Delta Dental PPO℠

Seattle Pacific University

Delta Dental of Washington

Plan Number: 00333

Effective Date: January 1, 2023

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

We believe everyone can enjoy good oral and overall health, with no one left behind. It drives everything we do and has been our sole focus for over 60 years.

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

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

Questions Regarding Your Plan

If you have questions regarding your dental benefits Plan, please call or email our Customer Service Department at:

800-554-1907

CService@DeltaDentalWA.com

Written inquiries may be sent to:

Delta Dental of Washington

Customer Service Department

P.O. Box 75983

Seattle, WA 98175-0983

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

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

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

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

Dial 711 (the statewide telephone relay number) or 800-833-6384 to connect with a Washington Relay Service communications assistant. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. They will then relay the conversation between you and our customer service representatives.

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

Table of Contents

Section A – Summary of Benefits

Reimbursement Levels for Allowable Benefits

In-Network – Delta Dental PPO Dentists

Class I	100%
Class II	80%
Class III	50%
Orthodontic procedures	50%
Annual Deductible per Person	No Deductible
Annual Deductible — Family Maximum	No Deductible

Out-of-Network – Non-Delta Dental PPO

Class I	100%
Class II	80%
Class III	50%
Orthodontic procedures	50%
Annual Deductible per Person	$50
Annual Deductible — Family Maximum	$150

Plan Maximum

Annual Plan Maximum per Person $1,750

Lifetime Orthodontic Benefits per Person $1,000

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

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III Covered Dental Benefits, orthodontic benefits (for enrolled eligible children only), and accidental injury benefits.

The annual deductible is waived for:

- ◊ Class I Covered Dental Benefits.

How to use your Plan

The best way to take full advantage of your dental Plan is to know its features. You can learn them by reading this benefit booklet before you go to the Dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions. If you have questions or do not understand something, please give us a call at 800-554-1907. We're more than happy to help.

Consult your provider regarding any charges that may be your responsibility before treatment begins.

Coinsurance

DDWA will pay a percentage of the cost of your treatment, and you are responsible for paying the allowable balance. The part you pay is called the coinsurance. If your Plan has a deductible, you are responsible for the coinsurance even after a deductible is met.

Please see your "Reimbursement Levels for Allowable Benefits" under the "Summary of Benefits" section for details on the coinsurance required by your Plan.

Benefit Period

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

Plan Maximum

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

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

Plan Deductible – In-Network

This Plan does not have an In-Network deductible requirement.

Plan Deductible – Out-of-Network

Your Plan has a deductible, which can be found in the "Summary of Benefits" section. This means that from the first payment or payments DDWA makes for Covered Dental Benefits, a deduction is taken. This deduction is owed to the provider by you. Once an Enrolled Person has satisfied the deductible during the benefit period, no further deduction will be taken for that Enrolled Person until the next benefit period.

Your family deductible is also listed in the “Summary of Benefits” section. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

Reimbursement Levels

Your dental Plan offers different classes of covered treatment. Each class also specifies Limitations and Exclusions. For more information about reimbursement levels for your plan, see the “Summary of Benefits” section.

Refer to the “Benefits Covered by Your Plan” section for specific Covered Dental Benefits under this Plan.

Section B – Your Benefits

Benefits Covered By Your Plan

The following are the Covered Dental Benefits under this Plan and are subject to the Limitations and Exclusions (refer also to "General Exclusions" section) contained in this benefit booklet. Such benefits (as defined) are available only when provided by a licensed Dentist or other Licensed Professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

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

The amounts payable by DDWA for Covered Dental Benefits are described in the "Summary of Benefits" section.

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

- Comprehensive, or detailed and extensive oral evaluation.
- Diagnostic evaluation for routine or emergency purposes (dental exam).
- X-rays.

Limitations

- Comprehensive, or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same Dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same Dentist are paid as a Periodic Oral Evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- A set of Bitewing X-rays (two or more images) is covered once in a benefit period.
    - ◊ A single Bitewing X-ray is covered, there are no Limitations on the number of single Bitewing X-rays a patient can have.
- A Complete Series or Panoramic X-ray is covered once in a five-year period from the date of service.
    - ◊ Any number or combination of x-rays, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a complete series, will be considered a complete series for payment and benefit limitation purposes.

