Washington Public Employees and Retirees

# DeltaCare®

A Managed Care/HMO Plan

# 2027

DeltaCare® 2027

Administered by:

Delta Dental of Washington

Published under the direction of the Washington State Health Care Authority

DeltaCare®
Administered by Delta Dental of Washington

# Group #03100 A Managed Care Dental Plan

Delta Dental of Washington

Effective: **January 1, 2027**

## SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by Delta Dental of Washington. 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 for 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

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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

**Annual open enrollment:** A period of time defined by HCA when a Subscriber may change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

**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. For an appeal related to PEBB eligibility or enrollment, see "Appeal rights" in the "Eligibility and Enrollment" section for more information.

**Continuation coverage:** The temporary continuation of PEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or PEBB policies.

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

**Covered Service:** means a dental service listed as covered in this Certificate of Coverage for which benefits are provided to Enrollees.

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

**Dependent**: A spouse, state-registered domestic partner or child of the Insured who meets the eligibility requirements as shown in the Eligibility and Enrollment section of this Certificate of Coverage and is enrolled for coverage under the subscriber.

**Employing agency:** A division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by HCA statute.

**Enrollee**: The subscriber or dependent 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 other contracting entity that has entered into this Contract for the provision for dental benefits for its subscribers and their eligible dependents.

**HCA**: Health Care Authority is the Washington state agency that administers the PEBB and SEBB Programs.

**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.

**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.

**PEBB Employer group** — for the Public Employees Benefits Board (PEBB) Program means those counties, municipalities, political subdivisions, the Washington health benefits exchange, tribal governments, and employee organizations representing state civil service employees obtaining employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the PEB board.

**Plan:** DeltaCare, a managed dental benefit plan of coverage. In the eligibility sections “plan” may mean a plan other than DeltaCare not sponsored by the PEBB Program.

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

**Primary Care Dentist (PCD)**: A general practitioner that has chosen to be a DeltaCare network provider and whom the enrollee or dependent has selected as their dentist or facility.

**Public Employees Benefits Board (PEBB)**: A group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

**Public Employees Benefits Board (PEBB) Program**: The HCA program that administers PEBB benefit eligibility and enrollment.

**Retired Employee of a Former Employer Group** — includes a retired employee of a PEBB employer group and a retired school employee of a SEBB employer group continuing enrollment in PEBB health plan coverage after losing eligibility for PEBB retiree insurance coverage upon the employer group ending participation in insurance plans and contracts with the health care authority (HCA).

**School Employees Benefits Board (SEBB)**: A group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

**School Employees Benefits Board (SEBB) Organization**: A public school district or educational service district or charter school established under Washington State statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).

**School Employees Benefits Board (SEBB) Program**: The program within HCA that administers insurance and other benefits for eligible school employees, eligible dependents, and eligible school board members.

**SEBB Employer group** — for the School Employees Benefits Board (SEBB) Program means an employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.

**State agency**: An office, department, board, commission, institution, or other separate unit or division, however designated, of the Washington state government. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

**Specialist:** A Dentist professionally qualified as an endodontist, oral pathologist, oral surgeon, orthodontist, pediatric dentist, periodontist, or prosthodontist.

**Subscriber:** Eligible employee, retiree, continuation coverage enrollee, retired employee of a former employer group, or survivor who has been determined eligible and is enrolled in this dental plan, and is the individual to whom the PEBB Program or this Plan will issue notices, information, requests, and premium bills on behalf of an Enrollee.

## 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.

## Choosing a Primary Care Dentist (PCD)

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

If you do not select a PCD within 60 days, we will assign you to one near your home. The choice of PCD can be changed with proper notice to DDWA. A 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 letter which will include the address and telephone number of your PCD. You can also receive information about your PCD on our website at www.DeltaDentalWA.com/group/pebb 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 from DDWA. 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. In all instances, your PCD will coordinate care and is required to provide notification to you and DDWA prior to referral of specialty services.

## 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 Pre-Treatment Cost Estimate if a prudent layperson acting reasonably would believe that such an emergency condition exists.

## 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

Communication with Delta Dental of Washington is available through Washington Relay Service, a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

This service allows individuals who are Deaf, Hard of Hearing, DeafBlind, or speech disabled to communicate with Delta Dental of Washington through specially trained communications assistants using a variety of relay methods.

To access the relay service, dial 711 (statewide) or 800-833-6384. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. The assistant will then relay the conversation between you and our representatives.

The Washington Relay Service is available 24 hours a day, 7 days a week, at no cost to users. All relay calls are confidential.

## 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 1,2027.**

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.

Your Dentist may recommend treatments that are not covered by this Plan.

DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your Dentist should discuss which services may not be covered as well as any fees that are your responsibility.

