Willamette Dental

HCA | Health Care Authority
Public Employees Benefits Board

Certificate of Coverage

Effective: January 1, 2027

Underwritten by Willamette Dental of Washington, Inc.
002-WAPEBB(1/27)

Willamette Dental

Welcome to Willamette Dental!

Please use the following contact information for questions or assistance. To schedule an appointment, contact our Appointment Center. Additionally, Willamette Dental has a full staff of member service representatives who will answer any question that you may have about your dental plan or service.

CONTACT INFORMATION

Appointments

1.855.433.6825

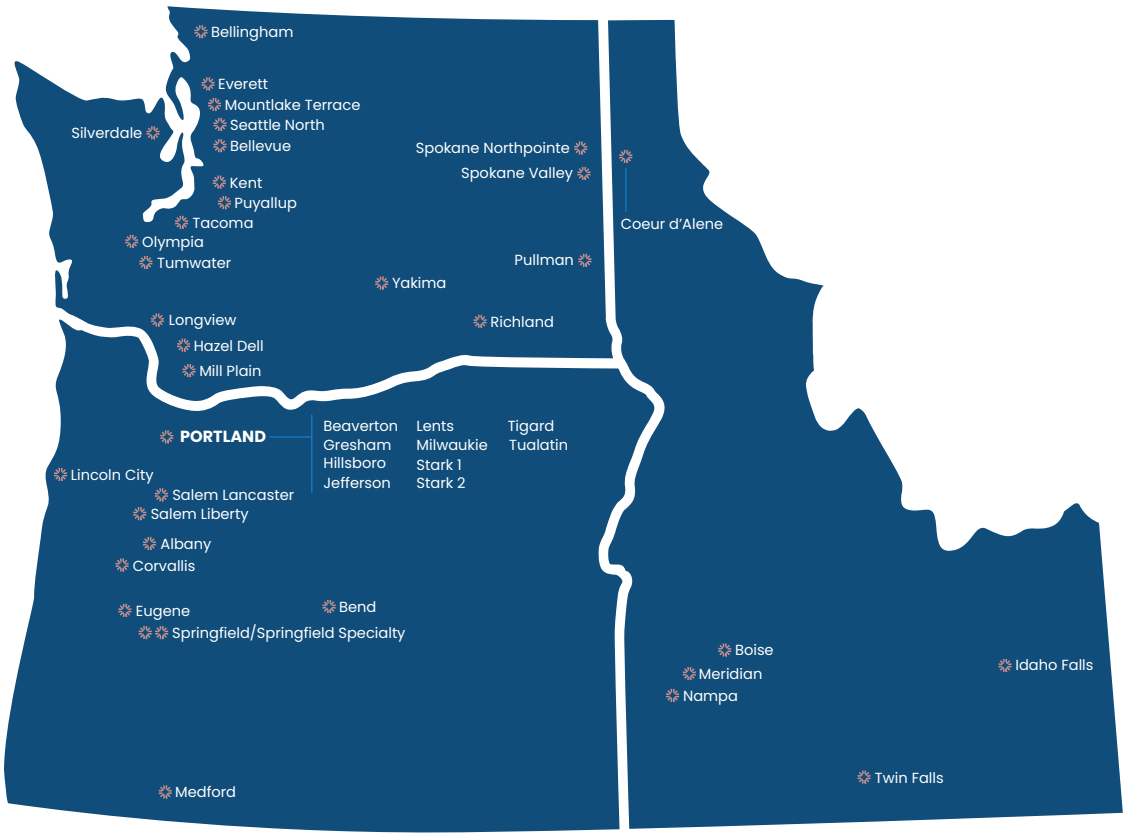
Scheduling hours: Mon - Fri 7 AM to 5:30 PM PT,
Sat 7 AM to 1 PM PT

Dental emergency assistance available
24 hours per day, 7 days per week

Questions about your benefits?

Contact Member Services at 1.855.433.6825 or memberservices@willamettedental.com

Member Services Hours: Mon - Fri 8 AM to 5 PM PT



willamettedental.com/wapebb

Visit our website for the most up-to-date locations and doctor profiles, complete with photos, to help you find the best office and provider for you and your family.

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This Certificate of Coverage replaces and supersedes all prior certificates of coverage. Possession of this Certificate of Coverage does not necessarily mean the Enrollee is covered.

Effective: January 1, 2027 • Group Plan Number WA82

Underwritten by Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124

CHOOSING A PRIMARY CARE DENTIST

Enrollees are encouraged to establish a long-term relationship with a primary care Dentist. The primary care Dentist each Enrollee selects will coordinate all the Enrollee's dental care needs. A primary care Dentist offers a personal and individual approach to dental treatment by becoming familiar with each Enrollee's dental history. Once the Enrollee selects their Dentist, future appointments will be scheduled with that Dentist. The Enrollee is also free to change their primary care Dentist or location at any time. For further information, please call toll free 1.855.4DENTAL (1.855.433.6825).

APPOINTMENTS

Willamette Dental Group, P.C. (WDGPC) has office locations throughout Washington, Oregon, and Idaho. Enrollees can schedule at any WDGPC office location. Each of WDGPC's office locations practice a simple scheduling method. Through this model, more appointment types are offered everyday so you can be seen when it fits your schedule and needs.

The length of wait-time for an appointment may vary based on your choice of provider, dental office location, appointment type and your desired day or time of appointment. WDGPC's goal is to get you in within days or weeks to fit your lifestyle.

To schedule an appointment that meets your scheduling needs, please call the Appointment Center toll free at 1.855.4DENTAL (1.855.433.6825).

Appointment Center Hours:
Monday – Friday: ..... 7 a.m. to 5:30 p.m. PT
Saturday: ..... 7 a.m. to 1 p.m. PT

Your First Visit
At your first visit to a WDGPC office, you will receive a thorough dental examination that includes X-rays and comprehensive risk assessments. Then, your Dentist will develop a proactive dental care plan based on your immediate needs, current dental health and long term oral health goals. This individual plan will include recommendations for cleanings, restorations and preventive treatments.

SPECIALTY SERVICES

Participating Providers provide a full range of general and specialty dental services. For most treatment, the Enrollee will see their selected primary care Dentist; however, the Dentist may refer the Enrollee for a Covered Service to a Specialist. The Enrollee's Participating Provider will provide services or coordinate referrals for specialty care for all covered and prescribed dental services. Specialty services, including orthodontia and implant treatment, are generally available on a regional basis. To find out where specialty services are available in your area, simply contact the Appointment Center toll free at 1.855.4DENTAL (1.855.433.6825).

An Enrollee will only be covered for benefits when services are provided by a Participating Provider or upon referral by the Participating Provider to a Non-Participating Provider or Specialist. Benefits for implant and orthodontic treatment are provided only if treatment is provided from a Participating Provider or a Specialist employed by or under contract with the Participating Provider. If a referral is made to a Non-Participating Provider or Specialist, the Copayments as stated in Appendix A will apply.

The Plan agrees to provide benefits for services provided by a Specialist or Non-Participating Provider only if:

- The Participating Provider refers the Enrollee;
- The services are authorized by the referral; and
- The services are covered under this Plan.

