DeltaCare® 2020

Washington Public Employees and Retirees

DeltaCare®

Administered by Delta Dental of Washington

2020

Administered by:

DELTA DENTAL®

Delta Dental of Washington

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Published under the direction of the Washington State Health Care Authority

DeltaCare®
Administered by Delta Dental of Washington

Group #03100 State Managed Care Plan

Delta Dental of Washington

Effective: **January 1, 2020**

SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by the Washington State Health Care Authority. This booklet, which explains program eligibility and general provisions, constitutes the certificate of coverage for enrollees in this dental plan. This certificate of coverage replaces and supersedes any and all previous certificates.

It is your responsibility to be informed about your benefits. To avoid penalty or loss of benefits, please note all plan Cost of Treatment and Cost requirements, service area restrictions and benefit limitations. If provisions within this booklet are inconsistent with any federal or state statute or rules, the language of the statute or rule will have precedence over that contained in this publication.

This booklet was compiled by the Washington State Health Care Authority, P.O. Box 42684, Olympia, Washington 98504-2684. If you have questions on the provisions contained in this booklet, please contact the dental plan.

Certificate of Coverage

Table of Contents

Certificate of Coverage iii
Table of Contents iii
Introduction 1
Terms Used in This Booklet 1
Retiree Participation 3
Choosing a Primary Care Dentist (PCD) 4
Appointments 4
Specialty Services 4
Urgent Care 4
Emergency Care 5
Benefit Period 5
Communication Access Assistance 5
    Basic Benefits 13
Prosthodontic Services 14
Implant Services 14
Orthodontic Services 14
Temporomandibular Joint Treatment 14
Orthognathic Surgery 15
    Dental Limitations and Exclusions 15
    General Exclusions 18
Governing Administrative Policies 19
Eligibility 22
Enrollment 24
When dental coverage begins 25
Annual open enrollment 26
    When may a subscriber change their health plan? 27
Medicare entitlement 29
When dental coverage ends 29
  Paid Family Medical Leave Act 30
When a Third Party is Responsible for Injury or Illness (Subrogation) 31
  Claim Review and Appeal 33
  Confirmation of Treatment and Cost 33
  Urgent Confirmation of Treatment and Cost Requests 33
  Appeals of Denied Claims 33
  How to contact us 33
  Authorized Representative 34
  Informal Review 34
  Formal Review 34
When the Member Has Other Dental Coverage 34
Subscriber Rights and Responsibilities 39
HIPAA Disclosure Policy 40
Nondiscrimination and Language Assistance Services 41

This booklet sets forth in summary form an explanation of the coverage available under your dental plan.

For customer service, call the Delta Dental of Washington DeltaCare® Client Services Team at 1-800-650-1583

DeltaCare®, a managed care dental plan
Administered by Delta Dental of Washington

Introduction

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

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

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

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

Terms Used in This Booklet

Appeal: An appeal is a written or oral request from an enrollee or, if authorized by the enrollee, the enrollee's representative to change a previous decision made by Delta Dental of Washington concerning: a) access to dental care benefits, including an adverse determination made pursuant to utilization review; b) claims handling, payment, or reimbursement for dental care and services; c) matters pertaining to the contractual relationship between an enrollee and Delta Dental of Washington or d) other matters as specifically required by state law or regulation.

Copayment: The dollar amount enrollees pay when receiving specific services.

Dental Emergency: The emergent and acute onset of a symptom or symptoms, including severe pain that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention.

Dental Necessity: A service is "dentally necessary" if it is recommended by the treating provider and if all of the following conditions are met.

Necessary vs. Not Covered Treatment: You and your provider should discuss which services may not be Covered Dental Benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your plan. However, there are certain treatments that remain the responsibility of the patient.

1. The purpose of the service, supply or intervention is to treat a dental condition;

2. It is the appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;

3. The level of service, supply or intervention is known to be effective in improving health outcomes;

4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and

5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

- A health “intervention” is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a dental condition (i.e., disease, illness, injury, genetic or congenital defect or a biological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of “dental necessity,” a health intervention means not only the intervention itself, but also the dental condition and patient indications for which it is being applied.
- “Effective” means that the intervention, supply or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- An intervention, supply or level of service may be dentally indicated, yet not be a covered benefit or meet the standards of this definition of “dental necessity.” DDWA may choose to cover interventions, supplies, or services that do not meet this definition of “dental necessity,” however, DDWA is not required to do so.
- “Treating provider” means a health care provider who has personally evaluated the patient.
- “Health outcomes” are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- An intervention is considered to be new if it is not yet in widespread use for the dental condition and patient indications being considered.
- “New interventions” for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (See “existing interventions” below).
- “Scientific evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
- For “existing interventions,” the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of “dental necessity.” If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet DDWA’s definition of “dental necessity” in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A level of service, supply or intervention is considered “cost effective” if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

Dependent: Eligible dependent covered under the subscriber.

Enrollee: The employee, retiree, continuation coverage subscriber, or survivor enrolled in this plan.

Experimental or Investigative: A service or supply that is determined by DeltaCare to meet any one of the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.

1. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
2. The provider has not demonstrated proficiency in the service, based on knowledge, training, experience and treatment outcomes.
3. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
4. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee's health or safety.

Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols or scientific data from another provider studying the same service.

The documentation used to establish the plan criteria will be made available for enrollees to examine at the office of DeltaCare if enrollees send written requests.

If DeltaCare determines that a service is experimental or investigative, and therefore not covered, the enrollee may appeal the decision. DeltaCare will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with the enrollee's informed written consent.

Group: The employer or entity that is contracting for dental benefits for its employees.

HCA: Health Care Authority.

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

Member: Enrollee, Subscriber, or dependent, who has completed the enrollment process.

Plan: DeltaCare, a managed dental benefit plan of coverage.

Plan Designated Facility or Dentist: A licensed dentist or dental facility that has agreed to perform services under this plan.

Primary Care Dentist (PCD): Dentist or facility that enrollee or dependent has selected.

Subscriber: Eligible employee, retiree, continuation coverage subscriber, or survivor who has completed the enrollment process and is enrolled in this dental plan.

Retiree Participation

Retirees and eligible survivors enrolled in retiree coverage must be enrolled in a medical plan to be eligible to enroll in the dental plan. If retirees or eligible survivors enroll in the medical and dental plans, any eligible dependents they elect to enroll must also be enrolled under both plans. Once enrolled in the medical and dental package, retirees or eligible survivors cannot change to "medical-only" for at least two years. The two-year requirement does not apply when coverage is terminated or deferred per Public Employees Benefits Board (PEBB) Program rules.

Choosing a Primary Care Dentist (PCD)

When you enroll in the DeltaCare Plan, you must complete the enrollment information and may indicate your dental office choices at that time. New enrollees have 60 days to select and notify us of your preferred Primary Care Dentist (PCD). A PCD is a Washington state General Practitioner that has chosen to participate in the DeltaCare Network.

If you do not select a PCD within 60 days, we will assign you to a provider near your home. The choice of PCD can be changed with proper notice to DDWA, the request to change your PCD must be received by the 20th of the month to be eligible by the first day of the following month with the newly chosen DeltaCare Dentist Please contact us at 1-800-650-1583 for more information on selecting or changing your PCD or to notify us of your selection.

Your selected dental office is now the center for all of your dental needs. The PCD will perform most dental services. For specialty care, the PCD may elect to refer treatment to a DeltaCare Dental Plan Specialist.

After you have enrolled, you will receive a membership card and letter. The letter will include the address and telephone number of your PCD. You can also receive information about your PCD's on our website at www.DeltaDentalWA.com or you may call us at 1-800-650-1583.

If your PCDs participation in the DeltaCare Network ends for any reason, you will receive written notification. This notification will explain your option to: 1) automatically be assigned to another PCD; or 2) select another PCD from the directory of open PCDs.