There is no deductible for this Plan.

| 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 - comprehensive 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 | |
| D0396 | 3D printing of a 3D dental surface scan | 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 | Application of medicament - topicalfluoride varnish; full mouth | 0 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| D1208 | Application of medicament - topical fluoride – excluding varnish; full mouth | 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 | |
| D1354 | Application of caries arresting medicament without surgical intervention – per tooth | 0 | |
| D1355 | Application of medicament – Primary prevention, or remineralization without surgical intervention – per 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 | |
| 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 (anterior) | 15 | |
| D2390 | Resin-based composite crown - direct | 50 | |
| 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 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| D2642 | Onlay - porcelain/ceramic - two surfaces | 125 | |
| D2643 | Onlay - porcelain/ceramic - three surfaces | 125 | |
| D2644 | Onlay - porcelain/ceramic - 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 | 175 | |
| 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 | 175 | |
| D2799 | Interim crown | 125 | |
| 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 |
| D2940 | placement of interim direct 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 | |
| D2956 | Removal of an indirect restoration on a natural tooth | 0 | |
| D2957 | Each additional prefabricated post - same tooth | 0 | |
| D2971 | Additional procedures to customize a crown to fit under an existing partial denture framework | 0 | |
| D2976 | Band stabilization - per tooth | 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 | |
| D2989 | Excavation of a tooth resulting in the determination of non-restorability | 0 | |
| **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 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| D3221 | Gross pulpal debridement, primary and permanent teeth | NB | |
| D3230 | Pulpal therapy (resorbable filling), primary tooth (excluding final restoration) | NB | |
| D3240 | Pulpal therapy (resorbable filling), primary tooth (excluding 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 | Apexification/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 |
| 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 |
| D3471 | Surgical repair of root resorption - anterior | 35 | |
| D3472 | Surgical repair of root resorption – premolar | 35 | |
| D3473 | Surgical repair of root resorption – molar | 35 | |
| D3501 | Surgical exposure of root surface without apicoectomy of repair of root resorption – anterior | 35 | |
| D3502 | Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar | 35 | |
| D3503 | Surgical exposure of root surface without apicoectomy or repair of root resorption – molar | 35 | |
| D3911 | Intraorifice barrier | 0 | |
| D3920 | Hemisection including root removal | 0 | R |
| D3921 | Decoronation or submergence of an erupted tooth | 10 | |
| **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 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| 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 | |
| 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 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| 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 (including retentive/clasping materials, rests, and teeth) | 140 | |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | 140 | |
| D5227 | Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) | 140 | |
| D5228 | Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) | 140 | |
| D5284 | Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant | NB | |
| D5286 | Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, 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 | |
| D5511 | Repair complete denture base, mandibular | 15 | |
| D5512 | Repair complete denture base, maxillary | 15 | |
| D5520 | Replace missing or broken teeth - complete denture | 15 | |
| D5521 | Replace all teeth on complete denture – maxillary | 140 | |
| D5522 | Replace all teeth on complete denture – mandibular | 140 | |
| 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 missing or broken teeth – partial denture - per tooth | 10 | |
| D5650 | Add tooth to existing partial denture – per tooth | 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 | |
| D5725 | Rebase hybrid prosthesis | 40 | |
| D5730 | Reline complete maxillary denture (chairside) | 40 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| 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 | |
| D5765 | Soft liner for complete or partial removable denture – indirect | 50 | |
| D5850 | Tissue conditioning, maxillary | 15 | |
| D5851 | Tissue conditioning, mandibular | 15 | |
| D5863 | Overdenture – complete maxillary – natural tooth borne | 175 | |
| D5864 | overdenture – partial maxillary - natural tooth borne | 175 | |
| D5865 | overdenture – complete mandibular - natural tooth borne | 175 | |
| D5866 | Overdenture – partial mandibular - natural tooth borne | 175 | |
| **D6000-D6199** | **VIII. Implant Services – See Implant Services section below** | | |
| **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 | 150 | |
| 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 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| 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 |
| 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 | |
| D7961 | Buccal/labial frenectomy (frenulectomy) | 20 | R |
| D7962 | Lingual frenectomy (frenulectomy) | 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 | |

| Procedure | Description | Copayment | Notes |
|---|---|---|---|
| **D9000 - D9999** | **XII. Additional Procedures** | | |
| D9110 | Palliative treatment of dental pain per visit | 15 | |
| D9211 | Regional block anesthesia | 0 | |
| D9212 | Trigeminal division block anesthesia | 0 | |
| D9215 | Local anesthesia | 0 | |
| D9222 | Administration of deep sedation/general anesthesia – first 15 minutes increment, or any portion thereof | 25* | |
| D9223 | Administration of Deep sedation/general anesthesia – each subsequent 15 minute increment or any portion thereof | 25* | R |
| D9239 | Intravenous Administration of moderate (conscious) sedation/analgesia intravenous – first 15 minutes increment or any portion thereof | 25 | |
| D9243 | Intravenous Administration of moderate (conscious) sedation/analgesia intravenous– each subsequent 15 minute increment or any portion thereof | 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 | |
| D9912 | Pre-visit patient screening | 0 | |
| 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** | **= Pre-Treatment Cost Estimate recommended** |
| **R** | **= Referable to a specialist** |
| **TMJ** | **= TMJ Covered** |
| **GAP** | **= Guidelines apply** |
| **NB** | **= Not a Benefit on plan** |
| **OP** | **= Optional Treatment** |

