AUGUST 2022

SUMMARY PLAN DESCRIPTION

Dental Plan

WASHINGTON TEAMSTERS WELFARE TRUST

www.wateamsters.com

INTRODUCTION

This booklet describes the benefits and provisions of the Washington Teamsters Welfare Trust Dental Plan for employees of employers who negotiate a collective bargaining agreement requiring Plan contributions. This plan is designed to assist you and your family in paying the cost of dental care. Although the plan provides coverage for many dental services, it will generally pay only a portion of the charges, not the whole cost. We encourage you to become familiar with your dental benefits and to discuss costs with your dentist before service begins, to prevent misunderstandings. If you have any questions not answered by this booklet, please contact Delta Dental of Washington which administers this plan on behalf of the Washington Teamsters Welfare Trust. Delta Dental of Washington handles most of the administrative details, such as paying claims and answering your benefit questions.

Delta Dental of Washington is a member of the Delta Dental Plans Association (DDPA), the nation's largest, most experienced dental benefits organization. The DDPA is made up of local, not-for-profit Delta Dental plans that provide a range of employee dental benefit programs. DDPA is unique in that its members contract with close to 124,000 dentists nationwide who provide dental care to subscribers at previously agreed-upon fee levels.

This Plan is funded directly by the Trust, using contributions from both employers and participants. This money goes into the Trust and the Trustees, representing the participating employers and local union members, decide the level of funding and plan design. Delta Dental of Washington follows the rules set forth by the Trustees and takes care of the plan's benefit and claims administration.

As you think about how to use your benefits, consider that your use of the plan directly affects costs. We encourage you to be a wise consumer and to evaluate all your treatment options.

IMPORTANT NOTICE

Payment of benefits as specified in this booklet depends on your employer making contributions for you to the Washington Teamsters Welfare Trust sufficient to maintain these benefits. The amount of necessary employer contributions may increase from time to time. If your employer doesn't pay the required contributions, your coverage may be transferred to a lower-cost plan. If you are ineligible for Plan coverage, the fact that contributions were made on your behalf will not entitle you to benefits.

Only Delta Dental of Washington is authorized by the Trustees to administer the Plan and provide information about the amount of benefits. Similarly, only the Trust Administrative Office, Northwest Administrators, Inc. is authorized to administer eligibility issues and provide eligibility information. No union employee, union officer, business agent, employer or employer representative or representative of any other organization except Delta Dental of Washington or the Trust Administrative Office is authorized to give Plan information, interpret the Plan or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

While no change in the Plan is anticipated, the Trustees reserve the right to terminate, amend or eliminate benefits as deemed necessary. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust fund.

Si necesita ayuda para entender este panfleto, comuniquese con la oficina administrativa.

General Information

General Information

Administrator

This plan is administered by Delta Dental of Washington. To file a dental claim or for questions about benefits covered under this Plan, whether you are eligible for a specific benefit (such as orthodontia or a cleaning), or to check on the status of a dental claim contact:

Delta Dental of Washington
Customer Service Department
PO Box 75983
Seattle, WA 98175-0983

Telephone: 206-522-2300 or 800-554-1907

For questions about enrollment in the Plan and whether you have eligibility for coverage, contact the Trust Administrative Office:

Washington Teamsters Welfare Trust
Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102

Telephone: 800-458-3053
Online: www.nwadmin.com

Enrollment

Participant Data Form

To receive benefits under this Plan and avoid delays in claim administration, you must complete and submit a Participant Data Form to the Trust Administrative Office when you first become eligible. Participant Data Forms can be obtained from the Trust Administrative Office or your local union.

Updating Enrollment Data

Accurate and efficient claim processing depends, in part, on Delta Dental of Washington having current data for you and your covered dependents. Changes in address, marital status, number of dependents and information about other insurance are critical. It is your or your dependent's responsibility to notify the Trust Administrative Office within 60 days of a qualifying event that causes coverage to end for a covered dependent. Divorce or a dependent child losing eligibility due to age are both examples of qualifying events that end coverage under the Plan. You may update your information by submitting a revised Participant Data Form or you may update your information online at www.nwadmin.com.

Your employer is responsible for notifying the Trust Administrative Office only when an employee's coverage ends.

ID/Information Card

Your ID/Information card contains important information for you and your providers, such as who can answer questions and where to send claims. It also lets providers know that you're a Trust member. Carry your ID card at all times and present it to your dental providers. If you would like to request an ID/Information card or if you lose your card, contact the Trust Administrative Office.

Quick Guide to Claim Filing

Delta Dental of Washington In-Network Dentists

You may receive services from any licensed dentist, but costs may be lower if you receive service from a Delta Dental of Washington in-network participating provider. When using a participating dentist:

- Be sure to present your ID/Information card when receiving treatment. This card identifies you as a Washington Teamsters Welfare Trust participant and tells the provider where to send the bill for payment.
- You do not need to fill out a claim form if you use a Delta Dental of Washington participating dentist. The dentist will submit the claim for you.
- If another plan is primary, submit an Explanation of Benefits (EOB) from the other plan with your claim.
- You will receive an EOB specifying what was paid under this Plan and your financial responsibility.
- Neither Delta Dental of Washington nor the Trust is obligated to pay for treatment performed if the claim is submitted more than 12 months after the date treatment is provided.

Non-participating Dentists

If you receive services from a dentist who is not a participating provider of Delta Dental of Washington, follow these steps:

- Have your dentist complete and sign an American Dental Association-approved claim form and submit it to Delta Dental of Washington.
- If another plan is primary, submit an Explanation of Benefits (EOB) from the other plan with your claim.
- Neither Delta Dental of Washington nor the Trust is obligated to pay for treatment performed if the claim is submitted more than 12 months after the date treatment is provided.
- You will receive an EOB specifying what was paid under the Plan and your financial responsibility.

If You Have Questions

For claim inquiries and questions about the benefits, contact Delta Dental of Washington at (206) 522-2300 or (800) 554-1907.

For information about enrollment, contact the Trust Administrative Office at (800) 458-3053.

For information about the claim review and appeal process, see the Claim Review and Appeal Procedures on page 45.

If you would like to request an ID/Information card or if you lose your card, contact the Trust Administrative Office.

Eligibility and Coverage Effective Dates

Eligibility and Coverage Effective Dates

Who's Eligible

To become eligible for contributions to be made to the Trust on your behalf, you must first meet the requirements in your employer's collective bargaining agreement, consistent with Trust guidelines. You also must be an active employee with the minimum number of compensable hours or hours worked (usually 80) during a month for any one employer who makes Plan contributions.

Coverage Effective Dates

Lag Month Rule

To help ensure timely eligibility information is provided to your health care providers, the Trust uses a lag month system — the Trust advances eligibility for one month while you continue working enough hours each month for a contribution to be made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February (the lag month), your coverage is effective in March (rather than February). This continues until you have a break in contributions (see Breaks in Contributions below).

Any month the Trust waives contributions for you due to a disability will be considered a month in which contributions were made for the purpose of determining if you had a break in contributions.

When Coverage Begins

Coverage and benefits for new hires begin after one month's contribution is made on your behalf under the lag month system. For example, if you are a new hire who has satisfied the requirements of your collective bargaining agreement, you work enough hours in June and your employer makes a contribution in July (the lag month), your coverage begins August 1. *Please note, you may need at least two consecutive months of contributions to avoid a loss of the first month of coverage. See Breaks in Contributions below for more information.*

The lag month eligibility system continues while you continue working enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in July, and your employer makes a contribution in August (the lag month), coverage and benefits will be provided in September.

When you have a break in contributions due to layoffs, a reduction in your work hours, termination of employment, disability (unless contributions are waived), or for any reason *other than* retirement or resignation, or your employer's cessation of participation in the plan, your coverage will continue until the end of the *second* month following the month in which you last had the minimum number of hours requiring contributions as stated in your collective bargaining agreement. For example, if you are laid off in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on June 30. If you are laid off in April without enough hours to receive a contribution, and the final contribution from your employer is made in April (for your March hours), your coverage will end on May 31.