Exclusions

- Consultations – diagnostic services provided by a Dentist other than the requesting Dentist.
- Study models.
- Diagnostic services and x-rays related to Temporomandibular Joints (jaw joints) are not a Class I paid Covered Dental Benefit.

Class I Preventive

Covered Dental Benefits

- Prophylaxis (cleaning).
- Periodontal maintenance.

- Topical application of Fluoride including fluoridated varnishes.
- Sealants.
- Space maintainers.
- Preventive resin restoration.
- Application of Caries arresting medicament.

Limitations

- Any combination of Prophylaxis (cleaning) and periodontal maintenance is covered twice in a benefit period.
    - ◊ Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- For any combination of adult Prophylaxis (cleaning) and periodontal maintenance, third and fourth occurrences may be covered if your gums have Pocket depth readings of 5mm or greater.*
- Topical application of Fluoride is limited to two covered procedures in a benefit period.
- The application of a sealant is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
    - ◊ Benefit coverage for application of Sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- Space maintainers are covered once in a patient's lifetime through age 17 for the same quadrant.
- The application of a preventive resin restoration is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
    - ◊ Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
    - ◊ The application of a preventive resin restoration is not a Covered Dental Benefit for two years after a sealant or preventive resin restoration on the same tooth.
- The application of Caries arresting medicament is a Covered Dental Benefit twice per benefit period per tooth.
    - ◊ Benefits for restorations placed in a tooth within two months of the medicament application are denied.

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

Exclusions

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

Class I Periodontics

Covered Dental Benefits

- Prescription-strength Fluoride toothpaste.
- Prescription-strength antimicrobial rinses.

Limitations

- Prescription-strength Fluoride toothpaste and antimicrobial rinse are Covered Dental Benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.

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

Class II Benefits

Class II Sedation

Covered Dental Benefits

- General Anesthesia.
- Intravenous moderate sedation.

Limitations

- General Anesthesia is a Covered Dental Benefit only in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with Class I, II, III or Orthodontic Covered Dental Benefits.*
- Intravenous moderate sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.*
- Sedation, which is either General Anesthesia or intravenous moderate sedation, is a Covered Dental Benefit only once per day.
- General Anesthesia or intravenous moderate sedation for routine post-operative procedures is a Covered Dental Benefit only for children through the age of six, or a physically or developmentally disabled person.

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

Exclusions

- General Anesthesia or intravenous moderate sedation for routine post-operative procedures is Not a Paid Covered Dental Benefit for children over the age of seven or for persons who are not physically or developmentally disabled.

Class II Palliative Treatment

Covered Dental Benefits

- Palliative Treatment for pain.

Limitations

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

Class II Restorative

Covered Dental Benefits

- Restorations (fillings).
- Stainless steel Crowns or prefabricated Crowns.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- Restorations are covered for the following reasons:
    - ◊ Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).
    - ◊ Fracture resulting in significant loss of tooth structure (missing cusp).
    - ◊ Fracture resulting in significant damage to an existing restoration.
- If a Resin-Based Composite or glass ionomer restoration is placed in a posterior tooth, it will be considered an elective procedure and an Amalgam allowance will be made, with any difference in cost being the responsibility of the patient. For this purpose, buccal (facial) surfaces of bicuspids are considered anterior teeth.
- Stainless steel Crowns or prefabricated Crowns are covered once in a two-year period from the date of service.

Exclusions

- Overhang removal.
- Copings.
- Re-contouring or polishing of a restoration.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion.

Please also see:

- "Class III Restorative" for more information regarding coverage for Crowns (other than stainless steel), Inlays, Veneers or Onlays.

Class II Oral Surgery

Covered Dental Benefits

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

Exclusions

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

Please also see:

- "Class II Sedation "section for additional information.

