Uniform Dental Plan 2024

Washington Public Employees and Retirees

Uniform Dental Plan

A Preferred Provider Plan (PPO) for your dental insurance, self-insured by the State of Washington

2024

Administered by:

DELTA DENTAL®

Delta Dental of Washington

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Published under the direction of the Washington State Health Care Authority

SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by the Washington State Health Care Authority. The 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 Confirmation of Treatment and Cost requirements, service area restrictions and benefit limitations. If provisions within this booklet are inconsistent with any federal or state statute or rules, the language of the statute or rule will have precedence over that contained in this publication.

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

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To obtain this publication in alternative format such as Braille or audio, call 1-800-200-1004.

UNIFORM DENTAL PLAN

Self-Insured by the State of Washington

FOR BENEFITS AVAILABLE BEGINNING JANUARY 1, 2024

Administered by
Delta Dental of Washington
P.O. Box 75983
Seattle, Washington 98175-0983
1-800-537-3406

Questions Regarding Your Plan

If you have questions regarding your dental benefits plan, you may call:

Delta Dental of Washington Customer Service 1-800-537-3406

Written inquiries may be sent to:

Delta Dental of Washington
Customer Service Department
P.O. Box 75983
Seattle, WA 98175-0983

You can also email us at CService@DeltaDentalWA.com .

Finding a Delta Dental PPO Network Dentist

You can find the most current listing of participating PPO dentists by going online to DeltaDentalWA.com.

When you use the online directory, please be sure to search using the Delta Dental PPO network. If you call your dentist's office to check if they are in network, please tell them you are a Delta Dental PPO plan member.

With the Uniform Dental Plan (UDP), you get the best coverage and financial protection when you see a dentist who is part of the Delta Dental PPO network. Participating PPO network dentists can also save you time and money. That's because they submit claim forms directly to Delta Dental and agree to provide care at discounted fees.

If you choose to get care out-of-network, you're covered. You may get care from Delta Dental Premier® dentists, or from other non-network dentists. Plan benefits are usually lower compared to in-network PPO dentists and you may need to have your dentist complete and sign a claim form. Please remember, non-contracted, out-of-network dentists may bill you for charges in excess of the Uniform Dental Plan's allowed payments.

Manage your benefits online

Healthy smiles start by getting the most of your dental benefits and we've got the tools to help you. The MySmile® Personal Benefits Center and Delta Dental Mobile App give you the information you need to understand and manage dental benefits for you and your family.

Both tools allow you to securely check your coverage, view claim status, monitor dental activity, find a dentist, and get ID cards. MySmile is our most comprehensive tool. It also helps you compare dental costs and choose personal profile features like earth-friendly, paperless Explanations of Benefits. The Delta Dental mobile app puts key information at your fingertips when you're on the go.

Your online account allows you to access MySmile with a single username and password. Register for MySmile at DeltaDentalWA.com.

Certificate of Coverage

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Welcome to the Uniform Dental Plan and Delta Dental of Washington (DDWA).

Delta Dental of Washington began providing dental benefits coverage in 1954 and has been providing coverage to state of Washington employees through the Uniform Dental Plan since 1988. DDWA is now the largest dental benefits provider in Washington State, serving approximately 2 million people nationwide.

In 1994, the Uniform Dental Plan introduced the DDWA preferred provider (PPO) program. This program continues to provide enrollees with the freedom to choose any dentist, and it gives subscribers the opportunity to receive a higher level of coverage by receiving treatment from those dentists who participate in the Uniform Dental Plan (DDWA's Delta Dental PPO plan). Today, more than 60 percent of the dentists in Washington participate in the Delta Dental PPO program.

Delta Dental of Washington works closely with the dental profession to design dental plans that promote high-quality treatment along the most cost-effective path. As any dental care professional will attest, the key to having good oral health and avoiding dental problems is prevention. The Uniform Dental Plan and all DDWA programs are structured to encourage regular dental visits and early treatment of dental problems before they become more costly.

Delta Dental of Washington is committed to providing the highest quality customer service to all enrollees. DDWA's dedicated customer service representatives are available toll-free to enrollees from 7 a.m. to 5 p.m., Monday through Friday. You can also access information through our automated inquiry system with a touch-tone phone by entering your Social Security number or Member ID number, as applicable.

Thank you for enrolling in the Uniform Dental Plan. We are happy to be serving 283,000 enrollees.

To obtain services, inform your dentist that you are covered by the Uniform Dental Plan, DDWA program number **03000**.

Retiree Participation

Retirees and eligible survivors enrolled in retiree coverage must be enrolled in a medical plan to enroll in the dental plan. If they enroll in the medical and dental plans, any eligible dependents they elect to enroll must also enroll under both plans.

Terms Used in This Booklet

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

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 DDWA 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 DDWA 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.

