Delta Dental PPO℠

Theatrical and Stage Employees Health and Welfare Trust – Local 15

Delta Dental of Washington

Plan No. **00324**

Effective: **May 1, 2016**

Welcome to your Delta Dental PPO℠ plan, administered by Delta Dental of Washington, a founding member of the nationwide Delta Dental Plans Association.

Our mission is to support your overall health by providing excellent dental benefits and the advantages of access to care within the largest network of dentists in Washington and nationwide. Supporting healthy smiles has been our focus for over 60 years.

Your PPO plan is a resource to make it easy for you to care for your smile. This benefit booklet summarizes your coverage and describes how your benefits may be used. Understanding your benefits is the first step to getting the most from your dental plan. Review this booklet before you visit your dentist and keep it as a reference for later on.

You deserve a healthy smile. We're happy to help you protect it.

Questions Regarding Your Plan

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

Delta Dental of Washington Customer Service
800-554-1907

Written inquiries may be sent to:

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

You can also email us at CService@DeltaDentalWA.com.

For the most current listing of Delta Dental Participating Dentists, visit our online directory at www.DeltaDentalWA.com or call us at 800-554-1907.

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

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

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

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

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

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Summary of Benefits

Reimbursement Levels for Allowable Benefits

In Network – Delta Dental PPO Dentists

Class I	Constant 100%
Class II	Constant 80%
Class III	Constant 50%
Annual Deductible per Person	$0
Annual Deductible — Family Maximum	$0

Out-of-Network – Non-Delta Dental PPO

Class I	Constant 80%
Class II	Constant 70%
Class III	Constant 40%
Annual Deductible per Person	$50
Annual Deductible — Family Maximum	$150

Plan Maximum

Annual Plan Maximum per Person	$2,000

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

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III covered dental benefits and accidental injury benefits.

The annual deductible is waived for:

- Class I covered dental benefits
- Accidental Injury benefits

How to Use Your Plan

The best way to take full advantage of your dental Plan is to understand its features. You can do this most easily by reading this benefit booklet before you go to the dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this benefit booklet does not answer all of your questions, or if you do not understand something, call a DDWA customer service representative at 800-554-1907. *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

Choosing a Dentist

With DDWA, you may select any licensed dentist to provide services under this Plan; however, if you choose a dentist outside of the Delta Dental PPO Network, your costs may be higher than if you were to choose a Delta Dental PPO Dentist. Dentists that do not participate in the Delta Dental PPO Network have not contracted with DDWA to charge our established PPO fees for covered services. As a result, your choice of dentists could substantially impact your out-of-pocket costs. Once you choose a dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your group and your member identification number. Your group information can be found on the identification card document provided to you at enrollment. Additionally, you may obtain your group information and your member identification number by calling our customer service number at 800-554-1907 or through our website at www.DeltaDentalWA.com.

Delta Dental of Washington assigns a randomly selected identification number to ensure the privacy of your information and to address concerns about identify theft. Please note that ID cards are not required to see your dentist, but are provided for your convenience.

Delta Dental Participating Dentists

Dentists who have agreed to provide treatment to patients covered by a DDWA plan are called 'Participating' Dentists, because they participate in our program of plans. For your Plan, Participating Dentists may be either Delta Dental Premier® Dentists or Delta Dental PPO Dentists. You can find the most current listing of Participating Dentists by going online to the Delta Dental of Washington website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their filed fee under our standard agreement.

Delta Dental PPO Dentists

Some dentists also offer our patients a more value-added option by agreeing to provide services at a fee lower than their original filed fee. These are our PPO Dentists.

If you select either a Delta Dental Premier Dentist or a Delta Dental PPO Dentist, they will complete and submit claim forms, and receive payment directly from DDWA on your behalf. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurances, deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

Non-Participating Dentists

If you select a dentist who is not a Delta Dental Participating Dentist, you are responsible for ensuring your dentist complete and submit a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You can also download claim forms from our website at www.DeltaDentalWA.com or obtain a form by calling us at 800-554-1907.

Payment for services performed by a Non-Participating Dentist will be based on their actual charges or DDWA's maximum allowable fees for Non-Participating Dentists, whichever is less. You will be responsible to the dentist for any balance remaining. Please be aware that DDWA has no control over Non-Participating Dentist's charges or billing practices.

Out-of-State Dentists

If you receive treatment from a dentist outside Washington State, other than a Delta Dental Participating Dentist, you may be responsible for having the dentist complete and sign a claim form. It may be up to you to ensure that the claim is sent to DDWA. Payment will be based upon the lesser of either the actual charges or the allowed fees, at the percentage levels listed for PPO Dentists.