Class II Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- Periodontal scaling/Root Planing.
- Periodontal surgery.
- Limited adjustments to occlusion (eight teeth or fewer).
- Localized Delivery of Antimicrobial Agents.*
- Gingivectomy.

Limitations

- Periodontal scaling/Root Planing is covered once per quadrant in a three-year period from the date of service.
- Limited Occlusal Adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
    - ◊ Periodontal surgery must be preceded by scaling and Root Planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- Soft tissue grafts (two sites per quadrant) are covered once in a three-year period from the date of service.
- Localized Delivery of Antimicrobial Agents is a Covered Dental Benefit under certain conditions of oral health, such as periodontal Pocket depth readings of 5mm or greater.*
    - ◊ When covered, Localized Delivery of Antimicrobial Agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
    - ◊ When covered, Localized Delivery of Antimicrobial Agents must be preceded by scaling and Root Planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.

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

Please also see:

- "Class II Sedation" section for additional information.
- "Class III Periodontics" section for complete occlusal equilibration or Occlusal Guard.

Class II Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, including pulp exposure treatment, Pulpotomy, and Apicoectomy.

Limitations

- 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.

Exclusions

- Bleaching of teeth.

Please also see:

- "Class II Sedation" section for additional information.

Class II Occlusal Guard (Nightguard)

These benefits are available for patients with periodontal Pocket depth readings of 5mm or greater only, as determined by your Dentist. It is strongly recommended that prior to treatment you have your Dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

- Occlusal Guard (Nightguard).
- Repair and relines of Occlusal Guard.

Limitations

- Occlusal Guard is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.

Class III Benefits

Class III Periodontics

These benefits are available for patients with periodontal Pocket depth readings of 5mm or greater only, as determined by your Dentist. It is strongly recommended that prior to treatment you have your Dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

- Complete occlusal equilibration.

Limitations

- Complete occlusal equilibration is covered once in a lifetime.

Class III Restorative

Covered Dental Benefits

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

Limitations

- A Crown, Veneer, or Onlay on the same tooth is covered once in a five-year period from the Seat Date.

- An Implant-supported Crown on the same tooth is covered once in a five-year period from the original Seat Date of a previous Crown on the same tooth.
- An Inlay (as a single tooth restoration) will be considered as elective treatment and an Amalgam allowance will be made, with any difference in cost being the responsibility of the Enrolled Person, once in a two-year period from the Seat Date.
- Payment for a Crown, Veneer, Inlay, or Onlay shall be paid based upon the date that the treatment or procedure is completed.
- A Crown buildup is 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.
- A Crown buildup is covered once in a two-year period on the same tooth from the date of service.
- A post and core is covered once in a two-year period on the same tooth from the date of service.
- Crown buildups or post and cores are Not a Paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.
- A Crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial Denture is Not a Paid Covered Dental 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.

Exclusions

- Copings.
- A core buildup is not billable with placement of an Onlay, 3/4 Crown, or Veneer.
- A Crown or Onlay is Not a Paid Covered Dental Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A Crown or Onlay placed because of weakened cusps or existing large restorations.

Class III Prosthodontics

Covered Dental Benefits

- Dentures.
- Fixed Partial Dentures (fixed Bridges).
- Inlays when used as a retainer for a Fixed Partial Denture (fixed Bridge).
- Removable partial Dentures.
- Adjustment or repair of an existing prosthetic appliance.
- Surgical placement or removal of Implants or attachments to Implants.

Limitations

- Replacement of an existing fixed or removable partial Denture is covered once every five years from the Delivery Date and only then if it is unserviceable and cannot be made serviceable.
- Payment for Dentures, Fixed Partial Dentures (fixed Bridges), Inlays (only when used as a retainer for a fixed Bridge), and removable partial Dentures shall be paid upon the Seat/Delivery Date.
- Implants and superstructures are covered once every five years.
- **Temporary Denture -** DDWA will allow the amount of a reline toward the cost of an interim partial or full Denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.

- **Denture adjustments and relines -** Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

- Crowns in conjunction with Overdentures.
- Duplicate Dentures.
- Personalized Dentures.
- Copings.
- Maintenance or cleaning of a prosthetic appliance.