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

Coinsurance — DDWA will pay a predetermined percentage of the cost of your treatment (see Reimbursement Levels for Allowable Benefits under the Benefit Levels for Uniform Dental Plan) and you are responsible for paying the balance. What you pay is called the coinsurance. It is paid even after a deductible is reached.

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.

DDWA — Delta Dental of Washington, a not-for-profit dental service corporation.

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, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

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

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

Dependent — Eligible dependent as described in the dependent eligibility section of this certificate who is covered under the subscriber.

Eligible Dependent — Any dependent of an Eligible Subscriber who meets the conditions of eligibility established by Group as described in the eligibility section of this certificate.

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.

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

Enrollee — The subscriber or dependent enrolled in this plan.

Experimental or Investigative — A service or supply that is determined by the Uniform Dental Plan 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 the Uniform Dental Plan, if enrollees send a written request.

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

Group — The employer or entity that is contracting for dental benefits for its subscribers and their dependents.

HCA — The 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 or her license. Licensed professional includes, but is not limited to, denturist, hygienist and radiology technician.

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

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." UDP may choose to cover interventions, supplies, or services that do not meet this definition of "dental necessity"; however, UDP 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 UDP'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.

Not a paid covered benefit — Any dental procedure which, under some circumstances, would be covered by DDWA but is not covered under other conditions, examples of which are listed in Benefits Covered by Your Plan.

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

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

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.

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

Plan or UDP — The Uniform Dental Plan. In the eligibility sections “plan” may mean a plan other than the Uniform Dental Plan not sponsored by the PEBB Program

Plan Designated Facility or Provider — Administered by Delta Dental of Washington.

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

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.

Resin-based Composite — Tooth-colored filling, made of a combination of materials, used to restore teeth.

Retired Employee of a Former Employer Group — includes a retired employee from a PEBB employer group and a retired school employee from a SEBB employer group who is continuing enrollment in PEBB health plan coverage by self-paying premiums 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 and eligible dependents.

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 employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.

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

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.

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.

Choosing a Dentist

Once you choose a dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your group and your member identification number. You may obtain your group information and your member identification number by calling our customer service number at 800-554-1907 or through our website at www.DeltaDentalWA.com. Delta Dental of Washington uses a randomly selected identification number or universal identifiers to ensure the privacy of your information and to help protect against identify theft. Please note that ID cards are not required to see your dentist, but are provided for your convenience.

Delta Dental Participating Dentists

Delta Dental Participating Dentists have agreed to provide treatment for enrolled persons covered by DDWA plans. Just tell your dentist that you are covered by a DDWA dental Plan and provide your identification number,

the Plan name and the group number. You will not have to hassle with sending in claim forms. Participating dentists complete claim forms and submit them directly to DDWA. They receive payment directly from DDWA.

You will be responsible only for stated coinsurances, deductibles, any amount over the Plan maximum, and for any elective care you choose to receive outside the covered dental benefits. You will not be charged more than the participating dentist's approved fee or the fee that the Delta Dental dentist has filed with us.

There are two categories of Participating Dentists that you may choose: a Delta Dental Premier® Dentist or a Delta Dental PPO Dentist. If you select a dentist who is a Delta Dental PPO Dentist, your benefits will likely be paid at the highest level and your out-of-pocket expenses may be lower.

Delta Dental Premier® Dentists

Delta Dental Premier® dentists have contracted with DDWA to provide you with covered dental benefits at an agreed upon maximum allowable fee.

Delta Dental PPO Dentists

PPO dentists have contracted to receive payment based on their PPO-filed fees at the percentage levels listed on your Plan for PPO dentists, which are often lower than the Delta Dental Premier® maximum allowable fees. Patients are responsible only for percentage coinsurance up to the PPO filed fees.

Nonparticipating Dentists

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

Payment by DDWA to nonparticipating dentist for services will be based on the dentist's actual charges or DDWA's maximum allowable fees for nonparticipating dentists, whichever is less. You will be responsible for paying any balance remaining to the dentist. Please be aware that DDWA has no control over nonparticipating dentists' charges or billing practices.

Out-of-State Dentists

If you receive treatment from a Non-Participating Dentist outside of the state Washington your coinsurance amounts will be based on the coinsurance percentage established for a Delta Dental PPO Dentist. Allowable amounts paid for covered services will be based on the maximum allowable fee for a Participating Dentist in that state, or their actual fee, whichever is less.

Service Area

The Uniform Dental Plan preferred provider organization (PPO) service area is all of Washington state. If enrollees need assistance in locating PPO providers in their areas, they should contact the plan.

The out-of-PPO service area is any location outside of Washington state. If enrollees are treated by out-of-state dentists, they will be responsible for having the dentists complete and sign claim forms. It will also be up to them to ensure that the claims are sent to DDWA. For covered services, the plan will pay either the dentists' actual charges or the maximum allowable fee normally paid to Delta Dental participating dentists for the same services, whichever is less.