When you retire or resign, or if your employer ceases to participate in the Plan, your coverage will stop at the end of the *first* month following the month in which you last had the minimum number of hours requiring contributions as stated in your collective bargaining agreement. For example, if you retire in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on May 31. If you retire in April without enough hours, and the final contribution from your employer is made in April (for your March hours) your coverage will end on April 30.

If you return to work after 1) you had a break in contributions, or 2) you resigned or retired, or 3) your employer ceased making contributions, and contributions are again made on your behalf, coverage will resume under the lag month eligibility system the same as for a new hire. Trust eligibility for new hires begins after one month's contribution is made on your behalf under the lag month system. For example, if contributions are first made on your behalf in October based on your employment in September, your coverage begins November 1.

Note: Some collective bargaining agreements may have a waiting period before contributions become payable to the Trust. An agreement may also require a minimum number of hours be worked in order for contributions to be made. Refer to your collective bargaining agreement or contact your local union or employer about any waiting periods or hour requirements. In no event, however, will a waiting period exceed a cumulative hours of service requirement of twelve hundred (1,200) hours, followed by a 90 day waiting period.

If you are a new hire or an employee reestablishing eligibility, you must have at least two consecutive months of employer contributions in order to preserve lag month coverage for the first contribution if you subsequently lose coverage due to *resignation, retirement (or if your employer ceases to participate in the Plan).* For example, if you have only one contribution on your behalf and you resign or retire, you will not qualify for coverage. However, if you have only one contribution on your behalf and your employment is terminated, you are laid-off, disabled, or do not work enough hours, you will receive one month of coverage.

When Coverage Ends

Coverage for you and your dependents will end if this Plan terminates or if your employer ceases to make required contributions or stops participating in the Plan. A dependent's coverage also will end when he or she no longer meets the Plan's eligibility requirements.

When you have a break in contributions, as explained in the preceding section, coverage stops at the end of the first or second month following the month in which you last have the minimum number of hours requiring contributions as stated in the collective bargaining agreement. Whether coverage stops at the end of the first month or second month depends on the reason for the break in contributions (see previous section).

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 18 and COBRA Self-Pay Option on page 20.

Eligible Dependents

Eligible dependents include:

- Your spouse (meaning the individual you are legally married to, as recognized under the laws of the state or jurisdiction in which the marriage was entered into - including, if applicable, your same-sex spouse)
- Your domestic partner ***if*** your local union and your employer negotiated domestic partner benefits for your group (see "Domestic Partner Benefits" below).
- Your children under age 26 who are your:
    - Natural children
    - Adopted children
    - Step children
    - Children placed with you for adoption

These children do not have to depend on you for support, do not have to attend school full time, can be married, and can have access to other health coverage through their own employment.

Your eligible dependent children also include your unmarried children up to age 19 who live with you, are dependent on you for support and are:

- Children for whom you are the court-appointed guardian
- Grandchildren
- Children of your domestic partner if your local union and employer negotiated domestic partner benefits (see Domestic Partner Benefits below).

These dependent children who would otherwise qualify as eligible dependents but are 19 years or older will be eligible until age 26 (through 25th year) if they are unmarried, depend on you for support/maintenance, and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance. A dependent who (i) takes a physician certified medically necessary leave of absence from a postsecondary school (college, university, or trade school) due to a serious illness or injury, which causes the dependent to lose student status and (ii) was an eligible dependent immediately before the first day of the medical leave, will continue to have coverage through the "Applicable Period." Applicable Period means the earlier of one year from the first day of the medical leave of absence or the date on which dependent coverage under the Plan would otherwise terminate. Proof of a medically necessary leave of absence must be certified in writing to the Plan by the student's treating physician. If the student recovers from the serious illness or injury, he or she must notify the Plan immediately and begin classes again at (or enroll again in) a postsecondary school if within the Applicable Period in order to resume dependent student status under the Plan. If the medical leave of absence exceeds the Applicable Period, a dependent cannot resume student status but may be eligible for COBRA coverage. COBRA coverage will run consecutive with any student disability coverage.

- Your unmarried eligible dependent child who is physically or mentally incapable of self-support (but only if your own coverage is in effect). To cover a child under this provision, you must file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.
- Children (called alternate recipients) that the Trust is directed to cover them pursuant to a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction (but only if your own healthcare coverage is in effect).
- Contact the Trust Administrative Office for details.

Except as noted below for children of domestic partners, all children who qualify as eligible dependents are eligible for dental benefits from the later of the effective date of your coverage or the date the child meets the requirements above.

Domestic Partner Benefits

If your local union and employer have negotiated to add domestic partner benefits, you may enroll your same or opposite sex domestic partner for benefits if:

- You (the covered participant) and your domestic partner have registered as domestic partners or entered into a civil union in the state or municipality where registered, or
- You and your domestic partner meet all of the following requirements:
  - You are both at least age 18
  - Neither of you is legally married to another person of the opposite sex or in a domestic partnership with another person
  - You are not related by blood to a degree of closeness that would prohibit marriage
  - You are in an exclusive, committed relationship that is intended to be permanent
  - You share a mutual obligation of support and responsibility for each other's welfare
  - You currently share a principal residence and have done so for at least 6 months, and intend to do so permanently

Coverage of a domestic partner is effective upon the Trust's receipt of the required enrollment form and documentation.

Documentation Required

If your local union and employer negotiate domestic partner benefits and you want to enroll your domestic partner, you and your partner will be required to complete a notarized Affidavit of Domestic Partnership and submit a birth certificate or driver's license as proof of your domestic partner's age, plus additional documentation to verify your domestic partner's eligibility including that you have shared a principal residence for at least six months. This additional documentation must include any three of the following:

- Declaration, Affidavit, or Certification of Civil Union from a state or municipality that issues such
- Legal documents indicating that, as domestic partners, they are responsible for each other's welfare
- Home title or other documents showing joint ownership of significant property
- Rental agreement documenting joint tenancy
- Canceled checks showing rent or utility payments from both partners at the same address, or bills proving same
- Evidence of joint banking accounts (savings, checking, etc.)
- Power of Attorney (durable property or healthcare)
- Wills, life insurance policies, or retirement annuities naming each other as primary beneficiary
- Co-parenting or adoption agreement.

Children of Domestic Partners

If your local union and employer negotiate domestic partner benefits and you want to enroll children of your domestic partner, the child(ren) may be enrolled subject to the plan's preceding dependent children eligibility requirements including that the child(ren) are:

- Dependent upon you for support and maintenance, and
- Unmarried, and
- Under 19 years old and residing with you and your domestic partner ***or*** at least 19 but under 26 and enrolled full-time in an accredited educational institution ***or*** disabled and physically or mentally incapable of self-support (provided the applicable requirements set forth in the "eligible dependents" section above are met).

Other Important Information about Domestic Partner Benefits

It's important to note that domestic partner benefits are subject to different federal and state tax rules. Income taxes may be payable as a result of the Trust providing benefits to your domestic partner and his or her children. If your bargaining unit has bargained domestic partner benefits and you are covering a domestic partner, you may wish to consult a tax professional for advice on your personal situation. Domestic partners are not eligible for COBRA self-pay benefits when coverage ends and in most cases; the domestic partner's children will not be eligible for COBRA continuation benefits either.

Dependent Consent to Disenroll

Participants may elect to not cover their spouse if they are legally separated and provide documentation of this fact to the Trust Administrative Office. Participants may otherwise elect to not cover their spouse only if their spouse consents to not being covered. Participants may elect to later reenroll their spouse or their spouse may revoke consent and again be enrolled.

