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WEYERHAEUSER DENTAL PLAN

Eligible U.S. Employees

Summary Plan Description
Effective January 1, 2017

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ABOUT THIS SUMMARY PLAN DESCRIPTION

This summary plan description (SPD) provides a concise description of the Weyerhaeuser Dental Plan coverage available to you and your eligible dependents effective January 1, 2017, under the Weyerhaeuser Company Health and Dental Plan. This SPD contains detailed and important information about the Weyerhaeuser Dental Plan (the "Plan"). Every attempt has been made to communicate this information clearly and in easily understandable terms. Key terms are described in the "Glossary."

If there is any conflict between the information in this SPD and the legal Plan documents or group insurance policies, the legal Plan documents or insurance policies will govern. Weyerhaeuser Company ("Weyerhaeuser" or the "Company") or its applicable delegate has sole and absolute discretion and authority to interpret the terms of Weyerhaeuser employee benefit plans, resolve any ambiguities and inconsistencies in the Plan, and make all decisions about eligibility for and entitlement to benefits. When applicable, Weyerhaeuser may defer this discretion and authority to the issuers of group insurance policies under which benefits are payable.

Weyerhaeuser is the Plan sponsor, and contracts with Washington Dental Service ("claims administrator") a member of the Delta Dental Plans Association, to handle day-to-day administration of the plan. The claims administrator provides customer service, processes claims, and determines whether services are covered in accordance with standard dental practices, the administrator's own standard processes, and the Plan.

This SPD, together with any group policies, constitutes the legal Plan document for the dental benefits it describes. The Weyerhaeuser Company Flexible Benefits Plan provides for payment of employee contributions for dental coverage on a pre-tax basis and, as such, governs the pre-tax features of the Plan.

Esta Descripción de Resumen del Plan describe los beneficios bajo el plan y sus derechos, en el idioma inglés. Si tiene difi cultades para entender alguna parte de esta Descripción de Resumen del Plan, por favor llame al Centro de Servicio para Empleados de Weyerhaeuser (Weyerhaeuser Employee Service Center) al 800-833-0030 y solicite hablar con un traductor. Los representates se encuentran ahora disponibles de lunes a viernes, de 6:00 a.m. – 3:00 p.m., hora del Pacífico.

UPDATES

If the Company changes the Plan, you will receive a Summary of Material Modifications (SMM) document that describes the changes. SMM documents and the Plan changes they describe become part of this SPD and, as such, should be kept with this SPD.

OVERVIEW

The Plan is designed to provide you and your eligible dependents with quality, comprehensive dental care at a reasonable cost. The Plan emphasizes preventive care through routine exams to help you and your family maintain good oral health. You must meet the requirements described in this SPD to receive coverage.

HIGHLIGHTS

Who is eligible	You and your dependents who meet requirements as defined in "Eligibility"
When to enroll	As a new employee, you may enroll within 31 days after your date of hire; you may also enroll during annual open enrollment or within 31 days following a special enrollment event or qualifying status change
How to enroll	Call the Employee Service Center at 800-833-0030
Coverage changes	You may change coverage during open enrollment or within 31 days following a special enrollment event or qualifying status change
When coverage begins	As a new employee, coverage begins on the first day of the month following one month of continuous employment. If you enroll: • During open enrollment, coverage begins on the following January 1 • Within 31 days following a special enrollment event or qualifying status change, coverage begins on the date of the change

How much you pay	You and Weyerhaeuser share the cost of coverage: **Contribution:** Generally, you pay a pre-tax monthly contribution through payroll deduction; the amount is based on your coverage level (employee or employee + family) and may change annually **Annual maximum deductible:** $50 for individual; $100 for family **Coinsurance:** For preventive/diagnostic services, you pay 0% of covered charges; not subject to the deductible For basic/restorative services, you pay 20% of covered charges, after the deductible For major services, you pay 40% of covered charges, after the deductible For orthodontia, you pay 50% based on total case fee and treatment plan, after deductible For temporomandibular joint TMJ/orthognathic treatment, you pay 50% of covered charges, after the deductible Note: You also pay any amounts for services that exceed the maximum allowable fees and Plan limits
How much the Plan pays	**Coinsurance:** Generally, 100%, 80%, and 60% of the maximum allowable fee, for preventive and diagnostic, basic, and major services, respectively **Annual benefit maximum:** $1,500 per person per calendar year (Effective January 1, 2018: $2,000 per person per calendar year) **Orthodontia lifetime maximum:** $1,500 per person (Effective January 1, 2018, $2,000 per person) **TMJ/orthognathic nonsurgical lifetime maximum:** $500 per person **Plan lifetime maximum:** None
Dental providers	You may use any dental provider. However, if you use Delta Dental Plan's broad preferred provider organization (PPO), your cost for services will likely be less. To find a preferred provider in your area, go to the provider directory on www.DeltaDentalWA.com, (select "national access" to locate providers outside of Washington state) or call 800-554-1907

Customer service, Plan information, claims	Washington Dental Service 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time www.DeltaDentalWA.com	Washington Dental Service Claims Processing PO Box 75983 Seattle, WA 98175-0688
Enrollment and eligibility	Weyerhaeuser Employee Service Center 800-833-0030 Monday – Friday, 6:00 a.m. – 3:00 p.m., Pacific time Roots; myGuide on Weyerhaeuser intranet	

ELIGIBILITY

This section of your booklet describes the requirements for you and your dependents to be eligible for coverage.

Eligible Employees

You are eligible for the Plan if you are an employee of Weyerhaeuser or a participating subsidiary who is on the U.S. payroll, in a position that is classified as salaried or hourly production with salaried benefits, and regularly scheduled to work 25 or more hours each week. You also are eligible for the Plan if you are a full-time union-represented or non-union hourly employee in an eligible location.

You may also be eligible as a result of a prior coverage continuation election under COBRA, where such election was made under this Plan, or under a different plan for which Weyerhaeuser has subsequently designated this Plan as replacement or alternative plan.

You are not eligible for the Plan if you are performing services for Weyerhaeuser as a contractor, leased employee, or in a temporary capacity (including through a staffing agency), whether or not you are paid by Weyerhaeuser and even if you are later determined to have been a common-law employee for such time period.

Eligible Dependents

As an eligible employee, you may elect coverage for your eligible dependents under the Plan. Only dependents who meet the eligibility requirements and rules are eligible for Plan coverage. Use this information as a guide to ensure each dependent you enroll in the Plan meets Plan eligibility requirements and rules.

Dual Coverage
If both you (the employee) and your spouse/domestic partner are eligible to enroll in the Plan as Weyerhaeuser employees, you have two options for coverage: • You both may enroll as an employee. In this case, each eligible child, if any, can be covered only under your Plan or your spouse's/domestic partner's Plan (not both), and a participant cannot be covered as a dependent of the other. Neither you nor your spouse/domestic partner or children may be enrolled in this Plan and another Weyerhaeuser-sponsored dental Plan that is administered by Washington Dental Services. • One of you may enroll as an employee and the other may be covered (along with any eligible children) as a dependent under that person's coverage.

SPOUSE

You may elect coverage for your spouse if:

- You elect coverage for yourself.
- Your spouse is legally married to you as defined by federal law, or as allowed in certain states, by common law.

You may not cover a former spouse from whom you are currently divorced or legally separated. Weyerhaeuser-sponsored plans do not recognize (and are not required to recognize) any court-approved divorce decrees that require continued benefit coverage for your former spouse.

DOMESTIC PARTNER

You may elect coverage for your domestic partner if you elect coverage for yourself and you and your domestic partner are both all of the following:

- At least 18 years old and in an exclusive, long-term, committed relationship with each other, and
- Live together (and have done so continuously for at least six months immediately prior to requesting coverage) with the intention to do so indefinitely, and
- Financially interdependent with each other and unrelated by blood, and
- Not legally married to anyone else or a member of another domestic partner relationship, and
- Mentally competent to make a contract.

You must complete and return the *Declaration of Domestic Partner Status* form to the Weyerhaeuser Employee Service Center.

Special rules apply if you want to end coverage during the Plan year due to your relationship ending. Call the Employee Service Center at 800-833-0030 for more information.

CHILDREN

You may elect coverage for your child if:

- You elect coverage for yourself (and your domestic partner, if covering your domestic partner's child).
- The child is under age 26, and is your (or your domestic partner's):
  - Natural or legally adopted child, or
  - Stepchild, or
  - Eligible foster child if placed by an authorized placement agency or by judgment decree, or
  - Child placed in your home for adoption.

You may also cover a child for whom you, your spouse, or your domestic partner have court-appointed guardianship or for whom you have a Qualified Medical Child Support Order (QMCSO).

DISABLED CHILDREN

Your adult child (age 26 and older) may be eligible to remain covered under your plan indefinitely if he or she meets all of the requirements for a child and meets the following additional requirements.

- You elect coverage for yourself (and your domestic partner, if covering your domestic partner's child).
- Your child is already enrolled in the Plan on the date he or she otherwise would become ineligible for coverage due to Plan age requirements, even if all other criteria are met.

Your adult child must also be disabled and all of the following must apply. Your child is:

- Unmarried and not covered by another group dental plan as an employee.
- Unable to earn a living because of an approved disability.
- Living with you and does not provide more than half of his or her support, or you (or your spouse/domestic partner) provide 50% or more of his or her financial support, regardless of whether the child is living with you.