If your PCD is to be absent for an extended period of time, your PCD is required to provide you with a back-up provider. You may be re-assigned to another PCD during the period of the absence. To be re-assigned to your original PCD upon their return, please contact us at 1-800-650-1583 for more information on changing your PCD.

Appointments

To receive dental care, simply call your primary care dental office to make an appointment. Routine, non-emergency appointments will be scheduled within 3 weeks of the date of the request. Dental services which are not performed by the assigned PCD or properly referred to a DeltaCare Dental Plan Specialist will not be covered by the DeltaCare Plan.

Specialty Services

Your PCD is responsible for coordinating all specialty care and will either perform the specialty treatment or refer you to a DeltaCare Network Specialist. In some unique cases the PCD may refer you to a non-DeltaCare Network Specialist, but prior authorization from DDWA is required.

Urgent Care

Your PCD shall provide urgent dental care for a covered procedure within 24 hours of being contacted. If you require urgent dental care and are not able to be seen by your PCD within 24 hours or you are not within a reasonable distance of your PCD's office, you may receive treatment from another dentist. Such treatment is limited to the treatment that is necessary to evaluate and stabilize you until further treatment can be obtained from your PCD. Please call us at 1-800-650-1583 for more information.

Emergency Care

DeltaCare Network Dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, every day of the year. Treatment of a dental emergency, those rare dental health instances that may be life threatening or cause severe bodily injury, shall not require a Confirmation of Treatment and Cost if a prudent layperson acting reasonably would believe that such an emergency condition exists. The Plan would encourage the enrollee to seek a preauthorization from the Plan for such emergency care if at all practical, but would not require preauthorization if the treatment is a listed procedure under the terms of coverage.

Benefit Period

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

Communication Access Assistance

For Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

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

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

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) or 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial DDWA Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the DDWA customer service representative.

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

Schedule of Benefits and Co-Payments

Please see the following table which describes the Benefits and Co-Payments for this Plan. The Benefits and Co-Payments listed below are Effective as of **January 1, 2020.**

The services covered under the DeltaCare Dental Plan are listed in the following schedule. These co-payments are your total price, including lab work. All coverage is subject to the exclusions and limitations set forth in the benefit descriptions and exclusions.

Procedure	Description	Copayment	Notes
D0100 - D0999	**I. Diagnostic**		
D0120	Periodic oral evaluation – established patient	0	
D0140	Limited oral evaluation-problem focused	0	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0	
D0150	Comprehensive oral evaluation - new or established (inactive) patient	0	
D0160	Detailed and extensive oral evaluation - Problem focused, by report	0	
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit)	0	
D0180	Comprehensive Periodontal Exam – GP	0	
	Copay for Specialist Exam - use above codes	0	R
D0210	Intraoral - complete series of radiographic images	0	
D0220	Intraoral - periapical first radiographic image	0	
D0230	Intraoral - periapical each additional radiographic image	0	
D0240	Intraoral - occlusal radiographic image	0	
D0270	Bitewing - single radiographic image	0	
D0272	Bitewings - two radiographic images	0	
D0273	Bitewings - three radiographic images	0	
D0274	Bitewings - four radiographic images	0	
D0330	Panoramic radiographic image	0	
D0419	Assessment of salivary flow by measurement	0	
D0460	Pulp vitality tests	0	R
D0470	Diagnostic casts	0	
D1000 – D1999	I. Preventative		
D1110	Prophylaxis cleaning - adult	0	
D1120	Prophylaxis cleaning - child	0	
D1206	topical application of fluoride varnish	0	
D1208	topical application of fluoride – excluding varnish	0	
D1330	Oral hygiene instructions	0	
D1351	Sealant - per tooth	0	
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	0	
D1510	Space maintainer - fixed, unilateral – per quadrant	20	
D1516	Space maintainer - fixed, bilateral, maxillary	30	
D1517	Space maintainer - fixed, bilateral, mandibular	30	
D1520	Space maintainer - removable, unilateral – per quadrant	20	
D1526	Space maintainer - removable, bilateral, maxillary	30	

Procedure	Description	Copayment	Notes
D1527	Space maintainer - removable, bilateral, mandibular	30	
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	10	
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	10	
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	10	
D1556	Removal of fixed unilateral space maintainer – per quadrant	10	
D1557	Removal of fixed bilateral space maintainer – maxillary	10	
D1558	Removal of fixed bilateral space maintainer – mandibular	10	
D2000 – D2335	**III. Minor Restorative**		
D2140	Amalgam - one surface, primary or permanent	10	
D2150	Amalgam - two surfaces, primary or permanent	10	
D2160	Amalgam - three surfaces, primary or permanent	10	
D2161	Amalgam - four or more surfaces, primary or permanent	10	
D2330	Resin-based composite - one surface, anterior	15	
D2331	Resin-based composite - two surfaces, anterior	15	
D2332	Resin-based composite - three surfaces, anterior	15	
D2335	Resin-based composite - four or more surfaces or involving incisal angle	15	
D2391	Resin-based composite - one surface, posterior	50	
D2392	Resin-based composite - two surfaces, posterior	50	
D2393	Resin-based composite - three surface, posterior	50	
D2394	Resin-based composite - four or more surfaces, posterior	50	
D2510 – D2999	**IV. Major Restorative**		
D2510	Inlay - metallic - one surface	115	
D2520	Inlay - metallic - two surfaces	115	
D2530	Inlay - metallic - three surfaces	115	
D2543	Onlay - metallic - three surfaces	125	
D2544	Onlay metallic - four or more surfaces	125	
D2740	Crown - porcelain/ceramic	155	
D2750	Crown - porcelain fused to high noble metal	175	
D2751	Crown - porcelain fused to predominantly base metal	125	
D2752	Crown - porcelain fused to noble metal	150	
D2753	Crown - porcelain fused to titanium or titanium alloy	OP	
D2790	Crown - full cast high noble metal	175	
D2791	Crown - full cast predominantly base metal	125	
D2792	Crown - full cast noble metal	150	
D2794	Crown – titanium/titanium alloy	OP	
D2799	Provisional crown	OP	
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations	0	
D2915	Re-cement or rebond indirectly fabricated or prefabricated post and core	0	
D2920	Re-cement or rebond crown	0	
D2921	Reattachment of tooth fragment, incisal edge or cusp	15	
D2930	Prefabricated stainless steel crown - primary tooth	100	
D2931	Prefabricated stainless steel crown - permanent tooth	100	
D2932	Prefabricated resin crown anterior teeth only	100	Gap

Procedure	Description	Copayment	Notes
D2940	Sedative filling	20	
D2941	Restorative foundation for an indirect restoration	20	
D2950	Crown build-up (substructure) including any pins when required	0	
D2951	Pin retention - per tooth, in addition to restoration	0	
D2952	Post and core in addition to crown, indirectly fabricated	0	
D2953	Each additional indirectly fabricated post – same tooth	0	
D2954	Prefabricated post and core in addition to crown	0	
D2957	Each additional prefabricated post - same tooth	0	
D2971	Additional procedures to construct new crown under existing partial denture framework	0	
D2980	Crown repair necessitated by restorative material failure	30	
D2981	Inlay repair necessitated by restorative material failure	30	
D2982	Onlay repair necessitated by restorative material failure	30	
D2983	Veneer repair necessitated by restorative material failure	30	
D3000 - D3999	**V. Endodontics**		
D3110	Pulp cap-direct (excluding final restoration)	0	
D3120	Pulp cap-indirect (excluding final restoration)	0	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp	0	
D3221	Gross pulpal debridement, primary and permanent teeth	NB	
D3230	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	NB	
D3240	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	NB	
D3310	Root canal therapy - anterior (excluding final restoration)	100	
D3320	Root canal therapy – premolar (excluding final restoration)	125	
D3330	Root canal therapy – molar tooth (excluding final restoration)	150	R
D3346	Retreatment of previous root canal therapy - anterior	100	R
D3347	Retreatment of previous root canal therapy – premolar	125	R
D3348	Retreatment of previous root canal therapy - molar	150	R
D3351	ation/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, pulp space disinfection, etc.)	10	R
D3352	Apexification/recalcification - interim visit	10	R
D3353	Apexification/recalcification - final visit	10	R
D3410	Apicoectomy – anterior	70	R
D3421	Apicoectomy – premolar (first root)	50	R
D3425	Apicoectomy molar (1st root)	100	R
D3426	Apicoectomy (additional root)	25	R
D3427	Periradicular surgery without apicoectomy	35	
D3428	Bone graft in conjunction with periradicular surgery – per tooth; first surgical site	100	
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	50	
D3430	Retrograde filling - per root	5	R
D3450	Root amputation - per root	0	R
D3920	Hemisection including root removal	0	R