Other Benefits

Orthodontic Benefits for Covered Children

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

The lifetime maximum amount payable by DDWA for orthodontic benefits provided to an Enrolled Person shall be $1,000. Not more than $500 of the maximum, or one-half of DDWA's total responsibility shall be payable at the time of initial banding. Subsequent payments of DDWA's responsibility shall be made on a monthly basis throughout the length of treatment submitted, providing the employee is enrolled and the dependent is in compliance with the age limitation.

Additionally, payment for orthodontic benefits is based upon eligibility. If individuals become dis-enrolled prior to the payment of benefits, subsequent payment is not made.

Covered Dental Benefits

- Fixed or removable appliance therapy for the treatment of teeth or jaws.
- Orthodontic records: exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

- Payment is limited to:
    - ◊ Completion of the treatment plan, or any treatment that is completed while you are eligible for the Orthodontic Benefit, whichever occurs first.
    - ◊ Treatment received after coverage begins (claims must be timely submitted to DDWA). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- Treatment that began prior to the start of coverage will be prorated. Allowable payment will be calculated based on the balance of treatment costs remaining on the date of eligibility.
- In the event of termination of the treatment plan prior to completion of the case, or termination of this Plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

- Charges for replacement or repair of an appliance.
- Self-Administered Orthodontics.
- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by DDWA.

It is strongly suggested that a request for a Confirmation of Treatment and Cost, including your orthodontic treatment plan, be submitted to DDWA prior to commencement of treatment. A Confirmation of Treatment and Cost is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the subsequent payment of benefits, subsequent payment is not covered. If you have any questions about your Covered Dental Benefits or Plan Maximums, please see the "Questions Regarding Your Plan" section on how to contact Customer Service.

Accidental Injury

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

General Exclusions

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

These items are not paid Covered Dental Benefits under this Plan.

1) Dentistry for cosmetic reasons.
2) Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which 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 covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4) Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5) Experimental services or supplies.
    a) This includes:
        i) Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
            (1) The services are in general use in the dental community in the state of Washington;
            (2) The services are under continued scientific testing and research;
            (3) The services show a demonstrable benefit for a particular dental condition; and
            (4) They are proven to be safe and effective.
    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 an Appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.
    d) Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or

an oral Appeal and issue a decision no later than 72 hours after receipt of the Appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.

6) Analgesics such as nitrous oxide, conscious sedation, and 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) Charges for missed 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.), this does not include Occlusal Guard, see "Class II Periodontics" for benefit information.
16) TMJ services or supplies.
17) This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable 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 a 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 benefit booklet and may seek judicial review of any denial of coverage of benefits.

Necessary vs. Not Covered Treatment

Your Dentist may recommend a treatment plan that includes services which may not be covered by this Plan. DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While a treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your Dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Confirmation of Treatment and Cost" section.

Confirmation of Treatment and Cost

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

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

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

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

Urgent Confirmation of Treatment and Cost Requests

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

Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the Contract provisions.

Section C – Choosing a Dentist

Your Provider Network is: Delta Dental PPO Network.

You may select any licensed Dentist to provide services under this Plan; however, if you choose a Dentist outside of the Delta Dental PPO Network, your costs may be higher than if you were to choose a Delta Dental PPO Dentist. Dentists that do not participate in the Delta Dental PPO Network have not contracted with DDWA to charge our established PPO fees for covered services. As a result, your choice of Dentists could substantially impact your out-of-pocket costs.

Once you choose a Dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your Group and your member identification number. Your Group information can be found on the identification card document provided to you at enrollment or printed from www.DeltaDentalWA.com. You may also obtain your Group information and your member identification number by calling our Customer Service Department at 800-554-1907 or through our website at www.DeltaDentalWa.com.

DDWA uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft.

Please note that ID cards are not required to see your Dentist but are provided for your convenience.

Delta Dental Participating Dentists

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

Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their Filed Fee under our standard agreement.

Delta Dental PPO Dentists

Our PPO Dentists have agreed to provide services at a fee lower than their original Filed Fee. Because of this, selecting a PPO Dentist may be a more cost-effective option for you.