EMERGENCY DENTAL CARE

Participating Providers will provide treatment for Dental Emergencies during office hours. If an Enrollee has a Dental Emergency, the Enrollee may call the Appointment Center toll free at 1.855.4DENTAL (1.855.433.6825). The Plan will provide benefits for Covered Services provided by Participating Providers for treatment of a Dental Emergency. If the Participating Providers' offices are closed, the Enrollee may access after-hours telephonic clinical assistance by calling the Appointment Center toll free at 1.855.4DENTAL (1.855.433.6825). There is no cost for accessing after-hours telephonic clinical assistance.

Out of Area Emergency Care

Participating Provider will provide treatment for a Dental Emergency when an Enrollee is within 50 miles from a Participating Provider office. If an Enrollee is **more than 50 miles from a Participating Provider office**, the Enrollee may obtain services for treatment of Dental Emergency from any Dentist, and the Plan will reimburse the Enrollee up to $200 per covered emergency appointment for the cost of Covered Services minus the applicable Copayments stated in Appendix A.

The Enrollee will need to submit a written request for reimbursement after receiving services for treatment of a Dental Emergency while out of area from a Non-Participating Provider. The Enrollee should request two copies of the itemized bill from the Non-Participating Provider and submit the following information:

- Enrollee's Name and/or Subscriber's name, date of birth, address, phone number, insurance ID number, and employer name.
- Nature of the Dental Emergency and an itemized statement by the attending Non-Participating Provider.

All requests for out of area Dental Emergency reimbursement must be submitted within six months after the date of service. Requests for reimbursement should be mailed to:

Willamette Dental Group, P.C.
Attn: Emergency Treatment Reimbursement Request
6950 NE Campus Way
Hillsboro, OR 97124-5611

Section 1 Definitions

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

1.2 **"Appeal"** means a request for review of a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. An Appeal must involve one or more of the following: a) access to dental benefits, including an adverse determination made pursuant to utilization review; b) claims handling, payment, or reimbursement for dental services; c) matters pertaining to the contractual relationship between an enrollee and Willamette Dental of Washington, Inc. 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 Section 2: Dental Plan Eligibility and Enrollment for more information.

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

1.4 **"Copayment"** means the fixed dollar amount that is the Enrollee's responsibility to pay under the Plan for each office visit or Covered Service. All Copayments are due at the time of visit or service.

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

1.6 **"Dental Emergency"** means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in: (i) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part.

1.7 **Dentally Necessary**: A service is "dentally necessary" if it is recommended by the treating Participating Provider and if all of the following conditions are met:

1. The purpose of the service is to treat a diagnosed dental condition;
2. It is the appropriate level of treatment considering the potential benefits and harm to the Enrollee; and
3. The service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A service may be Dentally Necessary yet not be a covered benefit.

1.8 **"Dentist"** means a person licensed to practice dentistry in the state where treatment is provided.

1.9 **"Denturist"** means a person licensed to practice denturism in the state where treatment is provided. Benefits for Covered Services provided by a Denturist will be provided if (i) the service is within the lawful scope of the license, and (ii) the Plan would have provided benefits if the Covered Service had been performed by a Dentist.

1.10 **"Dependent"** means a spouse, state-registered domestic partner or child who meets the dependent eligibility requirements as shown in the Eligibility and Enrollment section of this Certificate of Coverage and is enrolled for coverage under the Subscriber**.**

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

1.12 **"Enrollee"** means a Subscriber or a Dependent, who is enrolled in this Plan, and for whom applicable premium payments have been made.

1.13 **"Experimental or Investigational"** means a service that is determined to be experimental or investigational. In determining whether services are Experimental or Investigational, the Plan will consider the following:

- Whether the services are in general use in the dental community in the State of Washington;
- Whether the services are under continued scientific testing and research;
- Whether the services show a demonstrable benefit for a particular illness, disease, or condition;
- Whether the services are proven safe and effective; and
- Whether the services are approved by the American Dental Association and such approval was in effect on the date services are provided.

1.14 **"Grievance"** means a complaint expressing dissatisfaction with a service provided by Willamette Dental of Washington, Inc. or other matters related to the Plan. A Grievance must involve one or more of the following: a) access to dental benefits, including an adverse benefit determination; b) out of network reimbursements for dental services; c) matters pertaining to the contractual relationship between an Enrollee and Willamette Dental of Washington, Inc.; d) delays in obtaining dental services; or e) other matters as specifically required by Washington state insurance regulations.

1.15 **"HCA"** means the Washington State Health Care Authority, the State Agency that administers the PEBB and SEBB Programs.

1.16 **"Just Cause"** means a legitimate reason or action that, in similar circumstances, would be considered as a good and sufficient basis for disenrollment from an insurance carrier.

1.17 **"Non-Participating Provider"** means a Dentist or Denturist, who is not employed by or under contract with the Participating Provider.

1.18 **"Participating Provider"** means Willamette Dental Group, P.C., and the Dentists and Denturists who are employees of Willamette Dental Group, P.C. The Participating Provider contracts with Willamette Dental of Washington, Inc., to provide Covered Services to Enrollees. The Participating Provider agrees to charge Enrollees only the Copayments specified in the appendices for Covered Services.

1.19 **"PEBB Employer Group"** for the 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 HCA to participate in PEBB benefit plans.

1.20 **"Plan"** means this PEBB dental benefit plan of coverage. In the eligibility sections "plan" may mean a plan other than a plan underwritten by Willamette Dental of Washington, Inc., not sponsored by the PEBB Program.

1.21 **"Public Employees Benefits Board (PEBB)"** means 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.

1.22 **"Public Employees Benefits Board (PEBB) Program"** means the HCA program that administers PEBB benefit eligibility and enrollment.

1.23 **"Reasonable Cash Value"** means the Participating Provider's usual and customary fee-for-service price of services.

1.24 **"Retired Employee of a Former Employer Group"** means a retired employee of a PEBB Employer Group and a retired school employee of a SEBB Employer Group continuing enrollment in PEBB health plan coverage after losing eligibility for PEBB retiree insurance coverage upon the employer group ending participation in insurance plans and contracts with the Health Care Authority (HCA).

1.25 **"School Employees Benefits Board Organization"** or "**SEBB Organization**" means 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.

1.26 **"SEBB"** means the School Employees Benefits Board, 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.

1.27 **"SEBB Employer Group"** for the SEBB Program means an employee organization representing school employees and a tribal school as defined in Washington State statute, obtaining school employee benefits through a contractual agreement with HCA to participate in SEBB benefit plans.

1.28 **"SEBB Program"** means the program within the HCA that administers insurance and other benefits for eligible school employees, eligible dependents, and eligible school board members.

1.29 **"Specialist"** means a Dentist professionally qualified as an endodontist, oral pathologist, oral surgeon, orthodontist, pediatric dentist, periodontist, or prosthodontist.

1.30 **"Specialist Office Visit Copayment"** means the Copayment the Enrollee must pay for each visit for specialty treatment, including: endodontic services; oral surgery; periodontic services; or prosthodontic services.