Procedure	Description	Copayment	Notes
D4000 - D4999	**VI. Periodontics**		
D4210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	75	
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	35	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure; per tooth	35	
D4240	Gingival flap procedure - allowed only in conjunction with D4263/D4264	0	R
D4241	Gingival flap procedure - allowed only in conjunction with D4263/D4264	0	R
D4245	Apically positioned flap	0	R
D4249	Crown lengthening - hard/soft tissue	35	R
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more Contiguous teeth or tooth bounded spaces per quadrant	100	R
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	75	R
D4263	Bone replacement Graft - first site in quadrant	100	R
D4264	Bone replacement Graft - each additional site in quadrant	50	R
D4270	Pedicle soft tissue graft procedure	100	R
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	50	
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	25	
D4341	Periodontal root planing - four or more teeth per quadrant	35	
D4342	Periodontal root planing - one to three teeth per quadrant	15	
D4355	Full Mouth debridement, once every 12months and diagnosis on subsequent visit.	25	
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	0	R
D4910	Periodontal maintenance following active therapy	35	
D5000 - D5899	**VII. Prosthodontics, removable**		
D5110	Complete denture, maxillary	140	
D5120	Complete denture, mandibular	140	
D5130	Immediate denture, maxillary	140	
D5140	Immediate denture, mandibular	140	
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	140	GAP
D5212	Mandibular partial denture - resin base resin base (including retentive/clasping materials, rests, and teeth)	140	GAP
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	140	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	140	

Procedure	Description	Copayment	Notes
D5221	Immediate maxillary partial denture – resin base (including any retentive/clasping materials, rests and teeth)	140	
D5222	Immediate mandibular partial denture – resin base (including any retentive/clasping materials, rests and teeth)	140	
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	140	
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	140	
D5225	Maxillary partial denture - flexible base	OP	
D5226	Mandibular partial denture - flexible base	OP	
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth)- per quadrant	NB	
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) - per quadrant	NB	
D5410	Adjust complete denture – maxillary	0	
D5411	Adjust complete denture – mandibular	0	
D5421	Adjust partial denture – maxillary	0	
D5422	Adjust partial denture – mandibular	0	
D5512	Repair broken complete denture base, maxillary	15	
D5520	Replace missing or broken teeth - complete denture	15	
D5612	Repair resin partial denture base, maxillary	15	
D5621	Repair cast partial framework, mandibular	45	
D5622	Repair cast partial framework, maxillary	45	
D5630	Repair or replace broken retentive clasping materials – per tooth	30	
D5640	Replace broken teeth - per tooth	10	
D5650	Add tooth to existing partial denture	20	
D5660	Add clasp to existing partial denture – per tooth	20	
D5670	Replace teeth and acrylic on cast metal framework (mandibular)	NB	
D5671	Replace teeth and acrylic on cast metal framework (maxillary)	NB	
D5710	Rebase complete maxillary denture	60	
D5711	Rebase complete mandibular denture	60	
D5720	Rebase maxillary partial denture	40	
D5721	Rebase mandibular partial denture	40	
D5730	Reline complete maxillary denture (chairside)	40	
D5731	Reline complete mandibular denture (chairside)	40	
D5740	Reline maxillary partial denture (chairside)	40	
D5741	Reline mandibular partial denture (chairside)	40	
D5750	Reline complete maxillary denture (laboratory)	50	
D5751	Reline complete mandibular denture (laboratory)	50	
D5760	Reline maxillary partial denture (laboratory)	50	
D5761	Reline mandibular partial denture (laboratory)	50	
D5850	Tissue conditioning, maxillary	15	
D5851	Tissue conditioning, mandibular	15	
D5863	Overdenture - complete upper	175	
D5864	Overdenture - partial upper	175	

Procedure	Description	Copayment	Notes
D5865	Overdenture - complete lower	175	
D5866	Overdenture - partial lower	175	
D6000-D6199	**VIII. Implant Services**		
	Pre-Implant Consultation Fees	25	R
	Initial Implant Exam or Consultation		
	Detailed and Extensive Oral Evaluation	125	R
	Implant Fees - Case Rates		
	Single Tooth	2,800	R
	Two Teeth	5,464	R
	Three Teeth	7,644	R
	Full Denture (two implants)	5,120	R
	Full Denture (three implants)	6,885	R
	Each additional tooth	2,095	R
D6200 - D6999	**IX. Prosthodontics, Fixed**		
D6210	Pontic - cast high noble metal	175	
D6211	Pontic - cast predominantly base metal	125	
D6212	Pontic - cast noble metal	150	
D6240	Pontic - porcelain fused to high noble metal	175	
D6241	Pontic - porcelain fused to predominantly base metal	125	
D6242	Pontic - porcelain fused to noble metal	150	
D6243	Pontic - porcelain fused to titanium or titanium alloys	NB	
D6251	Pontic - resin with predominantly base metal	150	
D6252	Pontic - resin with noble metal	OP	
D6750	Crown - porcelain fused to high noble metal	175	
D6751	Crown - porcelain fused to predominantly base metal	125	
D6752	Crown - porcelain fused to noble metal	150	
D6753	Retainer crown - porcelain fused to titanium or titanium alloys	NB	
D6780	Crown - 3/4 cast high noble metal	175	
D6784	Retainer crown ¾ - titanium and titanium alloys	NB	
D6790	Crown - full cast high noble metal	175	
D6791	Crown - full cast predominantly base metal	120	
D6792	Crown - full cast noble metal	150	
D6930	Re-cement or rebond fixed partial denture	0	
D6940	Stress breaker	65	
D6980	Fixed partial denture repair necessitated by restorative material failure	NB	
D7000 - D7999	**X. Oral Surgery**		
D7111	Extraction, coronal remnants – primary tooth	10	
D7140	Extraction, erupted tooth or exposed root	10	
D7210	Surgical removal of erupted tooth	10	
D7220	Removal of impacted tooth - soft tissue	30	R
D7230	Removal of impacted tooth - partially bony	40	R
D7240	Removal of impacted tooth - completely bony	50	R
D7241	Removal of impacted tooth-completely bony w/complications	50	R
D7250	Surgical removal of residual tooth roots	50	R

