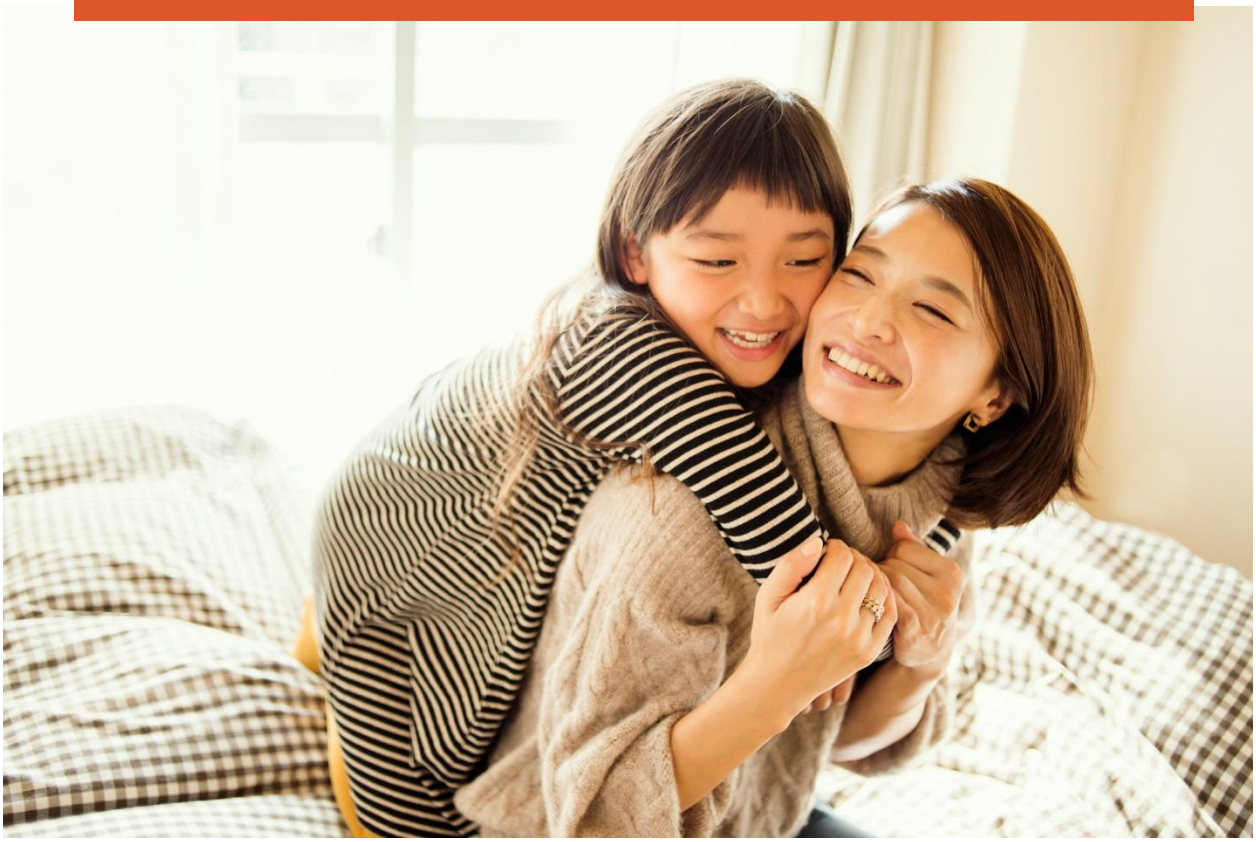
DELTA DENTAL

Delta Dental of Washington

Delta Dental PPO Plan

Benefit Booklet

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



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Who We Are

Delta Dental of Washington (referenced here simply as DDWA) is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from DDWA, you join more than 60 million people across the nation who have discovered the value of our coverage.

This benefit booklet, and Plan Overview Page make up your complete plan documents. Please hold onto your benefit booklet and Plan Overview Page, they have answers to many questions about your dental coverage including eligibility, enrollment, changes to enrollment, benefits and claims administration.

Welcome to your Delta Dental PPO Plan

Thank you for choosing our Delta Dental PPO Plan for your family. We hope you will take a few minutes to get familiar with this benefit booklet. We set it up so you will have all the information you need right at your fingertips. If you ever need help beyond this booklet, call us at 800-554-1907, or visit our website www.DeltaDentalWA.com.

Smile, you are covered.

Covered Dental Benefits

Covered Dental Benefits

The benefits listed below are covered for all individuals who are enrolled in this plan. These benefits are available only if they are performed by someone legally authorized to perform services and when dentally appropriate as determined by the standards of generally accepted dental practice.