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

1.32 **"Subscriber"** means an employee, retiree, Continuation Coverage enrollee, Retired Employee of a Former Employer Group, or survivor who has been determined eligible and is enrolled in this plan, and is the individual to whom the PEBB Program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an Enrollee.

Section 2 Dental Plan Eligibility and Enrollment

ELIGIBILITY

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

Eligibility for subscribers and dependents

Employee eligibility

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

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

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

Continuation coverage eligibility

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

Retired Employee of a Former Employer Group eligibility

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

Retiree and survivor eligibility

Retiree: The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of their election to enroll. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal eligibility decisions. Information about appeals can be found under “Appeal rights.”

Survivor: The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor. If an election to enroll is required, eligibility will be determined upon receipt of their election to enroll. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

Dependent eligibility

The following are eligible dependents:

- **Legal spouse**
- **State-registered domestic partner** and substantially equivalent legal unions from jurisdictions as defined in Washington state statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- **Children**, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:
    - **Children based on establishment of a parent-child relationship**, as described in Washington state statutes, except when parental rights have been terminated.
    - **Children of the subscriber's spouse**, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
    - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
    - **Children of the subscriber's state-registered domestic partner**, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.
    - **Children specified in a court order or divorce decree** for whom the subscriber has a legal obligation to provide support or health care coverage.
    - **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner**. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
    - **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:
        - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
        - The subscriber must notify the PEBB Program in writing when the child is no longer eligible under this subsection.
        - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
        - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.

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

A retiree, a survivor, or their enrolled dependents are required to enroll and stay enrolled in Medicare Part A and Part B, if eligible. This is a requirement for enrollment in a PEBB retiree health plan. A retiree or survivor must provide a copy of their or their dependent's Medicare card or Medicare benefit verification letter with Medicare Part A and Part B effective dates by uploading it online using Benefits 24/7, the PEBB Program's online enrollment system, or providing it to the PEBB Program. If a retiree, a survivor, or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the retiree or survivor must upload or provide the PEBB Program with a copy of the denial letter from the Social Security Administration. If this procedural requirement is not met, eligibility will not be established or will end as described in the termination notice sent by the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

ENROLLMENT

For all subscribers and dependents

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

Employee enrollment

An employee is required to enroll in PEBB dental except where PEBB Program rules allow otherwise.

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

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

Continuation coverage and retired employees of a former employer group enrollment

A continuation coverage subscriber, a Retired Employee of a Former Employer Group or their dependent can enroll in only one PEBB dental plan, even if eligibility criteria is met under two or more subscribers.

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

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

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

Retiree and survivor enrollment

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

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

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

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

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

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

An eligible survivor of an emergency service personnel killed in the line of duty must enroll by submitting a *PEBB Retiree Election Form* (form A) along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker's death; or
- The last day the survivor was covered under any health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

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

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

A retiree or a survivor enrolled in Medicare whose enrollment is deferred while permanently residing outside of the United States or due to a temporary absence from the United States and who returns to the United States, must also submit proof of enrollment in Medicare Parts A and B, proof of permanent residence in the United States, and proof they currently reside in the United States; evidence of continuous enrollment in qualified coverage is not required. The online enrollment must be completed or the forms must be received no later than 60 days after the date the permanent move begins or 60 days following the month of the permanent move, whichever is later.

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

Dependent enrollment

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

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

Dual enrollment

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

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

For example:

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

When dental coverage begins

Employees and dependents

For a newly eligible employee and their eligible dependents, dental coverage begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

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

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

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

Retirees and dependents

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

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

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

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

Survivors and dependents

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

For an eligible survivor of an employee or school employee and their eligible dependents, dental coverage begins the first day of the month following the later of the date of the employee's or school employee's death or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

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

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

Continuation coverage subscribers and dependents

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

Retired Employees of a Former Employer Group and dependents

For a Retired Employee of a Former Employer Group and their eligible dependents enrolling when newly eligible, dental coverage begins the first day of the month following the day they lost eligibility for PEBB retiree insurance coverage.

All subscribers and dependents

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

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

If the special open enrollment is due to the **birth or adoption of a child**, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, dental coverage will begin as follows:

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

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

Making changes

Removing a dependent who is no longer eligible

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

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

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

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

Voluntary termination for a retiree, a survivor, a continuation coverage subscriber, or a Retired Employee of a Former Employer Group

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

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

Making changes during annual open enrollment and special open enrollment

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

Annual open enrollment changes

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

- Enroll or remove eligible dependents
- Change their dental plan

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

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

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

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

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

Special open enrollment changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

A special open enrollment event must be other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits.

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

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

To request a special open enrollment:

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

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

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

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

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

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

- Subscriber gains a new dependent due to:
    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan. If the subscriber or their dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber's or the dependent's new residence, the subscriber may select a new dental plan.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug (MAPD) or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependent's enrollment in Medicare, the subscriber must select a new medical plan.
- Subscriber or their dependent gains, loses, or has a change in low-income subsidy (LIS) eligibility. They have three months to enroll in a MAPD plan, Medicare Supplement plan, or the Uniform Medical Plan Classic Medicare with Part D (PDP) if eligible, after they gain, lose, or have a change in LIS eligibility, or notification of such a change, whichever is later.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
    - Active cancer treatment, such as chemotherapy or radiation therapy
    - Treatment following a recent organ transplant
    - A scheduled surgery
    - Recent major surgery still within the postoperative period

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

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

Special open enrollment events that allow adding or removing a dependent

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

- Subscriber gains a new dependent due to:
    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.
- Subscriber or their dependent enrolled in a Medicare Advantage Prescription Drug plan, Medicare Supplement plan, or the Uniform Medical Plan Classic Medicare with Part D (PDP) who gains, loses, or has a change to their low-income subsidy eligibility.
- Subscriber or their dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.

When dental coverage ends

Termination dates

Dental coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible.
- On the date a dental plan terminates or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB dental plan.
- **For an employee** and their dependents, on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
    - On the date specified in an employee's letter of resignation.
    - On the date specified in any contract or hire letter.
    - On the effective date of an employer-initiated termination notice.

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

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

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

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

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

Final premium payments

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

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

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

OPTIONS FOR CONTINUING PEBB DENTAL COVERAGE

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

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

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

PEBB Continuation Coverage

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

- **PEBB Continuation Coverage (COBRA)** includes eligibility and administrative requirements under federal COBRA laws and regulations. Some enrollees who are not qualified beneficiaries under federal COBRA may also qualify for PEBB Continuation Coverage (COBRA).
- **PEBB Continuation Coverage (Unpaid Leave)** is an option created by the PEBB Program with wider eligibility criteria and qualifying event types than COBRA.

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

Premium payments for PEBB Continuation Coverage

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges.

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

PEBB retiree insurance coverage

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

- Retiring employee or retiring school employee
- Separating employee or separating school employee who is at least age 55 and meets specific retirement plan and years of service requirements and who will not yet receive a monthly retirement plan payment

- Eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office
- Dependent becoming eligible as a survivor
- Retiree or a survivor enrolled in PEBB retiree insurance coverage

See the *PEBB Retiree Enrollment Guide* for details.