The child must have been covered and disabled on the day before his/her 26th birthday and you must begin the application process at least 30 days before his/her 26th birthday. If your application for continued coverage is not approved, coverage will end. If approved, ongoing proof of permanent and total disability is required.

Important
Call the Employee Service Center at 800-833-0030 to request continued coverage at least 31 days before the disabled child's coverage would normally end (e.g. prior to attaining age 26.

CERTIFICATION AND DOCUMENTATION

Any time you elect or maintain Plan coverage for your dependent (spouse/domestic partner, child, or domestic partner's child) you certify that he or she is eligible for coverage under the Plan. You are always responsible for notifying the Employee Service Center as soon as possible, but no later than 31 days, of any changes that may affect the eligibility of your dependent's coverage under the Plan.

Periodically you will be required to certify your dependent's Plan eligibility; you may also be required to periodically provide documentation that proves your dependent's eligibility. Failure to provide any of the requested certifications or documentation may interrupt or delay coverage under the Plan. Weyerhaeuser retains the right to conduct periodic audits of eligible dependents at any time.

FRAUDULENT DEPENDENTS

Weyerhaeuser monitors the eligibility of dependents through periodic audits. If it is determined that you fraudulently elected or maintained coverage for an ineligible dependent, you may be required to reimburse the cost of any claims or expenses paid under the Plan for that dependent. In addition, Weyerhaeuser reserves the right to permanently terminate Plan coverage for you and your dependents for fraudulently electing or maintaining coverage for an ineligible dependent. Any employee who fraudulently enrolls or maintains Plan coverage for an ineligible dependent may also be subject to disciplinary action, up to and including termination of employment or legal action.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Plan complies with Qualified Medical Child Support Orders (QMCSOs). You may obtain a copy of the Plan's QMCSO procedures free of charge by calling the Employee Service Center at 800-833-0030.

ENROLLMENT AND COVERAGE CHANGES

This section describes the steps that are required to enroll in dental coverage or to make changes to your existing level of coverage.

When to Enroll

As a newly hired employee, you have 31 days after your date of hire to enroll yourself and your eligible dependents in the Plan. You also may enroll for the first time during any future annual open enrollment after you are hired.

If you do not enroll in the Plan, you will not be covered and will be considered to have waived coverage under the Plan. Unless you have a qualifying status change, you must wait until the next open enrollment to enroll in the Plan.

How to Enroll

Weyerhaeuser provides Plan enrollment information soon after your date of hire; you will also receive login information to access the online benefits enrollment tool. You must complete enrollment within 31 days after your first day of work. For more information, call the Employee Service Center at 800-833-0030.

When Coverage Begins

As a newly hired employee, after you and your dependents enroll in the Plan, dental coverage begins on the first day of the month following one full month of continuous employment.

Changes During Open Enrollment

Dental coverage for you and your dependents begins January 1 of the following year if you enroll during open enrollment.

If you waive coverage or do not enroll when you first become eligible, or as allowed under “Changes During the Year,” you may change your dental election only during open enrollment.

During open enrollment, you may:

- Enroll yourself, your eligible spouse/domestic partner, eligible children, and your eligible domestic partner’s children.
- If you are already enrolled, you may add your eligible spouse/domestic partner, eligible children, and your eligible domestic partner’s children.
- Stop coverage for yourself or any covered dependents.

All changes in dental coverage made during open enrollment become effective on January 1 of following year.

Changes During the Year

If you experience a special enrollment event or qualifying status change, you may:

- Enroll for the first time (if you previously elected to waive coverage).
- Change your existing dental coverage election.

Generally, any election change must be consistent with the qualifying status change that affects eligibility for you, your spouse/domestic partner, your dependent children, or your domestic partner's dependent children under this Plan or another employer's plan. Otherwise, you may make changes only during open enrollment. (See "Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Events" and "Qualifying Status Changes" for more information.)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT EVENTS

During the Plan year, at times other than annual open enrollment, you may be eligible for HIPAA special enrollment rights if you experience certain changes in eligibility for benefits under this Plan. These rights and the Plan allow you to add yourself, if you are not already enrolled and any eligible dependents to this Plan (even if your other eligible dependents are not directly affected by the event) as long as you enroll within 31 days after the event under the following circumstances:

- You gain a new dependent because of marriage, birth, adoption, or placement for adoption.
- You decline enrollment when initially eligible for yourself, your spouse/domestic partner, and/or your or your domestic partner's dependent children because you (or they) have other dental coverage and eligibility for such coverage is subsequently lost.
  - Coverage loss must be due to loss of eligibility for the other dental coverage. This includes loss due to divorce, death, termination of domestic partner relationship, termination of employment, or reduction in hours of employment, moving outside of a dental maintenance organization plan's service area with no other coverage available from the other employer, or reaching the lifetime limit on all benefits from the other employer's plan.
  - If you and/or your dependent becomes eligible to add Plan coverage due to loss of eligibility for Medicaid or a State Children's Health Insurance Program (CHIP); or is determined to be eligible for assistance with the cost of participating in the Plan through the Medicaid plan or the State CHIP plan in which you and/or your dependent participate, you may request enrollment in this Plan within 60 days of the loss of coverage under Medicaid or CHIP or 60 days from the date you become eligible for the premium subsidy.

Important
Adding Coverage? If you have a special enrollment event or qualifying status change that allows you to become eligible to add or drop coverage during the Plan year, you have 31 days after the date of the special enrollment event or qualifying status change to enroll or end coverage in the Plan. Coverage begins on the date of the change if you provide notification within the 31-day period. Note: If you and/or your dependent are eligible for special enrollment rights through Medicaid or Children's Health Insurance Program (CHIP) you must enroll in this Plan within 60 days of the event. **Dropping Coverage?** If you have a qualifying status change that requires you to drop coverage for a dependent during the Plan year, you must notify the Company as soon as possible (but no later than 60 days after the date of the qualifying status change) to stop Plan coverage. Coverage ends on the last day of the month following the status change. If applicable, COBRA coverage may be available. Call the Employee Service Center at 800-833-0030 to report these changes.

QUALIFYING STATUS CHANGES

If you experience a qualified status change, you may be able to enroll in Plan coverage, change your current Plan coverage, or drop your Plan coverage during the year. Any change to your Plan coverage must be consistent with the status change that affects your or your dependent's eligibility for Company-sponsored Plan coverage or coverage sponsored by your eligible dependent's employer. The following qualifying status changes allow you to change your dental coverage during the Plan year:

- **Legal marital or domestic partnership status.** You marry, divorce, or legally separate; your marriage is annulled; your domestic partner newly meets plan requirements, or your domestic partner relationship ends.
- **Employment status.** Your or your eligible dependent's job situation changes due to termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, a change between a salaried and an hourly position, a change between a part-time and a full-time position, or a change between a salaried non-union position and a union-represented position. If you, your spouse/domestic partner, or dependent child gains eligibility under another employer's plan as a result of a job situation change, your election to stop or change Plan coverage will correspond with that status change only if coverage for that individual becomes effective or is increased under the other employer's plan.
- **Leave of absence.** You take an approved unpaid leave of absence in accordance with the Family and Medical Leave Act (FMLA). See "Leave of Absence" for more information.

- **Number of dependents.** You lose a dependent through death, divorce, legal separation, or end of a domestic partnership; you add a dependent through birth, marriage, establishment of a valid domestic partnership, adoption or placement of a child in your home for adoption, or court-appointed guardianship for which you have a legal and financial support obligation.
- **Dependent child's eligibility.** Your or your domestic partner's child becomes eligible or ineligible for coverage (e.g., the child can no longer be covered because he or she turns 26).
- **Judgment, decree, or court order.** You receive a judgment, decree, or court order (e.g., a Qualified Medical Child Support Order) that requires you to add or remove dental coverage for a dependent child.
- **Cost or change in coverage.** If the cost of coverage changes during a Plan year by an insignificant amount, your monthly contribution is automatically adjusted. If the cost or level of coverage changes significantly during a Plan year, you may make election changes. The Company determines if a change in cost or level of coverage is significant.
- **Coverage changes due to different enrollment periods under a spouse's/domestic partner's benefit plans.** You may add or stop coverage for yourself, a spouse/domestic partner, or dependent child if the change is due to and corresponds with a change made under a cafeteria plan or qualified benefit plan of your current or former spouse's/domestic partner's or dependent child's employer, and the other plan's coverage period differs from this Plan's coverage period. (For example, if your spouse's coverage period is from May 1 to April 30, and he or she drops coverage under that plan, you may enroll your spouse for coverage under the Plan.)

When Coverage Ends

Coverage category	Dental coverage ends when any of the following occurs
Your dental coverage	At the end of the month you are no longer eligible; if you qualify for retirement, there is a one-month extension of active coverage for you and your eligible dependents

Your spouse's/ domestic partner's dental coverage	The date your coverage ends, unless your coverage ends due to your death The last day of the month in which your marriage is annulled or you become legally separated or divorced The last day of the month in which your domestic partner relationship ends The last day of the month in which your spouse/domestic partner becomes ineligible
Your or your domestic partner's child's dental coverage	The date your coverage ends, unless your coverage ends due to your death The last day of the month in which your child becomes ineligible: • Turns age 26 • Your disabled child over age 25 is no longer disabled or incapacitated

If you are or a covered dependent is in the middle of certain treatments when coverage would ordinarily end, the Plan may pay additional benefits depending on how close the treatment is to completion. The following covered treatments may be considered in process:

- Dentures or bridges, if the impression has already been taken.
- Orthodontia.
- Restorations for teeth that are prepared.