Class I Diagnostic Services

Diagnostic services help your Dentist determine the health of your mouth. You are covered for the following diagnostic services:

- Routine diagnostic oral exams
  - Covered for two routine exams per Benefit Period. Routine exams are not as in-depth as comprehensive oral exams.
- Comprehensive oral exams
  - Covered for one comprehensive oral exam per Dentist for the entire time you are on this plan. If you change Dentists, you are covered for a new comprehensive oral exam. After that, if your Dentist wants to do more comprehensive oral exams, we will cover additional exams at the same rate as a routine check-up, and you would be responsible for any additional costs.
- Limited or problem-focused oral exams
  - Covered two times per Benefit Period.
  - Limited or problem-focused exams are covered when they are not part of any other oral exam.
- X-rays
  - Covered for one set of bitewing x-rays (two or more images) per Benefit Period.
  - Covered for a single bitewing x-ray as needed, there are no Limitations on the number of single bitewing x-rays you can have.
  - Covered for a complete series or panoramic x-ray once every five years from the date of service.
  - Covered for one cone beam CT scan per Benefit Period.
  - If any number or combination of x-rays are billed for the same date of service where the combined fees are equal to or exceed the allowed fee for a complete series, it will be paid as a complete series. If you have already had a complete series paid for within the last five years it will not be covered, and you will be responsible for the cost.

These diagnostic services are not covered

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

Covered Dental Benefits

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

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

Class I Preventive Services

Preventive services help keep your teeth healthy by preventing tooth decay and gum disease. Good preventive practices — such as visiting the Dentist twice a year, brushing twice a day and flossing — can mean fewer serious dental problems. You are covered for the following preventive services:

- **Prophylaxis (cleaning)**
  - Any combination of prophylaxis or periodontal maintenance is covered twice in a Benefit Period.
  - Additional prophylaxis or periodontal maintenance is covered (up to four treatments combined) if your gums have Pocket Depth readings of 5mm or greater.
- **Periodontal (gum) maintenance**
  - Covered only if you have completed active periodontal treatment.
  - Any combination of prophylaxis or periodontal maintenance is covered twice in a Benefit Period.
  - Additional prophylaxis or periodontal maintenance is covered (up to four treatments combined) if your gums have Pocket Depth readings of 5mm or greater.
- **Sealants**
  - Covered for posterior (back) teeth that have no restorations (includes preventive resin restorations) on the biting surface.
  - Covered every two years (from treatment date) per tooth.
- **Topical application of fluoride including fluoridated varnish**
  - Covered two times in a Benefit Period.
- **Preventive resin restoration**
  - Covered only on permanent molars with no restorations on the biting surface.
  - Preventive resin restorations are not covered for two years after a sealant or preventive resin restoration is put on the same tooth.
- **Application of caries arresting medicament**
  - Covered twice per Benefit Period per tooth.
- **Space maintainers**
  - Covered for children through the age of 17.
  - Covered once for each of the four sections (Quadrants) of the child's mouth, the entire time the child is on this plan.

These preventive services are not covered

- Plaque control program which includes oral hygiene instruction, dietary instruction and home fluoride kits.

Class I Periodontics

In order to be covered for these benefits, you must have a history of periodontal treatment, or your Dentist must submit proof that you have had a periodontal procedure within the previous 180 days. You are covered for the following periodontic services:

- Prescription-strength fluoride toothpaste
  - Covered after periodontal surgery or other covered periodontal procedures and must be provided by your dental office.
- Prescription-strength antimicrobial rinses
  - Covered after periodontal surgery or other covered periodontal procedures.
  - Antimicrobial rinse may be dispensed once per periodontal treatment. The periodontal treatment may take several visits to finish.
  - Covered during pregnancy without any periodontal procedure.

Class II Sedation and Palliative Treatment

Sedation plays a supporting role in your treatment, and palliative treatment is treatment to lessen pain from an oral condition. You are covered for the following sedation and palliative treatment services:

- Intravenous moderate sedation
  - Covered when you are having endodontic, periodontic and oral surgery services that are covered by this plan.
  - Intravenous moderate sedation is a Covered Dental Benefit only once per day.
- General anesthesia
  - Covered for certain endodontic, periodontic and oral surgery procedures that are covered by your plan.
  - Covered for children through age six.
  - Covered when medically necessary for physically or developmentally disabled persons when done with Class I, II, III, TMJ or optional Orthodontic Covered Dental Benefits.
- Pain relief
  - Services needed after oral surgery, called post-operative care and treatment, are considered part of the surgery and not covered separately.
  - Treatment for complications after surgery are considered part of the surgery and are included in the cost of surgery charged by your provider. Additional costs for this treatment are not billable separately by your provider if done within 30 days of the surgery.

These sedation and palliative services are not covered

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

Covered Dental Benefits

Class II Restorative Services

These services provide coverage for fillings and other treatment for cavities. You are covered for the following restorative services:

- Fillings (includes white fillings on your back Molars)
  - The same surface on the same tooth is covered once every two years, in the following cases:
    - decay is visible on the tooth,
    - a fracture (crack) has caused the loss of a significant part of a tooth cusp,
    - or, a fracture causes significant damage to an existing filling.
- Stainless steel crowns or prefabricated crowns
  - Covered once per tooth every two years.