Family and Medical Leave Act of 1993

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

The employing agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

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

Paid Family and Medical Leave Act

An employee on approved leave under the Washington state Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward PEBB benefits. The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

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

Payment of premiums during a labor dispute

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

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

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

TERMINATION FOR JUST CAUSE

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider’s request to terminate an enrollee’s coverage from this plan for Just Cause.
A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program’s procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program

- Knowingly providing false information
- Failure to pay the monthly premium and applicable premium surcharges when due
- Misconduct. Examples of such termination include, but are not limited to the following:
    - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium
    - Abusive or threatening conduct directed to an HCA employee, a health plan, or other HCA-contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons

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

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

APPEAL RIGHTS

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

Any current or former employee of an employer group, such as a county, city, port, water district, etc., that contracts with HCA for PEBB benefits, or their dependent may appeal a decision made by an employer group regarding PEBB eligibility, enrollment, or premium surcharges to the employer group.

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

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

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

RELATIONSHIP TO LAW AND REGULATIONS

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

Section 3 Coordination of Benefits

This coordination of benefits (COB) provision applies when a person has dental coverage under more than one Plan. Plan is defined below.

3.1 The Order of Benefit Determination Rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense.

3.2 Definitions

a. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.
   1. Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group or individual coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   2. Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.
   3. Each contract for coverage under 1. or 2. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

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

c. The Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one plan. When This Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When This Plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

d. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the Reasonable Cash Value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable Expense. The Allowable Expense for the Secondary Plan is the amount it allows for the service in the absence of other coverage that is primary.

e. The following are examples of expenses that are not Allowable Expenses:
   1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
   2. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

f. Closed Panel Plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

g. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

3.3 Order of Benefit Determination Rules. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. Except as provided in subsection c., a plan that does not contain a coordination of benefits provision that is consistent with state regulation regarding coordination of benefits is always primary unless the provisions of both plans state that the complying plan is primary.

c. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that this supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

e. Each plan determines its order of benefits using the first of the following rules that apply:
   1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.
   2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the Custodial Parent, first;
- The plan covering the spouse or state-registered domestic partner of the Custodial Parent, second;
- The plan covering the noncustodial parent, third; and then
- The plan covering the spouse or state-registered domestic partner of the noncustodial parent, last.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section e.1. can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section e.1. can determine the order of benefits.
5. Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

3.4 **Effect on the Benefits of This Plan.** When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

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

3.7 **Right of Recovery.** The issuer has the right to recover excess payment whenever it has paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or from any other issuers or plans.

3.8 If an Enrollee is covered by more than one plan, and the Enrollee does not know which is the Primary Plan, the Enrollee may contact any one of the plans to verify which plan is primary. The plan the Enrollee contacts is responsible for working with the other plan to determine which is primary and will let the Enrollee know within 30 days. Plans may have timely claim filing requirements. If the Enrollee or provider fails to submit a claim to a Secondary Plan within that plan's claim filing time limit, the plan can deny the claim. If the Enrollee experiences delays in the processing of a claim by the Primary Plan, the Enrollee or provider will need to submit a claim to the Secondary Plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if an Enrollee is covered by more than one plan, the Enrollee should promptly report to providers and plans any changes in coverage.

Section 4 Subrogation

4.1 Covered Services for the diagnosis or treatment of an injury or disease, which is possibly caused by a third party, are provided solely to assist the Enrollee. By providing Covered Services, the Plan and the Participating Provider are not acting as volunteers and are not waiving any right to reimbursement or subrogation.

4.2 If the Plan and Participating Provider provide Covered Services for the treatment of an injury or disease, which is possibly caused by a third party, it will:

a. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Covered Services provided; and
b. Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Covered Services provided, subject to the limitations specified below.

4.3 As a condition of receiving Covered Services, the Enrollee shall:

a. Provide the Plan and Participating Provider with the name and address of the parties liable, all facts known concerning the injury or disease, and other information as reasonably requested;
b. Hold in trust any damage recoveries until the final determination or settlement is made and to execute a trust agreement guaranteeing the Plan's and Participating Provider's subrogation rights; and
c. Take all necessary action to seek and obtain recovery to reimburse the Plan and Participating Provider for the Reasonable Cash Value of the Covered Services.

4.4 The Enrollee is entitled to be fully compensated for the loss. After the Enrollee has been fully compensated for the loss, the Plan and Participating Provider are entitled to the remaining proceeds of any settlement or judgment that results in a recovery from the third party or third party's insurer(s) up to the Reasonable Cash Value of the Covered Services provided.

4.5 Services payable under any motor vehicle medical, motor vehicle no-fault, underinsured or uninsured motorist, personal injury protection, homeowner's, commercial premises coverage, workers' compensation, or other similar contract or insurance are not covered under the Plan.

Section 5 Complaints, Grievances, and Appeals

5.1 Complaints.

a. Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider and Participating Provider's staff. Most matters can be resolved with the Participating Provider and Participating Provider's staff.

b. If the Enrollee requests a specific service, the Participating Provider will use his/her judgment to determine if the service is Dentally Necessary. The Participating Provider will recommend the most appropriate course of treatment.

c. Enrollees may also contact the Member Services Department with questions or complaints at:

Willamette Dental of Washington, Inc.
Attn: Member Services
6950 NE Campus Way
Hillsboro, OR 97124-5611
1.855.4DENTAL (1-855-433-6825)

d. If the Enrollee is unsatisfied after discussion with the Participating Provider, Participating Provider's staff, or Member Services Department, grievance and appeal procedures are available.

5.2 Grievances.

a. A Grievance is a complaint expressing dissatisfaction with a service provided by Willamette Dental of Washington, Inc. or other matters related to the Plan.

b. Grievances may be submitted by writing or calling the Member Services Department (contact information listed above) no later than 180 days after the event occurred. The Enrollee should outline their concerns and specific request. The Enrollee may submit comments, documents, and other relevant information.

c. The Member Services Department accepts and logs the Grievance and will send an acknowledgment letter to the Enrollee within 5 business days of receiving the Grievance.

d. Willamette Dental of Washington, Inc. will review the Grievance and all information submitted. If Willamette Dental of Washington, Inc. does not receive all necessary documents from the Enrollee to make a decision, then the decision will be made on the information provided. Willamette Dental of Washington, Inc. will provide a written reply no later than 30 days after receipt of the Grievance, unless Willamette Dental of Washington, Inc., notifies the Enrollee that an extension is necessary to complete the decision for the Grievance; however, the extension cannot delay the decision beyond 30 days of the Grievance without the Enrollee's informed written consent. If the Grievance involves:

   1. A preauthorization, a written reply will be provided no later than 15 days after the receipt of a Grievance.
   2. Services deemed Experimental or Investigational, a written reply will be provided no later than 20 working days after the receipt of a Grievance and that period cannot be extended without the Enrollee's informed written consent.
   3. Services not yet provided for an alleged Dental Emergency, a reply will be provided no later than 72 hours of the receipt of a Grievance.

e. If the Grievance is denied, the written reply will include information about the basis for the decision, how to appeal, and other disclosures as required under state and federal laws.

f. After receiving the Grievance response, the Enrollee may ask Willamette Dental of Washington, Inc., to reconsider by submitting a request for an Appeal (see Section 5.3 below).