Treatment must be completed within 90 days after your coverage ends.

COSTS

This section describes how you and Weyerhaeuser share the Plan's costs.

Your Cost of Coverage

You and Weyerhaeuser share in the cost of your dental coverage. To help lower the cost, your contributions generally are deducted from your pay on a pre-tax basis.

If you elect coverage for your domestic partner, the cost of coverage is deducted from your pay on an after-tax basis. The Company's contribution toward domestic partner coverage will, in most cases, be considered imputed income and will be taxable income to you. You are responsible for the income tax on imputed income. This means that in most cases, the Company's contribution for your domestic partner and his or her dependent children will be added to your taxable income.

Your contributions for dental coverage are based on the level of coverage you choose:

- Employee only.
- Employee and family.

Your contributions are reviewed annually and subject to change, with any adjustments generally effective January 1. You will be notified in advance of changes.

YOUR ANNUAL DEDUCTIBLE

The annual deductible is the amount of money you must pay your provider(s) each calendar year for your initial covered dental care before Plan benefits are paid. The Plan has an employee deductible and a family deductible; the deductible amount is based on the coverage level you elect.

To encourage regular dental care and reduce the risk of serious dental disease, the Plan pays for preventive and diagnostic services, regardless of whether you have met the annual deductible. Amounts paid for preventive and diagnostic services do not count toward the annual deductible.

The deductible does not apply to:

- Class I Covered Dental Benefits
- Orthodontic Benefits
- Temporomandibular Joint Benefits
- Accidental Injury Benefits

INDIVIDUAL DEDUCTIBLE

The annual maximum individual deductible is $50.

FAMILY DEDUCTIBLE

All covered family members' expenses can be combined to meet the annual maximum family deductible of $100. After the annual maximum family deductible is paid, the Plan begins paying benefits for the family.

Coinsurance

Generally, the Plan pays a specific percentage toward the cost of covered charges after you pay the annual deductible, as applicable. You also pay a specific percentage toward the cost of covered charges. This percentage varies based on the class of dental service or treatment that you or your covered dependent receives, and is called coinsurance.

Coinsurance does not include noncovered charges (which may include amounts billed for noncovered services), any portion of a bill that exceeds the maximum allowable fee for a covered service, charges for services received before coverage began and ended, and charges that exceed the Plan's limits. You are responsible for any noncovered amounts, including charges over the maximum allowable fee or the dentist's filed *fee*, whichever is less.

The Plan and you share in the payment of the following covered expenses:

Type of service	Plan payment* (based on maximum allowable fees)	Your coinsurance payment (based on maximum allowable fees)
Class I Diagnostic and Preventive	100% of covered charges (not subject to annual deductible)	0% of covered charges (not subject to annual deductible)
Class II Basic	80% of covered charges (after annual deductible)	20% of covered charges (after annual deductible)
Class III Major	60% of covered charges (after annual deductible)	40% of covered charges (after annual deductible)
Orthodontia	50% of covered charges based on total case fee and treatment plan (after annual deductible)	50% of covered charges based on total case fee and treatment plan (after annual deductible)
TMJ and Orthognathic Treatment	50% of covered charges (after annual deductible)	50% of covered charges (after annual deductible)

*Payments are subject to Plan maximums

Except for orthodontia, the Plan pays for dental treatment only after the entire treatment is completed, even if the treatment takes several visits to complete. The cost of intermediate procedures that relate to a single treatment (e.g., installation of temporary appliances) is counted as part of the cost for the final procedure. This includes installing temporary crowns, bridges, and dentures.

The Plan pays orthodontia expenses over a period of time, even if you have prepaid the services in full:

- At the beginning of treatment, you or your provider will receive 50% of the total case fee multiplied by the Plan benefit of 50%.
- The remainder of the total case fee is then divided by the number of months in the total treatment plan.
- The resulting portion is considered to be incurred monthly, payable at 50% until the orthodontia lifetime maximum of $1,500 is paid, the treatment is completed, or the patient's eligibility ends (orthodontia lifetime maximum will increase to $2,000 effective January 1, 2018).

MAXIMUM ALLOWABLE FEES

Maximum allowable fees are determined differently, depending on whether you seek services from a participating or non-participating provider.

If you choose to seek services from a participating provider – either a PPO dentist or a Delta Dental Premier® dentist – the maximum allowable fee that your provider is paid represents an amount that your dentist has agreed to accept as reimbursement for specific services. Sometimes the provider may bill less than the agreed-upon fee. In these cases, the provider is paid based upon those lower fees. You are responsible only for your stated deductibles and coinsurance.

You may seek services from a nonparticipating provider. The plan then pays benefits based on the lesser of the maximum allowable fees that the claims administrator has approved for member dentists in the state where services are performed, or the provider's actual charges. If your nonparticipating dentist charges more than the maximum allowable fee, your dentist may require you to also pay the noncovered amount. The claims administrator has no control over nonparticipating dentists' charges or billing procedures.

When alternative procedures are available, the Plan covers the least expensive procedure. However, if your dentist submits satisfactory evidence to the Plan that a more expensive procedure is the only one professionally adequate for you, the plan will cover the more expensive procedure according to the appropriate benefit payment level.

Annual Benefit Maximum

The annual benefit maximum is the maximum dollar amount the Plan will pay for expenses you incur during a calendar year. The benefit maximum is based on the type of dental service you receive and the time frame covered. The maximum is $1,500 per person per calendar year (the annual maximum will increase to $2,000 per person per calendar year effective January 1, 2018).

Expenses that do not count toward the annual benefit maximum include:

- Charges for services not covered by the Plan.
- Charges that exceed the maximum allowable fee amounts.
- Charges for orthodontia expenses.

Lifetime Maximum

The annual lifetime maximum is the maximum dollar amount the Plan will pay for expenses you or your covered dependents incur during the time period you are a Plan participant. See "Orthodontia," and "Temporomandibular Joint (TMJ) and Orthognathic Benefits – Non-surgical."

BENEFITS

This section describes your Plan's dental benefits.

Services and Treatment

To be covered by the Plan, services and treatment must meet all of the following criteria:

- Provided by a dentist or oral surgeon (such as a DDS or DMD), or by an approved licensed professional as determined by the claims administrator.
- Necessary to restore the dental health of the mouth as defined by the claims administrator.
- Started while the participant is covered by the Plan, as indicated by the start dates of treatment in the following table. Some exceptions apply to orthodontia. See "Coinsurance" for details.

The decision to follow a particular treatment plan is between you and your dental provider. The Plan covers the least costly method of treatment that generally meets accepted dental care standards. If you and your dental provider decide to proceed with the more costly method, you will be responsible for the difference in cost.

Note: The Plan considers payment for claims only once treatment has been completed.

Choosing a Dentist

Under this Plan, you may choose any dentist. One benefit you have is the opportunity to seek services from a dentist who is in a Delta Dental participating network in your state. With access to two broad, national networks of providers, you can receive care from approved providers and limit your out-of-pocket costs.

- Delta Dental PPO providers have contracted with Delta to provide quality care and the deepest discounts. These providers will submit claims for you, accept payment based on their contracted fees with Delta Dental, and will not bill you for amounts that exceed these fees.
- You also have access to the Delta Dental Premier network, the nation's largest dental network. While Premier providers may not be part of the Delta Dental PPO network, they are participating providers and also provide you with the convenience of pre-negotiated fees, claim filing, and they receive payment directly from the claims administrator. As with PPO providers, you will not be billed for amounts that exceed the contracted fees.

- Nonparticipating providers receive the same level of coverage that the Plan allows for participating providers. You may be required to file your claims or assist your provider with filing information. Since no contract exists between Delta Dental and a nonparticipating provider, it is possible that your provider may charge a higher fee than Delta's maximum allowable fees. Any amounts that exceed the maximum allowable fees are your responsibility.

Understanding the Delta Dental network options	**Delta participating dentists**		**No network affiliation**
Features/Network	**Delta Dental PPO dentists**	**Delta Premier dentists**	**Nonparticipating dentists**
Access to any dentist	Yes	Yes	Yes
Contracted discounts on services	Yes, deepest discounts	Yes, pre-negotiated fees	No, your dentist may bill you for any amounts over Delta Dental's maximum allowable fee(s)
File your claims	Yes	Yes	Probably

Pretreatment Estimate

You do not need to obtain a predetermination under the Plan. However, it is recommended that you contact the claims administrator for a written estimate of covered charges (called a Predetermination of Benefits) before beginning treatment if you or a covered dependent expects significant dental work (nonemergency care costing more than $200). A predetermination of benefits is not a guarantee of payment.

To request predetermination of benefits estimates, your dentist should submit a pre-treatment plan, including the proposed course of treatment, estimate of charges, and copies of diagnostic records, to the claims administrator. On the form, your dentist's office will indicate that this is a predetermination of benefits estimate rather than an actual claim. The claims administrator will determine how much it will pay for these services and notify your dentist in writing. Final payment may differ from this estimate based on several factors (e.g., actual services received, amount of annual deductible yet to be paid, benefits paid by the primary plan, and applicable plan limits).