Participants may elect to not cover a child age 18 or older, however, under federal law such child has a right to be enrolled in coverage under the participants' plan through the age of 25, therefore, in order to not cover a child age 18 or older participants must first provide the Trust Administrative Office with the child's address in order for the child to be notified coverage is being terminated. The child will be given the right to re-enroll. Participants may elect to later re-enroll a child provided the child is under age 26 at the time.

Termination of coverage or coverage upon re-enrollment of a spouse or child will be effective the first of the month following receipt of written notification by the Trust.

Continuation of Coverage

Continuation of Coverage

This section describes various options for continuing dental coverage under specific circumstances.

Quick Guide to Continuing Your Coverage

The Trust offers a number of options for continuing your dental coverage after it would normally end, depending on your situation. The chart below provides an overview of these options, which are described in more detail in the following pages.

Continuing Your Dental Coverage Overview			
Continuation option *	**How long coverage can be continued**	**Who can be covered**	**For details**
Continue coverage lost due to delinquency of employer contributions	Up to three months	You and your eligible dependents	See page 17
Continuing coverage lost due to a strike, lockout or labor dispute	Up to six months	You and your eligible dependents	See page 18
Continuing coverage during a military leave	During your military leave (maximum of24 months)	You and your eligible dependents	See page 18
Continuing coverage during a Family or Medical Leave (FMLA)	During your FMLA leave (maximum of 12 weeks)	You and your eligible dependents	See page 19
Total Disability Waiver of Contributions	Up to three months	You and your eligible dependents	See page 19
COBRA (self-pay option)	Normally up to 18 months Up to 29 months if disabled Up to 36 months for dependents in certain circumstances	You and/or your eligible dependents	See page 20

* *You may generally only continue coverage you already had through the Trust. For instance, you may continue dental coverage only if you had dental coverage through the Trust and it is allowed under the continuation option.*

Please note, this chart is only a brief summary and does not describe many details of the continuation options. Please refer to the pages shown in the chart for more detailed descriptions, or call the Trust Administrative Office.

Continuing Coverage Lost Due to Delinquency of Employer Contributions

Dental coverage for you and your eligible dependents may be continued for up to three months if your employer is delinquent in Plan contributions and the employer account has been referred for collection. To be eligible for continued coverage, you must provide proof of employment that would have created eligibility had the required employer contribution been made. This continued

coverage is for a maximum of three months after employer contributions stop and is available only once for an employer or successor. (This provision does not relieve an employer of any obligation to contribute to the Plan.)

Continuation of Dental Coverage in the Event of a Strike, Lockout or Other Labor Dispute

If your coverage terminates because active work ends as a result of strike, lockout or other labor dispute, your dental coverage may continue during the dispute while the Plan is in effect if you self-pay the required contributions. See pages 20 to 23 for information on COBRA self-pay coverage.

In no event may you continue your benefits beyond *the earliest* of these dates:

- Six months after you stop active work
- Your request that coverage be terminated
- Your failure to make the required self-payment on time
- Your eligibility for similar coverage under another group plan
- Termination of the Plan.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue your group health benefits — including medical, dental, vision and prescription drug coverage. If your military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts over 31 days, you and your dependents will be eligible to continue coverage through self-payment for up to 24 months. When you return to covered employment, your regular coverage will begin immediately, if you meet the requirements summarized below.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless precluded by military necessity or other reasonable cause). You should also tell your employer how long you expect to be gone. Upon release from military duty, you must apply for reemployment as follows:

- Less than 31 days military service — apply immediately, taking into account safe transportation plus an eight-hour rest period
- 31-180 days military service — apply within 14 days
- More than 180 days military service — apply within 90 days.

If you're hospitalized or convalescing, these reemployment deadlines are extended while you recover (but not longer than two years).

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

To ensure proper crediting of service under USERRA, have your employer notify the Trust Administrative Office when you go on leave and again when you are reemployed following your return from leave.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') medical, dental, vision and coverage (if covered under the Trust) for up to 12 weeks during a 12-month period if you're on leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse or parent
- Your own serious health condition.

Contact your employer as soon as you think you're eligible for a family or medical leave since the law requires you to give 30 day notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other rights under FMLA.

If you haven't returned to work when your coverage under FMLA ends, you and your dependents will be able to elect COBRA self-pay coverage, as described on 20 to 23.

If you qualify for a Disability Waiver of Contributions and under FMLA because of your own serious health condition, as described in the following section, employer contributions are not required by the Trust while you remain qualified for the Disability Waiver of Contributions.

Waiver of Contributions for Total Disability

If you fail to work the specified minimum monthly hours for eligibility because you're totally disabled, and you've submitted proof of the disability from your physician and employer, you may receive a waiver of contributions for up to *three* months if you remain totally disabled. The waiver period will begin on the first of the month following the month your employer's paid coverage ends. At the conclusion of the waiver period you may elect COBRA and begin making COBRA self-payments, but your combined continuation coverage under the waiver period and COBRA may not exceed 18 months (29 months if disabled). The combined continuation coverage maximum will be 21 months if you are on medical leave under FMLA while also eligible for waivers of contributions for total disability and your employer's contributions under FMLA are waived.

To determine eligibility for waiver of contributions, you must become disabled in a month for which you have eligibility based on an employer contribution. You must also be:

- Totally disabled due to a covered accident or illness (including pregnancy and its complications), and
- Unable to perform the normal duties of your occupation, and
- Not engaged in any occupation for wage or profit (except light-duty work that may be allowed under your collective bargaining agreement), and
- Under a physician's regular care for that injury or sickness.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it is due to a different cause and begins after you return to full-time work.

Self-Pay for Continuing Dental Coverage

COBRA Self-Pay Option

You may be eligible to continue dental coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the Plan, you and your covered dependents may choose COBRA self-pay coverage for up to 18 months if your coverage terminates for one of these qualifying events:

- A reduction in your hours of employment
- Termination of your employment for reasons other than gross misconduct.

A dependent spouse covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the participating employee
- Divorce from the participating employee
- Participating employee's entitlement to Medicare benefits.

A dependent child covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the participating employee
- Divorce of the participating employee and spouse
- Participating employee's entitlement to Medicare benefits (Part A, Part B or both)
- Participating employee's dependent child no longer meets the eligibility requirement under the Plan.

A spouse or dependent child who elects COBRA self-pay coverage for 18 months due to the employee's termination for reasons other than gross misconduct, or reduction in hours, may be eligible to continue coverage for up to 36 months for a second qualifying event:

- Death of the participating employee

- Participating employee divorces
- Participating employee's entitlement to Medicare benefits (Part A, Part B or both)
- Participating employee's dependent child no longer meets the eligibility requirements under the Plan.

It is your or your dependent's responsibility to inform the Trust Administrative Office of a divorce or loss of dependent status within 60 days from the latest of the following:

- Date of the divorce or loss of dependent status
- Date coverage is lost because of the event
- Date on which you were informed of the responsibility to provide the notice and of the Plan's procedures for notifying the Trust Administrative Office.

The employer is responsible for notifying the Trust Administrative Office when the employee's coverage ceases.

You or your dependent could receive a Social Security determination confirming disability at the time of the COBRA qualifying event (or within the first 60 days of continuation coverage due to the event). If this happens, the disabled person and all COBRA-eligible family members may be eligible for up to 29 months of continuation coverage. The Trust Administrative Office must receive a copy of the disability determination within *60 days* of the determination date and *within the original 18-month coverage period.*

If the disabled individual is later determined no longer to be disabled by the Social Security Administration, *you must notify the Trust Administrative Office within 30 days of the determination.* In this case, the 11-month COBRA extension will end as of the effective date the individual is no longer entitled to Social Security disability benefits.

When the Trust Administrative Office is notified that a qualifying event has occurred, it will supply details including:

- Application for COBRA self-pay coverage
- Cost information and payment procedures
- Requirements for continuation of coverage.

