dentist, the Plan shall reimburse the enrollee for the cost of such urgent dental care up to $100 maximum per 12 month calendar year. Urgent dental care shall be limited to listed procedures, and/or as described, “Palliative (emergency) treatment of dental pain under the conditions of which the enrollee can be screened and adequately stabilized to allow for further treatment from the enrollee’s assigned dentist. Any further treatment of the cause of such urgent dental care would require pre-authorization from the Plan provided it is practical according to a prudent layperson if the care is to be performed by a non-panel dentist. In cases which require immediate additional care beyond stabilization and palliative treatment, the Plan will carefully review and consider additional reimbursable coverage beyond the $100 maximum and according to the standard list of covered benefits under the plan.

Emergency Care

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

Orthodontic Care

Orthodontic care may be obtained from any licensed dentist. The lifetime maximum is $2,000 and will be paid on a fee-for-service basis at the 50% level. You must return to your DeltaCare dentist for any additional treatment your orthodontist recommends.

Grievance Resolution

We urge you to communicate directly with your DeltaCare dentist if you are dissatisfied with the service provided. We are confident that your DeltaCare dentist will welcome the opportunity to address your questions and concerns. If you are still dissatisfied, please contact DeltaCare Customer Service at 1 (800) 650-1583. A customer service representative will be available to assist you.

Member Rights and Responsibilities

As a DeltaCare member, you have the right to:

- Be provided with appropriate information about DeltaCare and its benefits, providers and policies
- Be informed of your diagnosis, the proposed treatment and prognosis by your dentist
- Give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment
- Obtain a copy of your dental record, in accordance with the law
- Be treated with respect and have your dignity and need for privacy recognized
You have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers
- Provide dentists with the information necessary to care for you
- Be familiar with DeltaCare benefits, policies and procedures by reading the plan’s written materials or calling the DeltaCare unit at Delta Dental of Washington
- Understand and follow dental office policy on late cancellations, broken appointments and scheduling

How to Report Suspicion of Fraud

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

- The National Insurance Crime Bureau (NICB). You can reach the NICB at 1 (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to www.insurance.wa.gov for more information.

Coordination of Benefits

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

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

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

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

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

Each contract for coverage under the above bullet points is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
“This Plan” means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other 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.

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% 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% of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

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

An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. The following are examples of expenses that are not Allowable Expenses:

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

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

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

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

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

A Plan that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both 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. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

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

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

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claims determination periods commencing after the Plan is given notice of the court decree;
   b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the Plan of the parent assuming financial responsibility is primary;
   c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
   d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
   e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
      I. The Plan covering the Custodial Parent, first;
      II. The Plan covering the spouse of the Custodial Parent, second;
      III. The Plan covering the noncustodial Parent, third; and then
      IV. The Plan covering the spouse of the noncustodial Parent, last

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

“Active Employee or Retired or Laid-off Employee:” The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the 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.

“COBRA or State Continuation Coverage:” If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the 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.

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

If the preceding rules do not determine the order of benefits, the Allowable 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% of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

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

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

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the Primary Plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract 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 providers 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 100% of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

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

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

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

If payments that should have been made under This Plan are made by another Plan, DDWA has the right, at its discretion, to remit to the other Plan the amount it determines appropriate. To the extent of such payments, DDWA is fully discharged from liability under This Plan.
Notice to covered persons If you are covered by more than one health benefit Plan, and you do not know which is your Primary Plan, you or your provider should contact any one of the health 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 provider, fail to submit your claim to a secondary health Plan within the Plan's claim filing time limit, the Plan can deny the claim. If you experience delays in the processing of your claim by the primary health Plan, you or your provider will need to submit your claim to the secondary health Plan within its claim filing time limit to prevent a denial of the claim.

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

Health Insurance Portability and Accountability Act (HIPAA)
Delta Dental of Washington is committed to protecting the privacy of your dental health information.

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

Children's Health Insurance Plan Reauthorization Act (CHIPRA)
CHIPRA allows special enrollment rights and allows states to subsidize premiums for employer-provided group health coverage for eligible children (excluding benefits provided under health FSAs and high-deductible health plans).

- Employees and dependents that are eligible but not enrolled for coverage may enroll under the following conditions:
- An employee or dependent loses Medicaid or CHIP coverage due to loss of eligibility, and the employee requests coverage within 60 days after the termination.
- An employee or dependent becomes eligible for a premium assistance subsidy under Medicaid of CHIP and the employee requests coverage within 60 days after the termination.