Claim Forms

American Dental Association-approved claim forms may be obtained from your dentist. You may also download claim forms from our website at www.DeltaDentalWA.com or call us at 800-554-1907 to have forms sent to you.

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than 6 months after the date of such treatment.

Reimbursement Levels

Your dental Plan offers 3 classes of covered treatment. Each class also specifies limitations and exclusions. For a summary of reimbursement levels for your plan, see the *"Summary of Benefits"* section in the front of this benefit booklet.

Refer to the *"Benefits Covered by Your Plan"* section of this benefit booklet for specific covered dental benefits under this plan.

Reimbursement Levels for Other Procedures

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

Coinsurance

DDWA will pay a percentage of the cost of your treatment and you are responsible for paying the balance. The part you pay is called the coinsurance. Coinsurance is payable even after your deductible is met, if applicable. See the "*Reimbursement Levels for Allowable Benefits*" section under the Summary of Benefits.

Plan Maximum

For your plan, the maximum amount payable by DDWA for Class I, II and III covered dental benefits (including Accidental Injury benefits) per Enrolled Person is $2,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the Plan maximum based on the incurred date.

Benefit Period

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

Plan Deductible – In Network

This Plan does not have an In Network deductible requirement.

Plan Deductible - Out of Network and Out of Service Area

Your Plan has a $50 deductible per Enrolled Person each benefit period. This means that from the first payment or payments DDWA makes for covered dental benefits, a deduction of $50 is taken. This deduction is owed to the provider by you. Once each Enrolled Person has satisfied the deductible during the benefit period, no further deduction will be taken for that Enrolled Person until the next benefit period. The maximum deductible for all members of a family (Enrolled Employee and 1 or more Enrolled Dependents) each benefit period is 3 times the individual deductible. This means that the maximum amount that will be deducted for all members of a family during a benefit period will not exceed $150. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

The annual deductible is waived for:

- Class I covered dental benefits
- Accidental Injury benefits

Employee Eligibility, Enrollment, and Termination

Participants are all full-time Eligible Employees working under a collective bargaining agreement of Local 15 of the International Alliance of Theatrical and Stage Employees.

Eligible Employees become Enrolled Employees once they have fully completed the enrollment process and DDWA has received the employer contributions for their enrollment.

New employees are eligible to enroll in this Plan on the first day of the calendar month following accumulation, in two consecutive months, of 180 hours in the Eligible Employee's Hour Bank. The monthly deduction for continuing eligibility shall be reduced from 120 hours per month to 90 hours per month. This means between the hours reported by your employer and the hours in your bank, you must have 90 hours to provide yourself with a month of coverage. For the work month of April, 90 hours will be deducted from your bank to provide June eligibility.

You must complete the enrollment process in order to receive benefits. DDWA must receive completed enrollment information within 60 days of employee's Eligibility Date. If the enrollment information is not received within 60 days, enrollment will not be accepted until the next Open Enrollment Period.

Eligibility and Coverage terminates at the end of the month in which you cease to be an employee, or at the end of the month for which a timely payment of monthly Premiums was made by Group on your behalf to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

In the event of a suspension or termination of compensation directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may remain enrolled by paying the applicable Premium directly to the employer for a period not to exceed 6 months. Payment of Premiums must be made when due, or DDWA may terminate the coverage.

The benefits under your DDWA dental Plan may be continued provided you are eligible for Federal Family and Medical Leave Act (FMLA) and you are on a leave of absence that meets the FMLA criteria. For further information, contact your employer.

Dependent Eligibility, Enrollment and Termination

Eligible Dependents are your spouse or domestic partner and children of yours, your spouse or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. Spouses and children of Dependents are not eligible for coverage under this plan.

Non-registered domestic partnership is a relationship whereby 2 people:

a) Share the same regular and permanent residence;
b) Have a close personal committed relationship;
c) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
d) Are not married to anyone;
e) Are each 18 years of age or older;
f) Are not related by blood closer than would bar marriage in their state of residence;
g) Were mentally competent to consent to contract when the domestic partnership began; and
h) Are each other's sole domestic partner and are responsible for each other's common welfare.

Eligible Dependents may not enroll in this Plan unless the employee is an Enrolled Employee.

A child will be considered an Eligible Dependent as an adopted child if 1 of the following conditions are met: 1) the child has been placed with the eligible Enrolled Employee for the purpose of adoption under the laws of the state in which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing. See the *"Special Enrollment"* section for additional information.