Uniform Dental Plan Providers

Delta Dental of Washington has participating dentist contracts with nearly 3,400 licensed dentists in the state of Washington.

Under the Uniform Dental Plan, enrollees have the option of seeking care from any licensed dentist, whether or not the dentist is a member of Delta Dental. However, their benefits may be paid at a higher level and their out-of-pocket costs will likely be lower if they see Delta Dental participating PPO dentists. This is because participating PPO dentists agree to provide care based on a lower average fee schedule.

Participating dentists submit claim forms to DDWA and receive payments directly from DDWA. Enrollees are responsible only for stated deductibles, copayments and/or amounts in excess of the program maximum.

More than 60% of Delta Dental participating dentists participate in the Uniform Dental Plan/Delta Dental PPO network. Enrollees are not required to choose a dentist at enrollment and are free to choose a different dentist each time they seek treatment.

If enrollees need assistance locating PPO dentists in their areas, or have questions about benefits or payment of claims, they should call the Uniform Dental Plan customer service team at (800) 537-3406. Customer service representatives are available weekdays from 8 a.m. to 5 p.m., Monday through Friday. In addition you can obtain a current list of Delta Dental dentists by going to our website at www.DeltaDentalWa.com. This will bring up the DDWA Find a Dentist directory. Be sure to click on the Delta Dental PPO plan and follow the prompts.

Enrollees may also seek treatment from Delta Dental Premier® dentists, who are members of Delta Dental's traditional fee-for-service plan. Their payments, however, are likely to be higher than if they see PPO dentists. Delta Dental Premier® dentists also submit claims forms and receive payments directly from DDWA. Enrollees are responsible only for stated deductibles, copayments and/or amounts in excess of the program maximum.

Nonparticipating dentists have not contracted with Delta Dental. Payment for services performed by a nonparticipating dentist is based upon enrollees' dentist's actual charges or Delta Dental's maximum allowable fees for nonparticipating dentists, whichever is less. If the enrollee sees a nonparticipating dentist, they will be responsible for having the dentist complete and sign claim forms. It will also be up to the enrollee to ensure that the claims are sent to DDWA.

Deductible

Your program has a $50 deductible per eligible person each benefit period. This means that from the first payment or payments DDWA makes for covered dental benefits, a deduction of $50 is made. This deduction is owed to the provider by you. Once each eligible person has satisfied the deductible during the benefit period, no further deduction will be taken for that eligible person until the next benefit period. The maximum deductible for all members of a family (Enrolled Subscriber and one or more Enrolled Dependents) each benefit period is three times the individual deductible, or $150. This means that the maximum amount that will be deducted for all members of a family during a benefit period, regardless of the number of eligible persons, will not exceed $150. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period. The deductible does not apply to Class I covered dental benefits or Orthodontic Benefits.

Maximum Annual Plan Payment

For your program, the maximum amount payable by DDWA/Delta Dental for Class I, II and III covered dental benefits per eligible person is $1,750 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

Lifetime Benefit Maximums

The lifetime maximum amounts payable per eligible person for covered dental benefits are:

1. Orthodontia: $1,750
2. Temporomandibular joint (TMJ) treatment: $500
3. Orthognathic surgery: $5,000

Specialty Services

Specialty treatment is a covered benefit under the Uniform Dental Plan. As with all dental treatment, enrollees will receive a higher level of benefits if they obtain treatment from a PPO dentist. Enrollees may want to ask their dentists to refer them to PPO specialists in the event they need specialty care. PPO specialists are listed in the Uniform Dental Plan provider directory, or enrollees may contact the Uniform Dental Plan customer service team at (800) 537-3406.

Benefit Levels for Uniform Dental Plan

Services	PPO Dentists in Washington State	Out of State	Non-PPO Dentist in Washington State
Diagnostic/preventive	100%	90%	80%
Restorative fillings	80%	80%	70%
Oral surgery	80%	80%	70%
Periodontic services	80%	80%	70%
Endodontic services	80%	80%	70%
Restorative crowns	50%	50%	40%
Prosthodontic (dentures and bridges)	50%	50%	40%
Orthodontic (to lifetime maximum plan payment of $1,750)	50%	50%	50%
Non-surgical TMJ (to lifetime maximum plan payment of $500)	70%	70%	70%
Orthognathic (to lifetime maximum plan payment of $5,000)	70%	70%	70%

Emergency Care

Emergency care is defined as treatment for relief of pain resulting from an unexpected condition that requires immediate dental treatment. Enrollees should first contact their dentists. If the enrollee's PPO dentist is not available, they should call the Uniform Dental Plan customer service team at (800) 537-3406. DDWA will find a PPO dentist who can treat the enrollee or will approve treatment from a non-PPO dentist and will pay benefits at the PPO benefit level. If an emergency occurs after regular office hours, enrollees should first contact their PPO dentists. If the enrollee's dentist is not available, enrollees may seek treatment from any dentist for pain relief. If a PPO dentist is not available, the enrollee's claim from a non-PPO dentist will be paid at the PPO benefit level. Emergency care treatment involving Restorative Fillings are not subject to the frequency limitations stated in the "Class II Restoration" section of this booklet.