Special Tax Credit for TAA

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be trade adjustment assistance (TAA) eligible individuals. TAA eligible individuals who declined COBRA when they were first eligible can elect COBRA within the 60-days of the first day of the month in which they become TAA eligible individuals. Nonetheless, this election may not be made more than six months after the date the TAA individual's group health plan coverage ended.

TAA eligible individuals are also eligible for a health insurance tax credit for a percentage of qualified health insurance premiums, including COBRA coverage. Beginning May 1, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) provided for an extension of the COBRA

coverage period under certain circumstances. The Omnibus Trade Act of 2010 and the Trade Adjustment Assistance Extension Act of 2011 generally extended the tax credit (at 72.5% of premiums for the months beginning after February 12, 2011) and the COBRA coverage period through January 1, 2014. Under the Trade Preferences Extension Act of 2015, the tax credit for eligible individuals was reinstated for months beginning January 1, 2014 through December 2019. If you have questions about your extended ability to elect COBRA coverage or this new tax credit you may call the IRS at (800) 829-1040. More information about the TAA Program and the extension of the tax credit described above is available at www.irs.gov/hctc.

Timing Is Important

Your application and self-payments must be timely. You will be eligible for COBRA self-pay coverage only within the following time frames:

- You have *60 days* to elect COBRA from the later of the date you are notified or the loss of coverage date. You won't be eligible for COBRA self-pay coverage after this 60-day election period ends.
- The first self-payment is due within *45 days* of the date your first payment notice is mailed. Subsequent self-payments will be due no later than the last day of the month for which payment is being made. Your COBRA coverage will terminate automatically unless you make timely payments.

Employees who qualify for a total disability extension and waiver of contributions, described on page 19, may not have to make COBRA payments during the three-month waiver period. However, the combined period under COBRA self-pay coverage and the waiver may not exceed 18 months (29 months if you are disabled and qualify for the COBRA disability extension). The combined continuation coverage maximum will be 21 months if you are on medical leave under FMLA while also eligible for waivers of contributions for total disability and your employer's contributions under FMLA are waived. To qualify for the additional 11-month COBRA disability period, you must qualify for and be receiving Social Security disability benefits. Contact the Trust Administrative Office for details.

COBRA self-pay coverage will be identical to that provided under the Plan to similarly situated active employees or dependents.

If you have other benefits under the Trust, such as medical and vision plan benefits, you may also be required to self-pay for those benefits in order to self-pay for dental plan benefits. Contact the Trust Administrative Office for details.

COBRA self-pay coverage will terminate before the COBRA eligibility period ends for any of the following reasons:

- Payment for continuation of coverage is not received by the last day of the month for which payment is being made.
- You, your spouse and/or eligible dependents obtain coverage under any other group health plan after the last date to elect COBRA self-pay coverage (unless the other plan excludes or limits your benefits because of a preexisting condition).
- You became entitled to Medicare benefits (Part A or Part B) after the last date to elect COBRA self-pay coverage; however, your dependents may be entitled to further

continuation of coverage. (If your spouse or dependent becomes eligible for Medicare for any reason, coverage for that individual will end.)

- The Plan terminates.
- Social Security determines you are no longer disabled during an 11-month disability extension period.

If you have any questions about COBRA coverage or the application of the law, contact the Trust Administrative Office. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

DENTAL PLAN PROVISIONS

DENTAL PLAN PROVISIONS

How to Use Your Program

The best way to take full advantage of your dental plan is to understand its features. You can do this most easily by reading this benefits booklet *before* you go to the dentist. The booklet is designed to give you a clear understanding of how your dental insurance works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this booklet doesn't answer all of your questions, or if you don't understand something, call a Delta Dental of Washington customer service representative at (800) 554-1907. If you have questions about your enrollment under the plan, call the Trust Administrative Office at (800) 458-3053.

Choosing a Dentist

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

Once you choose a dentist, tell them that you are covered by a Delta Dental of Washington dental plan and provide them the name and number of your group and your member identification number. The program name is Washington Teamsters Welfare Trust and the group number is **#9086**. Your group information can be found on the identification card document provided to you at enrollment or printed from www.DeltaDentalWA.com. You may also obtain your group information and your member identification number by calling our Customer Service Department at 800-554-1907 or through our website at www.DeltaDentalWa.com.

Delta Dental of Washington uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft. Please note that ID cards are not required to see your dentist but are provided for your convenience.

Delta Dental of Washington Participating Dentists

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

Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their filed fee under Delta Dental Washington's standard agreement.

Delta Dental PPO Dentists

PPO Dentists have agreed to provide services at a fee lower than their original filed fee. Because of this, selecting a PPO Dentist may be a more cost effective option for you. If you select a Delta Dental Participating Dentist they will complete and submit claim forms, and receive payment directly from Delta Dental Washington on your behalf. Payment will be based on the pre-approved fees your dentist has filed with their local Delta Dental Plan. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurance amounts or the difference between the approved fee and the scheduled allowance (see your Dental Plan Summary of Benefits Appendix), any amount over the Plan Maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

Participating dentists agree to charge only their pre-approved fees and no more. These fees are negotiated rates that have been agreed to by the participating dentist. You are not responsible for amounts in excess of these fees. As an example, assume your participating dentist typically charges $200 for a filling, and his or her pre-approved fee with Delta Dental of Washington is $175. The plan would pay the claim at a percentage of the $175 or the scheduled allowance as outlined in your Dental Plan Summary (see Appendix). Your total responsibility would be the difference between the paid amount and the $175. Your participating dentist cannot charge you more than the pre-approved fee.

These fees are for illustrative purposes only. Actual fees for both participating and non-participating dentists may vary.

Non-Participating Dentists

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

Non-Participating Dentist Allowable Fee

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

As an example, assume your non-participating dentist typically charges $200 for a filling, and the Delta Dental of Washington non-participating maximum allowable fee for a filling is $150. The plan will pay the claim at a percentage of the $150 or the scheduled allowance as outlined in your Dental Plan Summary (see Appendix). Your responsibility will be the difference between the paid amount and the $150, *plus* the difference between the dentist's charge of $200 and Delta Dental of Washington non-participating maximum allowable fee of $150, which is $50.

These fees are for illustrative purposes only. Actual fees for both participating and non-participating dentists may vary.

Limitations and Exclusions

This plan has certain limitations and exclusions, meaning that the plan does not cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this booklet under the sections called Covered Charges on page 28 and General Exclusions on page 37.

Program Maximum

The program maximum is the maximum dollar amount the plan will pay toward the cost of dental care within a calendar year. You are personally responsible for paying any costs above the annual maximum.

For your program, the maximum amount payable for covered dental benefits (including dental accident benefits) per eligible person is $2,675 each calendar year, except that there is no annual limit for essential pediatric dental care for children under age 19. Charges for dental procedures requiring multiple treatment dates are incurred at the time the treatment is completed. Amounts paid for such procedures will be applied to the program maximum of the calendar year in which the treatment is completed.

The lifetime maximum amount payable by Delta Dental of Washington for orthodontic benefits is $2,675 per eligible child.

All covered employees and covered dependents are eligible for service benefits excluding orthodontia. Only covered dependent children through the age of 25 are eligibile for orthodontic benefits.

Claims Filing and Deadlines

Neither Delta Dental of Washington nor the Trust is obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 12 months after the date the treatment is provided.

Predetermination of Benefits

If your dental care will be extensive, you may ask your dentist to complete and submit an American Dental Association-approved claim for an estimate. This "predetermination of benefits" will allow you to know in advance what procedures are covered, the amount the plan will pay toward the treatment and your financial responsibility.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For the Washington Teamsters Welfare Trust, the benefit period is January 1st through December 31st.