These restorative services are not covered

- Fillings for anything other than decay or fracture.
- Recontouring or polishing fillings.
- Overhang removal.
- Copings.
- Restorations necessary to correct vertical dimension or to alter the shape or occlusion.
- Benefits for restorations placed in a tooth are not covered for two months after application of caries arresting medicament.

Class II Oral Surgery

Oral surgery includes many common procedures that happen at the Dentist's office such as removing teeth and treating diseases. You are covered for the following oral surgery services:

- Removal of teeth
- Preparing the mouth for the insertion of dentures
- Treating traumatic injuries or diseases in the mouth
- Bone grafts
  - Covered only when done with treatment for periodontal disease.

These oral surgery services are not covered

- Bone replacement grafting for ridge preservation.
- Bone grafts of any kind to the upper or lower jaws, except when done with treatment for periodontal disease.
- Tooth transplants (re-implanting or relocating a tooth in the jaw).
- Placing materials in a hole in the jawbone to regrow bone (generate osseous filling) after a tooth or implant is removed.

Class II Periodontics

Periodontics is the part of dentistry that deals with the structures surrounding and supporting the teeth. In other words, it means things as simple as removing plaque or as complicated as surgical gum treatments. You are covered for the following periodontic services:

- Surgical and nonsurgical treatment of tissues supporting the teeth (gums)
  - Soft tissue grafts (two sites per quadrant) are covered once every three years.
- Limited Occlusal adjustments - Fixing how teeth bite together
  - Covered for eight teeth or fewer once in a 12-month period.
- Treating gum disease with nonsurgical periodontal scaling and root planing
  - Covered once every three years from the date of service.
- Periodontal surgery (per site)
  - Covered once every three years from the date of service.
  - You must have had scaling and root planing done six weeks - six months before the surgery, or you must be in active supportive periodontal therapy.

Class II Endodontics

Endodontic services focus on the insides of teeth. These services work to save damaged or decayed teeth by repairing or replacing the soft inner tissue, called the pulp. Endodontics also help maintain the health of the roots of teeth and the “canals” they run through. You are covered for the following endodontic services:

- Pulpal and root canal treatment (includes pulp exposure treatment, pulpotomy, and apicoectomy)
  - Root canal treatment on the same tooth is covered once in a lifetime.
  - Re-treatment of the same tooth is not a paid covered dental benefit when performed within two years of the previous root canal treatment.

These endodontic services are not covered

- Internal bleaching of teeth.

Class II Adjunctive General Service

Adjunctive general services are services that do not fall into another class of service. You are covered for the following adjunctive general services:

- Athletic mouthguard
  - Covered for children from 6 through 18 years of age, once every three years.

Class III Periodontics

These benefits are available only to those patients who have Pocket Depth readings of 5mm or greater. You are covered for the following periodontic services:

- Night guard (occlusal guard)
  - Covered once every three years from the date of service.
- Repair or reline of night guard
  - Covered when done more than six months from the initial date of service.

- Complete occlusal equilibration
  - Covered once for the entire time you are on this plan.

These periodontic services are not covered

- Appliances necessary to correct vertical dimension or restore the occlusion.

Class III Restorative Services (Crowns)

Crowns can have two meanings in dentistry. Dentists call the part of your teeth you can see when you smile the crown. But most people think of a crown as an artificial covering that gets cemented into your mouth over a tooth. Artificial crowns cover teeth that have been severely damaged. In this section, we are talking about the second type of crown — the artificial covering. You are covered for the following restorative (crowns) services:

- Crowns, veneers and onlays
  - Payment is based on Seat Date.
  - Covered on the same tooth once every seven years from the Seat Date.
  - Covered for treatment of cavities (visible decay) or fracture resulting in significant loss of tooth structure (missing cusp) when teeth cannot reasonably be restored with a filling.
  - An inlay as a single tooth restoration, will be considered as elective treatment and an amalgam (silver filling) allowance will be made once in a two-year period, with any difference in cost being your responsibility.
  - An implant-supported crown on the same tooth is covered once every seven years from the Seat Date.
  - A crown used to re-contour or reposition a tooth to provide additional retention for a removable partial denture is not a paid 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.
- Crown buildups
  - Covered once on each tooth in a seven-year period from the date of service.
  - Not covered within two years of a restoration on the same tooth from the date of service.
  - A crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
  - A crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- Post and core on endodontically-treated teeth
  - Covered once on each tooth in a seven-year period from the date of service.
  - Not covered within two years of a restoration on the same tooth from the date of service.

These restorative services are not covered

- Copings.
- A core buildup is not billable with placement of an onlay, 3/4 crown or veneer.
- A crown or onlay used to repair a microfracture when there are no symptoms, or when there is an existing restoration and no evidence of decay or fractured off tooth structure.