Procedure	Description	Copayment	Notes
D7280	Surgical exposure impacted/unerupted tooth - ortho	15	R
D7283	Placement of device to facilitate eruption of impacted tooth	15	R
D7286	Incisional biopsy of oral tissue-soft	0	R
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces – per quadrant	0	
D7311	Alveoloplasty in conj. With extractions - one to three teeth per quad	0	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces – per quadrant	0	
D7321	Alveoloplasty not in conj. With extractions - one to three teeth per quad	0	
D7340	Vestibuloplasty	NB	R
D7350	Vestibuloplasty - ridge extension	NB	R
D7471	Removal of exostosis - maxilla or mandible	0	R
D7472	Removal of torus palatinus	0	R
D7473	Removal of torus mandibularis	0	R
D7510	Incision and drainage of abscess	0	R
D7881	Occlusal orthotic device adjustment	TMJ	R
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	0	
D7960	Frenulectomy (frenectomy or frenotomy)	20	R
D7970	Excision of hyperplastic tissue - per arch	30	R
D8000 - D8999	**XI. Orthodontic Services**		
D8660	Initial orthodontic diagnostic work-up and X-rays	50	
D8070	Full Orthodontic Services	1500	
	Limited Orthodontic treatment of the primary dentition	Prorated	
	Limited Orthodontic treatment of the transitional dentition	Prorated	
	Limited Orthodontic treatment of the adolescent dentition	Prorated	
	Limited Orthodontic treatment of the adult dentition	Prorated	
	Final orthodontic diagnosis, work-up and X-rays	Included	
	Lost metal bands or loose brackets	*	
	* see orthodontic benefits per plan		
	Orthognathic Surgery	Lifetime max $5000	
	Orthognathic surgery	Pre-determination	
	Temporomandibular Joint Treatment	Lifetime max $5000	
	TMJ consultation	30	
	TMJ treatment	C	
D9000 - D9999	**XII. Additional Procedures**		
D9110	Palliative treatment	15	
D9211	Regional block anesthesia	0	
D9212	Trigeminal division block anesthesia	0	
D9215	Local anesthesia	0	
D9222	Deep sedation/general anesthesia – first 15 minutes	25*	
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	25*	R

Procedure	Description	Copayment	Notes
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	25	
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	25*	R
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0	
D9440	Office visit - after regularly scheduled hours (nights and weekends)	20	
D9944	occlusal guard – hard appliance, full arch	50	
D9945	occlusal guard – soft appliance, full arch	13	
D9946	occlusal guard – hard appliance, partial arch	25	
D9951	Occlusal adjustment - limited	35	
D9952	Occlusal adjustment - complete	50	
D9986	Missed appointment	10	
D9987	Canceled appointment	10	
D9997	Dental case management – patients with special health care needs	NB	

C	**= Confirmation of Treatment and Cost recommended**
R	**= Referable to a specialist**
TMJ	**= TMJ Covered**
GAP	**= Guidelines apply**
NB	**= Not a Benefit on plan**
OP	**= Optional Treatment**

* Coverage for general anesthesia is provided for children age 6 and under, or for children of any age with a developmental or physical disability, when medically necessary.

Unlisted dental procedures and treatments that are not specifically excluded will be assigned copayments consistent with those above, based upon comparative complexity and cost.

Basic Benefits

The following basic benefits will be covered subject to the copayment amounts:

1. Oral Examination - Exam of the mouth and teeth.
2. Prophylaxis - Cleaning, scaling and polishing of teeth.
3. Topical Fluoride Application - Applying fluoride to the exposed tooth surface.
4. Periapical and Bitewing X-rays - Dental X-rays of the inside of the mouth. Periapical X-rays reveal the entire tooth and surrounding bone and gum tissue. Bitewing X-rays reveal some of the upper and lower teeth in the same film.
5. Extractions - The surgical removal or pulling of teeth.
6. Fillings - Silver amalgam, resin based composites or Silicate or plastic restorative material is covered.
7. Palliative Emergency Treatment - Emergency treatment primarily for relief, not cure.
8. Space Maintainers - An appliance to preserve the space between teeth caused by premature loss of a primary tooth. The primary teeth are the first teeth, sometimes known as baby teeth.
9. Repair of Dentures and Bridges - Repair or reline artificial teeth.
10. Oral Surgery - Surgery for dental purposes pertaining to the gums, teeth or tooth structure and treatment of dislocations.

11. Apicoectomy - Surgical removal of the tip of the tooth root.
12. Endodontics - The prevention, diagnosis, and treatment of diseases and injuries of the tooth pulp, root and surrounding tissue. This includes pulpotomy, pulp capping and root canal treatment.
13. Periodontic Services and Periodontic Maintenance Procedures Services related to connective tissues around and supporting the teeth; surgical periodontic exams, gingival curettage, gingivectomy, osseous surgery including flap entry and closure, mucogingivoplastic surgery, frenectomy, periodontal grafts, root planing and curettage, and management of acute infection and oral lesions related to the tooth structure.

Prosthodontic Services

Dentures, bridges, partial dentures, related items — including crowns placed on dental implants — and the adjustment or repair of an existing prosthetic device are covered under this benefit.

Replacement of missing teeth with full or partial dentures, crowns or bridges is limited to the charge for the standard procedure.

These services do not include and do not cover:

1. Personalized restoration, precision attachments and special techniques.
2. Replacement of an existing denture, crown or bridge less than five years after the date of the most recent placement.
3. Denture replacements made necessary by loss, theft or breakage.

Implant Services

Dental implant Services are now available to PEBB members enrolled in the DeltaCare Dental Plan offered by Delta Dental of Washington. Implant Services will be available at select dental offices experienced in providing dental implants. Implant Services will not be available at every participating DeltaCare dental office location.

Enrollees who have been determined by their Primary Care Provider to be candidates for dental implants will be referred to the nearest select dental office trained in the surgical placement of implants.

Delta Dental of Washington strongly suggests that any implant services be submitted to Delta Dental of Washington for Confirmation of Treatment and Cost prior to commencement of treatment.

Initial Implant Exam or Consultation is subject to a copayment by the subscriber. However, should the enrollee or an enrolled dependent initiate implant services at the office performing the initial Implant Exam or Consultation, the copayment for the Initial Implant Exam or Consultation will be deducted from the copayment of the implant service provided.

Orthodontic Services

Delta Dental of Washington strongly suggests that orthodontic treatment be submitted to, and confirmed by, DDWA prior to commencement of treatment.

Initial orthodontic diagnostic work-up and X-rays are subject to a copayment. However, should the enrollee or an enrolled dependent undergo orthodontic treatment, the initial orthodontia copayment will be deducted from either the partial or full orthodontia copayment.

The copayment for limited orthodontic treatment will be prorated according to the extent of orthodontia services provided. The length of treatment of full orthodontic treatment is not limited. Orthodontic treatment must be provided by a DeltaCare orthodontist.

Temporomandibular Joint Treatment

All treatments of temporomandibular joint disorders (TMJ) must be confirmed before treatment begins. Benefits will be denied if treatment is not confirmed.

Services covered shall include but are not limited to: TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device (occlusal guard), removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis and manipulation under anesthesia.

Benefits for surgical and nonsurgical treatment of TMJ are paid at 70% to a lifetime maximum of $5,000. Annual maximum of $1,000. Covered services must be: 1) appropriate for the treatment of a disorder of the temporomandibular joint; 2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; 3) recognized as effective, according to the professional standards of good dental practice; 4) not investigational; and 5) not primarily for cosmetic purposes. All services must be provided or ordered by the enrollee's dentist. Any procedures that are performed in conjunction with TMJ services, and are covered benefits under another portion of the dental plan, are not covered under this portion.

Orthognathic Surgery

All orthognathic treatment must be authorized before treatment begins. Benefits will be denied if a Confirmation of Treatment and Cost is not confirmed.

Orthognathic treatment performed by a licensed dentist or physician is defined as the necessary surgical procedures or treatment to correct the malposition of the maxilla (upper jawbone) and/or the mandible (lower jawbone).

Benefits for orthognathic treatment are paid at 70% of the lesser of the maximum allowable fees or the fees actually charged. The lifetime maximum for orthognathic benefits is $5,000.

Complications will be covered only if treatment begins within 30 days of the original treatment.

Dental Limitations and Exclusions

Limitations

Diagnostic

- Examination is covered once in a 6-month period;
- Full mouth or panoramic X-rays limited to one set every 36 consecutive months;
- Bitewing X-rays limited to not more than one series of 4 films in any 6-month period;

Preventive

- Prophylaxis limited to one treatment in a 6-month period.
- Topical application of fluoride or fluoride varnish is covered twice in a calendar year. Preventive therapies (e.g., fluoridated varnishes) approved by DeltaCare are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy.
- Fissure sealants are limited to non-carious, non-restored permanent first and second molars through the age of 14. The application of fissure sealants or preventive resin restoration is a covered benefit only once in a 3-year period.
- Preventive Resin Restoration is limited to non-carious, non-restored permanent first and second molars through the age of 14. The application of preventive resin restoration or fissure sealant is a covered benefit only once in a 3-year period.
- Space maintainers are covered through age 17.