Covered Charges

The following are covered dental benefits, subject to the limitations and exclusions contained in this booklet. These benefits are available only when services are performed by a licensed dentist or other Delta Dental of Washington-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and Delta Dental of Washington.

Please note, some of the benefits described in this section may be available only under certain conditions of oral health. To find out whether or how much a specific treatment will be covered, you are strongly encouraged to have your dentist submit a predetermination of benefits to determine what will be covered.

Class I Services

Diagnostic

Covered Diagnostic Benefits

- Routine examinations (periodic oral evaluation)
- Comprehensive oral evaluation
- X-rays
- Emergency examinations
- Specialist examination performed by a specialist in an American Dental Association recognized specialty

Delta Dental of Washington-approved caries and periodontal susceptibility/risk tests.

Limitations

- Routine examinations are covered twice in a calendar year
- Comprehensive, or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist as one of the two covered examinations in a calendar year per eligible person. Subsequent comprehensive oral evaluations from the same dentist are covered as periodic oral evaluations.
- Complete series (any number or combination of intraoral and/or extraoral x-rays billed on the same date of service, that equal or exceed the allowed fee for a complete series is considered a complete series for payment purposes) or panorex X-rays are covered once in a three-year period
- Diagnostic services and X-rays related to temporomandibular joints (TMJ or jaw joints) are not a covered benefit.

Supplementary bitewing X-rays are covered twice in a calendar year.

Exclusions

- Elective second opinions

Study models.

Refer also to general limitations and exclusions.

Preventive

Covered Preventive Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure sealants
- Topical application of fluoride or preventive therapies such as fluoridated varnishes
- Space maintainers when used to maintain space for eruption of permanent teeth.
- Preventive resin restoration

Limitations

- Prophylaxis and/or periodontal maintenance procedures are limited to two procedures in a calendar year
- Under certain conditions of oral health and when approved by Delta Dental of Washington, prophylaxis or periodontal maintenance (but not both) may be covered, up to a total of four combined regular and periodontal visits in a calendar year. *Please note: It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be fully covered*
- Topical application of fluoride or preventive therapies (but not both) is covered twice in a calendar year
- Fissure sealants are available for children through age 18. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit once in a three-year period per tooth.
- Preventive resin restorations are available for children through age 18. Payment for preventive resin restorations will be for permanent molars with no restorations on the occlusal (biting) surface. The application of preventive resin restorations is a covered benefit once in a three-year period per tooth from the date of service. The application of preventive resin restorations is not a covered benefit for three-years after a sealant or preventive resin restoration on the same tooth.
- Replacement of a space maintainer previously paid for by Delta Dental of Washington is not a covered benefit.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)
- Cleaning of a prosthetic appliance

Refer also to general limitations and exclusions.

Class II Services

General Anesthesia

Covered General Anesthesia Benefits

- General anesthesia when administered by a licensed dentist or other Delta Dental of Washington-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by Delta Dental of Washington, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II and III covered dental procedures. Either general anesthesia or intravenous sedation (*but not both*) is covered when performed on the same day.
- General anesthesia for routine post-operative procedures is not a covered benefit.

Intravenous Sedation

Covered Intravenous Sedation Benefits

- Intravenous sedation when administered by a licensed dentist or other Delta Dental of Washington-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Limitations

- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by Delta Dental of Washington. Either general anesthesia or intravenous sedation (*but not both*) is covered when performed on the same day.
- Intravenous sedation for routine post-operative procedures is not a covered benefit.

Palliative Treatment

Covered Palliative Treatment Benefits

- Palliative treatment for pain.
- Palliative treatment will not be covered if the same provider performs any other definitive treatment such as a filling or crown on the same date of service.

Restorative

Covered Restorative Benefits

- Amalgam restorations, resin-based composite or glass ionomer restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp)
- Stainless steel crowns.
- Recementing of crowns, inlays, onlays, veneers and bridges.
- Repair of prosthetic appliances.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period
- Stainless steel crowns are covered once in a two-year period
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a covered benefit

Refer to Class III Limitations if teeth are restored with crowns, inlays or onlays.

Exclusions

- Overhang removal, copings, re-contouring or polishing of restoration.

Refer also to general limitations and exclusions.

Oral Surgery

Covered Oral Surgery Benefits

- Removal of teeth
- Preparation of the mouth for insertion of dentures
- Treatment of pathological conditions and traumatic injuries of the mouth
- Ridge extension for insertion of dentures (vestibuloplasty)

Tooth transplants and reimplants.

Limitations

- Tooth transplants or reimplants are covered only when performed for stabilization or splinting of a tooth due to an accident.

Exclusions

- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of natural teeth.

Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

Refer also to general limitations and exclusions.

Periodontics

Covered Periodontic Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planing, periodontal surgery, soft tissue grafts and gingivectomy
- Limited adjustments to occlusion (eight or fewer teeth)
- Delta Dental of Washington-approved localized delivery of antimicrobial agents

Limitations

- Periodontal scaling/root planing is covered once in a three-year period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
- Soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- Gingivectomy is covered once in a three-year period from the date of service.
- Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions or oral health, as approved by Delta Dental of Washington.
    - When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a calendar year
    - When covered, localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or you must have been in active supportive periodontal therapy, prior to this treatment
- Localized delivery of chemotherapeutic agents is not a covered benefit when used for the purpose of maintaining non-covered dental procedures or implants.
- Periodontal surgery and localized delivery of chemotherapeutic agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment

- Periodontal splinting, crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances are not a covered benefit
- Occlusal guard (nightguard) is covered once in a two-year period from the date of service without clinical criteria. Coverage is for bruxism (grinding) only.

Exclusions

- Gingival curettage

Refer also to general limitations and exclusions.

Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. Keep in mind that predetermination is not a guarantee of payment.

Endodontics

Covered Endodontic Benefits

- Procedures for pulpal and root canal treatment
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period
- Retreatment of the same tooth is covered when performed by a different dental office

Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions

- Bleaching of teeth.

Refer also to general limitations and exclusions.

Class III Services

Restorative

Covered Restorative Benefits

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

- Repair of crowns, onlays, and veneers.

Limitations

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a five-year period. The five-year limitation on replacement of a crown is waived if replacement is due to dental necessity as a result of an injury to the crown.
- Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.
- Inlays, as a single tooth restoration (with limitations) are considered a cosmetic procedure. A benefit to pay up to an amalgam restoration allowance will be made once in any two-year period, however any difference in cost is your responsibility.
- Crown buildups are a covered benefit when more than 50% of the natural coronal tooth structure is missing or 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
- Crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a covered benefit.
- A crown buildup or a post and core are covered once in a two-year period from the date of service on the same tooth in keeping with Delta Dental of Washington's policy for all cast restorations.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a 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
- Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliance are not a covered benefit
- Crown buildups or post and cores are not a covered benefit within two years from the date of service of a restoration on the same tooth.

Exclusions

Refer also to general limitations and exclusions.

Prosthodontics

Covered Prosthodontic Benefits

- Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) removable partial dentures and the adjustment or repair of an existing prosthetic device
- Surgical placement or removal of implants or attachments to implants.

Limitations

- Replacement of an existing prosthetic device is covered only once every five years and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered benefit on the same teeth once in a five-year period only when used as an abutment for a fixed bridge.
- Replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures will be paid on the delivery date.
- Crowns in conjunction with overdentures are not a covered benefit.
- **Full, immediate and overdentures** — Delta Dental of Washington will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment (adding a special filling on a denture to make it look more like your natural tooth). You will be responsible for any amount above the preapproved fee.
- **Temporary/interim dentures** — Delta Dental of Washington 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.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level.
- **Partial dentures** — If a more elaborate or precision device is used to restore the case, Delta Dental of Washington will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or jump rebases (but not both) will be covered once in a 12-month period.