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

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

Out-of-State Dentists

If you receive treatment from a Non-Participating Dentist outside of the state of Washington, your coinsurance amounts will be based on the coinsurance 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.

Section D – Eligibility and Termination

Who is Eligible for Coverage?

Subscriber Eligibility

Eligible subscribers include:

- active, regular employees of Seattle Pacific University who regularly work a minimum nine-month work schedule and 20 hours per week
- retirees

Dependent Eligibility

Eligible dependents include:

- The subscriber's husband or wife
- An eligible child through age 25. An eligible child is one of the following:
  - A natural offspring of either or both the subscriber or spouse
  - A legally adopted child of either or both the subscriber or spouse
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
  - A legally placed ward of the subscriber or spouse living permanently in the home of the subscriber

Foster children are not eligible for coverage. Spouses and children of married dependents are not eligible for coverage under this plan.

When Does Coverage Begin?

Enrollment

New employees are eligible to enroll in this Plan on the first day of the month on or after the date of hire. If an employee starts on the first workday of the month, which is not the first of the month, they will start on the first day of the month.

When the subscriber becomes eligible to enroll, they must complete an enrollment form for themselves and any eligible dependents.

You become eligible to enroll in this program within 30 days of the following dates:

- For the subscriber and existing eligible family members, as of the date the subscriber becomes eligible as an employee or retiree.
- For a spouse and eligible children acquired through marriage, as of the date of marriage.
- For a natural newborn child as of the child's birthdate if born on or after the subscriber's effective date.
- For an adoptive child, as of the date the child is placed with the subscriber for the purpose of legal adoption.

DDWA must receive a completed enrollment form within 30 days of subscriber's eligibility date. If the enrollment form is not received within 30 days, enrollment will not be accepted until the next open enrollment period.

Eligible subscribers or dependents who are not enrolled in a timely fashion may not enroll until the next open enrollment period, unless a new dependent is acquired or unless they qualify under the Special Enrollment Period.

Waivers of Coverage

If an employee wants to decline coverage when first eligible, the Group requires the employee to sign a written waiver. Unless the employee qualifies under "Special Enrollment," the employee then loses the right to enroll in this plan for

two years after the date the waiver was signed. The employee can then enroll during the first open enrollment period after the two-year period ends. Please see "Special Enrollment" and "Open Enrollment" later in this section.

Special Enrollment Periods

Special enrollments may occur when an eligible person with other dental coverage loses that coverage or if an eligible person becomes a new dependent through marriage, birth, adoption or placement for adoption, or a current plan's lifetime maximum benefits have been met. If a triggering event is a birth, adoption or placement for adoption, the child, the employee, and the employee's spouse are entitled to special enrollment — either individually or in any combination.

Special Enrollment – Eligible Employees

Voluntary Waiver of Coverage

If you didn't enroll when you were first eligible because of a required personal premium contribution and your position with the employer has changed such that you are now eligible without said required personal premium contribution, you may enroll within 30 days of the change in the employee's position.

Involuntary Loss of Other Coverage

If you didn't enroll in this plan when you were first eligible because you weren't required to do so, you may later enroll outside of the annual open enrollment period if each of the following requirements is met:

- You were covered under group health coverage or a health insurance plan at the time coverage under this plan was previously offered
- You stated in writing the reason you declined coverage under this plan at the time this coverage was previously offered
- Your coverage under the other group health coverage or health insurance plan was terminated as a result of one of the following:
    - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or the reduction in the number of hours of employment)
    - Termination of employer contributions toward such coverage
    - You were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted

When your completed enrollment application is received and any required subscription charges from the Group within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment application. If your completed enrollment application is not received within 30 days of the date prior coverage ended, please see the "Open Enrollment" provision later in this section.

Special Enrollment – Subscriber and Dependent

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under "Special Enrollment" in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents.

A retiree subscriber may also enroll dependents who have involuntarily lost insurance or newly acquired dependents in the case of marriage, birth or adoption.