5.3 Appeals.

a. An Appeal is a request for review of a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service.
b. An Appeal must be submitted in writing to the Member Services Department (contact information listed above) no later than 180 days after the date of the denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. The Enrollee should indicate the reason for the Appeal and may include written comments, documents, records, or any relevant information.
c. The Member Services Department accepts and logs the Appeal and will send an acknowledgment letter to the Enrollee within 5 business days of receiving the Appeal.
d. Willamette Dental of Washington, Inc. will review the Appeal and all information submitted. Willamette Dental of Washington, Inc. will provide a written reply no later than 30 days after the receipt of a written request for an Appeal unless Willamette Dental of Washington, Inc., notifies the Enrollee that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond 60 days of the request for an Appeal without the Enrollee's informed written consent. If the Appeal involves:
    1. A preauthorization, a written reply will be provided no later than 30 days after the receipt of a written request for an Appeal.
    2. Services deemed Experimental or Investigational, a written reply will be provided no later than 20 working days after the receipt of a written request for an Appeal and that period cannot be extended without the Enrollee's informed written consent.
    3. Services not yet provided for an alleged Dental Emergency, a reply will be provided no later than 72 hours after the receipt of a written request for an Appeal.
e. If the Appeal is denied, the written reply will include the basis for the decision and other disclosures as required under state and federal laws.

5.4 Authorized Representative. Enrollees may authorize another person to represent the Enrollee and to whom the Plan can communicate regarding a specific Grievance or Appeal. The authorization must be in writing and signed by the Enrollee. The appeal process for an Appeal submitted by a representative of the Enrollee will not commence until this authorization is received. If the written authorization is not received by the Plan, the Grievance or Appeal will be closed.

Section 6 General Provisions

6.1 Rights Not Transferable. The benefits of the Plan are not transferable.

6.2 State Law. The Plan is entered into and delivered in the State of Washington. Washington law will govern the interpretation of provisions of the Plan unless federal law supersedes.

6.3 Waiver and Severability. If Willamette Dental of Washington, Inc. does not enforce a provision of the Plan, it will not constitute a waiver of that or any other provision at any time in the future. If any provision of the Plan is declared unenforceable by a court having jurisdiction, the provision is ineffective only to the extent declared unenforceable. The remainder of the provision and all other provisions of this Certificate of Coverage shall continue in full force and effect.

6.4 Statements. In the absence of fraud, statements made by an Enrollee are representations which Willamette Dental of Washington, Inc. may rely upon. Statements made for the purpose of acquiring coverage will not void the coverage or reduce benefits, unless contained in a written instrument signed by the Enrollee.

6.5 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.

6.6 Release of Information. Enrollees may be required to provide Willamette Dental of Washington, Inc., or the HCA with information necessary to determine eligibility, administer benefits, or administer dental treatment encounters. This could include, but is not limited to, dental records. Coverage could be denied if Enrollees fail to provide such information when requested.

Section 7 Dental Coverage

7.1 Agreement to Provide Covered Services. The Plan shall provide benefits for prescribed Covered Services listed as covered in the appendices. Covered Services must be provided by the Participating Provider, except as specified otherwise. All Covered Services are expressly subject to the Copayments, exclusions, limitations, and all other provisions of the Plan. Enrollees may freely contract at any time to obtain health care services outside of the Plan or for services not covered under the Plan on any terms or conditions acceptable to the health care provider and Enrollee.

7.2 Referrals. The Participating Provider may refer Enrollees to a Specialist or Non-Participating Provider for Covered Services. The Plan will provide benefits for Covered Services provided by a Specialist or Non-Participating Provider only if:

a. The Participating Provider refers the Enrollee;
b. The Covered Services are specifically authorized by the Participating Provider's referral; and
c. The Covered Services are listed as covered in the appendices and are not otherwise limited or excluded.

7.3 Dental Emergency. Participating Providers will provide treatment for Dental Emergencies during office hours. The Plan will provide benefits for Covered Services provided by Participating Providers for treatment of a Dental Emergency. If the Participating Providers' offices are closed, the Enrollee may access after-hours telephonic clinical assistance by calling the Appointment Center toll free at 1.855.4DENTAL (1-855-433-6825). There is no cost for accessing after-hours telephonic clinical assistance.

7.4 Dental Emergency While Out of Area. The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is more than 50 miles from any Participating Provider office. The Plan will reimburse the Enrollee up to the out of area emergency reimbursement amount less any Copayments specified in Appendix A for the cost of the Covered Services. The Enrollee must submit a written request for reimbursement to Willamette Dental of Washington, Inc. no later than 6 months after the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information, including X-rays and other data, may be requested by Willamette Dental of Washington, Inc. to process the request. The benefit for out of area Dental Emergency treatment will not be provided if the requested information is not received.

7.5 Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. Enrollees who are terminated for good cause or failure to pay the premium are not eligible for an extension of benefits.

a. **Crowns or Bridges.** Adjustments for crowns or bridges will be covered for up to 6 months after placement, if the final impressions are taken prior to termination and the crown or bridge is placed no later than 60 days after termination.
b. **Removable Prosthetic Devices.** Adjustments for removable prosthetic devices will be covered for up to 6 months after placement, if final impressions are taken prior to termination and the prosthesis is delivered no later than 60 days after termination. Laboratory relines are not covered after termination.
c. **Immediate Dentures.** The delivery of immediate dentures will be covered, if final impressions are taken prior to termination and the immediate dentures are delivered no later than 60 days after termination. If coverage terminates prior to the extraction of teeth, the extractions will not be covered.
d. **Root Canal Therapy.** The completion of root canal therapy will be covered if the root canal is started prior to termination and treatment is completed no later than 60 days after termination. Pulpal debridement is not a root canal start. If the root canal requires retreatment after 60 days from termination of coverage, retreatment will not be covered. Restorative work following root canal therapy is a separate procedure and not covered after termination.

e. Extractions. Post-operative checks are covered for 60 days from the date of the extraction for extractions performed prior to termination. If teeth are extracted in preparation for a prosthetic device and coverage terminates prior to the final impressions, coverage for the prosthetic device will not be extended. Extractions are a separate procedure from prosthetic procedures.

Section 8 Exclusions and Limitations

8.1 Exclusions. The Plan does not provide benefits for any of the following conditions, treatments, services, or for any direct complications or consequences thereof. The Plan does not provide benefits for excluded services even if approved, prescribed, or recommended by a Participating Provider.

1. Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings, if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
2. Completing insurance forms or reports, or fees for providing records.
3. The completion or delivery of treatments or services initiated prior to the effective date of coverage under this Plan including the following:

a. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under this Plan; or

b. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under this Plan.