*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;

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: full-mouth application of medicament, including fluoridated varnishes - 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

Your DeltaCare Dental Plan does not cover implant services. However, we have partnered with select providers to offer Dental implant Services to PEBB Members enrolled in the DeltaCare Dental Plan. Implant Services will be available at select dental offices experienced in providing dental implants, at the below cost to you. Implant Services will not be available at every participating DeltaCare dental office location.

Enrollees who have been determined by their PCD to be candidates for dental implants will be referred to the nearest select dental office trained in the surgical placement of implants. The fees established below are only applicable if you see a select provider. Please contact us at 1-800-650-1583 for questions regarding implant services.

If you choose to receive an implant from the selected provider, the treatment and payment arrangements are between you and that provider. The implant is not covered under your dental plan, and DDWA is not responsible for the service or any related charges.

| Implant Services | |
|---|---|
| Initial Implant Exam or Consultation | 25 |
| Detailed and Extensive Oral Evaluation | 125 |
| **Implant Fees - Case Rates** | |
| Single Tooth | 2,800 |
| Two Teeth | 5,464 |
| Three Teeth | 7,644 |
| Full Denture (two implants) | 5,120 |
| Full Denture (three implants) | 6,885 |
| Each additional tooth | 2,095 |

Initial Implant Exam or Consultation is subject to a copayment by the patient. 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 adjustment, 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 Pre-Treatment Cost Estimate 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 Fluoride: full-mouth application of medicament, including fluoridated varnishes 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 for the same quadrant.
- The application of caries arresting or primary preventive medicament without surgical intervention is a Covered Dental Benefit twice per benefit period per tooth.

### 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 or prefabricated 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 (two teeth per quadrant) 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. 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, including crowns, 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 Pre-Treatment Cost Estimate of dental treatment performed at a hospital is submitted to and approved by DeltaCare. Such request for Pre-Treatment Cost Estimate 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;

Laboratory tests and laboratory exams;

— 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

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.
8. 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.
9. Composite resin restorations in posterior teeth are a covered benefit once in a two-year period.
10. 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.
11. A crown placed on a specific tooth is allowable only once in a five year period from initial placement.
12. 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**

13. 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.
14. Fixed bridges for patients under the age of 16 are optional to a partial denture.
15. 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.
16. 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.
17. 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**

18. 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. Pre-Treatment Cost Estimate 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**

19. 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**

20. 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.
21. Follow-up examinations for reevaluation, particularly periodontal reevaluation, are considered to be part of the general services rendered.

**Interim partials (Stayplates)**

22. 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**

23. 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**

24. Referrals to a pediatric Dentist must be preauthorized by DeltaCare. Benefits for dependent children through age 18 are covered at 100% of the agreed upon fee less any applicable co-payments for covered benefits.

**Treatment Planning**

25. 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, the term "retiree" or "retiring employee" includes a retiring or eligible separating employee from a Public Employees Benefits Board (PEBB) employing agency or employer group, and an elected or full-time appointed official of the legislative and executive branch of state government. The term "retiree" or "retiring school employee" includes a retiring or eligible separating school employee from a School Employees Benefits Board (SEBB) organization or employer group. Additionally, "health plan" is used to refer to a plan offering medical, dental, vision, or any combination of these coverages developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

# Eligibility for subscribers and dependents

## Employee eligibility

The employee's state agency will inform the employee in writing whether they are eligible for PEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the employee's right to appeal eligibility and enrollment decisions.

An employee of an employer group (such as a county, city, port, water district, etc.) that contracts with HCA for PEBB benefits should contact their payroll or benefits office for eligibility criteria.

Employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under "Appeal rights."

## Continuation coverage eligibility

The PEBB Program determines whether subscribers are eligible for PEBB Continuation Coverage (COBRA or Unpaid Leave) upon receipt of their election to enroll. If the subscriber requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

## Retired employee of a former employer group eligibility

The PEBB Program determines whether a retired employee, a retired school employee, or an eligible survivor of a former employer group is eligible to self-pay coverage in PEBB Continuation Coverage (Employer Group Ended Participation) upon receipt of their election to enroll. If the retired employee, the retired school employee, or the survivor requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

## Retiree and survivor eligibility

**Retiree:** The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of their election to enroll. 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 eligibility decisions. Information about appeals can be found under "Appeal rights."