- A crown or onlay placed because of weakened cusps or existing large restorations.
- Benefits for restorations placed in a tooth less than two months after application of caries arresting medicament.

Class III Prosthodontics

Prosthodontics involves making and fitting artificial teeth, also known as dentures or bridges. You are covered for the following prosthodontic services:

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

These prosthodontic services are not covered

- Crowns in conjunction with overdentures.
- Duplicate dentures.
- Personalized dentures.
- Copings.
- Appliances that correct vertical dimension or restore the occlusion (the position of your teeth when your jaw is closed, or more simply, your bite).
- Benefits for restorations placed in a tooth are not covered for two months after application of interim caries arresting medicament.

Orthodontia

More commonly called braces, orthodontic services work to position teeth to improve your bite or smile. Please see your Plan Overview Page for information regarding optional Orthodontic coverage.

Orthodontic treatment is appliance therapy necessary for the correction of teeth or jaws that are positioned improperly.

- Orthodontic procedures necessary for the treatment of malalignment of teeth and/or jaws, including:
  - Orthodontic records.
  - Exams (initial, periodic, comprehensive, detailed and extensive).
  - X-rays (intraoral, extraoral, diagnostic radiographs, panoramic).
  - Diagnostic photographs.
  - Cephalometric films.
  - Diagnostic casts (study models).
- Payment for orthodontic services
  - For orthodontia claims, the initial banding date is considered the treatment date when looking to see if your claim was submitted on time.
  - Payment is made monthly and is only made for treatment received while a patient is eligible. If individuals become ineligible prior to the payment of all benefits, any future payments are not made.
  - If treatment began prior to the start of coverage under this plan, payment will be prorated based on the balance remaining after the down payment and monthly charges which were due prior to the date of eligibility are deducted.

These orthodontic services are not covered

- Replacement or repair of an appliance.
- Self-administered orthodontics.
- No benefits shall be provided for services considered inappropriate and unnecessary.

Temporomandibular Joint Benefits

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

- Dental services for the treatment of disorders associated with the TMJ
  - Procedures for the treatment of a documented and diagnosed temporomandibular joint dysfunction.
  - Effective for the control or elimination of one or more of the following issues which are caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
  - Recognized as effective, according to the professional standards of good dental practice; and
  - Not experimental or primarily for cosmetic purposes.

- Surgical treatment
- Non-surgical treatment including but not limited to:
  - TMJ examination,
  - X-rays (including TMJ film and arthrogram),
  - Cone beam CT scan for TMJ series is covered once per lifetime,
  - temporary repositioning splint,
  - occlusal orthotic device,
  - removable metal overlay stabilizing appliance,
  - fixed stabilizing appliance,
  - occlusal equilibration,
  - arthrocentesis,
  - and manipulation under anesthesia.

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

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

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

Accidental Injury

DDWA will pay 100 percent of the Filed Fee or the Maximum Allowable Fee, whichever is less, for Class I, Class II, and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily injury. However, payment for Accidental Injury claims will not exceed the unused plan maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the Benefit Period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

General Exclusions

This Plan does not cover every aspect of dental care. The benefits covered under this plan are subject to Limitations listed above which affect the type or frequency of procedures which will be reimbursed. Additionally, there are Exclusions to the type of services covered. These Limitations and Exclusions are detailed with the specific benefits listed above and in this section. Please read these Limitations and Exclusions carefully.

These items are not paid covered benefits under this Plan:

1. Dentistry for cosmetic reasons.

2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Procedures include: restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.
3. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5. Experimental services or supplies, which include:
    a. Procedures, services or supplies for which the use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
        i. The services are in general use in the dental community in the state of Washington;
        ii. The services are under continued scientific testing and research;
        iii. The services show a demonstrable benefit for a particular dental condition; and
        iv. They are proven to be safe and effective.
    b. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
    c. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the eligible person.
    d. Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review.
6. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs.
7. Injections of anesthetic not in conjunction with a dental service.
8. Injection of any medication or drug not associated with the delivery of a covered dental service.
9. Prescription drugs.
10. Laboratory tests and laboratory exams.
11. Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
12. Broken appointments.
13. Behavior management.
14. Completing claim forms.
15. Habit-breaking appliances which are fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), does not include Occlusal Guard, see the *"Class III Periodontics"* section for benefit information.
16. Orthodontic services or supplies are not covered unless optional Orthodontic coverage has been selected. Please see your Plan Overview Page for more information.
17. This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured

motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

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

Additional Procedures

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the Plan. In such instances, the Plan will pay the proper percentage of the lowest fee. The balance of treatment cost remains the enrolled person’s responsibility.

Enrollment and Using Your Benefits

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

Enrollment and Using Your Benefits

Enrollment Information

You have signed up for the Delta Dental PPO Plan. Please see below for information about enrollment for you and your family. If you have questions please visit our website at www.DeltaDentalWA.com, or call us at 800-554-1907.