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

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

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

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

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

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

Provided the injured party is in compliance with the above, Participating Plan will prorate any attorneys’ fees incurred in the recovery.

What this means is that if an eligible person receives this program’s benefits for an injury or condition possibly caused by another person, he or she must include in his or her insurance claim or liability claim the amount of these benefits. After he or she has been fully compensated for his or her loss, any money recovered in excess of that loss must be used to reimburse Participating Plan.

Participating Plan shall prorate any attorneys’ fees against the amount owed to Participating Plan.

Claim Review and Appeal

Predetermination of Benefits
A predetermination is a request made by your dentist to DDWA to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but rather is strictly an estimate for services. Payment for services is determined when the claim is submitted. (Please refer to the Initial Benefits Determination section regarding claims requirements.)

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, DDWA may request additional information, request an extension of 15 days and pend the predetermination until all of the information is received. Once all of the information is received, a determination will be made within 15 days of receipt. If no information is received at the end of 45 days, the predetermination will be denied.

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

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

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

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

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

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

- Your name and ID number
- The group name and number
- The claim number (from your explanation of benefits form)
- The name of the dentist

Please submit your request for a review to:

Attn: Appeals Coordinator
Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

For oral appeals, please refer to the phone numbers listed on the inside front cover of your dental benefits booklet.

You may include any written comments, documents or other information that you believe supports your claim.

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

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, DDWA will consult with a dental professional advisor.

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

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

The Appeal Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, DDWA will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with this the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

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

Initial claim determination will be performed on all properly submitted claims within 30 days of receipt (predeterminations will be 15 days). A 15-day extension is available if the claim determination is delayed for reasons beyond our control. In that case we will notify the subscriber.

If a claim is denied, in whole or part, the eligible person will be given a written notice of an adverse benefit determination that will include:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information necessary to process the claim
- The appropriate information as to the steps to be taken for an appeal

Member Appeal Rights

Should a claim/predetermination be denied, in whole or in part, the eligible person has a right to a full and fair review. The request to have a denied claim reviewed may be submitted orally or in writing and within 180 days from the date the claim was denied. Further consideration will not be allowed after 180 days. A final benefit determination will be made within 30 days (predeterminations will be 15 days) following receipt of an appeal. In the case of an urgent claim, Delta Dental of Washington will notify you of its decision within 72 hours. An appeal must include name, identification number, group number, claim number, and dentist’s name as shown on the Explanation of Benefits.

Send your appeal to:
Delta Dental of Washington
DeltaCare
Appeals/Customer Service
Post Office Box 75983
Seattle, WA 98175-0983

Written comments, documents or other information may be submitted in support of an appeal.

Legal Action

DDWA shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this document. 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 document and may seek judicial review of any denial of coverage of benefits.

Boeing Prepaid Plan Covered Benefits

All covered dental services (subject to the limitations and exclusions), except out-of-area emergency care, will be provided through the plan. All necessary dental services and supplies will be provided at no cost to the employee and each eligible dependent of the employee, except for the orthodontic provisions specified below.

Covered Benefits

Diagnostic and Preventive

1. **Diagnostic**: Routine examination, Comprehensive oral evaluation X-rays, emergency examination and examination by a Specialist, if referred by a Participating Provider.

2. **Preventive**: Prophylaxis (cleaning), either a regular prophylaxis or a periodontal prophylaxis, and topical application of fluoride or preventive therapies (e.g., fluoridated varnishes). Fissure sealants and preventive resin restorations include topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

3. **Restorative**: Restoration of carious (decayed) teeth to a state of functional acceptability either utilizing filling materials such as amalgam, silicate, plastic; or glass ionomer or with crowns, inlays or onlays (whether they are gold, porcelain, plastic, gold substitute castings or combinations thereof).
4. **Oral Surgery**: Removal of teeth and surgical procedures. Services covered include surgical and non-surgical extractions, preparation of the alveolar ridge and soft tissues of the mouth for insertion of dentures; ridge extension for insertion of dentures (vestibuloplasty); treatment of pathological conditions and traumatic facial injuries; and general anesthesia when administered by a Participating Provider or referred specialist in connection with a covered oral surgery procedure.