Exclusions

- Duplicate dentures
- Personalized dentures
- Cleaning of prosthetic appliances

Refer also to general limitations and exclusions.

Accidental Injury

Delta Dental of Washington will pay 100% of 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 program maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

Orthodontic Benefits for Eligible Children

You may choose any licensed orthodontist. There is no network of providers for orthodontic benefits.

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

Only dependent children are eligible for orthodontic benefits and orthodontic treatment must start prior to the date they reach their 26th birthday. Orthodontia services for dependent children after age 25 are not covered, whether treatment is completed or not.

The lifetime maximum amount payable by Delta Dental of Washington for orthodontic benefits for an eligible child is $2,675. Delta Dental of Washington will pay 70% of the fees actually charged for orthodontic benefits up to this lifetime orthodontia maximum.

Payments of Delta Dental of Washington's responsibility will be made on a monthly basis, if the employee is eligible and the dependent is within the age limitation.

To find out how orthodontic treatment will be covered, you are strongly encouraged to have your dentist submit an orthodontic treatment plan to Delta Dental of Washington for predetermination before treatment begins. Keep in mind that a predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based on eligibility. Payments will stop if the patient becomes ineligible.

Covered Orthodontia Benefits for Children Through the Age of 25

- Treatment of malalignment of teeth and/or jaws.

Limitations

Payment is limited to:

- Treatment through age 25, whether completed or not
- 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
- Termination of the treatment plan prior to completion of the case
- Termination of the contract.

Exclusions

- Charges for replacement or repair of an appliance
- No benefits will be provided for services considered inappropriate and unnecessary, as determined by Delta Dental of Washington.
- Orthodontics for adults age 26 and older regardless of the reason for the treatment.

Refer also to general limitations and exclusions.

Special Treatment Benefit

Additional coverage is available for you and your eligible family members who experience deterioration of the teeth and gums as a result of radiation treatment for cancers in the head, neck or throat. Necessary dental services are covered up to a $10,000 lifetime maximum. This benefit is in addition to the annual dental maximum of $2,675. Dental services are covered only when they are:

- Necessary as a result of radiation treatment directly related to cancer of the head, neck or throat
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing.

You will be required to provide proof of the medical treatment, corresponding deterioration and be approved by the Plan before the Special Treatment benefit will apply.

Dental benefits are not paid for any of the following items. These limitations and exclusions are in addition to the exclusions and limitations listed in Covered Charges on pages 28 to 37.

1. General anesthesia/intravenous (deep) sedation except as specified by Delta Dental of Washington for certain oral, periodontal, or endodontic surgical procedures. General anesthesia except when medically necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with covered dental procedures.

General Exclusions

Dental benefits are not paid for any of the following items. These limitations and exclusions are in addition to the exclusions and limitations listed in Covered Charges on pages 28 to 37.

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. General anesthesia/intravenous (deep) sedation except as specified by Delta Dental of Washington for certain oral, periodontal, or endodontic surgical procedures. General anesthesia

except when medically necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with covered dental procedures.

4. Services for injuries or conditions that are compensated under workers' compensation or employers' liability laws. Services that are provided by any federal or state or provincial government agency or provided without cost 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.

5. Treatment of temporomandibular joint dysfunction (TMJ).

6. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).

7. Experimental services or supplies. Experimental 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, Delta Dental of Washington, in conjunction with the American Dental Association, will consider if:

   (a) The services are in general use in the dental community in the state of Washington;

   (b) The services are under continued scientific testing and research;

   (c) The services show a demonstrable benefit for a particular dental condition; and

   (d) They are proven to be safe and effective.

   Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

   Any denial of benefits by Delta Dental of Washington on the grounds that a given procedure is deemed experimental, may be appealed to Delta Dental of Washington. By law, Delta Dental of Washington must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual. Whenever Delta Dental of Washington makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, Delta Dental Washington 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, Delta Dental Washington shall presume the need for expeditious determination in any independent review.

8. 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.

9. Prescription drugs

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

11. Charges for missed appointments

12. Patient behavior management problems

13. Completing claim forms

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

15. Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

16. All other services not specifically included in this program as covered dental benefits.

Delta Dental of Washington has the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this Summary Plan Description.

Dental Plan Definitions

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

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

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

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

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

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

Caries Susceptibility Test — A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

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

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

Coping — A thin covering of the tooth used as part of a restoration.

Covered Dental Benefit — Those dental services covered under this program, subject to the limitations set forth in Benefits Covered by Your Program.

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

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

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

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

Exclusions — Dental services not provided under a dental insurance plan.

Filed Fees — Approved fees that participating Delta Dental of Washington dentists have agreed to accept as the total fees for the specific services performed.

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

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

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

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

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

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

Licensed Professional — An individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to, denturist, hygienist and radiology technician.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured.

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

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

Nightguard — See Occlusal Guard.

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

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

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

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

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

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

Periodic Oral Evaluation (routine examination) — An evaluation to determine any changes in a patient's dental and medical health status following a previous comprehensive or periodic evaluation.

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

Prophylaxis — Cleaning and polishing of teeth.

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

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

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

Root Planning — A procedure done to smooth roughened root surfaces.

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

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

Temporomandibular Joints (TMJ) — The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

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

PLAN ADMINISTRATION

PLAN ADMINISTRATION

About the Privacy of Your Health Information

As part of the normal process of administering its health care plans, the Trust, the Plan Sponsor (which is the Board of Trustees), and its health care claims administrators may receive personal health information about you and your covered dependents. The use and disclosure of certain types of health information (called protected health information) will be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, federal laws that governs the privacy of individuals' protected health information.

The Plan Sponsor and the Trust group health care plans (the dental plan described in this booklet) are subject to HIPAA's privacy requirements and privacy protections.

Participants will receive a copy of the Trust's HIPAA privacy notice separately.

Coordination With Other Dental Benefits

Coordination of Benefits or COB refers to how the Plan coordinates benefits when you or your dependents have dental coverage under more than one plan.

Benefits otherwise payable under this Plan for allowable expenses during a claim determination period may be reduced if:

- Benefits are payable under any other plan for the same allowable expenses; and
- Under the rules listed below, benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to ensure that the sum of payments under this Plan plus benefits under the other plan is not more than the total of allowable expenses. Each benefit that would be payable without this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include those that would have been paid if claims had been made for them.

Order of Benefit Determination

The benefits payable by a plan that doesn't have a COB provision will be determined before those of a plan that does have a COB provision. In all other instances, the order of determination will be (the first of the following that applies will be used):

1. **Employee/Dependent.** The benefits of a plan that covers the person as an employee participant are determined before those of a plan that covers the person as a dependent participant.

If you are covered under a Trust dental plan as both the employee and a dependent (for example, if your spouse also has Trust coverage as an employee and covers you as an eligible dependent), the Trust Plan will be both primary and secondary.

2. **Dependent Child — Parents Not Separated or Divorced.** When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

3. **Dependent Child — Parents Separated or Divorced.** If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   - First, the plan of the parent with custody of the child
   - Then, the plan of the spouse of the parent with custody of the child
   - Finally, the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the entity obligated to pay or provide benefits for the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. (This doesn't apply to any claim determination period or plan year when any benefits are actually paid or provided before the entity has that knowledge.)

4. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan doesn't have this rule, and if, as a result, the plans disagree on the order of benefits, this rule will not apply.

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that has covered a person longer are determined before those of a plan that has covered the person for a shorter time. It does not apply to prescription drug, mental health or chemical dependency benefits.

Subrogation (Third-Party Reimbursement)

If you or your dependents incur any dental expense resulting from injury or sickness for which there is right of recovery against a third party (including workers compensation claims), Trust benefits will be paid on the condition the Trust will be reimbursed from any amount you or your dependents receive in settlement or judgment. You or your dependents also must give the Trust (through its Plan Benefits Administrator) the name and address of the responsible third party and, if requested, execute a Trust Subrogation Agreement agreeing to reimburse the Trust. The Trust may withhold benefit payment if you are requested to execute a Trust Subrogation Agreement and do not comply.