**Survivor:** The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor. If an election to enroll is required, eligibility will be determined upon receipt of their election to enroll. 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 appeals can be found under "Appeal rights."

## Dependent eligibility

The following are eligible dependents:

**Legal spouse**

**State-registered domestic partner** and substantially equivalent legal unions from jurisdictions as defined in Washington state statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.

**Children**, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:

- **Children based on establishment of a parent-child relationship**, as described in Washington state statutes, except when parental rights have been terminated.

- **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.
- **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
- **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.
- **Children specified in a court order or divorce decree** for whom the subscriber has a legal obligation to provide support or health care coverage.
- **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the 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 foster children 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.
- **Children of any age with a developmental or physical disability** that renders them 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 when the child is no longer eligible under this subsection.
  - A child with a developmental or physical disability who becomes self-supporting is not eligible 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 if they later become incapable of self-support.
  - 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 beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

**A retiree, a survivor, or their enrolled dependents are required to enroll and stay enrolled in Medicare Part A and Part B, if eligible.** This is a requirement for enrollment in a PEBB retiree health plan. A retiree or survivor must provide a copy of their or their dependent's Medicare card or Medicare benefit verification letter with Medicare Part A and Part B effective dates by uploading it online using Benefits 24/7, the PEBB Program's online enrollment system, or providing it to the PEBB Program. If a retiree, a survivor, or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the retiree or survivor must upload or provide the PEBB Program with a copy of the denial letter from the Social Security Administration. If this procedural requirement is not met, eligibility will not be established or will end as described in the termination notice sent by the PEBB

Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

# Enrollment for subscribers and dependents

## For all subscribers and dependents

- To enroll at any time other than during the initial enrollment period, see "Making changes."
- Any dependents enrolled in PEBB dental will be enrolled in the same dental plan as the subscriber.

## Employee enrollment

**An employee is required to enroll in PEBB dental except where PEBB Program rules allow otherwise.** An employee must use Benefits 24/7 or submit a *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency when they become newly eligible or regain eligibility for PEBB benefits. The online enrollment must be completed or the forms must be received no later than 31 days after the date the employee becomes eligible or regains eligibility.

If the employee does not enroll online or return the form by the deadline, the employee will be enrolled in Uniform Dental Plan. 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 that allows enrolling a dependent. See "Special open enrollment changes."

## Continuation coverage and retired employees of a former employer group enrollment

**A continuation coverage subscriber, a retired employee of a former employer group, or their dependent** can enroll in only one PEBB dental plan, even if eligibility criteria is met under two or more subscribers.

A subscriber enrolling in PEBB Continuation Coverage (COBRA or Unpaid Leave) or PEBB Continuation Coverage (Employer Group Ended Participation) may enroll by using Benefits 24/7 or by submitting the applicable *PEBB Continuation Coverage Election/Change* form and any supporting documents to the PEBB Program.

For PEBB Continuation Coverage (COBRA or Unpaid Leave), the online enrollment must be completed or the PEBB Program must receive the election form no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the PEBB *Continuation Coverage Election Notice* sent by the PEBB Program, whichever is later. For PEBB Continuation Coverage (Employer Group Ended Participation), the online enrollment must be completed or the PEBB Program must receive the required form no later than 60 days after the employer group's date of termination.

Premiums associated with continuing PEBB dental must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for continuing PEBB dental coverage" and the *PEBB Continuation Coverage Election Notice* sent by the PEBB Program.

## Retiree and survivor enrollment

**An eligible retiree or survivor must enroll in PEBB medical to enroll in PEBB dental. An eligible retiree, a survivor, or their dependent** can enroll in only one PEBB dental plan, even if eligibility criteria is met under two or more subscribers.

**An eligible retiring employee or a retiring school employee** must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the employee's or the school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

**An eligible elected or full-time appointed official** must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the official leaves public office. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

**An eligible survivor of a retiree** who is enrolled at the time of the retiree's death will be enrolled under their own account with no gap in coverage in the same PEBB health plan coverage they were enrolled in. To make changes to their PEBB health plan coverage, they must submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree. An eligible survivor of a retiree who is not enrolled at the time of the retiree's death, must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree.

**An eligible survivor of an employee or school employee** must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

**An eligible employee or school employee determined to be retroactively eligible for disability retirement** must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election* Form *(form A*) along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the date on the determination letter. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

**An eligible survivor of an emergency service personnel killed in the line of duty** must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received 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 any health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

**A retiree or a survivor whose enrollment is deferred** and is enrolling in a PEBB retiree health plan, must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program.

