Uniform Dental Plan 2025

Washington School Employees

Uniform Dental Plan

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

2025

Administered by:

DELTA DENTAL® Delta Dental of Washington

HCA | Health Care Authority
School 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, 2025

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 6 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.

To obtain services, inform your dentist that you are covered by the Uniform Dental Plan, DDWA program number **09600**.

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 SEBB 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 SEBB 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 SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or SEBB 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.

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.

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 SEBB 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.

School Board Member — means the board of directors of a school district as governed by chapter 28A.343 RCW or the board of directors of an educational service district as governed by chapter 28A.310 RCW who is self-paying for SEBB health plan coverage.

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.

Subscriber — Eligible school employee, school board member, or continuation coverage subscriber who has been determined eligible and is enrolled in this dental plan, and is the individual to whom the SEBB 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/sebb. 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 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.

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.

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.

Out-of-Country Coverage

Dentists who are located outside of the United States (this does not include US Territories – Guam, Puerto Rico, and the US Virgin Islands) are Non-Participating Dentists. If you receive treatment outside of the United States, you are responsible for ensuring either you or your Dentist completes and submits a claim form. We will accept an Out-of-Country claim form which can be downloaded from our website at www.DeltaDentalWA.com or obtained by calling us at 800-554-1907. You may submit the claim by email at outofcountry@deltadentalwa.com, by mail at the following address: Delta Dental of Washington, P.O. Box 75688, Seattle, WA 98175-0983, or by fax at 509-685-6599. When submitting the claim, you must include a copy of the payment receipt showing treatment has been paid. For more information, please call us at 800-554-1907.

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 4,500 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 6 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/sebb. 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.

Communication Access Assistance

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

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

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

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

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

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, and is waived for children under age 15.

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. Orthognathic surgery: $5,000

Temporomandibular Joint Benefits (TMJ) Maximum

The annual maximum amount payable by DDWA for covered dental services related to the treatment of TMJ disorders is $1,000, with a Lifetime Maximum amount payable of $5,000, for each covered person, after you have satisfied your Deductible (if applicable). The amounts payable for TMJ benefits during the Benefit Period shall not be applied to the covered person’s annual Plan Maximum.

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%
Crowns	70%	70%	60%

Prosthodontic (dentures and bridges)	50%	50%	40%
Orthodontic (to lifetime maximum plan payment of $1,750)	50%	50%	50%
Non-surgical TMJ (annual maximum plan payment $1,000 & lifetime maximum plan payment of $5,000)	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, periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation 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), periodontal maintenance, and scaling in presence of generalized moderate or severe gingival inflammation, 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).

Please also see:

- Refer to "Class II Periodontics" section for scaling in presence of generalized moderate or severe gingival inflammation.

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 enrollee 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
- Posterior composites
- 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
- Stainless steel crowns or prefabricated crowns are covered on all primary and permanent teeth 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 enrollee 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, “health plan” is used to refer to a plan offering medical, vision, dental, or any combination of these coverages developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility for subscribers and dependents

School employee eligibility

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

A school employee of an employer group (such as an employee organization representing school employees or a tribal school) that contracts with HCA for SEBB benefits should contact their payroll or benefits office for eligibility criteria.

School employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under “Appeal rights.”

Continuation coverage eligibility

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

School board member eligibility

The SEBB Program determines whether a school board member is eligible to self-pay coverage upon receipt of their election to enroll. If a school board member requests to enroll and is not eligible, the SEBB 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 SEBB 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 SEBB 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.

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

School employee enrollment

A school employee is required to enroll in SEBB dental unless otherwise described in SEBB Program rules.

A school employee must use Benefits 24/7, the online enrollment system, or submit a *School Employee Enrollment* form and any supporting documents to their SEBB organization or employer group when they become newly eligible or regain eligibility for SEBB benefits. The online enrollment must be completed or the form must be received no later than 31 days after the date the school employee becomes eligible or regains eligibility.

If the school employee does not enroll online or return the form by the deadline, the school employee will be enrolled in Uniform Dental Plan. Dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment that allows enrolling a dependent. See "Special open enrollment changes."