Children Covered Under Medical Child Support Orders

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. A subscriber, a custodial parent,

a state agency or an alternate recipient may enroll a dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for coverage pursuant to a QMCSO may not enroll dependents for coverage under the plan.

When the completed enrollment application is received within 30 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date the application is received for coverage. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures. If the subscriber is not enrolled on the date of the order, the subscriber will be allowed to enroll in order to enroll the child. However, no other dependents have the right to enroll.

A retiree subscriber may enroll a dependent covered under a medical child support order within 30 days of the date of the order. No other dependents have the right to enroll.

Open Enrollment

Within each 12-month period during this program, an open enrollment period shall be authorized to allow eligible subscribers to change their participation elections and enroll eligible dependents.

When Does Coverage End?

Coverage will end without notice on the last day of the monthly period for which required contributions have been paid in which one of these events occurs:

For the subscriber and dependents when;

- The plan terminates.
- The date on which the subscriber fails to meet the minimum eligibility requirements.
- The next required monthly charge for coverage isn't paid when due or within the grace period.
- The subscriber dies or is no longer eligible as a subscriber.
- On the date the subscriber is no longer actively employed.
- For a spouse when his or her marriage to the subscriber is annulled or he or she becomes legally separated or divorced.
- For a child when he or she is no longer eligible as a dependent.

For the retiree subscriber and dependents when;

- The plan terminates.
- The next required monthly charge for coverage isn't paid when due or within the grace period.
- The retiree subscriber or dependent is no longer eligible as a subscriber.
- For a spouse when his or her marriage to the retiree subscriber is annulled or he or she becomes legally separated or divorced.
- For a child when he or she is no longer eligible as a dependent

Notice: The subscriber and retiree subscriber must promptly notify the Claims Administrator when an enrolled family member is no longer eligible to be enrolled as a dependent under this program.

Termination of the Plan

The Plan Administrator has established the Health Benefit with the intention and expectation that it will continue indefinitely, but will have no obligation to maintain the Plan for any length of time. The Plan Administrator reserves the right to amend or terminate, in whole or part, this Plan at any time without liability. Termination and Plan amendments affecting enrollees will be communicated to them. Upon termination of the Plan, the rights of the enrollees to benefits are limited to claims incurred up to the date of termination.

COBRA for Eligible Employees

Under certain circumstances, you and your enrolled dependents may have the right to continue coverage at your own expense beyond the time coverage would ordinarily have ended.

If you are an employee covered under this Plan you have the right to elect continuation of coverage if you lose coverage under the Plan because of any one of the following "qualifying events":

- Termination (for reasons other than your gross misconduct) of your employment;
- Reduction in the hours of your employment;
- Leave of absence – Refer to "Leave of Absence" section for further information.

If you are the spouse of an employee covered by the Plan you have the right to elect continuation of coverage if you lose coverage under the Plan because of any of the following "qualifying events":

- The death of your spouse (employee);
- Termination of your spouse's (employee's) employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the spouse's Employer;
- Spouse's (employee) leave of absence;
- Divorce or legal separation from your spouse (employee); or
- Your spouse (employee) becomes entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the Plan, he or she has the right to elect continuation of coverage if they lose coverage under the Plan because of any of the following "qualifying events":

- The death of the employee;
- A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours;
- The employee becomes entitled to Medicare; or
- The dependent ceases to be an "eligible dependent" under Seattle Pacific University Group Health Plan.

Continuation Coverage for Retiree Subscriber

Retiree Subscribers will receive coverage for at least the same length of time as they would have received under COBRA.

Continuation Coverage for Retiree Subscriber Dependents

Retiree subscriber dependents may be eligible for continued coverage because of:

- Death of retiree subscriber
- Divorce or legal separation from the retiree subscriber
- The retiree subscriber's entitlement to Medicare Benefits
- Loss of dependent child status

Only in case of divorce/legal separation or loss of dependent child status will these individuals have coverage limited to the same length of time as they would have received under COBRA.