A retiree or a survivor whose enrollment is deferred while enrolled in other qualifying coverage must also submit evidence of continuous enrollment. The online enrollment must be completed or the forms must be received no later than 60 days after a loss of other qualifying coverage.

A retiree or a survivor enrolled in Medicare whose enrollment is deferred while permanently residing outside of the United States or due to a temporary absence from the United States and who returns to the United States, must also submit proof of enrollment in Medicare Parts A and B, proof of permanent residence in the United States, and proof they currently reside in the United States; evidence of continuous enrollment in qualified

coverage is not required. The online enrollment must be completed or the forms must be received no later than 60 days after the date the permanent move begins or 60 days following the month of the permanent move, whichever is later.

The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

### Dependent enrollment

**If a retiree or a survivor** chooses to enroll in PEBB dental under PEBB retiree insurance coverage, any dependents enrolled on the retiree or survivor's account will also be enrolled in PEBB dental.

**If a subscriber** chooses to enroll an eligible dependent, the subscriber must include the dependent's information using Benefits 24/7 or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in PEBB health plan coverage if the PEBB Program or the employing agency is unable to verify their eligibility within the PEBB Program enrollment timelines.

### Dual enrollment

**A subscriber** and their dependents may each be enrolled in only one PEBB dental plan.

**An employee** or their dependent who is eligible to enroll in both the PEBB Program and the School Employees Benefits Board (SEBB) Program is limited to a single enrollment in either the PEBB or SEBB Program.

For example:

- A child who is an eligible dependent under two parents enrolled in PEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in PEBB dental.
- A child who is an eligible dependent of an employee in the PEBB Program and a school employee in the SEBB Program may only be enrolled as a dependent under one parent in either the PEBB or SEBB Program.

## When dental coverage begins

### Employees and dependents

**For a newly eligible employee** and their eligible dependents, 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.

If the eligible employee is a faculty member hired on a quarter-to-quarter or semester-to-semester basis, dental coverage begins the first day of the month following the beginning of the second consecutive quarter or semester. If the first day of the second consecutive quarter or semester is the first working day of the month, dental coverage begins on that day.

**For an employee regaining eligibility,** including following a period of leave or after being between periods of leave as described in PEBB Program rules, and their eligible dependents, dental coverage begins the first day of the month the employee is in pay status eight or more hours. If the employee is a returning faculty member regaining eligibility no later than the 12th month after the month in which they lost eligibility for the employer contribution toward PEBB benefits, dental coverage begins the first day of the month in which the quarter or semester begins.

**Note:** When an employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Dental coverage begins the first day of the month in which the employee returns from active duty.

### Retirees and dependents

**For an eligible retiring employee or retiring school employee** and their eligible dependents, dental coverage begins on the first day of the month after the retiring employee's or the retiring school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends.

**For an eligible employee or school employee determined to be retroactively eligible for disability retirement** and their eligible dependents, dental coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

**For an eligible elected or full-time appointed official** and their eligible dependents, dental coverage begins the first day of the month following the date the official leaves public office.

**For an eligible retiree whose enrollment is deferred** and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, dental coverage for the retiree and their eligible dependents begins the first day of the month after the other qualifying coverage ends. For a retiree enrolled in Medicare whose enrollment was deferred while permanently residing outside of the United States or due to a temporary absence from the United States, and who returns to the United States, dental coverage for the retiree and their eligible dependents begins the first day of the month after the permanent move.

## Survivors and dependents

**For an eligible survivor of a retiree** and their eligible dependents, dental coverage will be continued without a gap, subject to payment of premiums and applicable premium surcharges. If the eligible survivor is not enrolled at the time of the retiree's death, dental coverage will begin the first day of the month following the retiree's death.

**For an eligible survivor of an employee or school employee** and their eligible dependents, 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 insurance coverage or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

**For an eligible survivor of emergency service personnel killed in the line of duty** and their eligible dependents, dental coverage begins on the date chosen, as allowed under PEBB Program rules.

**For an eligible survivor whose enrollment is deferred** and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, dental coverage for the survivor and their eligible dependents begins the first day of the month after the other qualifying coverage ends. For a survivor enrolled in Medicare whose enrollment was deferred while permanently residing outside of the United States or due to a temporary absence from the United States, and who returns to the United States, dental coverage for the survivor and their eligible dependents begins the first day of the month after the permanent move.

## Continuation coverage subscribers and dependents

**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.

## Retired employees of a former employer group and dependents

**For a retired employee of a former employer group** and their eligible dependents enrolling when newly eligible, dental coverage begins the first day of the month following the day they lost eligibility for PEBB retiree insurance coverage.