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

Payment will be made only if you remain eligible for coverage after the services have begun, as defined by the Plan.

COVERED SERVICES

Out-of-area care
The plan pays for covered services for you and your covered dependents whether you or they live in or outside of the United States.

The Plan's covered dental care services are organized into classes that determine how much the Plan covers.

See "Noncovered Services" for services, treatments, and supplies that are not covered by the Plan.

Class I Benefits – DIAGNOSTIC AND PREVENTIVE SERVICES

CLASS I: DIAGNOSTIC

Covered Dental Benefits

- Comprehensive, or detailed and extensive oral evaluation
- Diagnostic evaluation for routine or emergency purposes
- X-rays
- Caries (tooth decay) and periodontal susceptibility/risk tests as approved by the Claims Administrator

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 unlimited.

- Bitewing X-rays are covered twice in a benefit period.
- A panoramic x-ray is covered once in a three-year period from the date of service.
- A complete series is covered once in a three-year period from the date of service.
    - Any number or combination of x-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.

Exclusions

- Consultations – diagnostic service 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 benefit.

Please see "Temporomandibular Joint Benefits and Orthognathic Benefits – Non-Surgical" section for information on x-rays related to temporomandibular joint benefits.

CLASS I: PREVENTATIVE

Covered Dental Benefits

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

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period.
    - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- For any combination of adult prophylaxis and periodontal maintenance, third and fourth occurrences may be covered if the dentist determines the patient meets periodontal Case Type III or IV (Pocket depth readings of 5mm of 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 three-year period per tooth from the date of service.

  - Available for children through the age 15
  - Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
  - If eruption of permanent molars is delayed, sealants will be allowed if applied within 12-months of eruption with documentation from the attending Dentist.

- Space maintainers are covered once in a patient's lifetime through age 13 for the same missing tooth or teeth.
- The application of a preventive resin restoration is a covered dental benefit once in a three-year period per tooth from the date of service.
- Available for children through age 15
  - If eruption of permanent molars is delayed, preventive resin restorations will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
  - The application of a preventive resin restoration is not a Covered Dental Benefit for three years after a sealant or preventive resin restoration on the same tooth.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that the 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.

Exclusions

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

CLASS I: PERIODONTICS

Covered Dental Benefits

- Prescription-strength fluoride toothpaste
- Antimicrobial rinse dispensed by the dental office

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.
- Antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

Class II Benefits – BASIC SERVICES

CLASS II: SEDATION

Covered Dental Benefits

- General Anesthesia
- Intravenous Sedation

Limitations

- General Anesthesia or Intravenous Sedation are Covered Dental Benefits only when administered by a licensed dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- General Anesthesia is a Covered Dental Benefit only in conjunction with certain covered 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, TMJ or Orthodontic Covered Dental Benefits.*
- Intravenous Sedation is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA.*
- Sedation, which is either general anesthesia or intravenous sedation, is a Covered Dental Benefit only once per day.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that the 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.

Exclusions

- General anesthesia or intravenous sedation for routine post-operative procedures is not a paid covered benefit except as described above for children through the age of six or a physically or developmentally disabled person.

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.

RESTORATIVE

Covered Dental Benefits

- Restorations (fillings)
- Stainless steel crowns
- Implant supported crown
- Posterior composites
- Crowns, veneers, or onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in a significant loss of tooth structure (e.g., missing cusps, broken incisal edge)
- Crown buildups
- Post and Core on endodontically treated teeth
- Recementation of a crown

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
- Stainless steel crowns are covered once in a two-year period from the seat date.
- A crown, veneer or onlay on the same tooth is covered once in a five-year period from the original 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.
- Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- An inlay (as a single tooth restoration) will be considered as an elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being the responsibility of the covered person.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing and there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- A crown buildup or post and core is covered once in a five-year period on the same tooth from the date of service.
- Recementation of a crown is covered once in a 12-month period from the date of service.
- A crown buildup or post and cores are not a paid covered 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 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.
- Ceramic substrate/porcelain or cast metal crowns and onlays are not a paid covered benefit for children under 12 years of age.

Exclusions

- Overhang removal
- Copings
- Re-contouring or polishing of a restoration
- A crown or onlay placed because of weakened cusps or existing large restorations without overt pathology
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence or decay or other significant pathology.

CLASS II: ORAL SURGERY

Covered Dental Benefits

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

Exclusions

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

For Additional Information

See “Class II Sedation”

CLASS II: PERIODONTICS

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Occlusal guard (nightguard) covered for perio and bruxism
- Repair and relines of occlusal guard
- Periodontal scaling/root planing
- Periodontal surgery
- Limited adjustments to occlusion (eight teeth or fewer)
- Localized delivery of antimicrobial agents*
- Gingivectomy

Limitations

- Occlusal guard (nightguard) is covered once in a three-year period from the date of service.
- Periodontal scaling/root planing is covered once in a 24-month period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.

- Periodontal surgery (per site) is covered once in a 24-month period from the date of service.
- Soft tissue grafts (per site) for implants and natural teeth are covered once in a two-year period from the date of service.
- Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions of oral health, such as periodontal Case Type III or IV, and five mm (or greater) pocket depth readings.*
    - 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: These benefits are available only under certain conditions of oral health. It is strongly recommended that the 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. Please also see:

- "Class I Preventative" section for periodontal maintenance benefits
- "Class II Sedation" section for additional information.
- "Class III Periodontics" section for complete occlusal equilibration

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

Exclusions

- Bleaching of teeth

For Additional Information

See "Class II Sedation"

Class III Benefits – MAJOR SERVICES

CLASS III: PERIODONTICS

This benefit is available for patients with periodontal Case Type III or IV only, as determined by the dentist. It is strongly recommended that prior to treatment the 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: 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 prosthetic appliance is covered once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Fixed prosthodontics for children less than 16 years of age are not a paid covered benefit.
- 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.

  - Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.

- **Full and immediate dentures** – DDWA will allow the appropriate amount for a full or immediate denture toward the cost of an elective procedure such as an overdenture, a personalized restoration, or a specialized treatment.
- **Denture adjustments and relines** – Denture adjustments and relines done more than six months after the initial placement are covered two times in a 12-month period. 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
- Root canals in conjunction with overdentures

OTHER BENEFITS

TERMPOROMANDIBULAR JOINT BENEFITS (TMJ) AND ORTHOGNATHIC BENEFITS – NON-SURGICAL

For the purpose of this plan, Temporomandibular Joint (TMJ) treatment is defined as dental services provided by a licensed dentist for the treatment of disorders associated with the temporomandibular joint.

The Plan considers payment for TMJ benefits 50% of the lesser of the maximum allowable fees or the fees actually charged. The lifetime maximum amount payable by the Plan for dental services related to the treatment of TMJ or orthognathic surgery disorders is $500 per eligible person, after the application of deductibles and coinsurance. The amounts payable for TMJ benefits during the benefit period are not applied to the patient's annual maximum for Class I, Class II and Class III covered benefits.

TMJ disorders shall include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Covered services are:

- Appropriate, as determined by the claims administrator.
- Recognized as effective according to the professional standards of good dental practice.
- Not experimental or primarily for cosmetic purposes

Services covered are non-surgical procedures only and include but are not limited to:

- Arthrocentesis.
- Fixed stabilizing appliance.
- Manipulation under anesthesia.
- Occlusal equilibration.
- Occlusal orthotic device.
- Orthognathic examination.
- Removable metal overlay stabilizing appliance.
- Temporary repositioning splint.
- TMJ examination.
- X-rays (including TMJ film and arthrogram).

Also covered are services or supplies needed before or after TMJ or orthognathic surgery including:

- Diagnostic
- Occlusal orthotic device for headaches and jaw alignment related to a TMJ condition
- Office visits
- Splints

Exclusions:

- Hospital charges associated with TMJ and orthognathic services.
- Surgical treatment of TMJ and orthognathic services

These benefits are available only under certain conditions of oral health. It is strongly recommended that the 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.

ORTHODONTIC BENEFITS FOR COVERED ADULTS AND 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 $1,500 ($2,000 effective January 1, 2018). Not more than $750 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.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a Confirmation of Treatment and Cost request be completed 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 eligibility. If individuals become dis-enrolled prior to the payment of benefits, subsequent payment is 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 through the plan's limiting age for Orthodontics, 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
- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by DDWA.

WELL BABY CHECKUPS

For an infant child (three years of age and under), Delta Dental of Washington offers coverage for an oral evaluation and fluoride treatment through a family physician. Please ensure the infant child is enrolled in this dental plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure the physician offers this type of service. When visiting a physician with an infant, DDWA will reimburse the physician as a non-participating provider for oral evaluation and topical application of fluoride services

performed. Reimbursement will be based on 100 percent of the applicable non-participating provider fee for either oral evaluation or topical application of fluoride, or both, depending on actual services provided.

Delta Dental of Washington has no control over the charges or billing practices of non-dentist providers which may affect the amount delta dental of Washington will pay and the patients financial responsibility.

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

ACCIDENTAL INJURY

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

General Exclusions (Non-Covered Services)

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

1) Dentistry for cosmetic reasons.
2) Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, 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.

6) 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 under WAC 284-43-630.

7) Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.

8) Prescription drugs.

9) Hospitalization charges and any additional fees charged by the dentist for hospital treatment.

10) Charges for missed appointments.

11) Behavior management.

12) Completing claim forms.

13) Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), does not include Occlusal Guard, see "Class II Periodontics" for benefit information.

14) 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.

15) All other services not specifically included in this Plan as Covered Dental Benefits.

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

Claims

Delta Dental PPO dentists and Delta Dental Premier® dentists complete claim forms and submit them directly to Washington Dental Service/Delta Dental. If you use a non-member dentist, your dental provider may file a claim for reimbursement on your behalf. If not, you may file a claim with Washington Dental Service/Delta Dental for yourself or a covered dependent.

You have 12 months from the date the charges were incurred to file a claim. Services must be completed before claim submission.

Other Dental Coverage

If you or your dependents are covered by both the Plan and another group dental plan, both plans may have the option to consider a claim for coverage. To avoid duplicate payments, these plans must coordinate their benefits to determine which part of the bill each plan is responsible for paying. Under coordination of benefits rules, one plan is primary (the plan that considers the charges first); the other plan is secondary (the plan that considers the charges second). If you file a claim, you are responsible for knowing which plan is primary for each participant. If you have questions about situations not described in this section, please contact the Plan.

Important
You must notify the Plan if you have duplicate dental plan coverage or if your duplicate plan coverage changes. Failure to do so could affect dental claim payments.

Note: When determining whether the Plan is primary or secondary, certain rules apply based on the participant receiving the care. Additional information can be found under "You" and "Your Spouse/Domestic Partner."

YOU

If you are covered under this Plan as an employee and under your spouse's/domestic partner's plan as a dependent, and your spouse's/domestic partner's plan has a coordination of benefit provision, this Plan is primary and must consider the charges first. If your spouse's/domestic partner's plan does not have a coordination of benefit provision, that plan is primary and must consider charges first.

YOUR SPOUSE/DOMESTIC PARTNER

If your spouse/domestic partner is covered under the Plan as a dependent and under another plan as an employee, the other plan is always primary for your spouse/ domestic partner and must consider charges first.

CHILDREN COVERED BY PARENTS WHO ARE MARRIED OR LIVING TOGETHER

For the purposes of this Plan, "parent" is defined as you or your spouse/domestic partner, as applicable.

If your dependent child is covered by two plans, the plan of the parent whose birth month and day are earlier in the calendar year is primary and must consider charges first. For example, if one parent's birthday is January 3 and the other parent's is March 15, regardless of the year of birth the first parent's plan is primary for the child and must consider charges first.

If the other plan does not use birth dates to determine which plan is primary and which plan is secondary, the other plan's coordination of benefits provision will govern whether this Plan is primary or secondary for the child.

CHILDREN COVERED BY PARENTS WHO ARE LEGALLY SEPARATED, DIVORCED, OR NOT LIVING TOGETHER

If the parent with custody of the child has not remarried (or "is not married") that parent's plan is primary, followed by the plan of the parent without custody, if any, and finally, by the plan of the stepparent or domestic partner without custody, if any.

If the parent with custody has remarried (or "is married"), that parent's plan considers charges first, followed by the plan of the stepparent or domestic partner with custody, if any, followed by the plan of the parent without custody, if any, and, followed by the plan of the stepparent or domestic partner without custody, if any.

However, if a court order assigns financial responsibility for the child's dental expenses to one of the natural parents, regardless of which parent has custody, that parent's plan is primary.

WORK AND LIFE EVENTS

This section describes how your dental coverage continues when you are no longer actively at work.

Leave of Absence

Taking a leave of absence affects your dental coverage, as indicated in the following table.

Leave of absence	How your dental coverage is affected
Unpaid nonmedical leave	Generally, coverage ends on the last day of the month in which you begin your leave (coverage may be continued by paying your premium directly or through COBRA)
FMLA leave **Disability/medical leave**	Coverage may be extended during a disability. After your active paycheck stops, the Company may continue your coverage or you and/or your covered dependents may continue coverage through COBRA, if you pay the full, or a portion of, the premium associated with coverage. Continuation and cost is based on the length and type of leave of absence If you do not return to work after an FMLA leave or your FMLA leave ends before your return to work, you and/or your covered dependents may continue coverage through COBRA In some cases, Weyerhaeuser may recover premiums it paid for maintaining your dental coverage during your leave if you do not return to work
Military leave	Coverage continues during any portion of your paid leave; coverage ends on the last day of the month in which you receive your final paycheck You may continue coverage through COBRA for up to 24 months by paying the full premium plus a 2% administrative fee
Other paid leave	Coverage continues during your paid leave; coverage ends on the last day of the month in which you receive your final paycheck

For specific details and more information about how your leave of absence will affect your other benefits, contact the Employee Service Center at 800-833-0030.

Leaving the Company or Retirement

If you leave the Company before retirement, your Plan coverage ends on the last day of the month in which you are employed by the Company. At that time, you may be eligible for COBRA coverage. (See "COBRA Coverage" for details.)

If you retire from the Company (generally at age 65, or earlier if you meet certain requirements), your Plan coverage ends on the last day of the month following the month in which you retire. Upon retirement, you may choose COBRA coverage, if you are eligible to do so. (See "COBRA Coverage" for details.)

Death

If you die while employed by the Company, Plan coverage will continue for your surviving family members through the last day of the month following the month in which you die. If you die while employed by the Company in a work-related accident, Plan coverage will continue for your surviving family members for six months, through the end of the last day of the final month of coverage.

Your surviving family members may be eligible for COBRA coverage, which allows your dependents to continue coverage for up to 36 months. (See "COBRA Coverage" for details.)

COBRA COVERAGE

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, which requires continuation of dental coverage to certain eligible employees and/or their covered dependents in most circumstances where coverage would otherwise end. It contains important information about your right to COBRA coverage, which is a temporary extension of coverage under the Plan. It also explains when COBRA coverage may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA Coverage Eligibility

COBRA is a term that refers to continuation of your Plan coverage when it would otherwise end because of a life event known as a COBRA qualifying event.

After a qualifying event, COBRA coverage must be offered to each person who is a qualified beneficiary. You or your covered spouse/domestic partner, dependent children, or domestic partner's dependent children could become qualified beneficiaries if Plan coverage is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the full cost of coverage each month (the full premium), plus administration fees. If you or your covered dependents decline this coverage when you first are eligible, you may not enroll at a later date.

You and your covered dependents may continue your current coverage under the Plan if coverage ends because of one of these qualifying events:

You voluntarily terminate employment with Weyerhaeuser.

- Weyerhaeuser ends your employment for any reason, unless you are terminated because of gross misconduct.
- The total number of hours you are regularly scheduled to work is reduced below the number required for you to be eligible for benefits.
- You take an unpaid leave of absence.

COBRA coverage also is available for your covered dependents if their coverage would otherwise end because of one of these qualifying events:

- Your death.
- Your divorce, legal separation, or end of your covered domestic partner relationship.
- Your covered child or your domestic partner's covered child becomes ineligible for coverage.

Length of COBRA Coverage

As shown in the following table, COBRA coverage continues for up to 18, 24, 29, or 36 months depending on how you or your covered dependents become eligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

Maximum length of COBRA coverage	Reason coverage stops
18 months	• Your employment ends for any reason (other than due to gross misconduct) • Your hours of employment are reduced to fewer than the number required to be eligible for the Plan • You take an unpaid leave of absence (coverage can continue for the duration of the leave or 18 months, whichever is less); for FMLA leaves, the 18-month COBRA period does not start until the FMLA leave is over
24 months	• You take an unpaid military leave as a result of being called to active military duty
29 months	• The Social Security Administration determines that you or your covered dependent is permanently disabled. The disability must have started at some time during the first 60 days of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage • You or your covered dependent provides notice of the Social Security award prior to the end of the initial 18 months of coverage of your disability, and provide documentation of the SSA's determination to receive this extension.
36 months (for covered dependents)	• You die • You and your spouse divorce or legally separate or your relationship with your covered domestic partner ends • Your or your domestic partner's covered child becomes ineligible for coverage

If you or your covered dependent is disabled as determined by the Social Security Administration during the first 60 days of the COBRA period, you or your covered dependent must notify Conexis, Weyerhaeuser's COBRA administrator, in writing about the Social Security disability award within the first 60 days after it is granted. The award and notification must occur during the first 18-month COBRA period. See "Contacting the COBRA Administrator" for Conexis contact information.

When the qualifying event is leave of absence from the Company due to an employee being called to active military duty, COBRA coverage lasts for up to 24 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for the employee's dependents who are qualified beneficiaries and lost coverage as a result of the qualifying event can last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his or her employment terminates, COBRA coverage for spouse and children can last up to 36 months after the date of Medicare entitlement, which equals 28 months after the date of the qualifying event (36 months minus eight months).

Second Qualifying Event

If your dependent experiences another qualifying event while receiving 18 months of COBRA coverage, your dependent may be eligible for up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly and timely given to the Plan.

This extension may be available to covered dependents if the employee or former employee dies or gets divorced or legally separated, or if the covered child becomes ineligible for coverage under the Plan as a dependent child, but only if the event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred.

Important
You must notify Conexis within 60 days of the second qualifying event to extend coverage. See "Contacting the COBRA Administrator" for Conexis contact information.