Who Can Be Covered by This Plan?

- **Employees**
  To be covered under this plan you must meet all eligibility guidelines set by your employer and complete the enrollment process.

- **Dependents of Employees**
  Your Dependents can be covered under this plan. You may enroll the following Dependents:
  - Your spouse or domestic partner; and
  - Your Dependent children and the Dependent children of your spouse or your domestic partner. Dependent children are covered from birth through age 25. Dependent children are:
    - Biological Children
    - Stepchildren
    - Foster children
    - Adopted children
  - Dependent adult children over age 26
    Children over age 26 who are unable to live independently may stay enrolled in this plan if they meet these qualifications:
    - They are enrolled as a Dependent on your plan when they turn 26 years of age;
    - They are incapable of self-sustaining employment because of an intellectual disability (or related conditions which include cerebral palsy, epilepsy, autism, or another neurological condition which is closely related to intellectual disability or which requires treatment similar to that required for intellectually disabled individuals) or physical disability; and
    - They are chiefly Dependent upon you for support and maintenance.
    - Continued coverage requires that you send proof of incapacity and dependency to DDWA within 31 days of the child turning 26 years of age. DDWA reserves the right to periodically verify the disability and dependency, but not more frequently than annually after the first two years.

How To Enroll

If you are a new Employee, you and your Dependent(s) are eligible for benefits on the first day of the month following completion of the waiting period established by your Group and become enrolled when they have completed the enrollment process. You must complete this enrollment within 60 days of your eligibility date.

- **Open enrollment**
  If you do not enroll when you are a new Employee or if you want to make changes to your plan, you may do so during open enrollment. Open enrollment is an annual period set by your Group to allow you to make changes to your plan. You may be able to make changes outside of open enrollment if you have a qualifying event; this is called special enrollment.

- Special enrollment

  In specific situations, you can enroll, renew or make changes to your plan outside of open enrollment. These situations are called qualifying events. Qualifying events are:

  - You add to your family.
    - You or your spouse or domestic partner have a baby, adopt a child, or foster a child.
  - When you have a baby, adopt or foster a child.
    - Your newborn baby is covered at birth. Adopted and fostered children are covered on their adoption date, at the time of placement, or the date when you become legally responsible for their support. Dental coverage for newborns will include coverage for congenital anomalies from the moment of birth.
    - A child will be considered an Eligible Dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the Enrolled Employee for the purpose of adoption under the laws of the state in which the Employee resides 2) the Employee has assumed legal obligation for total or partial support or 3) upon placement of the child in anticipation of adoption.
    - When additional premium is required for your newborn or adopted child or child placed in anticipation of adoption, enrollment must be received within 60 days. When additional premium is not required, for your newborn or adopted child or child placed in anticipation of adoption, we encourage enrollment as soon as possible to prevent delays in claims processing but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.
  - There is a change in your status or that of your family.
    - If you get married or start a domestic partnership; or get divorced or end a domestic partnership; you must complete the enrollment process within 60 days to update your coverage.
  - Other qualifying events.
    - You or your child's parent/guardian no longer get coverage through work;
    - You or your child's parent/guardian no longer get COBRA coverage;
    - The loss of minimum essential benefits, including loss of employer sponsored insurance coverage, or of the coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's voluntary termination of employer sponsored coverage, the misrepresentation of a material fact affecting coverage, or for fraud related to the terminated health coverage;
    - If you or your eligible Dependent(s) lose eligibility for coverage under Medicaid or a public program;
    - A permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the dental plan under which they were covered does not provide coverage in that person's new service area;
    - If you or your eligible Dependent(s) current plan no longer offers eligibility or benefits;
    - Loss of coverage as a Dependent due to age Limitations;
    - Your child lost coverage because of mistakes made by health benefit exchange staff or the U.S. Department of Health and Human Services.

- Other eligibility information

  - No person can be enrolled in this dental Plan both as an Employee and as a Dependent and no person will be considered as a Dependent of more than one Employee on this Plan.

- Conversion option
  - If your dental coverage stops because there is an extended strike, lockout or labor dispute, you can continue your coverage under this Plan by self-paying the required Premium to the employer for up to six months. If your coverage stops because your employment, eligibility or group policy ends, or you have exceeded your six-month self-pay period, you may convert your coverage to a Delta Dental individual or family plan. You must apply within 63 days after your coverage ends, or after you receive notification that your coverage is ending, whichever is later.
  - NOTE: The benefits and premium costs of an individual or family plan may be different from what you have now.
  - Apply online at DeltaDentalCoversMe.com or by calling 888-899-3734.

When Does Coverage Start?

Coverage for you and your eligible Dependents begins on the first of the month after you have completed the enrollment process. Your newborn baby is covered at birth. Adopted and fostered children are covered on their adoption date, at the time of placement, or the date when you become legally responsible for their support.

When Does This Plan End?