As security for the Trust's right to this reimbursement, the Trust will be subrogated to all rights of recovery against the third party to the extent of any benefits the Trust paid. You or your

dependents must do whatever is necessary to fully secure and protect, and nothing to prejudice, the Trust's rights to this subrogation.

Recovery of Unauthorized Benefit Payments

The Trust provides benefits only under the written terms of this Plan. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Plan — or if you or a dependent fails to reimburse *benefits advanced under an agreement to reimburse — the individual profiting from* the benefit is obligated, upon notice from the Trust, to reimburse the overpayment. Otherwise, the Trust is entitled to bring legal action to recover the overpayment. The court may award the Trust reasonable attorney fees and court costs in addition to the overpayment amount.

The Trust also has the right to deduct the overpayment amount from any future benefits that are payable to the individual or others claiming eligibility through the same individual.

Use of Medical and Dental Consultants

The Board of Trustees has authorized the Plan Benefits Administrator to refer claims for dental benefits to outside doctors, dentists or other professionals for review and advice. In determining the issues presented, these consultants may rely on their own expertise and on professional standards, procedures and protocols.

Any claim denial that incorporates or is based on medical or dental consulting advice may, as any other claim denial, be reviewed in accordance with the Trust's appeals process (see page 45).

Interpretation of the Plan

Administration and interpretation of eligibility for coverage in this Plan is vested wholly and exclusively in the Trustees, who have sole discretion and entire authority to determine eligibility for benefits. The Trustees have contracted with Delta Dental of Washington and have delegated to Delta Dental of Washington the sole discretion and entire authority to interpret and apply the provisions of this Plan, their own motions, resolutions, administrative rules and regulations. Any benefit determination the Trustees or Delta Dental of Washington make in good faith will be conclusive and binding on the unions, employers, employees and beneficiaries under the benefit plans.

Claim Review and Appeal Procedures

The Washington Teamsters Welfare Trust plans have adopted specific procedures and timeframes, required by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. This section provides information about the specific timelines and information requirements that apply to your claims and appeals filings and the claim administrator's claims and appeals determinations. The claim administrator, unless otherwise specified, is Delta Dental of Washington.

If your claim for benefits is wholly or partially denied, you or your duly authorized representative may submit a written request for a review of the claim by the Washington Teamsters Welfare Trust Appeals Committee (Appeals Committee). The request for review must be submitted to the claims administrator within the timeframe applicable for that benefit plan and type of claim, as described in the following pages.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received. The claim administrator will consider the claim and notify you of an adverse decision on the claim, in writing, within the appropriate timeframes described on page 47, unless the claim administrator determines that special circumstances require an extension of time to process the claim. If such an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it, and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

Delta Dental of Washington (Delta Dental of Washington) is the claim administrator for all dental plans.

If you believe that you are entitled to a benefit under one of the Washington Teamsters Welfare Trust plans, or that you are entitled to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a written claim with the appropriate Claim Administrator listed above.

The claim review and appeal procedures apply to these types of claims:

Urgent Health Care Claim (before health care treatment)	A claim or pre-approval request for a dental benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Health Care Claim (before health care treatment)	*Any claim or pre-approval request for a dental benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.*
Concurrent Health Care Claim (changes in health care treatment)	*Any claim involving the reduction or termination of an ongoing course of treatment before the end of that course of treatment if the treatment was previously authorized by the Plan, or a request to extend treatment beyond the authorized time or number of treatments.*
Post-Service Health Care Claim (after health care treatment)	*Any claim for a dental benefit that is not a pre-service claim.*

Dental Claim Procedures

Timeframe for Initial Claim Decisions

The timeframe for initial claim decisions for dental plans depends on the type of claim filed:

Type of Claim	Timeframe for Notice of Claim Decision	Extensions*
Urgent care	The claim administrator will provide notice of claim approval or denial as soon as possible, taking into account the seriousness of your condition, but no longer than 72 hours; notice of denial may be by phone with written or electronic confirmation to follow within three days	If additional information is needed to complete your claim, you'll be notified within 24 hours
Pre-service	The claim administrator will provide notice of a claim approval or denial within 15 days	Up to 15 days, provided you are notified within the original 15-day period
Concurrent care	If an ongoing course of treatment that was previously approved by the Plan will be reduced or terminated, the claim administrator will notify you sufficiently in advance to give you an opportunity to appeal and obtain a decision on appeal before the reduction or termination takes effect. For any request to extend ongoing treatment in an urgent care situation, you'll be notified within 24 hours, provided your request is made at least 24 hours before the end of the approved treatment. For any request to extend ongoing treatment in a non-urgent care situation, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.	
Post-service	The claim administrator will provide notice of a claim approval or denial within 30 days	Up to 15 days, provided you are notified of the extension within the original 30-day period

**If more time is needed to process claims due to circumstances beyond the claim administrator's control.*

Insufficient Health Care Claims

Please note that the claims review and appeals procedures include rules that specify what happens if you file certain insufficient or incomplete claims.

Improperly Filed Pre-Service Claims

If your pre-service claim was filed improperly, you will be notified within five days after a pre-service claim is received (or within 24 hours in an urgent care case). Notice of an improperly filed pre-service claim may be provided by phone, or in writing upon request. The notice will identify the proper procedures to be followed in filing the claim.

To receive notice of an improperly filed pre-service claim, you or your authorized representative must have provided a communication regarding the claim to the claim administrator. This communication must include:

- Your name
- A specific medical condition or symptom
- Request for approval for a specific treatment, service or product.

Incomplete Pre- and Post-Service Claims

If more information is required to process your pre- or post-service health care claim, you'll be notified within the original 15-day period for pre-service claims, and within the original 30-day period for post-service claims. If you are notified of the need to provide additional information for a pre- or post-service claim, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days and your claim is denied, the claim administrator will notify you of the denial within 15 days after the requested information is received. If you do not supply the requested information within 45 days, your claim may be denied.

Incomplete Urgent Care Claims

If more information is needed to process a properly filed urgent care claim, you'll be notified as soon as possible, but no later than 24 hours after your claim is received. This notice will include the specific information necessary to complete the claim. Once you are notified of the need to provide more information, you'll have a reasonable amount of time — considering the circumstances, but not less than 48 hours — to submit the requested information. You'll receive notice of the claim decision as soon as possible, but no later than 48 hours after whichever occurs earlier:

- The claim administrator receives the information, or
- The additional period given for providing the information ends.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- The denial code (if any) and its corresponding meaning
- A statement regarding the availability of the diagnosis and treatment codes upon request
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- An explanation of the available external review procedures, including time limits

- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman
- If an internal rule, guideline or protocol or other similar criteria was relied upon in deciding your Claim, a copy of the rule, guideline, protocol or other similar criteria, or a statement that it is available upon request at no charge
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, or a statement that it is available upon request at no charge.
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

Claim Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

- In addition, you will automatically be provided with any and all new information generated in connection with your appeal. You will be offered the opportunity for a full and fair review on appeal.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination on health care claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described below and on page 50. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Timeframes for Filing and Determination of Dental Plan Appeals

You have 180 days from the date you receive notice of a dental claim denial to file your appeal. Appeal decision timeframes vary, depending on the type of health care claim filed:

- **Urgent care** – The Trust Administrative Office will provide notice of appeal decision as soon as possible, considering the medical situation, but no later than 72 hours after receiving your appeal, unless you do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan (see page 49).
- **Pre-service** – The Trust Administrative Office will provide notice of appeal decision within 30 days of appeal.
- **Post-service** – The Trust Administrative Office will provide notice of appeal decision within five days after the next quarterly meeting of the Appeals Committee if the appeal is received at least 30 days before the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If special circumstances require an extension of time for rendering a decision, the claim administrator will provide notice of the extension within the initial decision timeframe, and

a decision will be rendered at the next quarterly meeting, with notice provided within five days after that meeting.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial.
- References to specific plan provisions on which the denial is based.
- The denial code (if any) and its corresponding meaning.
- A statement regarding the availability of the diagnosis and treatment codes upon request.
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits.
- A statement of your right to bring a civil action under ERISA Section 502(a).
- An explanation of the available external review procedures, including time limits.
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman.
- If an internal rule, guideline or protocol or other similar criteria was relied upon in deciding your Claim, a copy of the rule, guideline, protocol or other similar criteria, or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, or a statement that it is available upon request at no charge.
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Request for External Review

You must complete the internal claims appeal process discussed above before requesting an external review. Once the internal claim appeal process is completed by the Appeals Committee making its decision, you will have four months from the date you receive that decision to file a request for an external review (if your claim is eligible for external review - as discussed in more detail below).