Claims for emergency treatment received by a non-PPO dentist when the enrollee's regular PPO dentist is not available must be sent with a written explanation to:

Send your claim to:

Delta Dental of Washington
Customer Service
Post Office Box 75983
Seattle, WA 98175-0983

Emergencies outside the PPO service area are paid as any other treatment received outside the service area.

Confirmation of Treatment and Cost

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, sometimes called a “Confirmation of Treatment and Cost.” This will allow you to know in advance what procedures may be covered, the amount DDWA may pay and your expected financial responsibility.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the request is made and is not a guarantee of payment.

A Confirmation of Treatment and Cost is valid for 6 months but in the event your benefits are terminated and you are no longer eligible, the Confirmation of Treatment and Cost is voided. DDWA will make payments based on your available benefits (maximum, deductible and other limitations as described in your benefits booklet) and the current plan provisions when the treatment is provided.

Second Opinion

To determine covered benefits for certain treatments, the Uniform Dental Plan may require a patient to obtain a second opinion from a DDWA-appointed consultant. The Uniform Dental Plan will pay 100% of the charges incurred for the second opinion.

Covered Dental Benefits, Limitations and Exclusions

The following covered dental benefits are subject to the limitations and exclusions contained in this booklet. Such benefits (as defined) are available only when rendered by a licensed dentist or other DDWA-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA. Claims for services must be submitted within 12 months of the completion of treatment.

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

The amounts payable by DDWA for covered dental benefits are described in the Benefit Levels for Uniform Dental Plan section of this benefit booklet.

Class I Benefits

Class I Diagnostic Services

Covered Dental Benefits

- Comprehensive, or detailed and extensive oral evaluation
- Diagnostic evaluation for routine or emergency purposes
- X-rays

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient’s lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.

- A Comprehensive Series or a panoramic X-ray is covered once in a five-year period from the date of service.
  - Any number or combination of X-rays, with the exception of a Panoramic X-ray, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a Comprehensive Series, will be considered a Comprehensive Series for payment and benefit limitation purposes.
- A set of Bitewing X-rays (two or more images) are covered once in a benefit period.
  - A single Bitewing X-ray is covered, there are no Limitations on the number of single Bitewing X-rays a patient can have.

Exclusions

- Consultations – diagnostic service provided by a dentist other than the requesting dentist
- Study models
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a Class I paid covered benefit.

Class I Preventive Services

Covered Dental Benefits

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

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a calendar year (refer to Class II Periodontics for additional limitation information).
  - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- For any combination of adult prophylaxis (cleaning) and periodontal maintenance, third and fourth occurrences may be covered if your gums have Pocket depth readings of 5mm or greater.*

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

- Topical application of fluoride is limited to two covered procedures in a benefit period.
- Sealants:
  - Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
  - The application of a sealant is a covered dental benefit once in a three-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 17.

- Preventive resin restorations:
  - Benefit coverage for application of sealants is limited to permanent molars that have no restorations on the occlusal (biting) surface.
  - The application of a preventive resin restoration is a covered dental benefit once in a three-year period per tooth from the date of service.
  - The application of a preventive resin restoration is not a paid covered benefit for three years after a sealant or preventive resin restoration on the same tooth from the date of service.
- The application of caries arresting medicament is a Covered Dental Benefit twice per benefit period per tooth.

Exclusions

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

Class I Periodontics

Covered Dental Benefits

- Prescription-strength fluoride toothpaste
- Prescription-strength antimicrobial rinses.

Limitations

- Prescription-strength fluoride toothpaste and Prescription-strength antimicrobial rinse are covered dental benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's history with DDWA must show a periodontal procedure within the previous 180 days.
- Prescription-strength antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- Prescription-strength antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

****Refer Also To General Limitations and Exclusions****

Class II Benefits

Note: The subscriber should consult the provider regarding any charges that may be the patient's responsibility before treatment begins.

Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment will be covered. See the "Confirmation of Treatment and Cost" section for additional information

Class II Sedation

Covered Dental Benefits

- General anesthesia
- Intravenous sedation

Limitations

- General anesthesia is a Covered Dental Benefit only in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III, TMJ or Orthodontic Covered Dental Benefits.*

- Intravenous sedation is covered in conjunction with covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.
- Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- Sedation, which is either general anesthesia or intravenous sedation, is a Covered Dental Benefit only once per day.