Coverage for an enrolled dependent child who attains the limiting age while covered under this Plan will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of a developmental disability (attributable to 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 2) chiefly dependent upon the Enrolled Person for support and maintenance. Continued coverage requires that proof of incapacity and dependency be furnished to DDWA within 31 days of the dependent's attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first 2 years.

The Plan also provides coverage for a child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. If the parent is not enrolled in this Plan, the parent must enroll for coverage for both the parent and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so. A child who is eligible for coverage through a QMCSO may not enroll their spouse or dependents for coverage under the plan.

Unless otherwise indicated, an Enrolled Dependent shall cease to be enrolled in this Plan on the last day of the month of the Enrolled Employees employment, or when the person no longer meets the definition of an Eligible Dependent, or the end of the calendar month for which Group has made timely payment of the monthly Premiums on behalf of the Enrolled Employee to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

An enrolled dependent may terminate coverage at the renewal or extension of the dental plan or at open enrollment only, unless changes are allowed following a qualifying event. Once an enrolled dependent's coverage is terminated, the coverage cannot be reinstated unless there is a qualifying event as defined in the "*Special Enrollment"* section.

A new family member, with the exception of newborns, adopted children and foster children, should be enrolled on the first day of the month following the date he or she qualifies as an Eligible Dependent (see "*Special Enrollment"*).

A newborn shall be covered from and after the moment of birth, and an adopted child or child placed in anticipation of adoption shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement. A foster child is covered from the time of placement. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing but coverage will be provided in any event. Dental coverage provided includes, but is not limited to, coverage for congenital anomalies of infant children. See the *"Special Enrollment"* section for additional information.

Eligible Employees who choose not to enroll an Eligible Dependent during the initial enrollment period of the dental Plan may enroll the Eligible Dependent only during an open enrollment, except under special enrollment.

Special Enrollment Periods

Enrollment is allowed at Open Enrollment times, and also during Special Enrollment Periods, which are triggered by the following situations:

1. **Loss of Other Coverage**

   If you and/or your Eligible Dependents involuntarily lose coverage under another dental plan, you may apply for coverage under this Plan if the following applies:

   - You declined enrollment in this Plan.
   - You lose eligibility in another health Plan or your coverage is terminated due to the following:
     - Legal separation or divorce
     - Cessation of dependent status
     - Death of Employee
     - Termination of employment or employer contributions
     - Reduction in hours
     - Loss of individual or group market coverage because of move from Plan area or termination of benefit plan
     - Exhaustion of COBRA coverage
   - Your application to enroll in this Plan is received by DDWA within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

If these conditions are not met, you must wait until the next Open Enrollment Period to apply for coverage.

DDWA or Group may require confirmation that when initially offered coverage the Eligible Person submitted a written statement declining because the Eligible Person or Eligible Dependent has other coverage. DDWA requests that application for coverage under this Plan must be made within 31 days of the termination of previous coverage. If an additional Premium for coverage is required and enrollment and payment is not completed within the 31 days, such Eligible Dependent may be enrolled during the next Open Enrollment.

2. **Marriage, Birth or Adoption**

If you declined enrollment in this Plan, you may apply for coverage for yourself and your Eligible Dependents in the event of marriage, birth of a child, or when you or your spouse assume legal obligation for total or partial support or upon placement of a child in anticipation of adoption.

- Marriage or Domestic Partner Registration — DDWA requests the application for coverage be made within 31 days of the date of marriage/registration. If enrollment and payment are not completed within the 31 days, the Eligible Dependent may be enrolled during the next open enrollment.

  DDWA considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefit booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. DDWA and the group will follow all applicable state and federal requirements, including any applicable regulations.

- Birth — A newborn shall be covered from and after the moment of birth. DDWA requests the application for coverage be made within 90 days of the date of birth. If an additional Premium for coverage is required and enrollment and payment is not completed within 90 days, the Eligible Dependent may be enrolled during the next open enrollment.

- Adoption —DDWA requests the application for coverage be made within 90 days of the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. If an additional Premium for coverage is required and enrollment and payment is not completed within the 90 days, the Eligible Dependent may be enrolled during the next open enrollment.

Extension of Benefits

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. An exception will be made for the completion of procedures requiring multiple visits that were started while coverage was in effect, are completed within 21 days of the termination date, and are otherwise benefits under the terms of this Plan.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or an individual might be committing insurance fraud, please contact DDWA at 800-554-1907. You may also want to alert any of the appropriate law enforcement authorities including:

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal Health Benefit Continuation Provision Applicable to the Theatrical and Stage Employees Health and Welfare Trust – Local 15 group health care plan. (Part of The Consolidated Omnibus Budget Reconciliation Act known as "COBRA." Public Law 99-272 and as Amended by Public Law 104-191.)