Restorative

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period;
- Crowns are covered once in a 5-year period;

- Stainless steel crowns on primary teeth are covered once in a 2-year period;
- Crowns on implants are covered as a specialty procedure once in a 5 year period, may be referred to specialist.

Periodontics

- Root planing/subgingival curettage is covered once in a 12-month period;
- Limited occlusal adjustments are covered once in a 12-month period;
- Site specific therapies (localized delivery of antimicrobial agents) are a covered benefit under certain conditions of oral health such as your gums have pocket depth readings of 5mm (or greater);
- Periodontal surgery is covered once in a 3-year period;
- Soft tissue grafts are covered once in a 3-year period;
- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment;
- One periodontal maintenance therapy treatment, specifically periodontal prophylaxis, is covered once in a 6-month period and is to be charged at the applicable copayment level. Periodontal prophylaxis treatments over one in a 6-month period will be a benefit if in the professional judgment of the DeltaCare primary care dentist the services are necessary for the oral health of the patient. Limited to one cleaning every three months.
- Full-mouth debridement is covered once in a 3-year period;

Endodontics

- Root canal treatment on the same tooth is covered only once in a 2-year period;

Prosthodontics

- Full upper and/or lower dentures are not to exceed one each in any 5-year period and only then if it is unserviceable and cannot be made serviceable;
- Partial dentures are not to be replaced within any 5-year period from initial placement unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible:
- Denture relines are limited to one per denture during any 12 consecutive months except in the case of an immediate denture then a reline is a benefit 6 months after the initial placement;

Accidental Injury

- Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;
- Accidental injury benefits are payable at 100% for an eligible person up to a maximum of $1,600 per patient per benefit period. Dental accidental injury benefits shall be limited to services provided to an eligible person when evaluation of treatment and development of a written treatment plan is performed within 30 days from the date of injury and shall not include any services for conditions caused by an accident occurring prior to the patient's eligibility date.
- Accidental injury. This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage;

Implant Limitations

- This benefit is limited to surgical placement of implants where the bone and soft tissues are sound and healthy.
- Additional surgery required to improve the site in order to support an implant is not covered.

- This benefit includes restoration of implants to replace single missing teeth and implants placed to support full or removable partial dentures and the full or partial denture that attaches to the implant.
- This benefit does not include an implant-supported bridge to replace multiple missing teeth.
- Implant services will only be covered if the entire implant procedure (including surgery and prosthetics) is performed while a Member or Dependent is covered under the Contract.

Orthodontic Limitations

This program provides coverage for orthodontic treatment plans provided through DeltaCare Primary Care orthodontists. The cost to the patient for the treatment plan is listed in the Schedule of Benefits and Copayments subject to the following:

1. Orthodontic treatment must be provided by a DeltaCare orthodontist.
2. Plan benefits cover active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits.
3. Should a patient's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the patient and not DeltaCare will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the patient's payment shall be based on the provider's allowable fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the patient on such terms and conditions as are arranged between the patient and the orthodontist.
4. If treatment is not required or the patient chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the patient will be charged a consultation fee of $25 in addition to diagnostic record fees.
5. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the dentist's maximum allowable fee.
6. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances.

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation;
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
7. Treatment related to temporomandibular joint disturbances;
8. Supplemental appliances not routinely utilized in typical Phase II orthodontics;
9. Restorative work caused by orthodontic treatment;
10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
11. Extractions solely for the purpose of orthodontics;

12. Treatment that began prior to the start of coverage will be prorated: Payment is based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted, except for Orthodontic treatment plans transferred to DDWA from Willamette, which will be prorated based on the amount of months the patient still has remaining in treatment, and any applicable patent co-payments;
13. Charges and/or payments incurred before transfer after banding has been initiated will be prorated: Payment is based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted, except for Orthodontic treatment plans transferred to DDWA from Willamette, which will be prorated based on the amount of months the patient still has remaining in treatment, and any applicable patent co-payments
14. Transfer after banding has been initiated (except for Orthodontic treatment plans transferred to DDWA from Willamette;
15. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

*Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Orthognathic Surgery Limitations

1. Services that would be provided under medical care including but not limited to, hospital and professional services.
2. Diagnostic procedures not otherwise covered under this plan.
3. Any procedures that are performed in conjunction with orthognathic surgery and are covered benefits under another portion of this plan.

General Exclusions

- General Anesthesia, intravenous and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia and intravenous sedation services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary for enrolled members through age 6, or physically or developmentally disabled;
- Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;
- Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act;
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion without sensitivity and restorations for malalignment of teeth;
- Application of desensitizing agents (treatment for sensitivity or adhesive resin application);
- 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.
- Dental services performed in a hospital and related hospital fees. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
  a. A hospital setting for the dental care must be medically necessary.
  b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
  c. Prior to hospitalization, a request for Confirmation of Treatment and Cost of dental treatment performed at a hospital is submitted to and approved by DeltaCare. Such request for Confirmation of Treatment and Cost must be accompanied by a physician's statement of dental necessity.

If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.

- Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);
- Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;
- Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility (except for Orthodontic treatment plans transferred to DDWA from Willamette);
- Cysts and malignancies;
- Laboratory examination of tissue specimen;
- Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;
- Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
- Prophylactic removal of impactions (asymptomatic, nonpathological);
- Specialist consultations for non-covered benefits;
- Orthodontic treatment which involves therapy for myofunctional problems, TMJ, dysfunctions, micrognathia, macroglossia, or hormonal imbalances causing growth and developmental abnormalities;
- All other services not specifically included on the patient's copayment schedule as a Covered Dental Benefit;
- Treatment of fractures and dislocations to the jaw;
- Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Care or Urgent Care".

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment options.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the patient selects a more expensive plan of treatment that is not a covered benefit, the more expensive treatment is considered optional. The patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the optional treatment plus any co-payment for covered benefits.

Failure to pay a scheduled co-payment at the time of service may prevent future dental services from being rendered with the exception of emergency services.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

Partial Dentures

1. A removable cast metal partial denture is considered the covered benefit in cases where one or more posterior teeth is missing in a dental arch or a combination of one or more posterior and anterior teeth are missing in a dental arch. A three unit bridge is considered the covered benefit if only one anterior tooth is missing in a dental arch. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentists' DDWA filed fees for the covered benefit and the optional treatment, plus any co-payment for the covered benefit.
2. If a cast metal partial denture will restore the case, the Primary Care Dentist will apply the difference of the cost of such procedure toward any alternative treatments which the patient and dentist may choose to

use. The patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the optional treatment plus any co-payment for the covered benefit.

3. An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. Patients will pay the applicable co-payment for a cast metal partial denture.

Complete Dentures

4. If, in the construction of a denture, the patient and the Primary Care Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit (a standard denture) and optional treatment (a personalized denture or a denture that employed specialized techniques), plus any co-payment for the covered benefit.

5. Full upper and/or lower dentures are not to exceed one each in any five year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either reline or repair.

Fillings and Crowns

6. Crowns will be covered only if there is not enough retention and resistance form left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

7. In most plans a full cast predominantly metal crown (D2791) is the covered benefit on molar teeth. In these plans all other crowns (high noble, noble, porcelain, porcelain fused to metal) on molar teeth are considered optional treatment. When optional treatment is performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the DDWA filed fee for the optional treatment (not to exceed $200.00), plus any co-payment for the covered benefit. In some plans all crown types are a covered benefit on molar teeth and there is no optional treatment. Always consult the patients benefit plan. The patient must be permitted the option of the cast metal crown as a benefit if desired.