## All subscribers and dependents

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

**For a subscriber or their eligible dependents enrolling during a special open enrollment**, dental coverage begins the first day of the month following the event date or the date the online enrollment election using Benefits 24/7 or the required form is received, whichever is later. If that day is the first of the month, dental coverage begins on that day.

If the special open enrollment is due to the **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 will begin as follows:

- **For an employee,** dental coverage will begin the first day of the month in which the event occurs.
- **For a newly born child,** dental coverage will begin the date of birth.
- **For a newly adopted child,** dental coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
- **For a spouse or state-registered domestic partner** of a subscriber, dental coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an **extended dependent or a dependent child with a disability**, dental coverage will begin the first day of the month following the event date or eligibility certification, whichever is later.

# Making changes

## Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child as described under "Dependent eligibility." The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

**An employee** must provide notice online using Benefits 24/7 or by submitting a written request to their employing agency.

**Any other subscriber** must provide notice online using Benefits 24/7 or by submitting a written request to the PEBB Program.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB dental under one of the continuation coverage options described in "Options for continuing PEBB dental coverage."
- The subscriber may be billed for claims paid by the dental plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent's dental plan coverage after the dependent lost eligibility.

## Voluntary termination for a retiree, a survivor, a continuation coverage subscriber, or a retired employee of a former employer group

A retiree, a survivor, a continuation coverage subscriber, or a retired employee of a former employer group may voluntarily terminate enrollment in a dental plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the dental plan will be terminated the last day of the month in which the request was received online or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, dental plan enrollment will be terminated on the last day of the previous month.

A retiree or a survivor who voluntarily terminates their enrollment in PEBB dental also terminates dental enrollment for all eligible dependents.

## Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment or when a specific life event creates a special open enrollment period.

## Annual open enrollment changes

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

Enroll or remove eligible dependents

Change their dental plan

**An employee** must submit the election change online using Benefits 24/7 or return the required *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period.

**Any other subscriber** may make the following changes to their enrollment during the PEBB Program's annual open enrollment period:

Enroll in or terminate enrollment in a dental plan

Enroll or remove eligible dependents

Change their dental plan

They must submit the election change online using Benefits 24/7 or return the required *PEBB Retiree Open Enrollment Election/Change Form (form A-OE) or PEBB Continuation Coverage Election/Change* form (as appropriate) and any supporting documents to the PEBB Program. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period.

The change will be effective January 1 of the following year, except when a subscriber chooses to terminate enrollment or remove an eligible dependent, then the change will be effective on December 31.

## Special open enrollment changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. 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 other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits.

A special open enrollment may allow a subscriber to make the following changes:

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

To request a special open enrollment:

**An employee** must make the change online using Benefits 24/7 or submit the required *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency.

**Any other subscriber** must make the change online using Benefits 24/7 or submit the required PEBB *Retiree Change Form (form E) or PEBB Continuation Coverage Election/Change* form (as appropriate) and any supporting documents to the PEBB Program.

The change must be completed online, or the forms must be received, no later than 60 days after the event that creates the special open enrollment. In many instances, the date the change is received online or the date the form is received affects the effective date of the enrollment or change in enrollment. Submitting the requested change sooner may avoid a delay in the enrollment or change. In addition, the PEBB Program or the employing agency will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

**Exception**: 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 complete the request online or notify their employing agency or the PEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required forms 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.

## Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

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

Subscriber gains a new dependent due to:

- Marriage or registering a state-registered domestic partnership.
- Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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).

Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.

Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.

Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan. If the subscriber or their dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber's or the dependent's new residence, the subscriber may select a new dental plan.

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).

Subscriber or their dependent enrolls in 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.

Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug (MAPD) or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependent's enrollment in Medicare, the subscriber must select a new medical plan.

Subscriber or their dependent gains, loses, or has a change in low-income subsidy (LIS) eligibility. They have three months to enroll in a MAPD plan, Medicare Supplement plan, or the Uniform Medical Plan Classic Medicare with Part D (PDP) if eligible, after they gain, lose, or have a change in LIS eligibility, or notification of such a change, whichever is later.

Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).

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 because the subscriber 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 not limit its consideration to the following:

- Active cancer treatment, such as chemotherapy or radiation therapy
- Treatment following a recent organ transplant
- A scheduled surgery
- Recent major surgery still within the postoperative period
- Treatment for a high-risk pregnancy

- Subscriber or their dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.
- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.
- The PEBB Program determines there has been a substantial increase in the employee's premiums when the employee transfers from one employing agency to another employing agency.

**Note:** The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change dental plans simply because their provider or health care facility discontinues participation with this dental plan until the PEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists.

## Special open enrollment events that allow adding or removing a dependent

Any of the following events may create a special open enrollment:
Subscriber gains a new dependent due to:

- Marriage or registering a state-registered domestic partnership.
- Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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).

Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.

Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan.

"Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.

Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.

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.

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).

Subscriber or their dependent enrolls in 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.

Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.

Subscriber or their dependent enrolled in a Medicare Advantage Prescription Drug plan, Medicare Supplement plan, or the Uniform Medical Plan Classic Medicare with Part D (PDP) who gains, loses, or has a change to their low-income subsidy eligibility.

Subscriber or their dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.

# When dental coverage ends

## Termination dates

Dental coverage ends on the following dates:

On the last day of the month when any enrollee ceases to be eligible.

On the date a dental plan terminates or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB dental plan.

**For an employee** and their dependents, 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.
- On the date specified in any contract or hire letter.
- On the effective date of an employer-initiated termination notice.

**Note:** If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, dental coverage ends the last day of the month that employee premiums were deducted.

**For a retiree, a survivor, a continuation coverage subscriber, or a retired employee of a former employer group,** who submits a request to terminate dental coverage, enrollment in dental coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, dental coverage will be terminated on the last day of the previous month.

When a retiree or a survivor's enrollment in PEBB retiree insurance coverage is deferred or terminated, enrollment in dental coverage will be terminated, including all enrolled dependents. When a dependent of a retiree or survivor is terminated from PEBB retiree insurance coverage, the dependent's enrollment in dental coverage is also terminated.

A retiree, a survivor, or their dependent's enrollment in dental coverage may also be terminated when they must be disenrolled by a Medicare Advantage Prescription Drug plan or Medicare Part D plan as required by federal law, due to permanently residing outside of the United States or due to a temporary absence from the United States that exceeds the permitted time allowed under the federal regulations and guidance of the Centers for Medicare and Medicaid Services. A retiree or a survivor's dependent's enrollment in dental coverage will be terminated along with their medical plan enrollment the last day of the month as required by federal law. A retiree or a survivor's enrollment in PEBB retiree insurance coverage (including medical and dental) will be automatically deferred by the PEBB Program.

A subscriber will be responsible for payment of any services received after the date dental coverage ends, as described above.

## Final premium payments

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their dental plan before the end of the month.

An exception occurs when an enrolled retiree dies, in which case, HCA will waive the premium payment for medical, dental, vision, and any applicable premium surcharges for the retiree for the month in which the death occurred.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, the account will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance and applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, the subscriber's dental coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. When a subscriber is terminated for non-payment of premiums and applicable premium surcharges, they may not enroll again unless they regain eligibility.

## Options for continuing PEBB dental coverage

When dental coverage ends, the subscriber and their dependents covered by this dental plan may be eligible to continue PEBB dental coverage during temporary or permanent loss of eligibility.

There are three options the subscriber and their dependents may qualify for when coverage ends.

- PEBB Continuation Coverage (COBRA)
- PEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage, this may include employees separating from employment

## PEBB Continuation Coverage

The PEBB Program administers the following continuation coverage options that 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 COBRA laws and regulations. Some enrollees who are not qualified beneficiaries under federal COBRA may also qualify for PEBB Continuation Coverage (COBRA).

**PEBB Continuation Coverage (Unpaid Leave)** is an option created by the PEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An enrollee who qualifies for both types of PEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of these options. See "Continuation coverage enrollment" and the *PEBB Continuation Coverage Election Notice* sent by the PEBB Program.

**Premium payments for PEBB Continuation Coverage**
If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges.

The PEBB Program also administers continued health plan enrollment under PEBB Continuation Coverage (Employer Group Ended Participation) for a retired employee, a retired school employee, or a survivor and their dependents covered by this dental plan who lose eligibility for PEBB retiree insurance coverage when their employer group ends participation with the Health Care Authority. Contact the PEBB Program at 1-800-200-1004 (TRS: 711) for details.

## PEBB retiree insurance coverage

The following are eligible to continue enrollment or defer (postpone) enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements:

- Retiring employee or retiring school employee
- Separating employee or separating school employee who is at least age 55 and meets specific retirement plan and years of service requirements and who will not yet receive a monthly retirement plan payment
- Eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office
- Dependent becoming eligible as a survivor
- Retiree or a survivor enrolled in PEBB retiree insurance coverage

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 benefits in accordance with the federal 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 their monthly premium contribution and applicable premium surcharges during this period.

If an employee exhausts the period of leave approved under FMLA, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the employing agency. See "Options for continuing PEBB dental coverage."

## Paid Family and 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 benefits.

The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

If an employee exhausts the period of leave approved under PFML, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the employing agency. See "Options for continuing PEBB dental coverage."

# General provisions for eligibility and enrollment

## Payment of premiums 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 HCA if the employee's compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute, for a period not to exceed six months.

When the employee's compensation is suspended or terminated, HCA will notify the employee immediately (by mail at the last address of record) that the employee may pay premiums as they become due.