An employee (and his/her family members) employed by Theatrical and Stage Employees Health and Welfare Trust – Local 15 affected by the above law, should be aware of the following terms, conditions and limitations of this law as it applies to temporary continuation of group health care coverage upon the occurrence of certain qualifying events. The following benefits are available as a medical/dental package only. Medical coverage may be purchased separately; dental coverage must be purchased in a package.

An employee of an employer covered by Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan, has a right to choose this continuation coverage if group dental coverage is lost because of a reduction in hours of employment or the termination of employment for reasons other than gross misconduct on the part of the employee.

The spouse of an employee covered by Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan, has the right to choose continuation coverage for himself or herself if group dental coverage under Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan is lost for any of the following four reasons:

1. The death of his or her spouse;
2. A termination of the spouse's employment (for reasons other than gross misconduct) or reduction in the spouse's hours of employment;
3. Divorce or legal separation from the spouse; or
4. The spouse becomes entitled to Medicare.

In the case of a child of an employee covered by Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan, he or she has the right to choose continuation coverage if group dental coverage under Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan is lost for any of the following five reasons:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with his or her employer;
3. Parents' divorce or legal separation;
4. A parent becomes entitled to Medicare; or
5. A child ceases to be an "eligible dependent" under Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan

Under the law, the employee or a family member has the responsibility to inform the employer of a divorce, legal separation or a child losing dependent status under Theatrical and Stage Employees Health and Welfare Trust – Local 15 Dental Plan.

When the employer is notified that one of these events has happened, the employer will in turn notify the employee of his or her right to choose continuation coverage. Under the law, the employee has up to 60 days from the date he or she would lose coverage because of one of the events described above to inform the employer that continuation coverage has been chosen.

If continuation coverage is chosen, it is retroactive to the date group dental coverage was lost. If continuation coverage is not chosen, the group dental coverage will end.

If continuation coverage is chosen, the employer is required to give the employee coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that the employee be afforded the opportunity to maintain continuation coverage for three years unless the loss of group dental coverage was because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

Dependents are eligible to continue coverage for 18 months when coverage is lost due to the employee's termination of employment or reduction in hours. Continuation coverage is available to dependents for 36 months from other qualifying events.

If the covered employee has a child or adopts a child during the period of COBRA coverage, such employee may elect to cover that child.

Disabled individuals, either employees or dependents, who are disabled at the time the employee terminates employment or has a reduction in hours, or if disability occurs at any time during the first 60 days of COBRA coverage, are eligible for an additional 11 months of continuation coverage. The total continuation coverage period will not exceed 29 months.

Generally, COBRA participants lose coverage when they become eligible under another group plan. However, if the new plan has pre-existing limitations or exclusions, affected individuals may continue coverage under the former plan until the pre-existing condition(s) is no longer limited or the continuation coverage period ends, whichever is later.

If a dependent is actively participating in COBRA and the covered employee becomes entitled to Medicare, the dependent can continue coverage for an additional 36 months from the date of Medicare entitlement. This policy can result in continuation coverage exceeding 36 months for dependents only.

COBRA payments are due within 45 days from the date of application. Payments must be made retroactively from the date of COBRA eligibility up through the current month of eligibility.

Dependents experiencing second qualifying events while under COBRA may extend coverage for an additional 18 months. The total COBRA period will not exceed 36 months from the first qualifying event.

Continuation coverage may be ended according to the law for any of the following reasons:

1. The employer no longer provides group dental coverage to any of its employees;
2. The premium for continuation coverage is not paid, or not paid on time, as provided by law;
3. The employee/dependent becomes covered under another group health care plan;
4. The employee becomes entitled to Medicare; or
5. The spouse is divorced from a covered employee and subsequently remarries and is covered under the new spouse's group dental plan.

Proof of insurability is not required to choose continuation coverage. However, under the law, the employee may have to pay all or part of the premium for the continuation coverage.

This new law applies to the Theatrical and Stage Employees Health and Welfare Trust – Local 15 Group Dental Plan only for qualifying events which occur on or after January 1, 1987.

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, which you may view and print by visiting www.DeltaDentalWA.com. You may also request a printed copy by calling DDWA at 800-554-1907.

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

Employees who join a branch of 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. For further information on your rights under this act, please contact your legal counsel.