Exclusions

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

Class II Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain

Limitations

- Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.
- Palliative treatment is not a paid covered benefit when the same provider performs any other definitive treatment on the same date

Class II Restorative

Covered Dental Benefits

- Restorations (fillings)
- Stainless steel crowns or prefabricated crowns
- Refer to "*Class III Restorative"* if teeth are restored with crowns, inlays, veneers, or onlays.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Stainless steel crowns or prefabricated crowns are covered once in a two-year period from the seat date.
- Restorations placed on the same tooth within two months of the application of Caries arresting medicament are Not a Paid Covered Dental Benefit.

Exclusions

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

Please also see:

- Refer to “Class III Restorative” for more information regarding coverage for crowns (other than stainless steel), inlays, veneers or onlays.

**Limitations for Restorative fillings do not apply to treatment received due to an emergent care situation. Please refer to the “Emergency Care” section for more information.*

Class II Oral Surgery

Covered Dental Benefits

- **Major and minor oral surgery which includes the following general categories:**
  - Removal of teeth
  - Preprosthetic surgery
  - Treatment of pathological conditions
  - Traumatic facial injuries
  - Ridge extension for insertion of dentures (vestibuloplasty)
- Refer to *“Class II Sedation”* for Sedation information.

Exclusions

- Iliac crest or rib grafts to alveolar ridges
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Class II Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Services covered include:
  - Periodontal scaling/root planing
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or fewer)
  - Localized delivery of antimicrobial agents
  - Gingivectomy

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

Limitations

- Periodontal scaling/root planing is covered once per quadrant in a 36-month period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
  - Periodontal surgery must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- Soft tissue grafts (two sites per quadrant) are covered once in a three-year period from the date of service.
- Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions of oral health, such as periodontal Pocket depth readings of 5mm or greater.*

- When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
- When covered, localized delivery of antimicrobial agents must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.

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

Class II Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy
- Refer to *"Class II Sedation"* for Sedation information.

Limitations

- Re-treatment of the same tooth is Not a Paid Covered Dental Benefit when performed within two years of the previous root canal treatment.
- Refer to Class III Prosthodontics if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions

- Bleaching of teeth

****Refer Also To General Limitations and Exclusions****

Class III Benefits

Note*: The subscriber should consult the provider regarding any charges that may be the patient's responsibility before treatment begins.*

Note*: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment will be covered.*

Class III Periodontic Services

Covered Dental Benefits

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard
  - Complete occlusal equilibration

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

Limitations

- Occlusal guard (nightguard) is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Class III Restorative Services

Covered Dental Benefits

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- Crown buildups
- Post and core on endodontically treated teeth
- Implant-supported crown

Limitations

- A crown, veneer or onlay on the same tooth is covered once in a five-year period from the seat date.
- An implant-supported crown on the same tooth is covered once in a five-year period from the original seat date of a previous crown on that same tooth.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any cost difference in cost being the responsibility of the enrolled person, once in a two-year period from the seat date.
- Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- A crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
- A crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- A crown buildup or a post and core are covered once in a five-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within two years of a restoration on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.

Exclusions

- Copings
- A core buildup is not billable with placement of an onlay, 3/4 crown, or veneer.
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations.

Class III Prosthodontics

Covered Dental Benefits

- Dentures

- Fixed partial dentures (fixed bridges)
- Removable partial dentures
- Inlays when used as a retainer for a fixed partial denture (fixed bridge)
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing fixed or removable partial denture is covered once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Payment for dentures, fixed partial dentures (fixed bridges); inlays (only when used as a retainer for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Implants and superstructures are covered once every five years.
- **Temporary dentures** — DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Denture adjustments and relines —** Denture adjustments and relines, done more than six months after the initial placement are covered.
    - Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance
- Copings
- Crowns in conjunction with overdentures

Orthodontic Benefits

It is strongly suggested that orthodontic treatment plan be submitted to, and a Confirmation of Treatment and Cost request be made by, DDWA prior to commencement of treatment. This will allow you to know in advance what procedures may be covered, the amount DDWA may pay toward the treatment and your expected financial responsibility. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information. Additionally, payment for orthodontia is based upon eligibility. If individuals terminate coverage prior to the subsequent payment of benefits, subsequent payment is not covered.

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

The lifetime maximum amount payable for orthodontic benefits rendered to an eligible person is $1,750. Not more than $875 of the maximum, or one-half of the plan's total responsibility, shall be payable for treatment during the "construction phase."

The remaining plan payments shall be made in monthly increments until completion, up to the plan maximum, providing the employee is eligible and the dependent meets eligibility requirements. The plan will not pay for treatment if claim forms are submitted more than 12 months after banding date.

The amount payable for orthodontic treatment shall be 50 percent of the lesser of the maximum allowable fees or the fees actually charged.

Covered Dental Benefits

- Fixed or removable appliance therapy for the treatment of teeth or jaws.