Continuation coverage enrollment

A subscriber enrolling in SEBB Continuation Coverage (COBRA or Unpaid Leave) may enroll by using Benefits 24/7, the online enrollment system, or by submitting the applicable *SEBB Continuation Coverage Election/Change* form and any supporting documents to the SEBB Program. The online enrollment must be completed or the SEBB Program must receive the election form no later than 60 days from the date the enrollee's SEBB health plan coverage ended or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program, whichever is later.

Premiums and applicable premium surcharges 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 SEBB dental coverage" and the *SEBB Continuation Coverage Election Notice*.

School board member enrollment

A school board member is required to enroll in SEBB dental.

A newly elected school board member may enroll and self-pay premiums by submitting the *SEBB School Board Member Election/Change* form and any supporting documents to the SEBB Program. The SEBB Program must receive the form no later than 60 days from the beginning of their elected or appointed term.

Premiums and applicable premium surcharges 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.

A school board member may renew their participation at the start of each subsequent term as a school board member. If a school board member is reelected for a new term consecutive from their previous term, they will not be required to make new elections.

Dependent enrollment

To enroll an eligible dependent, the subscriber must include the dependent's information using Benefits 24/7, the online enrollment system, or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program, the SEBB organization, or the employer group is unable to verify their eligibility within the SEBB Program enrollment timelines.

Dual enrollment

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

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

For example:

- A child who is an eligible dependent under two parents enrolled in SEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in SEBB dental.

- A child who is an eligible dependent of a school employee in the SEBB Program and an employee in the PEBB Program may only be enrolled as a dependent under one parent in either the SEBB or PEBB Program.

When dental coverage begins

School employees and dependents

For a newly eligible school employee and their eligible dependents, dental coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

- Dental coverage begins on the school employee's first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB organization.

- When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, dental coverage begins on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a school employee regaining eligibility, including following a period of leave as described in SEBB Program rules, and their eligible dependents, dental coverage begins the first day of the month following the school employee's return to work if the school employee is anticipated to be eligible for the employer contribution.

Note: When a school 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 SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Dental coverage begins the first day of the month in which the school employee returns from active duty.

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 SEBB dental.

School board members and dependents

For a newly elected or appointed school board member and their eligible dependents, dental coverage begins the first day of the month following the day the SEBB Program receives the required form.

All subscribers and dependents

For a subscriber or their eligible dependents enrolling during the SEBB 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 online enrollment election using Benefits 24/7 or 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 a school 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.

- **A school employee** must provide notice online using Benefits 24/7 or by submitting a written request to their SEBB organization or employer group.
- **Any other subscriber** must provide notice online using Benefits 24/7 or by submitting a written request to the SEBB 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 SEBB dental under one of the continuation coverage options described in “Options for continuing SEBB 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 continuation coverage subscribers or school board members

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

Note: A school board member must be enrolled in all SEBB health plan coverage, including SEBB medical, SEBB dental, and SEBB vision. A school board member who voluntarily terminates enrollment in SEBB dental also terminates all other health plan enrollment.

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

A school employee may make the following changes to their enrollment during the SEBB Program’s annual open enrollment period:

- Enroll or remove eligible dependents
- Change their dental plan

A school employee must submit the election change online using Benefits 24/7 or submit the required *School Employee Change* form and any supporting documents to their SEBB organization or employer group. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period. The change will be effective January 1 of the following year.

Any other subscriber may make the following changes to their enrollment during the SEBB Program’s annual open enrollment period:

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

They must submit the election change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage Election/Change* or *SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period. The change will be effective January 1 of the following year.

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 a school employee gaining initial eligibility or regaining eligibility for SEBB 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:

- **A school employee** must make the change online using Benefits 24/7 or submit the required *School Employee Change* form and any supporting documents to their SEBB organization or employer group.
- **Any other subscriber** must make the change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage Election/Change or SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program.

The change must be completed online, or the forms must be received, no later than 60 days after the event that creates the special open enrollment. In addition, the SEBB Program, the SEBB organization, or the employer group will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the subscriber should complete the request online or notify their SEBB organization, their employer group, or the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required forms must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

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

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

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

- Subscriber gains a new dependent due to:
- Marriage or registering a state-registered domestic partnership.
- Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber has a change in employment location that affects medical plan availability. If the subscriber changes employment locations and their current medical plan is no longer available, the subscriber must select a new medical plan as described in SEBB Program rules. If the subscriber has one or more new medical plans available, the subscriber may select to enroll in a newly available plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan as described in SEBB Program rules. If the subscriber or their dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber's or their dependent's new residence, the subscriber may select a new dental plan.

- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB 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. 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 SEBB Program determines that a continuity of care issue exists. The SEBB 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
- The SEBB Program determines that there has been a substantial decrease in the providers available under a SEBB medical plan.

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 SEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the SEBB 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 SEBB 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 SEBB 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. For a school board member this includes when their elected or appointed term ends.
- 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 SEBB dental plan.
- **For a school employee** and their dependents when the employment is terminated, dental coverage ends when:
    - The school employee resigns. If this is the case, dental coverage ends on the last day of the month in which a school employee's resignation is effective; or
    - The SEBB organization or employer group terminates the employment relationship. If this is the case, dental coverage ends on the last day of the month in which the employer-initiated termination is effective.

Note: If the SEBB organization or the employer group deducted the school employee's portion of the premium for SEBB insurance coverage after the school employee was no longer eligible for the employer contribution, dental coverage ends the last day of the month that school employee premiums were deducted.

- **For a continuation coverage subscriber or a school board member** who submits a request to terminate dental coverage, enrollment in dental coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 or by the SEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, dental coverage will be terminated on the last day of the previous month.
- **A SEBB Continuation Coverage (COBRA) subscriber** must notify the SEBB Program in writing within 30 days if, after electing SEBB Continuation Coverage (COBRA), a subscriber or their dependent becomes eligible for Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. If a subscriber or their dependent enrolls in SEBB Continuation Coverage (COBRA) and then becomes eligible for Medicare, their enrollment in SEBB Continuation Coverage (COBRA) will be terminated the last day of the month prior to the month their Medicare coverage begins. This may cause the SEBB Continuation Coverage (COBRA) to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. A subscriber or their dependents who are already enrolled in Medicare when they enroll in SEBB Continuation Coverage (COBRA) will not have their coverage terminated early.

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 SEBB dental coverage

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

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

- SEBB Continuation Coverage (COBRA)
- SEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

SEBB Continuation Coverage

The SEBB Program administers the following continuation coverage options that temporarily extend group insurance coverage when the enrollee's SEBB dental plan coverage ends due to a qualifying event:

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

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

Premium payments for SEBB 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 school employee or a dependent becoming eligible as a survivor is eligible to continue enrollment or defer enrollment in Public Employees Benefits Board (PEBB) insurance coverage if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional Continuation Coverage

Non-represented educational service district (ESD) school employees and their dependents may gain temporary eligibility for SEBB benefits, on a self-pay basis, if they meet the following criteria:

- A non-represented ESD school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB organization on December 31, 2023, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to continue existing enrollment in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months.
- A dependent of a SEBB eligible non-represented school employee of an ESD who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2023, who loses eligibility because they are not an eligible dependent may continue existing enrollment for a maximum of 36 months.
- A dependent of a non-represented school employee who is continuing medical, dental, or vision coverage through an ESD on December 31, 2023, may elect to continue existing enrollment to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program.

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the federal FMLA.

The SEBB organization or the employer group determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under FMLA, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the SEBB organization or the employer group. See "Options for continuing SEBB dental coverage."

Paid Family and Medical Leave Act

A school employee on approved leave under the Washington State Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward SEBB benefits.

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

If a school employee exhausts the period of leave approved under PFML, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the SEBB organization or the employer group. See “Options for continuing SEBB dental coverage.”

General provisions for eligibility and enrollment

Payment of premiums during a labor dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB organization or the employer group may pay premiums directly to HCA if the school 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 school employee’s compensation is suspended or terminated HCA will notify the school employee immediately (by mail at the last address of record) that the school employee may pay premiums as they become due.

If coverage is no longer available to the school employee under this certificate of coverage, then the school 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.

Appeal rights

Any current or former employee of a SEBB organization or their dependent may appeal a decision made by the SEBB organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB organization.

Any current or former school employee of an employer group that contracts with HCA for SEBB benefits, or their dependent may appeal a decision made by an employer group regarding SEBB eligibility, enrollment, or premium surcharges to the employer group.

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

Any enrollee may appeal a decision regarding the administration of a SEBB 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/sebb-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.

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 auxiliary 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 assistance 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 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.

Notice of Language Services
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 درباره‌یDelta 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.

Notice of Language Services
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.
Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.
Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.
Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde moɗon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.
Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.
Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.
Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.

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