Conversion Option

If your dental coverage stops because your employment or eligibility ends, the group policy ends, or there is an extended strike, or lockout or labor dispute, you may apply directly to DDWA to convert your coverage to a Delta Dental Individual plan. You must apply within 31 days after termination of your group coverage or 31 days after you receive notice of termination of coverage, whichever is later. The benefits and premium costs of a Delta Dental Individual plan may be different from those available under your current plan. You may learn about our Individual Plans and apply for coverage online at DeltaDentalCoversMe.com or by calling 888-899-3734.

Necessary vs. Not Covered Treatment

Your dentist may recommend a treatment plan that includes services which may not be covered by this Plan. Prior to treatment, you and your dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Confirmation of Treatment and Cost" section.

Benefits Covered By Your Plan

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

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

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

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

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

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- A complete series or a panoramic X-ray is covered once in a 3-year period from the date of service.
    - Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.
- Supplementary bitewing X-rays are covered twice in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits.

Exclusions

- Consultations
- Study models

Class I Preventive

Covered Dental Benefits

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

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period.
  - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) *may be* covered up to a total of 4 times in a benefit period.*

***Note**: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section" for additional information.*

- Topical application of fluoride is limited to 2 covered procedures in a benefit period.
- Sealants:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
  - The application of a sealant is a covered dental benefit once in a 3-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 17.
- Preventive resin restorations:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.

- The application of a preventive resin restoration is a covered dental benefit once in a 3-year period per tooth from the date of service.
- The application of preventive resin restoration is not a paid covered benefit for 3 years after a sealant or preventive resin restoration on the same tooth from the date of service.
- The application of preventive resin restoration is not a paid covered benefit after a sealant or preventive resin restoration on the same tooth.

Exclusions

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

Class II Benefits

Class II Sedation

Covered Dental Benefits

— General Anesthesia

— Intravenous Sedation

Limitations

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

— General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II and III covered dental benefits.*

— Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.

— Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.

— General anesthesia or intravenous sedation is only a paid covered benefit as specifically allowed above.

***Note:** *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section" for additional information.*

Class II Palliative Treatment

Covered Dental Benefits

— Palliative treatment for pain

Limitations

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

Class II Restorative

Covered Dental Benefits

— Restorations (fillings)

- Stainless steel crowns

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period from the date of service
- Restorations are covered for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Stainless steel crowns are covered once in a 2-year period from the seat date.

Exclusions

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

Please also see:

- Crowns (other than stainless steel), inlays, veneers or onlays are a Class III Restorative benefit. Refer to "*Class III Restorative"* for more information regarding coverage for crowns (other than stainless steel), inlays, veneers or onlays.

Class II Oral Surgery

Covered Dental Benefits

- Removal of teeth
- Preparation of the mouth for insertion of dentures
- Treatment of pathological conditions and traumatic injuries of the mouth

Exclusions

- Bone replacement graft for ridge preservation
- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Please also see:

- *"Class II Sedation"* for Sedation information.

Class II Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Services covered include:
  - Periodontal scaling/root planing
  - Periodontal surgery
  - Limited adjustments to occlusion (8 teeth or fewer)
  - Localized delivery of antimicrobial agents*
  - Gingivectomy

Limitations

- Periodontal scaling/root planing is covered once in a 36-month period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a 3-year period from the date of service.
  - Periodontal surgery must be preceded by scaling/root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Soft tissue grafts (per site) for implants and natural teeth are covered once in a 3-year period from the date of service.
- Localized delivery of antimicrobial agents is a covered dental benefit under certain conditions of oral health such as periodontal Case Type III or IV, and 5mm (or greater) pocket depth readings.*
  - Localized delivery of antimicrobial agents is limited to 2 teeth per quadrant and up to 2 times (per tooth) in a benefit period.
  - Localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.

***Note:** *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost (Formerly called Predeterminations)" section for additional information.*

Please also see:

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

Class II Endodontics

Covered Dental Benefits

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

- Apicoectomy

Limitations

- Root canal treatment on the same tooth is covered only once in a 2-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a dentist other than the dentist who performed the original treatment and if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions

- Bleaching of teeth

Please also see:

- *"Class II Sedation"* for Sedation information.

Class III Benefits

Class III Periodontics

These benefits are available for patients with periodontal case type III or IV only, as determined by your Dentist. It is strongly recommended that prior to treatment you have your dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

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

Limitations

- Occlusal guard (nightguard) is covered once in a 3-year period from the date of service.
- Repair and relines done more than 6 months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Class III Restorative

Covered Dental Benefits

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

Limitations

- A crown veneer or onlay on the same tooth is covered once in a 5-year period from the seat date.
- An implant-supported crown on the same tooth is covered once in a 5-year period from the seat date of a previous crown on that same tooth.

- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a 2-year period, with any difference in cost being the responsibility of the covered person.
- Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing and there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- A crown buildup is covered once in a 2-year period on the same tooth from the date of service.
- A post and core is covered once in a 5-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within 2 years of a restoration on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations without overt pathology is not a paid covered benefit.

Exclusions

- Copings

Class III Prosthodontics

Covered Dental Benefits

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

Limitations

- Replacement of an existing prosthetic appliance is covered once every 5 years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Payment for dentures, fixed partial dentures (fixed bridges); inlays (only when used as a retainer for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Implants and superstructures are covered once every 5 years.
- **Temporary dentures** — DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 6 months.
- **Denture adjustments and relines —** Denture adjustments, relines, repairs and rebases done more than 6 months after the initial placement are covered.

- Subsequent adjustments and repairs are covered.
- Subsequent relines or rebases will be covered once in a 12-month period.
- An adjustment or reline performed more than 6 months after a rebase will be covered.

Exclusions

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance
- Copings
- Crowns in conjunction with overdentures are not a paid covered benefit

Well Baby Checkups

For your infant child, Delta Dental of Washington offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of service. When visiting a physician with your infant (age 0-3), DDWA will reimburse the physician, as a Non-Participating provider, on your behalf for Oral Evaluation and Topical Application of Fluoride services performed. Reimbursement will be based on 100 percent of the applicable Non-Participating provider fee for either Oral Evaluation or Topical Application of Fluoride, or both, depending on actual services provided.

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

If your provider has received training regarding Well Baby Checkups from DDWA they will have been provided instructions on how to submit a claim form. If your provider has not received training from DDWA, or if any provider has questions regarding how to file a claim they may contact us at 800-554-1907 for information on submitting a standard claim form for this service. If you have paid your provider directly and have a receipt for these services, please call us at 800-554-1907 for information on how to obtain reimbursement.

Accidental Injury

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II and Class III Covered Dental Benefit expenses arising as a direct result of an accidental 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.

General Exclusions

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

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.
3. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal or state or provincial government agency or provided

without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.

4. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5. Experimental services or supplies, which include:
    a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
        i) The services are in general use in the dental community in the state of Washington;
        ii) The services are under continued scientific testing and research;
        iii) The services show a demonstrable benefit for a particular dental condition; and
        iv) They are proven to be safe and effective.
    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 covered person.
    d. Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.
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 drug.
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.
13. Orthodontic services or supplies.
14. TMJ services or supplies.
15. 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.
16. All other services not specifically included in this Plan as Covered Dental Benefits.

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

Frequently Asked Questions about Your Dental Benefits

What is a Delta Dental "Participating Dentist"?

A Delta Dental Participating Dentist is a dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to subscribers and their dependents covered by DDWA's group dental care plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients.

Can I choose my own dentist?

See *"Choosing a Dentist"* under the *"How to Use Your Plan"* section in the front of this benefit booklet.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your dentist. You can also obtain a copy of the approved claim form from our website at www.DeltaDentalWa.com. You may also obtain a claim form by calling our Customer Service Number at 800-554-1907. **Note**: If your dentist is a Delta Dental participating provider, he or she will complete and submit claim forms for you.

What is the mailing address for DDWA claim forms?

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

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

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

Does DDWA cover tooth-colored fillings on my back teeth?

It is your groups' choice to cover posterior composite filling (tooth-colored fillings on your back teeth), or only allow posterior amalgam fillings (silver filling on your back teeth). Please see the *"Benefits Covered by Your Plan"* section to determine which election your group has made. You may also log on to the "*MySmile® Personal Benefits Center*" on our website, www.DeltaDentalWa.com, or call us at 800-554-1907 for assistance in determining whether or not your plan covers posterior composite fillings.

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

You may ask your dentist to complete and submit a request for an estimate, called a "*Confirmation of Treatment and Cost*." The estimate will provide you with estimated cost and benefits for your procedure, but are not a guarantee of payment.

What is Delta Dental?

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

Is this plan a Qualified Dental Plan?

No, this plan has not been certified to meet the state and federal pediatric dental component of the Essential Health Benefits required for Qualified Health Plans.

Claim Review

Confirmation of Treatment and Cost (Formerly called Predeterminations)

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

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

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

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

Urgent Confirmation of Treatment and Cost Requests

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

Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost 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

How to contact us

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

Authorized Representative

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

Informal Review

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

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

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request to further appeal in writing. Your appeal will be reviewed formally by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or the previous review.

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

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

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 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 consistent with applicable regulation.