Electing COBRA Coverage

You and your covered dependents will receive election forms and more information about COBRA coverage from Conexis, Weyerhaeuser's COBRA administrator. In the case of a divorce, a legal separation, or the ineligibility of a dependent child, you or your covered dependents must call the Employee Service Center at 800-833-0030 within 60 days after becoming eligible to elect COBRA coverage.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your coverage in the Plan ends or 60 days after the date you receive the election form and notice of COBRA rights mailed to you by Conexis, whichever is later. *If you do not submit a completed election form by this due date, you lose your right to elect COBRA coverage*. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA coverage.

If you elect COBRA coverage because your employment terminated or your hours were reduced, and the Social Security Administration determines that you or a covered dependent is permanently and totally disabled at any time during the first 60 days of continuation coverage, you or your covered dependent must notify Conexis in writing within 60 days after the determination. The notice must be received by Conexis within the initial 18 months of COBRA coverage so you and your covered dependents can qualify for an additional 11 months of coverage.

When You Can Change COBRA Coverage

As a COBRA participant, you have the same opportunity as an active employee to make annual election changes to your benefits through a designated open enrollment period. You may:

- Choose different dental care plans, if any additional plan choices are available.
- Add or drop covered dependents.
- You can also enroll eligible dependents under special enrollment event and qualified status change rules. (For example, you may add a new dependent acquired through marriage, domestic partnership, birth, or adoption.)
- For more information, see "Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Events" and "Qualifying Status Changes."

Important
Call the Employee Service Center whenever you or your covered dependents experience an event that will end their eligibility to remain enrolled in the Plan.

Qualified Beneficiaries

To request COBRA coverage, you or your covered dependents are required to notify the Employee Service Center in writing or by phone within a maximum of 60 days after any of the following qualifying events:

- Your divorce or legal separation.
- The end of your domestic partner relationship.
- A dependent child becomes ineligible for coverage.

You will be given at least 60 days from the date coverage ends or the date you receive the COBRA notice and election forms, whichever is later, to elect COBRA coverage.

If you elect COBRA coverage, you or your covered dependents are also required to notify Conexis in writing within a maximum of 60 days after any of the following:

- A second qualifying event such as a divorce, legal separation, an end of a domestic partner relationship, death, a dependent child ceasing to be a dependent, or Medicare entitlement.

- Social Security Administration determination of disability.
- Social Security Administration determination of cessation of disability.

The notification must include your name, address, relationship to the employee, and a description and date of the qualifying event. See "Contacting the COBRA Administrator" for Conexis contact information.

ALTERNATE RECIPIENTS UNDER QMCSOS

A covered employee's child receiving Plan benefits under a Qualified Medical Child Support Order (QMCSO) that Weyerhaeuser receives during the covered employee's period of employment with Weyerhaeuser is entitled to the same COBRA coverage rights as an eligible dependent child of the covered employee.

When COBRA Coverage Ends

COBRA coverage ends when the earliest of the following events occurs:

- The maximum COBRA period (18, 24, 29, or 36 months) ends.
- Premiums are not paid on a timely basis.
- Weyerhaeuser terminates the Plan or amends the Plan to eliminate coverage and does not provide any other group dental plans to employees.
- The person who elected COBRA coverage becomes covered under another group dental plan after he or she has elected to continue coverage through COBRA and meets any pre-existing condition prohibitions or limitations affecting him or her.

Trade Act of 2002

The Trade Act of 2002 provides health care coverage expansion to certain employees who have lost their jobs or had a reduction in hours as a direct result of competition from foreign trade or production being moved overseas. As a result of this act, affected employees may be eligible for a second 60-day COBRA election period if they did not elect COBRA coverage when first eligible. This second election period begins on the first day of the month in which the employee is determined to be eligible for trade adjustment assistance (TAA).

In addition, TAA-eligible employees may also qualify for a federal tax credit of 65% of the COBRA premium if they elect COBRA coverage. If you are eligible for this tax credit, there are two options available to you for receiving this credit:

- Elect to claim the 65% credit on your annual federal tax return.
- Obtain an advance credit of 65% and pay the 35% balance of the monthly premium.

You will be notified if you are determined TAA-eligible. If you have questions about the Trade Act of 2002 or your eligibility for TAA assistance, contact SHPS, Weyerhaeuser's COBRA administrator. See "Contacting the COBRA Administrator" for contact information for Conexis.

Contacting the COBRA Administrator

To reach the COBRA plan administrator or ask questions about the Trade Act of 2002, contact:

CONEXIS/A Division of WageWorks
PO Box 226101
Dallas, TX 75222-6101
877-722-2667

RULES AND REGULATIONS

This section describes certain rules and regulations that affect you as a Plan participant.

Your Rights Under ERISA

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA), that entitle you to:

- Examine, at the Plan administrator's office and other specified locations, including work sites and union halls, if applicable, without charge, all Plan documents governing the Plan. These documents may include insurance contracts and certificates, collective bargaining agreements, if any, and 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 Employee Benefits Security Administration.
- Obtain, after sending a written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and certificates, collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated SPD. You may be asked to pay a fee for the copies.
- Receive a written summary of the Plan's latest annual report (Form 5500 Series). The Plan administrator is required by law to provide each participant with a copy of this summary annual report.

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

If your claim for a 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 several steps you can take to enforce your rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500 Series) from the Plan and do not receive it 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 Plan administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If Plan fiduciaries misuse 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 a 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have questions about the Plan, contact the Plan administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272 or by visiting http://askebsa.dol.gov.

Claim Review and Appeal Procedures

The Plan uses the following procedures when making decisions on claims and appeals. The procedures also include rules that you must follow to properly report a claim and appeal the denial of a claim under the Plan. Any reduction, denial, or termination of benefits will be treated as a claim denial and subject to the rules in the claim and appeal procedures. If you are denied eligibility to participate in the Plan, you may appeal that decision using the following procedures. You may not sue in court for Plan benefits until you complete all the claim and appeal procedures.

CLAIM AND APPEAL ADMINISTRATORS

The claims administrator is responsible for operating the Plan claim and appeal procedures.

Claims	
Dental benefits and claims	Washington Dental Service/Delta Dental PO Box 75983 Seattle, WA 98175-0983 Customer Service 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time

Eligibility appeals	
Eligibility to participate in the Plan*	Weyerhaeuser Employee Benefits Appeals Committee 220 Occidental Ave S. Seattle, WA 98104 Employee Service Center 800-833-0030 Monday – Friday, 6:00 a.m. – 3:00 p.m., Pacific time
First and second-level claims appeals	
Claims appeals	Washington Dental Service/Delta Dental Attn: Appeals Coordinator PO Box 75983 Seattle, WA 98175-0983 Customer Service 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time

*Only one level of appeal is provided.

Types of Claims and Appeals

Claim and appeal procedures require different rules for the following three claim and appeal types:

Pre-service claim. A pre-service claim is request for authorization before treatment is obtained to determine the dental benefits that are available. A pre-service appeal is an appeal of a pre-service claim denial.

Post-service claim. A post-service claim is a claim that is submitted after treatment has been obtained. Most claims under the Plan are post-service claims. A post-service appeal is an appeal of a post-service claim denial.

Urgent care claim. An urgent care claim is a pre-service claim (or appeal of a pre-service claim) when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that, in the opinion of a dental provider with knowledge of your condition, could cause severe pain that cannot be managed without the requested treatment.

The Plan will treat a claim or appeal as an urgent care claim or appeal if the physician or dentist treating you advises the Plan that it meets the criteria for an urgent care claim or appeal as defined previously. Whether a claim or appeal meets the urgent care criteria is determined at the time the claim or appeal is being considered.

INITIAL BENEFIT DETERMINATION

As the Plan's claims administrator, Washington Dental Service/Delta Dental will initially evaluate claims submitted by you or your dental provider for you or your covered dependent to determine whether dental services are covered as defined by the Plan.

In most cases, the Plan will send you a detailed statement called an explanation of benefits (EOB). The EOB explains amounts that have been paid, amounts that have not been paid, or why a claim was not paid. You may also receive other similar written notification in response to submitted claims. Notifications will be sent to you within certain time frames, based on the type of claim.

PRE-SERVICE CLAIMS

The claims administrator will provide written notice of its benefit determination within 15 days of receipt of your claim. If your pre-service claim is filed improperly, the claims administrator will notify you within five days following receipt of your claim.

If more information is needed to process your claim, or if the claims administrator determines an extension is necessary due to matters beyond the control of the Plan, the claims administrator will notify you of the information needed or the need for an extension and may request an extension of up to 15 days from when all information is received. The claims administrator will explain the reason for the extension and must state when the Plan expects to make a decision.

Once you are notified of the need to provide additional information, you have 45 days to supply this information. If you supply the requested information within 45 days, the claims administrator will notify you of its decision. If you do not supply the requested information within 45 days, your claim will be denied.

POST-SERVICE CLAIMS

The claims administrator will provide written notice of its benefit determination within 30 days of receipt of your claim. If more information is needed to process your claim, or if the claims administrator determines an extension is necessary due to matters beyond the control of the Plan, the claims administrator will notify you of the information needed or the need for an extension, and may request an extension of up to 15 days. The claims administrator must notify you of the extension within the original 30-day period and must state when the Plan expects to make a decision.