— Orthodontic records: exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

— Payment is limited to:
  - Completion of the treatment plan, or any treatment that is completed through the plan's limiting age for Orthodontics (refer to *"Dependent Eligibility and Termination"*), whichever occur first.
  - Treatment received after coverage begins (claims must be submitted to DDWA within the time limitation stated in the Claim Forms Section of the start of coverage). For orthodontia claims, the initial banding date, which is the date the treatment date considered in the timely filing.

— Treatment that began prior to the start of coverage will be prorated. Allowable payment will be calculated based on the balance of treatment costs remaining on the date of eligibility.

— In the event of termination of the treatment Plan prior to completion of the case or termination of this plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

— Charges for replacement or repair of an appliance

— Direct-to-consumer Orthodontics

— No benefits shall be provided for services considered inappropriate and unnecessary, as determined by DDWA.

****Refer Also To General Limitations and Exclusions****

General Exclusions

In addition to the specific exclusions and limitations stated elsewhere in this booklet, Uniform Dental Plan (UDP) does not provide benefits for:

1. Dentistry for cosmetic reasons.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
3. Services or supplies that the Uniform Dental Plan determines are experimental or investigative. 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.
4. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as premedication and nitrous oxide.
5. Laboratory tests and laboratory exams.
6. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. 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 a Confirmation of Treatment and Cost of dental treatment performed at a hospital is submitted to and approved by DDWA. Such request for Confirmation of Treatment and Costs must be accompanied by a physician's statement of medical 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.
7. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.

8. Services for accidental injury to natural teeth when evaluation of treatment and development of a written plan is performed more than 30 days from the date of injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified.
9. Expenses incurred after termination of coverage, except expenses for:
    a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
    b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
    c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
10. Missed appointments.
11. Completing insurance forms or reports, or for providing records.
12. Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), except as specified under the orthodontia benefit.
13. Full-mouth restoration or replacement of sound fillings. (Replacement of sound fillings will not be covered unless at the recommendation of a licensed dentist, and a Confirmation of Treatment and Cost is required.)
14. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, denturist or physician, as specified.
15. Services or supplies that are not listed as covered.
16. Treatment of congenital deformity or malformations.
17. Replacement of lost or broken dentures or other appliances.
18. Services for which an enrollee has contractual right to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowners or other no-fault insurance.
19. In the event an Eligible Person fails to obtain a required examination from a DDWA-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.

Delta Dental of Washington shall determine whether services are covered dental benefits in accordance with standard dental practice and the general limitations and exclusions shown in the Contract. Should there be a disagreement regarding the interpretation of such benefits; the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this contract and may seek judicial review of any denial of coverage of benefits.

Dental Plan Eligibility and Enrollment

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

Eligibility for subscribers and dependents

Employee eligibility

The employee’s state agency will inform the employee in writing whether or not 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 continuation coverage (COBRA or Unpaid Leave) upon receipt of a *PEBB Continuation Coverage (COBRA) Election/Change* or *PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. If the subscriber requests to enroll in and is not eligible for continuation coverage, 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 a completed *PEBB Retiree Election Form (form A)*. 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 upon receipt of a completed *PEBB Retiree Election Form (form A)*. 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 condition of their enrollment in a PEBB retiree health plan. A retiree or survivor must provide a copy of their or their dependent's Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B effective dates to the PEBB Program as proof of enrollment in Medicare. If a 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 provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

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 dental coverage will be enrolled in the same dental plan as the subscriber.

Employee enrollment

An employee is required to enroll in a dental plan unless otherwise described in PEBB Program rules.

An employee must 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 forms must be received by their employing agency no later than 31 days after the date the employee becomes eligible or regains eligibility.

If the employee does not 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."

Continuation coverage enrollment

A continuation coverage subscriber 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) may enroll by submitting the applicable *PEBB Continuation Coverage Election/Change* form and any supporting documents to the PEBB Program. 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.

Premiums and applicable premium surcharges 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.*

Retiree and survivor enrollment

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 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 employee’s or the school employee’s 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 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 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 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 an employee or school employee 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 later of the date of the employee’s or the school employee’s death, or the date the survivor’s PEBB insurance coverage, educational service district 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 submit a *PEBB Retiree Election* Form *(form A*) along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. They 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 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 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 who deferred enrollment and is enrolling in a PEBB retiree health plan, must submit a *PEBB Retiree Election Form (form A)* along with any other required forms, supporting documents, and evidence of continuous enrollment to the PEBB Program. They must be received no later than 60 days after a loss of other qualifying coverage. 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 a dental plan under PEBB retiree insurance coverage, any dependents enrolled on the retiree or survivor’s account will also be enrolled in dental coverage.

If a subscriber chooses to enroll an eligible dependent, the subscriber must include the dependent’s information 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.