If coverage is no longer available to the employee under this certificate of coverage, then the employee may be eligible to purchase an individual dental plan from this plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

## 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 an enrollee's coverage from this plan for just cause.

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

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

Knowingly providing false information

Failure to pay the monthly premium and applicable premium surcharges when due

Misconduct. Examples of such termination include, but are not limited to the following:

- 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
- 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 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 an employee and their eligible dependents in another PEBB dental plan upon termination from this plan.

## Eligibility Appeal rights

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

**Any current or former employee of an employer group,** such as a county, city, port, water district, etc., that contracts with HCA for PEBB benefits, or their dependent may appeal a decision made 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 dental plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Learn more at **hca.wa.gov/pebb-appeals**.

## Relationship to law and regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of Washington state 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

## Pre-Treatment Cost Estimate

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

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

A standard Pre-Treatment Cost Estimate 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 Pre-Treatment Cost Estimate. Once the additional information is available your Dentist should submit a new request for a Pre-Treatment Cost Estimate to DDWA.

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

## Urgent Pre-Treatment Cost Estimate Requests

Should a Pre-Treatment Cost Estimate 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 Pre-Treatment Cost Estimate 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

If your claim or Pre-Treatment Cost Estimate has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an Appeal. An appeal is a request for DDWA to reconsider the prior determination, and your opportunity to provide us with any additional comments or information you would like us to consider. The Appeals process includes two levels of review, informal and formal. An informal review of your Appeal is when DDWA staff evaluates the claim and the terms of your Plan to determine if the claim processed consistently with the terms of your Plan. A formal review of your Appeal is when our Appeals Committee evaluates your claim, the terms of your Plan, any existing or new information, all correspondence and communications between you and DDWA, and any clinical considerations in order to determine if a claim processed consistently with the terms of your plan.

## How to contact us

We will accept notice of an Appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us via email at memberappeals@deltadentalwa.com, by mail at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may also contact us by telephone at 1-800-537-3406 for assistance submitting an Appeal, or for more information. When submitting an Appeal, you may include any written comments, documents, or other information that you believe supports your claim.

## Authorized Representative

You may authorize another person to represent you or your dependent and receive communications from DDWA regarding you or your dependent's specific Appeal. The authorization must be in writing and signed by you. If an Appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The Appeal process will not commence until this form, or appropriate written authorization in another format, 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

Your first step in the Appeal process is to request an informal review of the decision. Either you, or your authorized representative (see the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your EOB form). A request for a review may be made orally or in writing and must include the following information:

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

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

## Formal Review

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

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

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

The decision of the Appeals Committee is final. If you disagree with this the outcome of your appeal and you have exhausted the appeals process provided by the Uniform Dental Plan, there may be other avenues available for further action, including legal action brought on your behalf. If so, these will be provided to you in the final decision letter.

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

## 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 is committed to protecting the privacy of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).You may obtain a copy of our Notice of Privacy Practices, which describes how your information may be used and disclosed and how you can access your information, by visiting www.DeltaDentalWA.com, or by calling 800-554-1907.

## Nondiscrimination and Language Assistance Services

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

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

Delta Dental of Washington:

Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language assistance services to 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: 1(800)554-1907.

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 and Privacy Officer/1557 Coordinator 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.

| Notice of Availability of Language Services |
|---|
| **Amharic**<br>እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ። |
| **Arabic**<br>إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907. |
| **Cambodian (Mon-Khmer)**<br>ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 800-554-1907។ |
| **Chinese**<br>如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。 |
| **Cushite (Oromo)**<br>Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili. |
| **French**<br>Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907. |

| Notice of Availability of Language Services |
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| **German**<br>Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an. |
| **Japanese**<br>ご本人様、またはお客様の身寄りの方でもDelta Dental of Washingtonについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907までお電話ください。 |
| **Korean**<br>귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907로 전화하십시오. |
| **Laotian**<br>ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907. |
| **Persian (Farsi)**<br>اگر شما، یا شخصی که به وی کمک می‌کنید، سؤالی درباره‌ی Delta Dental of Washington دارد، این حق را دارید که اطلاعات مورد نیازتان را به زبان تماس بگیرید. 800-554-1907 جهت صحبت با یک مترجم شفاهی، با شماره خود و بدون هیچ هزینه‌ای دریافت کنید. |
| **Punjabi**<br>ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ। |
| **Romanian**<br>Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907. |
| **Russian**<br>Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907. |
| **Serbo-Croatian**<br>Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem. |
| **Spanish**<br>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)**<br>To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde moɗon mere. Ngam wolwugo be lornowo, ewne 800-554-1907. |
| **Tagalog**<br>Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907. |
| **Ukrainian**<br>Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907. |
| **Vietnamese**<br>Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907. |

Delta Dental of Washington

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