You may request external review for any denied claim except for denials based on finding that you did not satisfy the eligibility requirements for a benefit under the terms of the applicable Plan or denials based on a legal or contractual interpretation of the Plan's terms.

Requests for external reviews should be sent to:

External Review Appeals
PO Box 12267
Seattle, WA 98102

Preliminary Review of External Review Request

Within five (5) business days of receiving a request for external review, the Trust will complete a preliminary review of the request to make sure that:

- The patient is or was covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;
- The decision being appealed does not relate to any failure to meet the applicable eligibility requirements, or to a legal or contractual interpretation of the Plan's terms;
- The Trust's internal claims appeal process has been completed; and
- All the information and forms required to process an external review have been received.
- The matter appealed involves either medical judgment, decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational or a rescission (meaning a retroactive termination of coverage).

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision. If the request is not eligible for external review, the Trust's notice will explain the reasons and provide any other information required, including contact information for the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). If the request for external review is incomplete, the Trust will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Trust will refer the matter to an Independent Review Organization (IRO).

Review by Independent Review Organization

After a properly filed request for external review is referred, the Trust will provide the IRO with the required documentation in the time required by applicable Federal regulations. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a

decision to reverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify you and the Plan.

Upon receipt of any information submitted by you, the assigned IRO will within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan, and the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your dental records;

2. The attending provider's recommendation;

3. Reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider;

4. The terms of the Plan;

5. Appropriate practice guidelines;

6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

7. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision to the Plan and to you within 45 days after the IRO received the request to review. The assigned IRO's decision notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the availability of diagnosis codes and their corresponding meaning, the availability of treatment codes and their corresponding meaning, the denial codes (if any); and the reason for the previous denial);

2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision; References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

3. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, considered in reaching its decision;

4. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the plan or to the claimant;

5. A statement that judicial review may be available to you; and contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO will make such record available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State and Federal privacy laws.

The Plan will ensure independence of all IROs, will contract with at least three IROs for assignments, and will rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The assigned IRO will use legal experts where appropriate to make coverage determinations under the plan.

Expedited External Review

You may request the IRO to provide you an expedited external review if you received:

- An adverse benefit determination involving a medical condition of the patient for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final adverse benefit determination, if the patient has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the patient received emergency services, but has not been discharged from a facility.

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that the appeal is eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by any other available expeditious method. The IRO will notify the Trust and you of its determination as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO will provide both you and the Trust written confirmation of the decision.

Actions Following the Decision of the IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under the applicable Plan in accordance with the decision. If the decision is adverse, you will have the right to pursue a suit pursuant to ERISA 502(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected a claimant must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

Administrative Details

The Employee Retirement Income Security Act of 1974 (ERISA) as amended, requires that certain information be furnished to Plan participants and beneficiaries:

Name of Plan

This Plan is known as the Washington Teamsters Welfare Trust — Dental Plan.

Name, Address and Telephone Number of Board of Trustees as Plan Sponsor

This Plan is sponsored by a joint labor-management Board of Trustees:

Board of Trustees of the Washington Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

You can obtain information on whether a particular employer or employee organization is a Plan sponsor (and, if so, their address) by writing to the Trustees. You can also obtain a complete list of employers sponsoring the Plan upon request. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Employer Identification Number and Plan Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-6034673.

The Plan number is 501.

Type of Plan

This Plan is a welfare plan that provides dental benefits.

Type of Administration

This Plan's benefits are administered by the Board of Trustees with the assistance of this administrative organization:

Delta Dental of Washington
Customer Service Department
PO Box 75983
Seattle, Washington 98175-0983
206-522-2300
800-554-1907
www.DeltaDentalWA.com

This Plan's COBRA administration, participant enrollment, and other services are administered by the Board of Trustees with the assistance of this administrative organization:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are below.

Legal process can also be served on:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102

Names and Addresses of Board of Trustees

Employer Trustees

Randall Zeiler
Allied Employers, Inc.
811 Kirkland Avenue Suite 100
Kirkland, Washington 98033-8140

Jerry D'Ambrosio
11019 SE 60th Street
Bellevue, Washington 98006-6302

Anthony DeCosmo
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Description of Collective Bargaining Agreements

This Plan is maintained under many collective bargaining agreements between various employers and labor organizations. You may obtain a copy of these collective bargaining agreements by writing to the Trust Administrative Office. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing the collective bargaining agreements. You may want to inquire about the charge before requesting a copy.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes those contributions to the Trust. The eligibility rules describing which employees and dependents are entitled to benefits begin on page 10. The benefits are described beginning on page 10.

Termination of Eligibility

An employee or dependent who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a self-payment, where authorized). See When Coverage Ends on page 11 and COBRA Self-Pay Option on page 20.
- The failure of the employee's employer to report the hours and remit contributions on the employee's behalf to the Trust Fund.
- An eligible dependent is no longer a dependent as described on page 12 or attains a disqualifying age as shown on page 12.
- Termination of the governing collective bargaining agreement or the Trust.

Future of the Plan and Trust Fund

The Board of Trustees has authority to terminate the Trust Fund. The Trust Fund will also terminate when collective bargaining agreements and special agreements requiring the payment of contributions expire. In the event of termination, the Board of Trustees will:

- Use the Trust Fund to pay expenses incurred up to the date of termination and expenses incident to the termination.
- Distribute the balance, if any, of Trust Fund assets to carry out the purpose of the Trust.
- Upon termination, the Board of Trustees may transfer remaining Trust Fund assets to the Trustees of any fund established to provide substantially the same or greater benefits than this Plan. In no event will any of the funds revert to or be recoverable by any employee, employer or union.

Source of Contributions

This Plan is funded through employer contributions; the amount is specified in the collective bargaining agreements. Also, self-payments by employees are permitted as outlined in this Plan booklet. The amount of the total plan cost is changed from time to time by the Board of Trustees,

including employer contributions alone or a combination of employer contributions and employee self-payments.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions are received and held in trust by the Board of Trustees pending the payment of benefits or premiums. The Trustees pay benefits directly from the Trust Fund. You may obtain copies of the collective bargaining agreements under which the Plan is maintained by writing to the Trustees. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Plan Year

This Plan is on a 12-month fiscal year basis beginning July 1 and ending the following June 30.

ERISA Rights and Protections

As a participant in the Trust, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants be entitled to:

- Examine, without charge, at the Trust Administrative Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Trust Administrative Office, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Trust Administrative Office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trust Administrative Office is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan to learn the rules governing these COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your Plan or insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after enrolling.

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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents or the latest annual report for the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust 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 Trust's control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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 have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, contact the Trust Administrative Office or Delta Dental of Washington. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrative Office or Delta Dental of Washington, contact the nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, Department of Labor 200 Constitution Avenue 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.