Medicare eligibility and enrollment

Employee and dependent

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

Continuation coverage subscriber and dependent

If a continuation coverage subscriber or their dependent becomes eligible for Medicare, federal regulations allow enrollment in Medicare three months before they turn age 65. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first eligible, a late enrollment penalty may apply.

Retiree or survivor and dependent

If a retiree, a survivor, or their enrolled dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about Medicare enrollment. The Medicare eligible subscriber or their dependent must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage. If this procedural requirement is not met, eligibility 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.

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 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 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 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 who deferred enrollment 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.

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, educational service district 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 who deferred enrollment 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.

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 plan 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 later of the event date or the date the required form is received. 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 notify their employing agency.
- **A retiree, a survivor, or continuation coverage subscriber** must notify the PEBB Program.

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

- The dependent may lose eligibility to continue PEBB dental coverage 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, or a continuation coverage subscriber

A retiree, a survivor, or a continuation coverage subscriber may voluntarily terminate enrollment in a dental plan at any time by submitting a request in writing to the PEBB Program. Enrollment in the dental plan will be terminated the last day of the month in which the PEBB Program receives the request 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 a dental plan 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 and if 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 in PEBB My Account or return the required *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency. The change must be completed in PEBB My Account or the forms received no later than the last day of the annual open enrollment period and will be effective January 1 of the following year.

A retiree, a survivor, or continuation coverage 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

A retiree, a survivor or continuation coverage subscriber must submit the election change online in PEBB My Account or return the required *PEBB Retiree Change Form (form A-OE), PEBB Continuation Coverage (COBRA)*

Election/Change, or *PEBB Continuation Coverage (Unpaid Leave) Election/Change* form (as appropriate) and any supporting documents to the PEBB Program. The change must be completed in PEBB My Account or the forms received no later than the last day of the annual open enrollment period and will be effective January 1 of the following year.

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. The subscriber must provide evidence of the event that created the special open enrollment.

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 submit the required *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency.
- **A retiree, a survivor, or continuation coverage subscriber** must submit the required *PEBB Retiree Change Form (form E), PEBB Continuation Coverage (COBRA) Election/Change,* or *PEBB Continuation Coverage (Unpaid Leave) Election/Change* form (as appropriate) and any supporting documents to the PEBB Program.

The forms must be received no later than 60 days after the event that creates the special open enrollment. 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.

Note: 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 in PEBB health plan coverage, the subscriber should 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 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 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 moves and their current health plan is not available in the new location, the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services. A dental plan is considered available if a provider is located within 50 miles of the subscriber's new residence.
- 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 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'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

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.

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 for which employee premiums were deducted.

- **For a retiree, a survivor, or continuation coverage subscriber** who submits a written request to terminate dental coverage, enrollment in dental coverage will be terminated the last day of the month in which the PEBB Program receives the request 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.

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.

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.

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

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*.

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.

PEBB retiree insurance coverage

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

Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB 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 to maintain eligibility.

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 to maintain eligibility.

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 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.

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 the Uniform Dental Plan 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.

Third Party Liability

(Subrogation/Reimbursement)

Benefits of the Uniform Dental Plan will be available to an enrollee who is injured or becomes ill because of a third party's action or omission. The Uniform Dental Plan shall be subrogated to the rights of the enrollee against any third party liable for the illness or injury. Subrogation means that the Uniform Dental Plan (1) shall be entitled to reimbursement from any recovery by the enrollee from the liable third party, and (2) shall have the right to pursue claims for damages from the party liable for the injury or illness. The Uniform Dental Plan's subrogation rights shall extend to the full amount of benefits paid by the Uniform Dental Plan for such an illness or injury. As a condition of receiving benefits for such an illness or injury, the enrollee, and their representatives, shall cooperate fully with the Uniform Dental Plan in recovering the amounts it has paid including, but not limited to:

(a) providing information to the Uniform Dental Plan concerning the facts of the illness or injury and the identity and address of the third party or parties who may be liable for the illness or injury, their liability insurers, and their attorneys; (b) providing reasonable advance notice to the Uniform Dental Plan of any trial or other hearing, or any intended settlement, or a claim against any such third party; and (c) repaying the Uniform Dental Plan from the proceeds of any recovery from or on behalf of any such third party.

Enrollee's Obligation to Notify the Uniform Dental Plan

Enrollees must notify the Uniform Dental Plan of any claim or lawsuit for a condition or injury for which the Uniform Dental Plan paid benefits. This includes promptly notifying the Uniform Dental Plan in writing of all the following matters:

- The facts of the enrollee's condition or injury,
- Any changes in the enrollee's condition or injury,
- The name of any person responsible for the enrollee's condition or injury and that person's insurance carrier, and
- Advance notice of any settlement the enrollee intends to make of the action or claim.