5. **Periodontics**: Surgical and non-surgical procedures for treatment of the tissues supporting the teeth. Services covered include root planing, subgingival curettage, gingivectomy and minor adjustments to occlusion such as smoothing of teeth or reducing cusps.

6. **Endodontics**: Procedures for pulpal and root canal therapy. Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

7. **Pедodontics**: Space maintainers when used to maintain space only.

8. **Prosthodontics**: Dentures, replacement bridges, partial dentures and related items, and the adjustment or repair of an existing prosthetic device.

9. **Orthodontia**: Covered orthodontic services are defined as necessary procedures, done by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention, for treatment of malalignment of teeth and/or jaws which significantly interfere with their function.

The amounts payable by Participating Plan shall be 50% of the lesser of the Maximum Allowable Fees, or the fees actually charged for the Orthodontic treatment.

The lifetime maximum amount payable by Participating Plan for Orthodontic Benefits rendered to an Eligible Person shall be **$2,000.00**. One half of the dentist's total charge, not to exceed **$1,000.00** shall be payable for the treatment during the "construction phase." Subsequent payments of Participating Plan’s responsibility will be made on a quarterly basis providing the employee is eligible.

In addition to the limitations and exclusions set forth in this Evidence of Coverage, the following limitations and exclusions apply to Orthodontic Benefits:

a. Separate charges for the cost or replacement of an Orthodontic appliance are not covered.

b. If the plan of treatment is terminated before all treatment is completed, the Participating Plan will not cover any charges incurred after the date that the last treatment is received.

c. If a covered person’s eligibility ceases during the plan of treatment, the Participating Plan will not cover any charges incurred after the date that eligibility ceases.

d. Orthognathic Surgery is not covered.

10. **Urgent Care**: The Panel Dentist shall provide urgent dental care for a covered procedure that is required if an enrollee is within 35 miles of the office of the Panel Dentist. If an enrollee requires urgent dental care and is more than 35 miles from the office of the Panel Dentist, the Plan shall reimburse the enrollee for the cost of such urgent dental care up to $100 maximum per 12 month calendar year. Urgent dental care shall be limited to listed procedures, and/or as described, "Palliative (emergency) treatment of dental pain under the conditions of which the enrollee can be screened and adequately stabilized to allow for further treatment from the enrollee’s assigned dentist. Any further treatment of the cause of such urgent dental care would require pre-authorization from the Plan provided it is practical according to a prudent layperson if the care is to be performed by a non-panel dentist.

In cases which require immediate additional care beyond stabilization and palliative treatment, the Plan will carefully review and consider additional reimbursable coverage beyond the $100 maximum and according to the standard list of covered benefits under the plan.
11. **Emergency Care**: DeltaCare Dental Plan primary dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, 365 days a year. Treatment of emergency dental care, those rare dental health instances that may be life threatening or cause severe bodily injury, shall not require pre-authorization if a prudent layperson acting reasonably would believe that such an emergency condition exists. The Plan would encourage the enrollee to seek a pre-authorization from the Plan for such emergency care if at all practical, but would not require pre-authorization if the treatment is a listed procedure under the terms of coverage. The enrollee should notify DeltaCare after receiving emergency dental care within 15 days, or when practical, as to the extent of such emergency dental treatment.

12. **Sedation**: General anesthesia or intravenous sedation when administered by a licensed Dentist or other DDWA-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

**Limitations**

1. **Diagnostic**: Examination is covered once in a 6-month period. Charges for the review of a proposed treatment plan or case presentation by the attending Dentist are not covered. Comprehensive oral evaluation is covered once in a 3-year period as one of the two covered examinations in a Benefit Period per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. The patient will not be responsible for any difference in cost when services are provided by a DeltaCare Dentist. Complete mouth or panoramic X-rays are covered once in a 36 month period. Supplementary bitewing X-rays are covered once in a 12 month period. Study and diagnostic models and caries susceptibility tests are not covered.

Fissure sealants are available for children through age 14. Limited to permanent first and second molars with no restoration on the occlusal (biting) surface. The application of a fissure sealant is not a covered dental benefit for three years after a fissure sealant or preventive resin restorations on the same tooth. The application of a fissure sealant is not a covered dental benefit after a preventive resin restoration on the same tooth.