Once you are notified of the need to provide additional information, you have 45 days to supply this information. If you supply the requested information within 45 days, the claims administrator will notify you of its decision. If you do not supply the requested information within 45 days, your claim will be denied.

URGENT CLAIMS

The claims administrator will provide notice of its benefit determination as soon as reasonably possible, taking into account the seriousness of your condition, but not later than 72 hours after receipt of your claim, unless you fail to provide the necessary information to decide your claim.

To expedite the processing of an urgent care claim, the claims administrator's notice may be oral, but a written hardcopy or electronic confirmation will follow within three days. If your urgent care claim is filed improperly, the claims administrator will notify you within 24 hours after receipt of your claim.

If additional information is needed to process your urgent care claim, the claims administrator will notify you within 24 hours. You must provide the additional information within 48 hours of when it is requested. If you do not provide the additional information within 48 hours of when it is requested, the claim will be denied. The claims administrator must notify you of its decision as soon as possible, but in no event later than 48 hours after it receives the specified information (or 48 hours after the deadline for you to provide the specified information, if that is earlier).

For all claims and appeals, the timeframe during which a decision must be made begins when the claim or appeal is filed, even if all the information necessary for the claims administrator (or the Plan administrator, in the case of a final appeal) to make a benefit decision is not included in the filing. A written claim is not considered filed before it is received by the claims administrator. All claim and appeal deadlines are based on calendar days (not business days).

Denied Claims

If your claim is denied, in whole or in part, you or your authorized representative will receive a written notification of the denial that will include:

- Specific reasons for the denial.
- References to the specific Plan provisions on which the benefit determination was based.
- A description of additional material or information necessary for you to further substantiate the claim and an explanation of why such information is necessary.
- A description of the Plan's appeal procedures and applicable time limits.
- A statement about your rights to obtain, upon request and free of charge, a copy of the internal rules or guidelines relied upon in making this determination, and if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request.

- In the case of an adverse determination involving urgent care, a description of the expedited review process is available for such claims. To expedite the process in a situation involving an urgent care claim, you or your authorized representative may be orally notified of an adverse claim determination, but a written notification will follow within three days.

Exhaustion of administrative remedies
You must first exhaust all administrative remedies as set forth in the Plan's claim procedure before you may bring suit in court for the denial of any claim. If you do not do so in a timely manner, you forfeit your right to sue.

CLAIM APPEAL PROCESS

An appeal is an oral or written request that the Plan reconsider the decision to deny, modify, reduce, or end payment, coverage, or authorization of coverage. If your benefit claim for dental services is denied, either in whole or in part, you may appeal the decision. The Plan offers two levels of appeal: the first-level appeal, which is considered an informal review, is to Washington Dental Service; the second-level appeal is reviewed by a separate area of Washington Dental Service for reconsideration of the original denial. Weyerhaeuser participates in review of second-level appeals.

Before appealing, however, you may first want to contact the Plan to see if you can resolve the issue to your satisfaction. If not, you may contact the Plan to request an informal review of the decision. See "Contacts" for contact information.

INFORMAL REVIEW

An informal review is available whenever a claim was denied in whole or in part. Either you, or your authorized representative, must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing, and must include the following information:

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

Please submit your request for a review to:

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

You may include any written comments, documents or other information that you believe supports your claim. The Plan will review your claim and make a determination within 30 days of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. If your appeal involves a dental judgment, the review will be done in consultation with a dental professional who has appropriate training and expertise in the relevant field of dentistry. As part of the Plan's appeal process, you consent to this referral and the sharing of pertinent dental claim information. If a dental professional is contacted in connection with an appeal, you will have the right to know the identity of such individual.

Eligibility appeals
See "Enrollment and Coverage Changes," to determine who can be covered under the Plan. Claim denials about eligibility to participate in the Plan may be appealed only once. The Weyerhaeuser Employee Benefits Appeals Committee decides eligibility appeals.

Special rule for urgent care appeals
If you or your dental provider requests an appeal for an urgent care request, you or your provider may register your appeal orally by calling the Plan at 800-554-1907 and speaking with a representative. In addition, all communications between you and the Plan about your urgent care appeal may be conducted by telephone, facsimile, or any other available expedited method of communication.

See "Once Your Appeal is Received" for additional information.

SECOND-LEVEL APPEAL

If your informal review/first-level appeal is denied, in whole or in part, you have the right to file a final, second-level appeal with the Washington Dental Service Appeals Committee. This committee, including a Weyerhaeuser representative, is comprised of individuals who were not involved in any previous review of your issue. You and/or your authorized representative have the right to meet with the Committee. A Weyerhaeuser representative will attend this committee as well. If you decide to continue with a second appeal review, send your request as soon as possible along with any additional supporting documentation that you think should be reviewed to the address indicated in "Contacts."

Second-level appeals must be filed as quickly as possible, but within 90 calendar days after the postmark date that contained the determination of your first-level appeal.

Those who review your appeals must take all the information you provide into account, even if it was not submitted or considered in any prior decisions. Reviewers must also draw their conclusion without regard to prior claim determinations.

A qualified individual or committee who was not involved in previous claim determinations (and is not that person's subordinate) will decide your appeal. If your appeal involves a dental judgment, the review will be done in consultation with a dental professional who has appropriate training and expertise in the relevant field of dentistry. As part of the Plan's appeal process, you consent to this referral and the sharing of pertinent dental claim information. If a dental professional is contacted in connection with an appeal, you will have the right to know the identity of such individual.

ONCE YOUR APPEAL IS RECEIVED

After receiving your appeal (either a first-level or second-level appeal), the claim administrator will provide a written notice of its decision within the following time frames:

Pre-service claim: Within 15 days after the receipt of your appeal.

Post-service claim: Within 30 days after the receipt of your appeal.

Urgent care claim: As soon as reasonably possible, taking into account the seriousness of your condition, but not later than 72 hours after the receipt of your appeal. In most cases, urgent care claim appeal decisions are initially delivered orally to expedite treatment.

If a longer review period of your post-service or pre-service claim appeal is required and additional information is needed, you will receive a written notice that requests an extension of up to 15 calendar days and specifies the additional information needed to complete the review. If you receive a notification that more information is needed to review your appeal, the time period to review your appeal stops until you have submitted the information and it has been received.

When an appeal is denied, in whole or in part, you and/or your authorized representative will receive a written notification of the denial that includes:

- Specific reasons for the denial.
- References to the specific Plan provisions on which the benefit determination was based.
- A description of additional material or information necessary for you to further substantiate the claim and an explanation of why such information is necessary.
- A description of the Plan's appeal procedures and applicable time limits and your right to bring an action under ERISA.
- A statement about your rights to obtain, upon request and free of charge, a copy of the internal rules or guidelines relied upon in making the determination, and if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances.

- A statement that you may have voluntary alternative dispute resolution options (e.g., mediation).

TIME LIMITS

You may not take legal action against the Company for any claim for benefits or denied participation under the Plan unless you file the legal action within 365 days after the date that the Plan denied, in writing, the rights or benefits claimed under the Plan, or from the completion date of the review/appeals process, if applicable.

RIGHTS OF RECOVERY AND SUBROGATION

Improper or Excess Plan Payments

You and your covered dependents must refund to the Plan any benefits paid, to the extent benefits were not paid in accordance with the terms of the Plan (improper payments), or to the extent benefit payments exceed the benefits that should have been paid by the Plan (excess payments). Accordingly, you and your covered dependents are responsible for any improper or excess Plan benefit payments made to you, your covered dependents, or providers. By enrolling in the Plan, you agree to assist with the collection of any refund due. Whenever recovery of improper or excess benefit payments is unsuccessful, future Plan benefits that are payable to or on behalf of you or your covered dependents may be reduced.

Third Party Liability

If the Plan makes claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, the Plan is entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or the Plan. This party includes a UIM carrier because it represents a liable third party and because the Plan excludes coverage for such benefits.

Payment Recovery

Subrogation is the legal term used to describe the right provided to the Plan or its designee, on behalf of the Plan, to recover from third parties. You are obligated to repay or reimburse any funds advanced by the Plan from amounts received on your claim.

The Plan has paid for your illness or injuries and, consequently, the Plan is entitled to recover those expenses. The Plan is entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits the Plan paid for the condition, whether or not you have been made whole prior to the Plan's recovery.

The Plan's right to recover exists regardless of whether it is based on subrogation, reimbursement, or restitution. This right allows the Plan to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the eligible employee or dependent from any source to the extent of payments made or to be made by the Plan on the claimant's behalf. The Plan's rights and priority are limited to the extent the Plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights.

In recovering benefits provided on behalf of the Plan, the Plan may hire an attorney or have the Plan be represented by your attorney. The Plan will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by the Plan on its behalf.

Before accepting any settlement on your claim against a third party, you must notify the Plan in writing of any terms or conditions offered in a settlement, and you must notify the third party of the Plan's interest in the settlement established by this provision. The Plan's right of subrogation and reimbursement is a first-priority right of reimbursement, to be satisfied before payment of any other claims, including attorney fees and costs, regardless of whether the amounts are characterized or described as medical or dental expenses.