8. The DeltaCare program provides amalgam (posterior) and resin-based (anterior) restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.

9. A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including, but not limited to cosmetics, abrasion, erosion, restoring or altering vertical dimension, or the anticipation of future fractures, are not covered benefits.

10. Composite resin restorations in posterior teeth are a covered benefit once in a two-year period.

11. Anterior porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.

12. A crown placed on a specific tooth is allowable only once in a five year period from initial placement.

13. A crown used as an abutment to a partial denture for purposes of re-contouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required.

Fixed Bridges

14. A fixed bridge to replace ONE missing permanent anterior tooth is covered for patients 16 or older. Such treatment will be covered if the patient's oral health and general condition permits.
15. Fixed bridges for patients under the age of 16 are optional to a partial denture.
16. A fixed bridge to replace more than one permanent anterior tooth or any number of permanent posterior teeth is optional to a removable partial denture. The patient must pay the difference in cost between the dentist's filed fee for the covered benefit (a removable partial denture) and the optional treatment (a fixed bridge), plus any co-payment for the covered benefit.
17. Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. A fixed bridge is not a covered benefit once a removable partial denture has been delivered in the same arch.
18. Replacement of an existing fixed bridge (to replace ONE missing permanent anterior tooth) is covered after five years from initial placement and only if it involves the same teeth as the prior bridge.

Reconstruction

19. The DeltaCare Plan provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits, unless the treatment is specifically to manage a TMJ disorder and the group has TMJ benefits specifically included above.

    Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction. Confirmation of Treatment and Cost must include full treatment plan, full mouth x rays and narratives on requested treatment. Build ups will be included in the full mouth treatment plans. Maximum payable, if approved, is $3,000 annually up to $9,000 over 3 consecutive years.

Specialized Techniques

20. Noble or titanium metal for removable appliances, crowns, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit. (As long as the patient has the option of the covered benefit procedure.)

Preventive Control Programs

21. Soft tissue management programs are not covered. Periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed co-payments, if any. Irrigation, infusion, special tooth brush, etc., are considered non-covered services. If these services are performed, the patient is responsible for the cost.
22. Follow-up examinations for reevaluation, particularly periodontal reevaluation, are considered to be part of the general services rendered.

Interim partials (Stayplates)

23. Interim partials (Stayplates) in conjunction with fixed or removable appliances are only a benefit to replace recently extracted anterior permanent teeth during a healing period.

Frenectomy

24. The frenum can be excised when the tongue has limited mobility; or there is a large diastema between anterior teeth; or when the frenum interferes with a prosthetic appliance.

Pedodontia

25. Pedodontic referrals for dependent children through age three are covered at 100% of the agreed upon fee less any applicable co-payments for covered benefits and children four years and older are at 50% of agreed upon fee less any applicable co-payments for covered services.

Treatment Planning

26. The objective of this program is to see that all patients are brought to a good level of oral health and that this level of oral health is maintained. To achieve these objectives takes treatment planning. Priorities have been established on the following basis:

    a. Pain and dysfunction

    b. Active dental disease – active decay and periodontal disease

    c. Replacement of missing teeth

    d. Exceptions are made to this treatment planning concept based on individual circumstances.

Dental Plan Eligibility and Enrollment

In these sections, we may refer to an employee, a Continuation Coverage subscriber, a retiree, or survivor as a "subscriber." The term "enrollee" refers to a subscriber and their dependents. The term "retiree" or "retiring employee" includes an elected or full-time appointed official of the legislative and executive branch of state government eligible to continue enrollment in Public Employees Benefits Board (PEBB) retiree insurance coverage. The term "retiree" or "retiring school employee" includes a retiring non-represented employee of an educational service district (ESD) or retiring school employee from a School Employees Benefits Board (SEBB) organization. Additionally, "health plan" is used to refer to a plan offering medical or dental, or both, developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility

The employee's employing agency will inform the employee whether or not they are eligible for benefits upon employment and whenever the employee's eligibility status changes. The communication will include information about the employee's right to appeal eligibility and enrollment decisions. Information about an employee's right to an appeal can be found on page 31 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of a completed *PEBB Retiree Coverage Election Form*. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appealing a PEBB Program decision can be found on page 31 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program determines if a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor upon receipt of a completed *PEBB Retiree Coverage Election Form*. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appealing a PEBB Program decision can be found on page 31 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program will determine eligibility for Continuation Coverage. If the subscriber is not eligible for Continuation Coverage, the PEBB Program will notify them of the right to appeal. Information about appealing a PEBB Program decision can be found on page 31 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

A retiree or survivor and their enrolled dependents are required to enroll and stay enrolled in Medicare Part A and Part B, if entitled. This is a condition of their enrollment in a PEBB retiree health plan. A subscriber or their dependent must provide a copy of their Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B effective dates to the PEBB Program as proof of enrollment in Medicare. If a subscriber or their dependent is not entitled to either Medicare Part A or Part B on their 65th birthday, they must provide the PEBB Program with a copy of their denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the "Enrollment" section. The PEBB Program or employing agency verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurred except as described in subsection (g) of this section. Children are defined as the subscriber's:

    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    b. Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
    c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    d. Children of the subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
    e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
    f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and
    g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:

        - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
        - The subscriber must notify the PEBB Program in writing, within 60 days of the last day of the month the child is no longer eligible under this subsection;
        - A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;
        - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and

- The PEBB Program (with input from the medical plan if enrolled in medical) will periodically verify the eligibility of a dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the subscriber.

4. Parents of the subscriber.
   a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:
      - The parent maintains continuous enrollment in PEBB medical;
      - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
      - The subscriber continues enrollment in PEBB insurance coverage; and
      - The parent is not covered by any other group medical plan.
   b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Enrollment

A subscriber or their dependent is eligible to enroll in only one PEBB dental plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same, or two different employers that participate in PEBB coverage may be enrolled as a dependent under only one parent.

An employee is <u>required</u> to enroll in a PEBB dental plan and any dependents enrolled on the employee's account for dental coverage will be enrolled in the same dental plan as the subscriber.

A Continuation Coverage subscriber, retiree, or survivor <u>may</u> enroll in a dental plan. If a retiree or survivor chooses to enroll in a dental plan under PEBB retiree insurance coverage, any dependents enrolled on the retiree or survivor's account will be enrolled in dental coverage and in the same dental plan as the retiree or survivor. The retiree or survivor must stay enrolled in retiree dental coverage for at least two years before dental can be dropped unless they defer or terminate coverage according to PEBB Program rules.

How to enroll

An employee must submit a *PEBB Employee Enrollment/Change* form to their employing agency when they become newly eligible for PEBB benefits. The form must be received no later than 31 days after the date the employee becomes eligible. If the employee does not return the form by the deadline, the employee will be enrolled in the Uniform Dental Plan and any eligible dependents cannot be enrolled until the PEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment.

A retiree or survivor must submit a *PEBB Retiree Coverage Election Form* along with any other required form, to the PEBB Program. The forms must be received within the required enrollment time limits listed under "When dental coverage begins." The first premium payment and applicable premium surcharges are due to the HCA no later than 45 days after the election period ends.

To enroll an eligible dependent, the subscriber must include the dependent's information on the form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified.

A subscriber enrolling in Continuation Coverage may enroll by submitting the required forms to the PEBB Program. The election must be received by the PEBB Program no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB Program, whichever is later. The first premium payment and applicable premium surcharges are due no later than 45 days after the election period ends as described above. Premiums associated with continuing PEBB dental must be made to the HCA. For more information see, "Options for continuing PEBB dental coverage" on page 29.

A subscriber or their dependents may also enroll during the PEBB Program's annual open enrollment (see "Annual open enrollment" on page 26) or during a special open enrollment (see "Special open enrollment" on page 27). The subscriber must provide proof of the event that created the special open enrollment.