Preventive resin restorations are available for children through age 14. Limited to permanent first and second molars with no restoration on the occlusal (biting) surface. The application of preventive resin restoration is not a covered dental benefit for three years after a fissure sealant or preventive resin restoration on the same tooth.

2. **Preventive**: Prophylaxis (cleaning), either a regular prophylaxis or a periodontic prophylaxis is covered once in a 4 month period. Topical application of fluoride or preventive therapies, but not both is covered once in a 6 month period, up to the patient's 19th birthday. Home fluoride kits, cleaning of a prosthetic appliance, plaque control, oral hygiene or dietary instructions are not covered.

Fissure sealants are available for children through age 14. Limited to permanent first and second molars with no restoration on the occlusal (biting) surface. The application of a fissure sealant is not a covered dental benefit for three years after a fissure sealant or preventive resin restorations on the same tooth. The application of a fissure sealant is not a covered dental benefit after a preventive resin restoration on the same tooth.

Preventive resin restorations are available for children through age 14. Limited to permanent first and second molars with no restoration on the occlusal (biting) surface. The application of preventive resin restoration is not a covered dental benefit for three years after a fissure sealant or preventive resin restoration on the same tooth.

3. **Restorative**:
   a. Restorations on the same surface or surfaces of the same tooth are covered once in a 2 year period.
   b. Crowns, implant-supported crowns, inlays or onlays on the same tooth are covered once in a 5 year period.
   c. Stainless steel crowns are covered once in a 2 year period.
   d. If a composite, glass ionomer or plastic restoration is placed on a posterior tooth, an amalgam allowance will be made for such procedure.

4. **Oral Surgery**: General anesthesia is covered only when administered by a dentist who meets the educational guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with a covered oral surgery procedure.

5. **Periodontics**: Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting are not covered. Root planing or subgingival curettage (but not both) are covered once in a 12 month period.

6. **Endodontics**: Root canal treatment on the same tooth is covered only once in a 2 year period. Re-treatment of the same tooth is allowed when performed by a different dentist at a different dental office.

7. **Pedodontics**: Replacement of a space maintainer that was previously covered under the Dental Plans is not covered.
8. **Prosthodontics**: Replacement of an existing prosthetic device will be covered only if it is unserviceable and cannot be made serviceable. Services which are necessary to make such a device serviceable will be covered. Prosthetic devices will be covered only after 5 years have elapsed following any prior provision of such a device under this Prepaid Provider Plan.

   a. **Full, immediate and overdentures**: If personalized restorations or specialized techniques are used, the patient will be responsible for that portion of the charges which exceeds the prepaid provider’s Maximum Allowable Fees or the fees actually charged for the full, immediate or overdenture.

   Root canal therapy performed in conjunction with overdentures is limited to 2 teeth per arch. Temporary dentures are not covered.

   b. **Partial dentures**: If a more elaborate or precision device is used to restore the case, the patient will be responsible for that portion of the charges which exceeds the Prepaid Provider’s Maximum Allowable Fees or the fees actually charged for a cast chrome and acrylic partial denture.

   c. **Denture adjustments and relines**: Denture adjustments and relines done more than 6 months after the initial placement are covered. Subsequent relines will be covered once in a 12 month period.

   d. **Implants**: Surgical placement or removal of implants or attachments to implants are not covered.

   e. **Fixed Bridges**: Fixed bridges are considered optional treatment; the covered benefit is a removable partial denture. The patient must pay the difference in cost between the dentist’s filed fee for the covered removable partial denture and the fixed bridge.

   Replacement of an existing fixed bridge is covered – as optional treatment – after five years from initial placement and only if it involves the same teeth as the prior bridge. Replacement of a fixed bridge within five years from initial placement is not covered.

   A fixed bridge is not a covered benefit after a removable partial denture has been delivered in the same arch.

9. **Orthodontia**: Charges for any services or supplies which are for Orthodontic treatment (straightening of teeth) including correction or prevention of malocclusion except as specifically provided as orthodontic care for Eligible Persons, including the employee, lawful spouse or domestic partner, and eligible children up to age 26 if attending school full-time or dependent on the employee for principal support.

10. **Sedation**: General Anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures. Intravenous sedation is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA. General anesthesia or intravenous sedation for routine post-operative procedures is Not a Paid Covered Benefit. Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day.

**Exclusions**

All other services not specified as Covered Dental Benefits or not specifically included in this program.