Continuation Eligibility for a Disabled Child

Coverage may continue for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all of the following are met:

- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the employee for support and maintenance.
- The subscriber is covered under this program.
- The child's subscription charges, if any, continue to be paid.

Leave of Absence

Coverage for a subscriber and enrolled dependents may be continued for up to six months when the employer grants the subscriber a medical leave of absence. Periods of medical and personal leave of absence count toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993 (Public Law 1033). Refer to the Employer's Benefits Handbook for information regarding personal leaves of absence or additional details.

A serious health condition that makes the employee unable to perform the functions of the position of such employee and terminates their coverage under the Plan, they will be allowed to re-enroll in the Plan upon return to active employment at the conclusion of a period not to exceed that defined by FMLA. Furthermore, the employee will not be subject to the Preexisting Conditions Provision of this Plan.

Labor Dispute

A subscriber may pay subscription charges through the Group to keep coverage in effect for up to six months in the event of suspension of compensation due to a lockout, strike or other labor dispute.

The six-month labor dispute period counts toward the maximum COBRA continuation period.

- Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for subscribers and covered dependents.

Section E – Claim Review

Claim Forms

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

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than 12 months after the date of such treatment. For orthodontia claims, the initial banding date, which is the date the appliance is placed, is the treatment date used to start this 12-month period.

Initial Benefit Determinations

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

If a claim is denied, in whole or in part, or is modified, we will send you an Explanation of Benefits (EOB) that will include the following information:

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

Appeals of Denied Claims

How to contact us

We will accept notice of an Appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us at the telephone number below or in writing us at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may also email us at memberappeals@deltadentalwa.com. When submitting an Appeal, you may include any written comments, documents or other information that you believe supports your claim. For more information, please call 800-554-1907.

Authorized Representative

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

Informal Review

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

- Your name, the patient's name (if different) and ID number
- The claim number (from your EOB)
- The name of the Dentist

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

Formal Review

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

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

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

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral Appeal and issue a decision no later than 72 hours after receipt of the Appeal. If the treating Licensed Professional determines that delay could jeopardize the Eligible Person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulations.

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.

Your Rights Under ERISA

As a participant in this employee benefit health and welfare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated documents. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the documents governing this Plan for the rules governing your COBRA continuation of coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your right under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial all, within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that the Plan fiduciaries misused the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Summary Plan Description

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

Name and Address of Employer	Seattle Pacific University 3307 Third Avenue West Seattle, WA 98119
Employer Identification Number (EIN):	91-0565553
Plan Number:	507
Plan Years	The financial records of the Plan are kept on a Plan Year basis. The Plan Year begins on each July.
Plan Administrator	The Employer named above. The Plan Administrator has authority to control and manage the operation and administration of the Plan.
Telephone Number of Plan Administrator	206-281-2809
Agent for Service of Legal Process	The Employer named above.
Type of Administration	The Plan is administered directly by the Plan Administrator. Benefits are provided in accordance with the provision of the group dental contract. The contract is issued by DDWA. Effective date January 1, 2023
Funding	The Plan is funded by the payment of dues required by the contract.

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.

Conversion Option

If your dental coverage stops because your employment or eligibility ends, the Group policy ends, or there is an extended strike, lockout or labor dispute, you may apply directly to DDWA to convert your coverage to a Delta Dental Individual and Family plan. You must apply within 63 days of termination of your Group coverage or 63 days after you receive notice of termination of coverage, whichever is later. The benefits and Premium costs of a Delta Dental Individual and Family plan may be different from those available under your current plan. You may learn about our

Individual and Family plans and apply for coverage online at www.DeltaDentalCoversMe.com or by calling 888-899-3734.

Extension of Benefits

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

Coordination of Benefits

IMPORTANT NOTICE
This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the Plans that cover members of your family. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The P*rimary Plan* always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member is covered under another Plan in addition to this one, we will be primary when:

Your Own Expenses

The claim is for your own health care expenses, unless you are covered by medicare and both you and your spouse are retired.

Your Spouse's Expenses

The claim is for your spouse, who is covered by medicare, and you are not both retired.

Your child's expenses.