A subscriber must provide notice to remove dependents who are no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child. The notice must be received within 60 days of the last day of the month the dependents no longer meet the eligibility criteria described in the "Eligibility" section on page 22. An employee must notify their employing agency. Any other subscriber must notify the PEBB Program. Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent losing eligibility to continue dental plan coverage under one of the continuation coverage options described on page 29 of this certificate of coverage;
- The subscriber being billed for claims paid by the dental plan that were received after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's dental plan coverage after the dependent lost eligibility.

When dental coverage begins

For an employee and their eligible dependents, enrolling **no later than 31 after the date the employee becomes newly eligible,** dental coverage begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

For an eligible retiring employee or retiring school employee, and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the employee's or school employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends.** Dental coverage begins on the first day of the month after the loss of employer-paid coverage, COBRA coverage, or continuation coverage.

For an eligible elected or full-time appointed official and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the official leaves public office.** Dental coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the death of the retiree.** Dental coverage will be continued without a gap subject to payment of premiums and any applicable premium surcharges.

For an eligible survivor of an employee or school employee and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the later of the date of the employee's or school employee's death, or the date the survivor's PEBB, educational service district, or School Employees Benefits Board (SEBB) insurance coverage ends.** Dental coverage begins the first day of the month following the later of the date of the employee's or school employee's death or the date the survivor's PEBB, educational service district, or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement, and their dependents, the PEBB Program must receive the required form(s) and formal determination letter **no later than 60 days after the date on the determination letter**. Dental coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible survivor of an emergency service personnel killed in the line of duty, the PEBB Program must receive the required form(s) **no later than 180 days after the later of**:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker's death; or

- The last day the survivor was covered under a health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

Dental coverage begins on the date chosen as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan, the PEBB Program must receive the required forms **no later than 60 days after a loss of other qualifying coverage,** dental coverage begins the first day of the month after the loss of other qualifying coverage. See the "Annual open enrollment" section for an additional enrollment time line.

For a Continuation Coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, dental coverage begins the first day of the month following the day they lost eligibility for PEBB dental plan coverage.

For a subscriber or their eligible dependent enrolling during the PEBB Program's annual open enrollment, dental coverage begins on January 1 of the following year.

For a subscriber or their eligible dependent enrolling during a special open enrollment, dental coverage begins the first of the month following the later of the event date or the date the form is received. If that day is the first of the month, coverage is effective on that day.

Exceptions:

1. If the special enrollment is due to birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, dental coverage begins as follows:.
    a. For an employee, dental coverage begins the first day of the month in which the event occurs;
    b. For the newly born child, dental coverage begins the date of birth;
    c. For a newly adopted child, dental coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
    d. For a spouse or state-registered domestic partner of a subscriber, dental coverage begins the first day of the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a dependent child with a disability, dental coverage begins on the first day of the month following eligibility certification.

Annual open enrollment

An employee may make the following changes to their enrollment during the PEBB Program's annual open enrollment:

- Enroll or remove eligible dependents; or
- Change their dental plan.

A retiree, survivor, or Continuation Coverage subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment:

- Enroll in or terminate enrollment in a dental plan;
- Enroll or remove eligible dependents; or
- Change their dental plan.

An employee must submit the change online in PEBB My Account or return the required form to their employing agency. Any other subscriber must submit the change online in PEBB My Account or return the required form(s) to the PEBB Program. The form(s) must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1 of the following year.

Exception: A Continuation Coverage subscriber, a retiree, or a survivor may voluntarily terminate enrollment in a PEBB dental plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB dental plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, dental enrollment will be terminated on the last day of the previous month.
Note: A retiree or survivor must stay enrolled in dental coverage for at least two years before dental can be

dropped unless they defer or terminate coverage according to PEBB Program rules.

Special open enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to, and be consistent with, the event that creates the special open enrollment for the subscriber, their dependent, or both. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits.

The special open enrollment may allow a subscriber to:

- Enroll in or change their dental plan; or
- Enroll or remove eligible dependents.

To make an enrollment change, the employee must submit the required form(s) to their employing agency. Any other subscriber must submit the required form(s) to the PEBB Program. The form(s) must be received no later than 60 days after the event that creates the special open enrollment. In addition to the required forms, the PEBB Program or the employing agency will require the subscriber to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exceptions:

- If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify their employing agency or the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form(s) must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

- A Continuation Coverage subscriber, a retiree, or a survivor may voluntarily terminate enrollment in a PEBB dental plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB dental plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, dental enrollment will be terminated on the last day of the previous month.

  Note: A retiree or survivor must stay enrolled in dental coverage for at least two years before dental can be dropped unless they defer or terminate coverage according to PEBB Program rules.

When may a subscriber change their health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
   a. Marriage or registering a state-registered domestic partnership;
   b. Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent, loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
   Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.
5. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;
6. A court order requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
7. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under

Medicaid or CHIP;

8. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP;
9. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or their dependent's entitlement to Medicare, the subscriber must select a new health plan;
10. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA); or
11. Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment for a high-risk pregnancy.

NOTE: If an enrollee's provider or dental care facility discontinues participation with this dental plan, the enrollee may not change dental plans until the PEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the PEBB Program determines that a continuity of care issue exists. This plan cannot guarantee that any one dentist, facility, or other provider will be available or remain under contract with us.

When may a subscriber enroll or remove eligible dependents?

Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
   Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.
5. Subscriber or their dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
6. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;
7. A court order requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP) program, or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Medicare entitlement

If an employee or their dependent becomes entitled to Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

If a Continuation Coverage subscriber or their dependent is entitled to Medicare, federal regulations require enrollment in Medicare the month before turning age 65. Otherwise, the Medicare effective date may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first entitled, a Medicare late enrollment penalty may apply.

If a retiree, survivor, or their enrolled dependent becomes entitled to Medicare, they should contact the Social Security Administration to ask about Medicare enrollment. The Medicare entitled subscriber or their dependent must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage. The only exception is if retirement occurred before July 1, 1991, or the enrollee is a dependent of an employee or school employee who retired before July 1, 1991 and is enrolled in PEBB retiree insurance coverage.

When dental coverage ends

Dental coverage ends on the following dates:

1. On the last day of the month when any enrollee ceases to be eligible;
2. On the date a dental plan terminates. If that should occur, the subscriber will have the opportunity to enroll in another PEBB dental plan;
3. For an employee, on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
   - On the date specified in an employee's letter of resignation; or
   - On the date specified in any contract or hire letter, or on the effective date of an employer-initiated termination notice.
4. On the last day of the month in which the monthly premium and applicable premium surcharges were paid. The subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharges remain unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid. A full month's premium is charged for each calendar month of coverage. Payments are not prorated during any month, even if an enrollee dies or if the subscriber requests to terminate their coverage before the end of the month.

When dental plan coverage ends, an enrollee may be eligible for continuation coverage described in the "Options for continuing PEBB dental coverage" section below.

An employee who needs the required forms for an enrollment or benefit change may contact their personnel, payroll, or benefits office. Any other subscriber may contact the PEBB Program at 1-800-200-1004.

Options for continuing PEBB dental coverage

A subscriber and their dependents covered by this dental plan may be eligible to continue enrollment during temporary or permanent loss of eligibility. There are two continuation coverage options for a PEBB dental plan enrollee:

1. PEBB Continuation Coverage (COBRA)
2. PEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the enrollee's PEBB dental plan coverage ends due to a qualifying event. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not

qualified beneficiaries under federal COBRA continuation coverage. PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types. An enrollee who qualifies for both types of PEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

The PEBB Program administers both continuation coverage options. Refer to the *PEBB Continuation Coverage Election Notice* booklet for details.

Option for coverage under PEBB retiree insurance

A retiring employee, eligible elected or full-time appointed official leaving public office, or a dependent becoming eligible as a survivor is eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage, if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB insurance coverage in accordance with the FMLA. The employing agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee monthly premium contribution and applicable premium surcharges during this period to maintain eligibility. If the employee's monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.