- Analgesics such as nitrous oxide, or any other euphoric drugs or prescription drugs.
- General anesthesia or intravenous sedation, except for certain covered oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.
- Any charge incurred while not covered under the Dental Plan, however:

   (1) Where the Covered Dental Benefit was:

      (i) submitted by the Eligible Person and/or Dentist to the administrative agent as part of a proposed program of dental treatment (Predetermination), or

      (ii) if such Covered Dental Benefit was not subject to the Predetermination Procedure, and it was noted by the Dentist as required, in advance of termination of the employee’s employment, the charges for such services will not be excluded which are actually performed during the 3 calendar months following termination of the employee’s employment.
(2) In connection with the charges for a prosthetic device, which includes the abutment crowns of a partial denture, such charges will be covered if the denture impressions were taken while actively employed and covered under the Dental Plan and installed or delivered to the Eligible Person within the 3 calendar months following termination of the Eligible Person's employment. Charges will not be covered if the denture impressions were taken before the date coverage commenced, or, if taken after the date of termination of employee's employment, unless meeting the requirements of (1) above.

(3) In connection with the charges for a crown required for the restoration of a tooth (independent of the use of the crown in connection with a partial denture), such charges will be covered if the tooth was prepared for the crown while eligible or the crown was installed in accordance with (1) above.

(4) The charges in connection with covered Orthodontic treatment will not be excluded if such services are actually performed during the 3 calendar months following termination of the eligible employee's employment.

- Application of desensitizing agents.
- Charges for covered dental benefits related to orthodontic care, in excess of the $2,000 lifetime maximum benefit per each eligible person.
- Charges for laboratory examination of tissue specimen.
- Completing claim forms.
- Experimental services and supplies.

Are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider it: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. 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.

Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental, may be appealed to DDWA. By law, DDWA must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20 day period may be extended only with written consent of the covered individual.

- Failure to keep a scheduled dental appointment.
- Habit-breaking appliances.
- Hospitalization charges.
- Patient management problems.
- Replacement of missing posterior teeth when the patient has at least 12 posterior teeth in occlusion (three-fourths of the masticatory table).
- Services or treatment which in the opinion of the Participating Provider are not necessary for the patient's dental health.
- Services with respect to treatment of temporomandibular joints (jaw joints).
- Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching.
- Restorations to increase vertical dimension.
- Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the Eligible Person by any federal or state or provincial government agency or provided without cost the Eligible Person by a 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.
• Full mouth reconstruction (extensive treatment plans involving 10 or more crowns or units of fixed bridgework) is considered full mouth reconstruction and is not a benefit of the DeltaCare program. Benefits only for emergency care will be available until the patient is able to transfer to the alternate plan during open enrollment or by contacting the Boeing Service Center.

• Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures)

• Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage

• Dental expenses incurred in connection with any dental procedure started prior to the enrollee’s eligibility

• Services or treatment which in the opinion of the participating provider are not necessary for the patient’s dental health.

• All other services, received from any dental office other than the assigned dental office, unless expressly authorized in writing by the plan or as cited under “Emergency Care”.

• Charges for replacement or repair of an Orthodontia appliance.

• No benefits shall be provided for services considered inappropriate and unnecessary, as determined by the DeltaCare Plan.

Specialty Care Covered Dental Benefits

Boeing Prepaid Plan subscribers are covered for the specialty procedures, on the following pages, whether the procedures are performed by the Prepaid Provider or a specialist to whom the patient is referred to by the Prepaid Provider. DeltaCare will reimburse the Prepaid Provider or the specialist at their DDWA filed fee for the specialty procedures

The specialist must be a Delta Dental member dentist.

When making referrals, send a referral form and X-rays. Clear instructions regarding the referral are necessary to ensure that only the specified treatment is performed.

The specialist’s examination fee is the responsibility of the primary provider.

When treatment is fully completed submit a completed claim form to DeltaCare for payment.

The specialist claim form must have the Prepaid Provider’s referral form attached in order for DeltaCare to make payment.

If you have questions regarding unusual circumstances, please contact the DeltaCare Unit at 1 (800) 650-1583.