Coordination of Benefits

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

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

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

A "***Plan***" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same

Plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

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

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has 6 parts and COB rules apply only to one of the 2, each of the parts is treated as a separate *Plan*.

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

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

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

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

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

- If you are covered by 2 or more Plans that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by 2 or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan's negotiated fee is not an *Allowable Expense*.

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

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

Order of Benefit Determination Rules: When you are covered by 2 or more *Plan*s, the rules for determining the order of benefit payments are as follows:

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

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

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

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

"***Non-Dependent or Dependent***" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the 2 *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

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

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
   a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
   b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
   b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
   c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of point 1) 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 point 1) above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
   e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
      I. The *Plan* covering the *Custodial Parent*, first;

II. The *Plan* covering the spouse of the *Custodial Parent*, second;

III. The *Plan* covering the non*custodial Parent*, third; and then

IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of points 1) or 2) above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

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

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

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one

hundred percent of the total allowable expense (the highest of the amounts allowed under each Plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

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

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

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

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

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

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

Subrogation

If we pay benefits under this policy, and you are paid by someone else for the same procedures we pay for, 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 pro-rated 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.

Your Rights and Responsibilities

We view our benefit packages as a partnership between DDWA, our subscribers and our Participating Dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have The Right To:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental Participating Dentist or Non-Participating Dentist), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.

- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact DDWA customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at DeltaDentalWA.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

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

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

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

Summary Plan Description

Required By the Employee Retirement Income Security Act of 1974 (ERISA)

Name of Plan: Theatrical and Stage Employees Health and Welfare Trust - Local 15

Description of Collective Bargaining Agreements:

This plan was established and is maintained as a result of collective bargaining between the participating employers and the Theatrical Stage Industry and Local 15 of the International Alliance of Theatrical Stage Employees of the United States and Canada. The source of contributions to the plan is employer contributions. The amount of the contribution is outlined in the section referring to Health and Welfare benefits in the current collective bargaining agreements. Employees contribute a portion of dependent costs. Copies of the pertinent sections of the agreements may be obtained by contacting Local 15, International Alliance of Theatrical Stage Employees, Room 203, Labor Temple, 2800 First Avenue, Seattle, Washington 98121.

In addition, a copy of any collective bargaining agreement and a complete list of employers sponsoring the plan are available for examination and may be obtained by participants and beneficiaries upon written request to the plan administrator.

Type of Administration:

This plan is administered by a Board of Trustees--half represent employees and half represent participating employers. Local 15, International Alliance of Theatrical Stage Employees selects employee Trustees and a majority of participating employers select employer Trustees. The Board of Trustees is responsible for establishing and administering the plan solely for the purpose of providing benefits to participants, their families and dependents. The Board of Trustees has engaged William C. Earhart Administration Company to assist in administration.

Address of Administration Office:

Board of Trustees
Theatrical and Stage Employees Health and Welfare Trust - Local 15
c/o William C. Earhart Co., Inc.
3140 NE Broadway
Portland, Oregon 97232

Employer Identification Number:

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-0853746 and the Plan Number is 501.

Type of Plan: This plan provides Dental Benefits.

Name and Address of Agent for Service of Legal Process:

William C. Earhart Co., Inc., is designated as agent for purposes of accepting service of legal process on behalf of the plan. Each Trustee of the Board of Trustees is also authorized to accept service of legal process on behalf of the plan. (See Address of Administration Office on previous page.)

Name and Address of Board of Trustees:

The names, titles and addresses of the individuals currently serving on the Board of Trustees who are administrators, as that term is defined in Section 3(16) of ERISA, are:

Employer Trustees:

Ms. Kathy A. Magiera
Health/Welfare Trust
Seattle Opera
1020 John Street
Seattle, WA 98109
Phone: (206) 389-7680
Fax: (206) 389-7651

Mr. Benjamin Moore
Chairman
Seattle Repertory Theatre
155 Mercer Street
Seattle, WA 98109
Phone: (206) 443-2210
Fax: (206) 443-2379

Mr. David Allen
Paramount Theater
907 Pine Street, #905
Seattle, WA 98101
(206) 467-5510 x110
(206) 682-4837 (fax)

Employee Trustees (Union):

Mr. William Droege
Secretary
4003 Cascadia Avenue South
Seattle, WA 98118
Phone: (206) 722-1103
Cell Phone: (206) 718-2875

John Lammon
5733 Broadway Avenue
Everett, WA 98203
Phone: (425) 290-3928

Mr. Sean Callahan
Health/Welfare Trust
7504 Third Avenue NW
Seattle, WA 98177
(206) 783-8399
Ben Hall: (206) 215-4794

Entities used for Accumulation of Assets and Payments of Benefits:

The employer contributions and self-contributions, if any, are received and held in trust by the Board of Trustees which pays these contributions to DDWA which underwrites the benefits. Funds remaining after the payment of monthly contributions and other expenses of operating the plan, if any, are also held in trust and invested by the Board of Trustees. Presently, the benefits of this plan are provided through Delta Dental of Washington.