If an employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharges set by the HCA, with no contribution from the employing agency while on approved leave. For additional information on continuation coverage, see the section titled “Options for continuing PEBB dental coverage.”

Paid Family Medical Leave Act

An employee on approved leave under the Washington state Paid Family and Medical Leave (PFML) program may continue to receive the employer contribution toward PEBB insurance coverage in accordance with the PFML. The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay the employee monthly premium contribution and applicable premium surcharges during this period to maintain eligibility. If the employee’s monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.

If an employee exhausts the period of leave approved under PFML, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharges set by the HCA, with no contribution from the employing agency while on approved leave. For additional information on continuation coverage, see the section titled “Options for Continuing PEBB dental coverage.”

General provisions

Payment of premium during a labor dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employing agency may pay premiums directly to the plan or the HCA if the employee’s compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee’s compensation is suspended or terminated, the HCA shall notify the employee immediately by mail to the last address of record, that the employee may pay premiums as they become due.

Termination for just cause

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider’s request to terminate coverage from this plan for Just Cause.

A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

1. Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;
2. Knowingly providing false information;
3. Failure to pay the monthly premium and applicable premium surcharges when due;
4. Misconduct. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:
    a. Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium;
    b. Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

The PEBB Program will enroll the employee and their eligible dependents in another PEBB dental plan upon termination from this plan.

Appeal rights

Any current or former employee of a state agency or their dependent may appeal a decision by the employing state agency regarding PEBB eligibility, enrollment, or premium surcharges to the employing agency.

Any current or former employee of an employer group or their dependent may appeal a decision by an employer group regarding PEBB eligibility, enrollment, or premium surcharges to the employer group.

Any enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of a PEBB health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Release of Information

Enrollees may be required to provide DeltaCare or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, dental records. Coverage could be denied if enrollees fail to provide such information when requested.

When a Third Party is Responsible for Injury or Illness (Subrogation)

To the extent of any amounts paid by DeltaCare for an eligible person on account of services made necessary by an injury to or condition of his or her person, DeltaCare shall be subrogated to his or her rights against any third party liable for the injury or condition. DeltaCare shall, however, not be obligated to pay for such services unless and until the eligible person, or someone legally qualified and authorized to act for him or her, agrees to:

- Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
- Repay DDWA those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;
- Cooperate fully with DeltaCare in asserting its rights under the Contract, to supply DeltaCare with any and all information and execute any and all instruments DeltaCare reasonably needs for that purpose.

Provided the injured party is in compliance with the above, DeltaCare will prorate any attorneys' fees incurred in the recovery. What this means to you is that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss, any money recovered in excess of full compensation must be used to reimburse DDWA. DDWA will prorate any attorneys' fees against the amount owed.

Uninsured or Underinsured Motorist Coverage

This DeltaCare program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage.

Claim Review and Appeal

Confirmation of Treatment and Cost

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

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

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

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

Urgent Confirmation of Treatment and Cost Requests

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

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

Initial Benefit Determinations

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

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

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

Appeals of Denied Claims

How to contact us

DDWA will accept notice of an Urgent Care Request or Appeal if made by you, your covered dependent, or an authorized representative orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 1-800-650-1583.

Authorized Representative

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

Informal Review

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

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

DDWA will review your claim, make a determination within 14 days of receiving your request, and may take up to an additional 16 days with the delivery of this notice, for a total of 30 days. DDWA will send you a written notification of the review decision and information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request in writing that your claim be reviewed formally by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

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

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

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

When the Member Has Other Dental Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
    a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
    b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
    b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
    c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
    d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
    e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
        I. The *Plan* covering the *Custodial Parent*, first;
        II. The *Plan* covering the spouse of the *Custodial Parent*, second;
        III. The *Plan* covering the non*custodial Parent*, third; and then
        IV. The *Plan* covering the spouse of the non*custodial Parent*, last
3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

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

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

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

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

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

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

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

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

If payments that should have been made under *This Plan* are made by another *Plan*, DDWA has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, DDWA is fully discharged from liability under *This Plan*.

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

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

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

Subscriber Rights and Responsibilities

At Delta Dental of Washington our mission is to provide quality dental benefit coverage to employers and employees throughout Washington. We view our benefit packages as a partnership between Delta Dental of Washington, our subscribers and our participating member dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

The enrollee or dependent has the right to:

- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.

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

To receive the best oral health care possible, it is the enrollee or dependents responsibility to:

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

HIPAA Disclosure Policy

Delta Dental of Washington maintains a Compliance Program which includes an element involving maintaining privacy of information as it relates to the HIPAA Privacy & Security Rule and the Gram-Leach Bliley Act. As such we maintain a HIPAA Privacy member helpline for reporting of suspected privacy disclosures, provide members a copy of our privacy notice, track any unintended disclosures, and ensure the member rights are protected as identified by the Privacy Rule.

Policies and procedures are maintained and communicated to DDWA employees with reminders to maintain the privacy of our member's information. We also require all employees to participate in HIPAA Privacy & Security training through on-line education classes, email communications, and periodic auditing.

Nondiscrimination and Language Assistance Services

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

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

Delta Dental of Washington:

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

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

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

- Qualified interpreters
- Information written in other languages

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

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington DC 20201, 800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Taglines
Amharic :እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Delta Dental of Washington ጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 800-554-1907 ይደውሉ።
Arabic إن كان لديك أو لدى أي شخص تساعده أسئلة بخصوص تغطيتك الصحية لدى Delta Dental of Washington ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع المترجم اتصل بـ800-554-1907.
Cambodian (Mon-Khmer) ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នក កំពុងតែជួយមានសំណួរអំពីធានា រ៉ាប់រងរបស់អ្នកជាមួយ Delta Dental of Washington អ្នកមានសិទ្ធិទទួល ជំនួយនិងព័ត៌មាននៅក្នុងភាសារបស់អ្នកដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយ ជាមួយអ្នកបកប្រែ សូម 800-554-1907។
Chinese 如果您，或是您正在協助的對象，有關於[插入項目的名稱Delta Dental of Washington方面的問題， 您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話[在此插入數字 800-554-1907。
Cushite (Oromo) Isin yookan namni biraa isin deeggartan Delta Dental of Washington irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 800-554-1907 tiin bilbilaa.
French Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-554-1907.

Taglines
German Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Washington haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.
Japanese ご本人様、またはお客様の身のりの方でもDelta Dental of Washingtonについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907までお電話ください。
Korean 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Washington에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 800-554-1907로 전화하십시오.
Laotian ຖ້າທ່ານ, ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳ ຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍ ເຫຼືອ ແລະ ຂໍ້ມູນຂ່າວສານນີ້ເປັນພາສາຂອງທ່ານ ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ ໂທຫາ 800-554-1907.
Persian (Farsi) .شما، یا کسی که شما به او کمک میکنید ، سوال در مورد ماس حاصل نمایید Delta Dental of Washington ته باشید حق این را دارید که کمک 800-554-1907 لاعات به زبان خود را به طور رایگان دریافت نمایي
Punjabi ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਜਿਸ ਵਿਅਕਤੀ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Delta Dental of Washington ਦੇ ਨਾਲ ਬੀਮਾ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹੁੰਦੇ ਹਨ, ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.
Russian Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Washington, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-554-1907.
Serbo-Croatian Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Washington Dental Service, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 800-554-1907.
Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.
Sudan (Fulfulde) To aan, malla goɗɗo mo mballata, e ɏama dow Delta Dental of Washington, a woodi baawɗe heƀuki habaru malla wallireeki wolde maaɗa naa maa a yoƀii. Mbolda e pirtoowo, nodda 800-554-1907.
Tagalog Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Delta Dental of Washington, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-554-1907.
Ukrainian Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Delta Dental of Washington, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 800-554-1907.

Taglines
Vietnamese Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Washington, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-554-1907.

Delta Dental of Washington

P.O. Box 75983
Seattle, WA 98175-0983

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