Right of Recovery

If an enrollee brings a claim or lawsuit against another person, the enrollee must also seek recovery of any benefits paid under this plan; the Uniform Dental Plan reserves the right to join as a party in any lawsuit the enrollee brings. The Uniform Dental Plan may, however, assert a right to recover benefits directly from the other person or from the enrollee. If the Uniform Dental Plan does so, the enrollee does not need to take any action on behalf of the Uniform Dental Plan. The enrollee must, however, do nothing to impede the Uniform Dental Plan's right of recovery. Should the Uniform Dental Plan assert its right of recovery directly, it has the right to join the enrollee as a party in the action or claim.

If the enrollee obtains a settlement or recovery for less than the insurance policy limits or reachable assets of the liable party, the enrollee is obligated to reimburse the Uniform Dental Plan for the full amount of benefits paid on the enrollee's behalf. If, however, the enrollee obtains a settlement or recovery that is equal to or greater than the liable party's insurance policy limits or assets, the enrollee is only obligated to reimburse the Uniform Dental Plan in the amount that is left after the enrollee has been fully compensated.

Any person who is obligated to pay for services or supplies for which benefits have been paid by the Uniform Dental Plan must pay to the Uniform Dental Plan the amounts to which the Uniform Dental Plan is entitled.

Coordination/Non-Duplication of Benefits

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 UDP employs a coordination of benefits method known as non-duplication of benefits when it is secondary to another group plan. This means that when the UDP is secondary it will pay no more than the amount it would have paid if it were the primary plan, minus what the primary plan has paid.

The UDP will coordinate benefit payments with any other group dental plan or Workers' Compensation plan which covers the enrollee. Benefit payments will not be coordinated with any individual coverage the enrollee has purchased.

If the enrollee is covered by more than one group dental insurance plan, please submit claims to DDWA and the other carriers at the same time. This helps to coordinate benefits more quickly.

The plan that is to provide benefits first will do so for all the expenses allowed under its coverage. The other plan will then provide benefits for the remaining allowed expenses.

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 7contracts 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 highest *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 DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the plans 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 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 the highest of the 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 highest *Allowable Expense* of the *Primary Plan* or the *Secondary Plan*. 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 plans allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the *Primary Plan*, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all plans for the claim 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. You, to claim benefits under *This Plan* 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.

In the event DDWA makes payments in excess of the maximum amount, DDWA shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

The two examples that follow explain how non-duplication of benefits works:

Example 1: Assume a subscriber has satisfied the deductible on both the primary dental plan and the UDP. The individual receives services for a root canal (Class II benefit) that costs $350. The primary plan pays Class II benefits at 90% and would pay $315 ($350 x 90%). The UDP pays Class II services at 80% and would have paid $280 ($350 x 80%) if it were primary. As secondary payer, the UDP subtracts what the primary payer paid and pays the difference ($280 - $315 = $0 payment).

Example 2: Assume the primary plan pays 50% for Class II benefits. The primary plan would pay $175 ($350 x 50%) for the root canal described in Example 1. As secondary payer, the UDP would pay $105 ($280 - $175).

Claim Review and Appeal

Confirmation of Treatment and Cost

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

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

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

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

Urgent Confirmation of Treatment and Cost

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

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

Initial Benefit Determinations

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

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

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

Appeals of Denied Claims

Informal Review

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

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

Please submit your request for a review to memberappeals@deltadentalwa.com, or by mail to:

Delta Dental of Washington

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

For oral appeals, please call Uniform Dental Plan Customer Service Department at 1-800-537-3406.

You may include any written comments, documents or other information that you believe supports your claim.

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

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, DDWA will consult with a dental professional advisor.

Appeals Committee

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

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

The Appeal Committee will review your claim and make a determination within 60 days of receiving your request or within 20 days for Experimental/Investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, DDWA will consult with a dental professional advisor.

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.

Authorized Representative

An enrollee may authorize another person to represent them and with whom they want DDWA to communicate regarding specific claims or an appeal. The authorization must be in writing, signed by the enrollee, and include all the information required in an appeal. (An assignment of benefits, release of information, or other similar form that the enrollee may sign at the request of their health care provider does not make the provider an authorized representative.) The enrollee can revoke the authorized representative at any time, and enrollees can authorize only one person as their representative at a time.

Your Rights and Responsibilities

At DDWA our mission is to provide quality dental benefit products to employers and employees throughout Washington through a network of more than 3,400 participating dentists. We view our benefit packages as a partnership between DDWA, our subscribers and our participating members' dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You have the right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta member / non-member), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact DDWA customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com
- Appeal 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 your responsibility to:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 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 which you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to DDWA to assist with the processing of claims.
- If applicable, pay the dental office the appropriate co-payments 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, or family status.

HIPAA Disclosure Policy

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

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

Nondiscrimination and Language Assistance Services

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

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 800-554-1907.

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: 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, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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

Taglines
Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.
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Sudan (Fulfulde) 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.
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