End of Plan Year: April 30.

Claim Procedures:

If a claim is denied or partly denied, you will have available the remedies set forth below:

Insurance Company Review Procedures: See page 24.

Board of Trustees Review Procedures:

If a claim is wholly or partially denied or is not acted on within 90 days--or 180 days if it is a special case--the claimant, or an authorized representative, may request a review upon written application to the Board of Trustees of the plan, may review pertinent documents at the administration office, and may submit issues and comments in writing. Requests for review must be mailed to the Board of Trustees in care of William C. Earhart Administration Company, 3140 N.E. Broadway, Portland, Oregon 97208, within 90 days after the claimant receives written notification of a claim denial, or within 180 days from the date the claim was made and not acted on.

Decision on Review:

A decision on the claim will be made by the Board of Trustees or an authorized claim review committee not later than 30 days after receiving a request for review from the claimant. In special cases, more time may be needed to make the decision on review. If the plan notifies the participant that there will be a delay and explains the reasons for needing more time, the plan may have 15 additional days in which to make the decision. The decision on review will be in writing and will include specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based.

Benefits:

An extensive program of benefits is provided under the plan and upon request, any specific or detailed benefit provision or schedule not outlined in this booklet will be provided to participants and beneficiaries without cost.

Glossary

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

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

Apicoectomy
Surgery on the root of a tooth.

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

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

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

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

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

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

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

Contract
The agreement between DDWA and Group. The Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding or negotiation between the parties.

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

Covered Dental Benefits
Those dental services that are covered under this Contract, subject to the limitations set forth in Benefits Covered by Your Plan.

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

DDWA
Delta Dental of Washington, a nonprofit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

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

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

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

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

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

Denture
A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces 1 to several missing upper or lower teeth.

Eligibility Date
The date on which an Eligible Person becomes eligible to enroll in the Plan.

Eligible Dependent
Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in "Dependent Eligibility, Enrollment and Termination."

Eligible Employee
Any employee who meets the conditions of eligibility set forth in "Employee Eligibility, Enrollment and Termination."

Eligible Person
An Eligible Employee or an Eligible Dependent.

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

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

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

Enrolled Dependent, Enrolled Employee, Enrolled Person
Any Eligible Dependent, Eligible Employee or Eligible Person, as applicable, who has completed the enrollment process and for whom Group has submitted the monthly Premium to DDWA.

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

Filed Fees

Approved fees that participating Delta Dental Participating Dentists have agreed to accept as the total fees for the specific services performed.

Filled Resin

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

Fixed Partial Denture

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

Fluoride

A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish

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

General Anesthesia

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

Group

The employer or entity that is contracting for the dental benefits described in this benefit booklet for its employees.

Implant

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

Inlay

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

Intraoral X-rays Complete Series (including bitewings)

A series of radiographs which display the root and coronal portions of all the teeth in the mouth.

Intravenous (I.V.) Sedation

A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

Licensed Professional

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

Limitations

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

Localized Delivery of Antimicrobial Agents

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

Maximum Allowable Fees

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

Nightguard

See “Occlusal Guard.”

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 Participating Dentist Agreement between a member of the Delta Dental Plans Association and such Dentist.

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

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

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

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

Open Enrollment Period
The annual period in which subscribers can select benefits plans and add or delete Eligible Dependents.

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

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

Palliative Treatment
Services provided for emergency relief of dental pain.

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

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

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

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

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

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

Premium
The monthly amount payable to DDWA by Group, and/or by Enrolled Employee to Group, as designated in the Contract.

Prophylaxis
Cleaning and polishing of teeth.

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

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

Qualified Medical Child Support Order (QMCSO)

An order issued by a court under which an employee must provide medical coverage for a dependent child. QMCSO's are often issued, for example, following a divorce or legal separation.

Resin-Based Composite

A tooth colored filling, made of a combination of materials, used to restore teeth.

Restorative

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

Root Planing

A procedure done to smooth roughened root surfaces.

Sealants

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

Seat Date

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

Specialist

A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, 2 or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

Temporomandibular Joint

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

Veneer

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