- Employees
  Coverage ends at the end of the month in which you are no longer an eligible or enrolled Employee.
- Dependents
  Dependent coverage ends at the end of the month in which the Employee's coverage ends, or when the Dependent is no longer eligible, whichever occurs first.

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

Enrolled Employees who join a branch of military service have the right to continue dental coverage as established by Group 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.

Family and Medical Leave Act (FMLA) and Paid Family Medical Leave (PFML)

The benefits for an enrolled member may be continued if the Employee is eligible for the Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and is on a leave of absence that meets that appropriate criteria. For further information, contact your employer.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This section applies to Groups with 20 or more Employees.

Federal law requires that if certain qualifying events occur that would normally terminate coverage, you may continue coverage for a period of time on a self-pay basis.

When you terminate employment for reasons other than gross misconduct, you may continue your dental benefits for up to 18 months by self-paying the required premium. This option to continue dental benefits ends if you become eligible for coverage under another group dental plan.

If your Dependent no longer meets the eligibility requirements due to the death, divorce or, dissolution of domestic partnership of the Employee, or does not meet the age requirement for children, coverage may continue up to three years by self-paying the required premium. This option to continue dental benefits ends if the Dependent is covered under another group dental plan.

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

Your Dentist and Our Networks

Your provider Network is: Delta Dental PPO.

You may choose 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.

Our Networks

We have different Networks, or groups, that our Dentists join. These Dentists are called Participating Dentists. Dentists in the Delta Dental PPO Network often have agreed to accept lower fees than Dentists in the Delta Dental Premier® Network. Dentists who choose to not join one of our Networks are called Non-Participating Dentists.

Participating Dentists

For your Plan, Participating Dentists may be either Delta Dental Premier Dentists or Delta Dental PPO Dentists.

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

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

Out-of state Dentists

If you receive treatment from a Non-Participating Dentist outside of the state of Washington, your out of pocket amount will be based on the percentage established for a Delta Dental PPO Dentist. Allowable amounts paid for covered services will be based on the Maximum Allowable Fee for a Participating Dentist in that state, or their actual fee, whichever is less.

To learn more about Delta Dental PPO and Delta Dental Premier Dentists and how to find one near you, check the next section of this booklet. To search for a network Dentist now, visit our online directory at www.DeltaDentalWA.com or call 800-554-1907.

Estimating your costs

Your Dentist can ask us for an estimate of how much we will cover for your family's dental work before the treatment is done. These cost estimates are called Confirmation of Treatment and Cost. For example, if your child visits the Dentist for a routine cleaning and the Dentist determines that they have a cracked tooth and needs a crown you might want to know how much it will cost. Ask your Dentist to send us a treatment plan, along with x-rays. After we look over the plan, we will send you and your Dentist an estimate for how much we will pay and what your out-of-pocket costs might be. It usually takes 15 days after we get your Dentist's request for us to make our estimate. We also have a tool on our website that can help you get an idea about how much your dental work will cost. You can use that at www.DeltaDentalWA.com, or you can call us at 800-554-1907.

Plan Details

Plan Overview Page

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

Benefit Period

Your plan is designed around a Benefit Period – the time period that your Limitations, Deductible, and maximums refer to. The specific Benefit Period for your plan is shown on your Plan Overview Page.

Deductible (For Plans with a Deductible)

This plan has an amount that you must pay directly to your Dentist before some benefits will begin. The amount of your Deductible, and what it applies to, is shown on your Plan Overview Page.

Waiting Period

There is no waiting period under this policy.

Maximum Benefit

There are Limitations on how much we will pay for claims during your Benefit Period. The plan maximum is shown on your Plan Overview Page. Benefits for Class I covered services do not apply to your annual maximum. You are responsible for paying costs above the annual maximum directly to your Dentist.

Reimbursement Levels

There are Limitations on the percentages we will pay for Covered Dental Benefits. The percentages are shown on your Plan Overview Page. You are responsible for paying the percentages not covered directly to your Dentist.

When We Pay

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

Time Limitations on Procedures

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

Bright Ideas

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

Bright Ideas

Visit a Participating Delta Dental Network Dentist

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

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

Three great reasons to visit a Delta Dental network Dentist

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist
Provides significant discounts for services	✓	✓	
Protects you from balance billing	✓	✓	
Files dental service claims paperwork for you	✓	✓	

Finding a Delta Dental network Dentist

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

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

You can also call us at 800-554-1907 for assistance finding a network Dentist.