4. Dentistry for cosmetic reasons or which is primarily intended to improve, alter, or enhance appearance. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
5. Endodontic therapy completed more than 60 days after termination of coverage.
6. Full-mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
7. Habit-breaking appliances, except as specified under the orthodontia benefit.
8. Hospital care or other care outside of a dental office for dental procedures, including physician services, and additional fees charged for hospital treatment.
9. Maxillofacial prosthetic services.
10. Prescription or over-the-counter drugs and medications. This includes analgesics (medications to relieve pain) and pain management drugs such as pre-medication and nitrous oxide.
11. Orthodontic treatment, orthognathic treatment, or treatment of TMJ disorders which are not prescribed by a Participating Provider.
12. Replacement of lost, missing or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
13. Restorations or appliances to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition and restorations for the malalignment of teeth.
14. Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.
15. Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Participating Provider.
16. Services and related exams or consultations to the extent they are not Dentally Necessary for the diagnosis, care, or treatment of the condition involved.
17. Services by any person other than a licensed Dentist, licensed Denturist, hygienist, or dental assistant within the scope of his or her lawful authority.
18. Services for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
19. Services not listed as covered in this Certificate of Coverage.
20. Services that Willamette Dental of Washington, Inc., determines are Experimental or Investigative.
21. Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
22. Invisalign treatment and appliances.

8.2 Limitations.

a. **Alternate Services.** If alternative services can be used to treat a condition, the service recommended by the Participating Provider is covered. In the event the Enrollee elects a service that is more costly than the service the Participating Provider has approved, the Enrollee is responsible for the Copayment for the recommended Covered Service plus the cost differential between the Reasonable Cash Value of the recommended service and the Reasonable Cash Value of the more costly requested service.

b. **Congenital Malformations.** Services listed in the appendices which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for Dependent Children if dental necessity has been established. Dental necessity means that treatment is primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function. Orthognathic surgery is covered as specified in Appendix A, if the Participating Provider determines orthognathic surgery is Dentally Necessary and authorizes the orthognathic surgery for treatment of an Enrollee who is under the age of 19 with congenital or developmental malformations.

c. **Endodontic Retreatment.** When the initial root canal therapy was performed by the Participating Provider, the retreatment of the root canal therapy will be covered as part of the initial treatment for the first 24 months. After 24 months, the applicable Copayments will apply. When the initial root canal therapy was performed by a Non-Participating Provider, the retreatment of such root canal therapy by the Participating Provider will be subject to the applicable Copayments.

d. **Anesthesia.** Deep sedation/general anesthesia (D9222 & D9223) and intravenous moderate (conscious) sedation/anesthesia (D9239 & D9243) are covered with the Copayments specified in Appendix A only if the following criteria are met:
   1. It is performed in a dental office;
   2. It is provided in conjunction with a Covered Service; and
   3. The Participating Provider determines that it is necessary because the Enrollee is under age 7, developmentally disabled, or physically disabled.

e. **Hospital Setting.** The services provided by a Dentist in a hospital setting are covered if the following criteria are met:
   1. The Participating Provider determines a hospital or similar setting is medically necessary;
   2. The services are authorized in writing by the Participating Provider;
   3. The services provided are the same services that would be provided in a dental office; and
   4. The applicable Copayments are paid.

f. **Replacements.** The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is Dentally Necessary due to one of the following conditions:
   1. A tooth within an existing denture or bridge is extracted;
   2. The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or
   3. The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under the Plan, and replacement by a permanent denture is necessary.

g. **Restorations.** Crowns, casts, or other indirect fabricated restorations are covered only if Dentally Necessary and if recommended by the Participating Provider. Crowns, casts, or other indirect fabricated restorations are Dentally Necessary if provided for treatment for decay, traumatic injury, or substantial loss of tooth structure undermining one or more cusps and the tooth cannot be restored with a direct restorative material or the tooth is an abutment to a covered partial denture or fixed bridge.

Appendix A - Schedule of Covered Services and Copayments

Office Visit Copayments

General Office Visit Copayment $0
Specialist Office Visit Copayment $0

Code	Procedure	Enrollee Pays
1.	**Diagnostic and Preventive Services**	
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0461	Testing for cracked tooth	$0
D0470	Diagnostic casts	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride - excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
2.	**Space Maintainers**	
D1510	Space maintainer - fixed, unilateral - per quadrant	$20
D1516	Space maintainer - fixed - bilateral, maxillary	$30

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D1517 Space maintainer - fixed - bilateral, mandibular $30
D1520 Space maintainer - removable, unilateral - per quadrant $20
D1526 Space maintainer - removable - bilateral, maxillary $30
D1527 Space maintainer - removable - bilateral, mandibular $30
D1551 Re-cement or re-bond bilateral space maintainer - maxillary $10
D1552 Re-cement or re-bond bilateral space maintainer - mandibular $10
D1553 Re-cement or re-bond unilateral space maintainer - per quadrant $10
D1556 Removal of fixed unilateral space maintainer - per quadrant $0
D1557 Removal of fixed bilateral space maintainer - maxillary $0
D1558 Removal of fixed bilateral space maintainer - mandibular $0

3. Restorative Services

D2140 Amalgam - one surface, primary or permanent $10
D2150 Amalgam - two surfaces, primary or permanent $10
D2160 Amalgam - three surfaces, primary or permanent $10
D2161 Amalgam - four or more surfaces, primary or permanent $10
D2330 Resin-based composite - one surface, anterior $15
D2331 Resin-based composite - two surfaces, anterior $15
D2332 Resin-based composite - three surfaces, anterior $15
D2335 Resin-based composite - four or more surfaces (anterior) $15
D2390 Resin based composite crown, anterior $50
D2391 Resin-based composite - one surface, posterior $50
D2392 Resin-based composite - two surfaces, posterior $50
D2393 Resin-based composite - three surfaces, posterior $50
D2394 Resin-based composite - four or more surfaces, posterior $50
D2510 Inlay - metallic - one surface $115
D2520 Inlay - metallic - two surfaces $115
D2530 Inlay - metallic - three or more surfaces $115
D2542 Onlay - metallic - two surfaces $125
D2543 Onlay - metallic - three surfaces $125
D2544 Onlay - metallic - four or more surfaces $125
D2610 Inlay - porcelain/ceramic - one surface $125
D2620 Inlay - porcelain/ceramic - two surfaces $125
D2630 Inlay - porcelain/ceramic - three or more surfaces $125
D2642 Onlay - porcelain/ceramic - two surfaces $125
D2643 Onlay - porcelain/ceramic - three surfaces $125
D2644 Onlay - porcelain/ceramic - four or more surfaces $125

4. Crowns

D2710 Crown - resin-based composite (indirect) $100
D2740 Crown - porcelain/ceramic $155
D2750 Crown - porcelain fused to high noble metal $175
D2780 Crown - ¾ cast high noble metal $175
D2790 Crown - full cast high noble metal $150
D2799 Interim crown - further treatment or completion of diagnosis necessary prior to final impression $0
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration $0
D2920 Re-cement or re-bond crown $0
D2930 Prefabricated stainless steel crown - primary tooth $100