You also must cooperate with the Plan in recovering amounts paid by the Plan on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse the Plan directly from the settlement or recovery. If you fail to cooperate fully with the Plan in the recovery of benefits the Plan has paid as described previously, you are responsible for reimbursing the Plan for such benefits.

PLAN TERMINATION

Weyerhaeuser intends to continue the Plan described in this SPD indefinitely. It does, however, reserve the right to amend, modify, suspend, or terminate any benefits in whole or in part, at any time and for any reason. While Weyerhaeuser may terminate the Plan at any time, no such termination will affect the right of any employee to receive benefits for claims or services incurred as a Plan participant.

ADMINISTRATIVE INFORMATION

The information in this SPD is intended to comply with disclosure requirements of regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Agent for service of legal process	Weyerhaeuser Company Corporate Secretary Law Department 220 Occidental Ave S. Seattle, WA 98104 206-539-3000 Service of legal process may also be made to the Plan administrator
Claims administrator	Washington Dental Service Claims Processing P.O. Box 75983 Seattle, WA 98175-0983 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time www.DeltaDentalWA.com
Employer identification number	91-0470860
Employer name and address	Weyerhaeuser Company 220 Occidental Ave S. Seattle, WA 98104 800-833-0030
Plan administrator	The Plan administrator has the authority to control and manage the operations and administration of the Plan You can reach the Plan administrator at: Weyerhaeuser Company Employee Benefits 220 Occidental Ave S. Seattle, WA 98104 800-833-0030
Plan name	Weyerhaeuser Company Health and Dental Plan
Plan number	577
Plan sponsor	Weyerhaeuser Company Employee Benefits 220 Occidental Ave S. Seattle, WA 98104 800-833-0030

Plan year	January 1 through December 31
Source of funding	You and Weyerhaeuser pay the cost
Third-party administrator	Washington Dental Service P.O. Box 75983 Seattle, WA 98175-0983 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time www.DeltaDentalWA.com
Type of administration	The Plan's benefits, claims, and determinations are administered by a third party

CONTACTS

Plan information, eligibility, benefits, and questions	
Ask questions about Plan information, eligibility and benefits	Weyerhaeuser Company Employee Service Center 220 Occidental Ave S. Seattle, WA 98104 800-833-0030
COBRA enrollment information	
Ask questions about COBRA	CONEXIS/A Division of WageWorks PO Box 226101 Dallas, TX 75222-6101 877-722-2667 8 a.m. – 8 p.m. EST Monday through Friday
Dental benefits and claims	
Ask questions about dental benefits and claims Mail completed claim forms (if your provider does not submit the claim)	Washington Dental Service P.O. Box 75983 Seattle, WA 98175-0983 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time www.DeltaDentalWA.com
Eligibility appeals*	
File an eligibility appeal*	Weyerhaeuser Employee Benefits Appeals Committee 220 Occidental Ave S. Seattle, WA 98104 Employee Service Center 800-833-0030 Monday – Friday, 6:00 a.m. – 3:00 p.m., Pacific time
First- and second-level claim appeals	
File a claim appeal	Washington Dental Service Attn: Appeals Coordinator P.O. Box 75983 Seattle, WA 98175-0983 800-554-1907 Monday – Friday, 8 a.m. – 5 p.m., Pacific time

*Only one level of appeal is provided.

GLOSSARY

Annual benefit maximum
The annual benefit maximum is the maximum dollar amount the Plan will pay for expenses you incur during a calendar year. The benefit maximum is based on the type of dental service you receive and the time frame covered. The maximum is $1,500 per person per calendar year.

Annual open enrollment
Open enrollment is a period of time designated by Weyerhaeuser, typically during the fall of each year, when you may generally make changes to your benefit elections, add or drop dependents, etc.

Benefit period
The period beginning January 1 and ending December 31.

Bitewing
A dental X-ray showing the clinical crown portions of the upper and lower back teeth.

Bridge
A fixed prosthetic replacing a missing tooth or teeth.

Coinsurance
A percentage of expenses that you are responsible for paying after you meet your deductible.

Coordination of benefits
A provision in group insurance plans that allows participants who have duplicate coverage to have their charges considered for payment by both plans, while not exceeding 100% reimbursement of the total charges.

Covered charge
The total dollar amount that the Plan will consider as a fee for each covered service that you or a covered dependent receives. The Plan calculates its benefit against the covered charge.

Covered provider
Any provider from whom the Plan will consider payment for covered services. The Plan will pay a benefit toward covered services only if the services are provided by a covered provider.

Covered service
Any procedure, supply, or equipment that the Plan will consider for coverage. The service must be necessary to restore the dental health of the mouth as defined by the Plan.

Crown or cap
A restoration replacing the entire surface of the tooth.

Deductible
Generally, the amount of covered dental expense you must pay before the Plan pays.

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

Denture
A replacement for natural teeth and adjacent tissue. A complete denture replaces all the upper or lower teeth.

Disability
A condition that causes you to be unable to perform one or more regular job duties.

Effective date of coverage
The earliest of the date coverage begins and the first day after the Plan's waiting period.

Endodontics
The care of the nerves and blood vessels of your natural teeth.

ERISA
The Employee Retirement Income Security Act of 1974, as amended, which provides certain rights to eligible participants.

Explanation of benefits (EOB)
A statement you receive from the dental claim administrator whenever you file a claim, giving specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, amount allowed, amount paid, and participant's balance due, if any.

Fluoride
A substance used on your tooth to make it more resistant to decay.

FMLA leave
Any leave taken under the Family and Medical Leave Act (FMLA) of 1993. Federal law and Weyerhaeuser's policy allow you to take up to 12 weeks of paid or unpaid leave during any 12-month period for one or more of the following reasons:

- To care for your newborn child.
- To care for your newly placed adopted or foster child.
- To care for your spouse, child, or parent who has a serious health condition as defined by the FMLA.

- To care for yourself when you have a serious health condition that makes you unable to perform the functions of your job (called a disability leave).

Important
California, Oregon, Washington, Arizona, and New York have state laws that could affect your FMLA leave.

Gingivectomy
The surgical removal of gum tissue alongside teeth.

Inlay
A dental filling shaped to fill a cavity, then inserted and cemented in the tooth.

Licensed professional
An individual legally authorized to perform services as defined in his or her license. Licensed professional includes, but is not limited to: anesthesiologist, denturist, endodontist, general practitioner, hygienist, oral pathologist, oral surgeon, orthodontist, pedodontist, periodontist, physician, prosthodontist and radiology technician. The professional must meet the educational, credentialing, and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Lifetime maximum
The lifetime maximum is the maximum dollar amount the Plan will pay for expenses you or your dependents incur during the time period you are a Plan participant.

Monthly contribution
Weyerhaeuser pays a premium to provide Plan coverage for each participant. Weyerhaeuser typically subsidizes most of this cost for you and/or your dependents. Any portion that is not subsidized by the Company is referred to as a monthly contribution and represents your portion of the insurance premium equivalent. The monthly contribution is deducted from your paycheck in equal increments throughout the year.

Nonparticipating provider
A dental professional who does not have a contract to provide services at negotiated, discounted rates. This type of provider may also be referred to as a nonpreferred provider or a non-network provider.

Open enrollment
Open enrollment is a period of time designated by Weyerhaeuser, typically during the fall of each year, when you may generally make changes to your benefit elections, add or drop dependents, etc.

Orthodontia
The branch of dentistry that deals with detecting and treating improper tooth and jaw alignment and function.

Participant
An employee or eligible dependent who is eligible for and enrolled in coverage under the Plan.

Periodontics
The treatment of the supporting and surrounding tissues of the tooth (i.e., the gum and supporting bone).

Plan benefit
The percentage that the Plan pays toward a covered charge.

Preferred provider
Any dental professional who has a contract to provide services at negotiated, discounted rates (sometimes referred to as a participating provider or a network provider).

Premium
The total monthly equivalent cost of providing Plan coverage for an eligible participant. Typically, the premium equivalent is the sum of a monthly contribution from the employee and a monthly contribution from Weyerhaeuser.

Pre-tax
Contributions taken from your paycheck before applicable federal, state, local, and other taxes are withheld.

Qualified Medical Child Support Order (QMCSO)
A judgment, decree, or order that meets the following criteria:

- Is issued by a court under a domestic relations law or community property law.
- Creates or recognizes the right of an alternate recipient to receive benefits under a parent's employer's group plan.

Qualifying Status Changes
Certain life events that allow you to add or drop coverage for yourself and/or your dependents.

Root canal therapy (complete)
Treatment of damaged or diseased root structures generally by removing pulp and filling the pulp chamber and root canals with a sealing material.

Sealant
The protective resin coating applied over grooves in teeth to prevent decay.

Secondary payer
The plan that is second in responsibility under coordination of benefits.

Space maintainer
An appliance children use in their mouths so their teeth do not drift or crowd new teeth.

Special enrollment rights

HIPAA special enrollment rights are available if you experience certain changes in eligibility for benefits under this Plan and allow you additional rights to add yourself and dependents to the Plan.

Spouse
Your husband or wife as defined by federal law or under state common-law standards, where applicable.

Summary plan description (SPD)
A legally required document describing your benefits in detail, how the Plan operates, how to file claims, and your rights and responsibilities as a Plan participant.

Temporomandibular joint (TMJ) syndrome
A medical or dental problem related to the temporomandibular joint that links the jawbone and skull.