BOEING SPECIALTY PROCEDURES

Prepaid 4100

Endodontic Procedures

D3330 Molar root canal filling
D3351 Apexification/recalcification – initial visit
D3352 Apexification/recalcification – interim visit
D3353 Apexification/recalcification – final visit
D3410 Apicoectomy - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid
D3425 Apicoectomy/per, surgery molar (1st root)
D3426 Apicoectomy/per, surgery molar (Additional root)
D3430 Retrograde filling
D3450 Root amputation, per root
D3920 Hemisection

Periodontal Procedures

D4240 Gingival flap procedure (for use with covered procedure D4263,D4264)
D4249 Crown lengthening – hard and soft tissue, by report
D4260 Osseous surgery- four or more teeth per quad
D4261 Osseous surgery - one to three teeth per quad
D4263 Bone replacement graft – first site
D4264 Bone replacement graft – each additional site in quadrant
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure

**Oral Surgery Procedures**
D7220 Impaction - soft tissue
D7230 Impaction - partial bony
D7240 Impaction - full bony
D7241 Removal of impacted tooth, completely bony, with unusual surgical complications
D7250 Root recovery
D7260 Oroantral fistula closure
D7280 Surgical exposure of impacted or unerupted tooth for ortho reasons
D7285 Biopsy of oral tissue – hard
D7286 Biopsy of oral tissue - soft
D7340 Vestibuloplasty - ridge extension (secondary epithelialization)
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle re-attachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

**Removal of Cysts and Lesions**
D7410 Excision of benign lesion up to 1.25 cm
D7411 Excision of benign lesion greater than 1.25 cm
D7440 Excision of malignant tumor up to 1.25 cm
D7441 Excision of malignant tumor greater than 1.25 cm

**Removal Of Cysts And Neoplasms**
D7450 Removal of odontogenic cyst or tumor up to 1.25 cm in diameter
D7451 Removal of odontogenic cyst or tumor greater than 1.25 cm in diameter
D7460 Removal of nonodontogenic cyst or tumor up to 1.25 cm in diameter
D7461 Removal of nonodontogenic cyst or tumor greater than 1.25 cm in diameter
D7465 Destruction of lesions by physical methods, by report

**Excision Of Bone Tissue**
D7470 Excision of exostosis - maxilla or mandible
D7472 Removal of torus palatinus
D7490 Radical resection of mandible with bone graft

**Surgical Incision**
D7510 Incision and drainage of abscess – intraoral soft tissue
D7520 Incision and drainage of abscess – extraoral soft tissue
D7530 Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540 Removal of reaction-producing foreign bodies - musculoskeletal system
D7550 Partial osteotomy/sequestrectomy for removal of non-vital bone
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

**Simple Fractures**
D7610 Maxilla - open reduction, teeth immobilized (if present)
D7620 Maxilla - closed reduction, teeth immobilized (if present)
D7630 Mandible - open reduction, teeth immobilized (if present)
D7640 Mandible - closed reduction, teeth immobilized (if present)
D7650 Malar and/or zygomatic arch - open reduction
D7660 Malar and/or zygomatic arch - closed reduction
D7670 Alveolus – closed reduction, may include stabilization of teeth
D7671 Alveolus – open reduction, may include stabilization of teeth
D7680  Facial bones-complicated reduction with fixation and multiple surgical approaches
D7710  Maxilla - open reduction
D7720  Maxilla - closed reduction
D7730  Mandible - open reduction
D7740  Mandible - closed reduction
D7750  Malar and/or zygomatic arch - open reduction
D7760  Malar and/or zygomatic arch - closed reduction
D7770  Alveolus - stabilization of teeth - open reduction splinting
D7780  Facial bones - complicated reduction with fixation and multiple surgical approaches

**Reduction Of Dislocation**
D7810  Open reduction of dislocation
D7820  Closed reduction of dislocation
D7830  Manipulation under anesthesia

**Other Repair Procedures**
D7960  Frenulectomy - separate procedure (frenectomy or frenotomy)
D7970  Excision of hyperplastic tissue (per arch)
D7980  Sialolithotomy
D7981  Excision of salivary gland, by report
D7982  Sialodochoplasty
D9110  Palliative treatment of dental pain
D9220  General Anesthetic, first 30 minutes
Delta Dental of Washington, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our communities since 1954. Today, as part of the nation’s largest dental benefits provider, we serve approximately 1.5 million people through our Delta Dental plans.

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

To learn more about Delta Dental of Washington and your benefits, visit our Internet Web site at www.DeltaDentalWA.com.