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D2931 Prefabricated stainless steel crown - permanent tooth $100
D2932 Prefabricated resin crown $100
D2933 Prefabricated stainless steel crown with resin window $100
D2940 Placement of interim direct restoration $0
D2950 Core buildup, including any pins when required $0
D2951 Pin retention - per tooth, in addition to restoration $0
D2952 Post and core in addition to crown, indirectly fabricated $0
D2954 Prefabricated post and core in addition to crown $0
D2955 Post removal $0
D2957 Each additional prefabricated post - same tooth $0
D2975 Coping $0
D2980 Crown repair necessitated by restorative material failure $0

5. Endodontics

D3110 Pulp cap - direct (excluding final restoration) $0
D3120 Pulp cap - indirect (excluding final restoration) $0
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament $0
D3221 Pulpal debridement, primary and permanent teeth $0
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) $0
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) $0
D3310 Endodontic therapy, anterior tooth (excluding final restoration) $100
D3320 Endodontic therapy, premolar tooth (excluding final restoration) $125
D3330 Endodontic therapy, molar tooth (excluding final restoration) $150
D3331 Treatment of root canal obstruction; non-surgical access $0
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth $0
D3333 Internal root repair of perforation defects $0
D3346 Retreatment of previous root canal therapy - anterior $100
D3347 Retreatment of previous root canal therapy - premolar $125
D3348 Retreatment of previous root canal therapy - molar $150
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) $10
D3352 Apexification/recalcification - interim medication replacement $10
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) $10
D3410 Apicoectomy - anterior $70
D3421 Apicoectomy - premolar (first root) $50
D3425 Apicoectomy - molar (first root) $50
D3426 Apicoectomy (each additional root) $50
D3430 Retrograde filling - per root $0
D3450 Root amputation - per root $50
D3911 Intraorifice barrier $50
D3920 Hemisection (including any root removal), not including root canal therapy $100
D3950 Canal preparation and fitting of a preformed dowel or post $0

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6. Periodontics

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant $75
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant $35
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant $100
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant $75
D4249 Clinical crown lengthening - hard tissue $100
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant $100
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant $75
D4263 Bone replacement graft - retained natural tooth - first site in quadrant $0
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant $0
D4270 Pedicle soft tissue graft procedure $100
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft $100
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) $100
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft $100
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site $100
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site $100
D4341 Periodontal scaling and root planing - four or more teeth per quadrant $35
D4342 Periodontal scaling and root planing - one to three teeth per quadrant $15
D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation $0
D4355 Full-mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit $25
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth $0
D4910 Periodontal maintenance $35

7. Prosthodontics - Removable

D5110 Complete denture - maxillary $140
D5120 Complete denture - mandibular $140
D5130 Immediate denture - maxillary $140
D5140 Immediate denture - mandibular $140
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) $140
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) $140
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) $140
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including

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retentive/clasping materials, rests and teeth) $140
D5282 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary $140
D5283 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular $140
D5410 Adjust complete denture - maxillary $0
D5411 Adjust complete denture - mandibular $0
D5421 Adjust partial denture - maxillary $0
D5422 Adjust partial denture - mandibular $0
D5511 Repair broken complete denture base, mandibular $15
D5512 Repair broken complete denture base, maxillary $15
D5520 Replace missing or broken teeth - complete denture - per tooth $15
D5611 Repair resin partial denture base, mandibular $0
D5612 Repair resin partial denture base, maxillary $0
D5621 Repair cast partial framework, mandibular $15
D5622 Repair cast partial framework, maxillary $15
D5630 Repair or replace broken retentive/clasping materials – per tooth $30
D5640 Replace missing or broken teeth - partial denture - per tooth $15
D5650 Add tooth to existing partial denture - per tooth $0
D5660 Add clasp to existing partial denture – per tooth $30
D5670 Replace all teeth and acrylic on cast metal framework (maxillary) $60
D5671 Replace all teeth and acrylic on cast metal framework (mandibular) $60
D5710 Rebase complete maxillary denture $60
D5711 Rebase complete mandibular denture $60
D5720 Rebase maxillary partial denture $60
D5721 Rebase mandibular partial denture $60
D5730 Reline complete maxillary denture (direct) $40
D5731 Reline complete mandibular denture (direct) $40
D5740 Reline maxillary partial denture (direct) $40
D5741 Reline mandibular partial denture (direct) $40
D5750 Reline complete maxillary denture (indirect) $50
D5751 Reline complete mandibular denture (indirect) $50
D5760 Reline maxillary partial denture (indirect) $50
D5761 Reline mandibular partial denture (indirect) $50
D5810 Interim complete denture (maxillary) $70
D5811 Interim complete denture (mandibular) $70
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary $70
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular $70
D5850 Tissue conditioning, maxillary $15
D5851 Tissue conditioning, mandibular $15
D5863 Overdenture - complete maxillary - natural tooth borne $140
D5864 Overdenture - partial maxillary - natural tooth borne $140
D5865 Overdenture - complete mandibular - natural tooth borne $140
D5866 Overdenture - partial mandibular - natural tooth borne $140
D5986 Fluoride gel carrier $0

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8. Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$175
D6212	Pontic - cast noble metal	$150
D6240	Pontic - porcelain fused to high noble metal	$175
D6241	Pontic - porcelain fused to predominantly base metal	$125
D6242	Pontic - porcelain fused to noble metal	$150
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$125
D6720	Retainer crown - resin with high noble metal	$125
D6750	Retainer crown - porcelain fused to high noble metal	$175
D6752	Retainer crown - porcelain fused to noble metal	$150
D6780	Retainer crown - ¾ cast high noble metal	$175
D6790	Retainer crown - full cast high noble metal	$175
D6792	Retainer crown - full cast noble metal	$150
D6930	Re-cement or re-bond fixed partial denture	$0
D6940	Stress breaker	$65
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

9. Oral Surgery

D7111	Extraction, coronal remnants - primary tooth	$10
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$10
D7220	Removal of impacted tooth - soft tissue	$30
D7230	Removal of impacted tooth - partially bony	$40
D7240	Removal of impacted tooth - completely bony	$50
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	$50
D7250	Removal of residual tooth roots (cutting procedure)	$50
D7260	Oroantral fistula closure	$50
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Exposure of an unerupted tooth	$0
D7283	Placement of device to facilitate eruption of impacted tooth	$50
D7286	Incisional biopsy of oral tissue - soft	$0
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$0
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	$50
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7520	Incision and drainage of abscess - extraoral soft tissue	$0
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$0
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$0

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D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone $0
D7670 Alveolus - closed reduction, may include stabilization of teeth $0
D7910 Suture of recent small wounds up to 5 cm $0
D7911 Complicated suture - up to 5 cm $0
D7953 Bone replacement graft for ridge preservation - per site $0
D79610 Buccal / labial frenectomy (frenulectomy) $50
D7970 Excision of hyperplastic tissue - per arch $50
D7971 Excision of pericoronal gingiva $50
Orthognathic surgery for treatment of congenital anomalies for enrolled Children under age 19 - Subject to a lifetime benefit maximum of $5,000 ..... 30% of charges

10. Anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures $0
D9222 Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof [1] $50
D9223 Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof [1] $0
D9239 Administration of moderate sedation - intravenous – first 15 minute increment, or any portion thereof [1] $50
D9243 Administration of moderate sedation - intravenous – each subsequent 15 minute increment, or any portion thereof [1] $0

[1] When performed in a dental office, provided in conjunction with a Covered Service, and the Participating Provider determines that it is necessary because the Enrollee is under age 7, developmentally disabled, or physically disabled.