The claim is for the health care expenses of your child who is covered by this Plan; and

You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or

You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the *Primary Plan*, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other Plan.

How We Pay Claims When We Are Secondary

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

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

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

We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plans* for the claim equal to one hundred percent of the total allowable expense (the highest of the amounts allowed under each Plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the Primary Plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

Questions About Coordination of Benefits?

Please Contact Your State Insurance Department

Subrogation

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

Section F - Resources

Frequently Asked Questions about Your Dental Benefits

What is a Delta Dental "Participating Dentist"?

A Delta Dental Participating Dentist is a Dentist who has signed an agreement with Delta Dental stipulating that they will provide dental treatment to subscribers and their dependents who are covered by DDWA's Group dental care Plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients.

Can I choose my own Dentist?

See the "Choosing a Dentist" section for more information.

How can I obtain a list of Delta Dental Participating Dentists?

You can obtain a current list of Delta Dental Participating Dentists by going to our website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your Dentist. You can also obtain a copy of the approved claim form from our website at www.DeltaDentalWA.com or by calling our Customer Service Number at 800-554-1907. Note: If your Dentist is a Delta Dental Participating Dentist, they will complete and submit claim forms for you.

What is the mailing address for DDWA claim forms?

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

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

If you have questions about your dental benefits, call DDWA's Customer Service Department at 800-554-1907. Questions can also be addressed via email at CService@DeltaDentalWA.com.

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

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

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

You are not required to get an estimate before having treatment, but you may wish to do so. You may ask your Dentist to complete and submit a request for an estimate, called a Confirmation of Treatment and Cost. The estimate will provide you with an estimated cost for your procedure but is not a guarantee of payment.

Who is Delta Dental?

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

Glossary

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

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

Apicoectomy
Surgery on the root of the tooth.

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

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

Bridge
Also known as a Fixed Partial Denture. See “Fixed Partial Denture”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligible Person
An Eligible Employee or an Eligible Dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Licensed Professional
An individual legally authorized to perform services as defined in his or her license. Licensed Professionals include, but are not limited to, denturist, hygienist and radiology technician. Benefits under this Contract will not be denied for any health care service performed by a registered nurse 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.

Lifetime Maximum
The maximum amount DDWA will pay in the specified Covered Dental Benefit class for an insured individual during the time that individual is on this Plan or any other Plan offered by this Employer.

Limitations
An exception or condition of coverage for a particular Covered Dental Benefit.

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

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

Nightguard
See "Occlusal Guard."

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

Not a Paid Covered Dental Benefit
Any dental procedure that, is covered under this Plan however is not payable based on specific conditions, such as clinical criteria.

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

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

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

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

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

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

Palliative Treatment
Services provided for emergency relief of dental pain.

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

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

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

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

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

Pocket Depth

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

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

Prophylaxis
Cleaning and polishing of teeth.

Prosthodontics
The replacement of missing teeth by artificial means such as Bridges and Dentures.

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

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

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

Restorative
Replacing portions of lost or diseased tooth structures with a filling or Crown to restore proper dental function.

Root Planing
A procedure done to smooth roughened root surfaces.

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

Seat Date
The date a Crown, Veneer, Inlay, or Onlay is permanently cemented into place on the tooth.

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

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

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

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:. 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.

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

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 kɛƀƀugo wallende be matinolji be wolde moɗon 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.

Your smile is part of an incredible, complex system – your body. Research shows your smile's health influences your body's health the same way an engine effects how a car performs. Taking care of your smile now helps prevent painful, expensive problems down the road.

Here are our top tips for a healthy smile:

- Brush for two minutes, twice a day with fluoride toothpaste
- Floss at least once a day
- Eat a well-balanced diet
- Drink fluoridated water
- Visit your Dentist at least once a year

Remember, your smile has a great service plan – your dental coverage. It makes dental visits easy and affordable.

So, why wait? Call your Dentist and schedule your next visit today. If you're looking for a Dentist, visit www.DeltaDentalWA.com to find one near you.

Follow us online for fun, helpful tips to keep your smile healthy and get the most from your dental benefits.