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

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

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

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

Bright Ideas

Tips for when you visit the Dentist

- ✓ Tell your Dentist that you are covered by Delta Dental of Washington
- ✓ Provide information on other dental coverage you may have
  - If you are covered by more than one dental plan, your Dentist's office will help coordinate your coverage. Your Dentist and dental plans will work together to make sure you get the most out of your dental benefits.
  - Tell your Dentist's office about both plans.
- ✓ Request a Confirmation of Treatment and Cost when your Dentist recommends treatment. This is a pre-treatment estimate, which is different from preauthorization, which is described in the section on enrollment and using your benefits.
  - For expensive, extensive treatment, get a precise estimate by asking your Dentist to submit a request. Once submitted, you will receive a Confirmation of Treatment and Costs from us.
  - A confirmation details your Dentist's specific treatment plan, what your benefits pay, and gives you an accurate out-of-pocket estimate. Many Dentists are able to get confirmations in real-time. If not, you can view your confirmation through your MySmile account or elect to have a copy sent to you.
- ✓ Talk about your health
  - A healthy smile is an important part of your overall health. Research shows there's a link between your oral and overall health. Telling your Dentist about your health helps them provide better care to your smile.
- ✓ Talk to your Dentist about:
  - Cancer; many treatments cause dry mouth and painful gums.
  - Diabetes; gum disease makes it harder to control blood sugar.
  - Heart disease; people with unhealthy gums are twice as likely to have heart disease.
  - Medications; many can cause dry mouth which can cause bad breath and cavities.
  - Pregnancy; moms can pass cavity-causing bacteria to their babies.
  - Tobacco use; increases your risk of tooth decay, gum disease, tooth loss and oral cancer.

Tips for after your dental care visit

Review your EOB

After your visit, sign in to MySmile and click "My dental activity" to review your Explanation of Benefits (EOB).

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

- ✓ Treatments billed by your Dentist
  Treatments listed should match the ones you received and were billed for. If you notice any inconsistencies, talk to your Dentist's office. If you are not satisfied that your EOB is correct, let us know.
- ✓ Your benefit maximums and deductibles
  This is helpful if you need more treatments. Use it to work with your Dentist on scheduling so you do not exceed your maximums for the year.
- ✓ Other dental overage (if applicable)
  Use this information to compare to your other plan's EOB and Dentist's bill. If you have other coverage that is primary and this is blank, talk to your Dentist office. If there is a number here and you do not think it is right, give us a call.

Bright Ideas

- ✓ How your benefits were applied - here is the math behind your cost share:
  - $ Total Billed by Your Dentist
  - – Network Savings
  - – Deductible
  - – Other Insurance (if applicable)
  - – Amount Paid by Your Dental Plan
  - $ Your Share

Reasons to save your EOB's

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

Sending Claims

In order for us to pay for your Dentist bills, you or your Dentist have to send us a claim. It is a lot like a bill — from your Dentist to us. Claims must be submitted to us within 365 days after your family's dental visit. Please see your Plan Overview Page to see if your group has Orthodontic benefits.

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

We accept all American Dental Association-approved claim forms. Your Dentist can download one from our website, www.DeltaDentalWA.com, or they can call us at 800-554-1907 to have one faxed or mailed.

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

If your claim is denied

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

How to file a claim yourself

If you get care from a Dentist who does not participate in a Delta Dental Network, you may need to file a claim yourself. You can download a claim form from our website, www.DeltaDentalWA.com. If you need help completing it, either ask your Dentist or call us at 800-554-1907. We can also mail or fax a claim form to you if you call us at that number.

Paying out-of-pocket costs

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

Bright Ideas

How to make sure your plan pays your Dentist bills

1. If you want a confirmation of treatment and cost, ask your Dentist to send one to us
2. Make sure a claim is sent to us
3. Review your Explanation of Benefits.
4. Pay your Dentist any out-of-pocket costs
5. Review your Explanation of Benefits and call us if you have questions about it

Important Details

This section gives you more information about our obligations to you, and your obligations to us.

Urgent Confirmation of Treatment and Cost Requests

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

Immediate treatment consistent with this plan is allowed in emergency situations without requiring a Confirmation of Treatment and Cost.

Examples of dental emergencies are:

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

Appeals

How to file an appeal

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

Your appeals request must include:

- Your name.
- The patient's name (if different) and ID number.
- The claim number (from the Explanation of Benefits).
- Your Dentist's name.

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

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

Please send your appeal requests to:

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

Or, call us at: 800-554-1907

Appeals have two parts: informal and formal reviews.

Step 1: Informal Review

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

We will review your request and make a decision within 14 days after we get it. We will send you written notice of our decision as soon as it is complete. If our decision is not in your favor, we will tell you what

else you can do to appeal our decision. You can ask us to send you copies of the information we used to make our decision.

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

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

Step 2: Formal review

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

You need to ask for a formal review within 90 days of the date of our informal review decision letter.

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

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

Making the appeals process fair

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

Other actions you can take

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

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

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

Fax: 360-586-2018

More Important Stuff

Notices

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

Any notice sent to DDWA must be sent by you or your authorized representative in writing (either electronically or by U.S. Postal Service). Your notice to us is considered delivered when sent to us at the email

address shown below; when given in person; or when sent registered or certified United States mail, return receipt requested, proper postage prepaid, and properly addressed to:

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

Email: CService@DeltaDentalWA.com

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

Phone: 800-554-1904
Fax: 206-985-4783

Please see the *"Appeals"* section for more detailed information on sending an appeal request.