11. Adjunctive General Services

D9110 Palliative treatment of dental pain - per visit $15
D9120 Fixed partial denture sectioning $0
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician $0
D9420 Hospital or ambulatory surgical center call (Copayments apply and facility fees not covered.) $0
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed $0
D9440 Office visit - after regularly scheduled hours $20
D9910 Application of desensitizing medicament $0
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth $0
D9943 Occlusal guard adjustment $0
D9944 Occlusal guard - hard appliance, full arch $50
D9945 Occlusal guard - soft appliance, full arch $50
D9946 Occlusal guard - hard appliance, partial arch $50
D9951 Occlusal adjustment - limited $35
D9952 Occlusal adjustment - complete $50

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Appendix B - Orthodontic Treatment

1. General Provisions.

a. Orthodontic treatment is covered only if the Participating Provider prepares the treatment plan prior to starting treatment. The treatment plan is based on an examination that must take place while the Enrollee is covered under this Plan. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.

b. The Enrollee must remain covered under this Plan for the entire length of treatment. The Enrollee must follow the post-treatment plan and keep all appointments after the Enrollee is de-banded to avoid additional Copayments.

c. Copayments may be adjusted based upon the services necessary to complete the treatment if orthodontic treatment is started prior to the effective date of coverage.

d. The Copayment may be prorated if coverage terminates prior to completion of treatment. The services necessary to complete treatment will be based on the Reasonable Cash Value after coverage terminates.

e. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services. The Pre-Orthodontic Copayment will be credited towards the Orthodontic Copayment due if the Enrollee accepts the treatment plan. The Copayment for limited orthodontic treatment may be prorated based on the treatment plan.

f. The General Office Visit Copayment listed in Appendix A is charged at each visit for orthodontic treatment. Services provided in connection with orthodontic treatment are subject to the Copayments listed in Appendix A.

g. Pre-Orthodontic and Orthodontic Copayments are in addition to the Specialist Office Visit Copayment.

2. Pre-Orthodontic Copayment.

Initial orthodontic exam:.....$50
Study models and X-rays: $0
Case presentation: $0

3. Orthodontic Copayment.

Comprehensive Orthodontic Copayment: $1,500
The following orthodontic procedures are Covered Services under this benefit:
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

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Appendix C - Temporomandibular Joint Disorder Treatment

Temporomandibular Joint Disorder (TMJ) means a disorder that has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint; internal derangements of the temporomandibular joint; arthritic problems with the temporomandibular joint; or an abnormal range of motion or limitation of motion of the temporomandibular joint.

1. **Benefits.** Benefits for non-surgical treatment of TMJ are limited to a yearly benefit maximum of $1,000 per Enrollee and a lifetime benefit maximum of $5,000 per Enrollee.

2. **Limitations and Exclusions.**

a. TMJ treatment is covered only if the Participating Provider prepares the treatment plan prior to the start of treatment and the treatment is provided by the Participating Provider or upon referral by the Participating Provider to a Non-Participating Provider or Specialist.
b. The repair or replacement of lost, stolen, or broken TMJ appliances is not covered.
c. To be covered, the Covered Services must be:
    1) Reasonable and appropriate for the treatment of TMJ;
    2) Effective for the control or elimination of pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food, which is caused by TMJ;
    3) Recognized as effective, in accordance with the professional standard of care;
    4) Not deemed Experimental or Investigational; and
    5) Not primarily intended to improve, alter, or enhance appearance.

Appendix D - Dental Implants

1. Benefits.

The benefits for implant services will be provided when the treatment plan is prepared by a Participating Provider prior to receiving implant services. The treatment plan is based on an examination that must take place while the Enrollee is covered. Benefits for implant services will be provided only if prescribed by a Participating Provider and if the entire implant procedure, including surgery and application of prosthetic, occurs while the Enrollee is covered under this Plan.

2. Services After Termination of Benefits.

If coverage under this Plan terminates prior to completion of implant treatment (including application of prosthetic), there may be additional charges for implant services provided after termination of coverage. If benefits for implant services terminate before the end of the prescribed treatment period, benefits will continue through the end of the month in which the benefits for implant services are terminated. Implant treatment provided after coverage under this Plan has terminated including application of prosthetic(s) will be pro-rated based on the Reasonable Cash Value of the services.

3. Services provided in connection with implant treatment are subject to the Copayments listed below and the applicable Copayments listed in Appendix A. All Copayments must be paid in full at the time of service. In addition, only the implant services listed below will be covered under the Implant Services Benefit. All other implant services will be subject to the Copayments, including any office visit Copayments, as stated in Appendix A or will not be covered.

CDT Code	Description	Enrollee Pays
D6010	Surgical placement of implant body: endosteal implant	$1,720
D6055	Connecting bar - implant supported or abutment supported	$0
D6056	Prefabricated abutment - includes modification and placement	$0
D6057	Custom fabricated abutment - includes placement	$0
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$1,080
D6062	Abutment supported cast metal crown (high noble metal)	$1,080
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$1,012*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$1,012*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$0
D6090	Repair implant/abutment supported prosthesis	$0
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$1,725
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$1,725
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$1,725
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$1,725
D6190	Radiographic/surgical implant index, by report	$0

* Two Teeth Implant or Three Teeth Implant: The total amount of Implant Copayments incurred by an Enrollee for procedures associated with a two teeth implant delivered on the same date of service shall not exceed $5,464 under the Implant Services Benefit. The total amount of Implant Copayments incurred by an Enrollee for procedures associated with a three teeth implant delivered on the same date of service shall not exceed $7,644 under the Implant Services Benefit. These amounts shall not include additional fees incurred by the Enrollee for services not covered under the Implant Services Benefit.

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Appendix E – Orthognathic Surgery

Orthognathic surgery performed by a Dentist means the Dentally Necessary surgical procedures or treatment to correct the mal-position of the maxilla (upper jawbone) or the mandible (lower jawbone). It may also include treatment of congenital or developmental malformations which impair functions of the teeth and supporting structures for a Subscriber's Dependent child under the age of 19, if the treatment is appropriate to be performed by a Dentist.

1. All orthognathic surgery must be prescribed by a Participating Provider before treatment begins. Benefits will be denied if treatment is not preauthorized. Orthognathic surgery is covered at 70%, up to a lifetime maximum of $5,000. Treatment for complications will be covered only if treatment begins within 30 days of the original treatment.

2. In addition to the limitations and exclusions set forth in this Certificate of Coverage, the following limitations and exclusions also apply to orthognathic treatment:

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