Delta Dental of Washington's Responsibility

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

Rights of Recovery (Subrogation)

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

Notice of Legal Action

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

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). You can reach the OIC at 360-725-7263 or go to www.insurance.wa.gov for more information.

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 the DDWA Customer Service Department during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at www.DeltaDentalWA.com.
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage and 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-hour 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 healthcare 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 Costs, or appeals.
- If applicable, pay the dental office any appropriate coinsurance or Deductible amounts 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.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your dental health information in compliance with the Health Insurance Portability and Accountability Act. You can get our Notice of Privacy Practices by visiting www.DeltaDentalWA.com, or by calling DDWA at 800-554-1907.

Extension of Benefits

Once a person ceases to be enrolled under this Plan, or the Plan terminates, DDWA will not pay for services performed after 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, are otherwise benefits under the terms of this Plan, and are not covered under a separate DDWA plan.

Coordination of Benefits

When you have dental coverage under more than one plan, those plans work together to provide you the benefit of that additional coverage. That is called coordination of benefits. The General Information below highlights what most people need to know. The information under *Full Coordination of Benefits Information* will give you all of the details of how we coordinate your benefits.

General Information

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

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

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

Full Coordination of Benefits Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) "Nondependent or Dependent." The plan that covers the person other than as a Dependent, for example as an Employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a medicare beneficiary and, as a result of federal law, medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (e.g., a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect on the Benefits of This Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the Total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed 100 percent of the total Allowable Expense for that claim. Total Allowable Expense is the Allowable Expense of the Primary Plan or the Secondary Plan up to this plan's allowable expense. In addition,

the Secondary Plan must credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other dental coverage.

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Notice to Covered Persons

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

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

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

Important Details

Definitions

These are some of the terms we use in this benefit booklet that you should understand. If you are not sure what they mean or how they impact your plan, please call our customer service team at 800-554-1907.

Accidental Injury

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

Benefit Period

The period of time in which your policy is effective as documented on the Plan Overview Page.

Calendar Year

January through December.

Covered Dental Benefit

Dental services that are covered under this policy, subject to the Limitations set forth.

Deductible

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

Dentist

A licensed Dentist legally authorized to practice dentistry at the time and in the place services are performed. This policy provides for covered services only if those services are performed by or under direction of a licensed Dentist or other Licensed Professional operating within scope of their license.

Dependent

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

Employee

An individual who meets all eligibility guidelines set by your employer and completes the enrollment process.

Exclusions

Dental services or procedures your plan does not cover.

Explanation of Benefits (EOB)

Once we process a claim from either you or your Dentist, we will provide you with an Explanation of Benefits. These are not bills. They explain what your Dentist's charges are, what we have paid to your Dentist, and what you might owe out-of-pocket.

Filed Fee

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

Licensed Professional

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

Limitations

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

Maximum Allowable Fee

The maximum dollar amount that will be allowed toward the payment or reimbursement for any service provided for a Covered Dental Benefit.

Maximum Amount

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

Molars

Teeth in the back of your mouth.

Network

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

Non-Participating Dentist

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

Participating Dentist or Participating Provider

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

Plan Overview Page

The summary of coverage, Deductible and co-insurance amounts and Benefit Period of this Policy. The

Plan Overview Page is incorporated into this policy by this reference. This is often referred to as a Declaration Page or Dec Page.

Pocket Depth

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

Quadrants

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

Seat Date

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

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Nondiscrimination and Language Assistance Services

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

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

We will provide free aids and services to people with disabilities to assist in communicating effectively with DDWA staff, such as:

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

We will provide free language services to assist in communicating effectively with DDWA staff for people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 800-554-1907. If you need translation or interpreter assistance at your dental provider's office, please contact their staff. The cost for translations and interpreter services for communication between you and your provider are not covered by DDWA.

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- The Washington State Office of Insurance Commissioner, electronically through the Office of Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-compliant-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Important Details

Taglines
Amharic እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።
Arabic إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.
Cambodian (Mon-Khmer) ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 800-554-1907។
Chinese 如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。
Cushite (Oromo) Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.
French Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.
German Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.
Japanese ご本人様、またはお客様の身寄りの方でもDelta Dental of Washingtonについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907までお電話ください。
Korean 귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907로 전화하십시오.
Laotian ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.
Persian (Farsi) اگر شما، یا شخصی که به وی کمک می کنید، سؤالی درباره‌یDelta Dental of Washington دارد، این حق را دارید که اطلاعات مورد نیازتان را به زبان تماس بگیرید. 800-554-1907 جهت صحبت با یک مترجم شفاهی، با شماره خود و بدون هیچ هزینه‌ای دریافت کنید.
Punjabi ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।

Important Details

Taglines
Romanian Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.
Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.
Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.
Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.
Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde modon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.
Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.
Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.
Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.