

Group Dental
Certificate of Coverage

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Introduction

This prepaid Willamette Dental Plan is offered by Willamette Dental of Washington, Inc., with dental services provided by Willamette Dental Group (WDG). Willamette Dental of Washington, Inc., together with its affiliated companies, is one of the largest managed care dental organizations in the nation. With over 30 years' experience in managed care, it will provide Enrollees with professional dental services at fair prices. WDG encourages the use of preventive services and provides urgent and routine care, including hygienist services and necessary restorative services. An Enrollee's dental work also includes specialty services paid in full after any applicable Co-payment. Enrollees must see a Participating Dentist for services to be covered and for all referrals. Dental services in Washington are provided at the offices listed below:

Bellevue

Park 120 Office Complex
626 120th Avenue NE
Suite B210
Bellevue, WA 98005

Bellingham

Pacific Meridian Plaza
4164 Meridian Street
Bellingham, WA 98226

Everett

4310 Colby Street, Suite 300
Everett, WA 98203

Federal Way

West Campus Professional
Building 1, Suite C-100
181 S. 333rd Street
Federal Way, WA 98003

Kennewick

Westhaven Professional Park
602 North Colorado
Kennewick, WA 99336

Kent

24722 – 104th Avenue SE
Kent, WA 98031

Lakewood

9307 Bridgeport Way SW
Tacoma, WA 98499

Longview

1461 Broadway Street
Suite A
Longview WA 98632

Lynnwood

Scriber Lake Office Center
6101 – 200th Street SW, Suite 201
Lynnwood, WA 98036

Olympia

Columbia Commons
3773-C Martin Way
Suite 105
Olympia, WA 98506

Pullman

1646 Wheatland Shopping Center
1646 S Grand Avenue
Pullman, WA 99163

Puyallup

702 South Hill Park Drive
Suite 201
Puyallup, WA 98373

Renton

1000 Oakesdale Avenue SW
Renton WA 98055

Richland

104 Columbia Point Drive
Richland, WA 99352

Seattle

133 Dexter Avenue North
Seattle, WA 98109

Seattle

2111 North Northgate Way, Suite 100
Seattle, WA 98133

Seattle Northgate Specialty

11011 Meridian Avenue N, Suite 104
Seattle, WA 98133

Silverdale

3505 NW Anderson Hill Road
Silverdale, WA 98383

Spokane - South Hill

Fidelity Associates Building
501 South Bernard, Suite 203
Spokane, WA 99204

Spokane - Northpointe

9717 N Nevada
Spokane, WA 99218

Tacoma - West

6th Ave Plaza Shopping Center
5401 Sixth Avenue, Suite 201
Tacoma, WA 98406

Tumwater

6120 Capitol Boulevard S
Tumwater, WA 98501

Vancouver - Mill Plain

9609 Mill Plain Boulevard
Vancouver, WA 98664

Vancouver - Hazel Dell

910 NE 82nd Street
Vancouver, WA 98665

Vancouver East

1201 SE Tech Center Drive, Suite 150
Vancouver, WA 98683

Wenatchee

Mission Plaza Professional Center
317 N Mission Street # 206
Wenatchee, WA 98801

Yakima

1200 Chesterly Drive, Suite 230
Yakima, WA 98908

Definitions

Appeal: A written or oral request from an Enrollee or authorized representative to change a previous decision made by Willamette Dental of Washington, Inc., concerning: a) access to dental care benefits, including an adverse determination; b) out of area Dental Emergency encounter including payment or reimbursement for dental care and 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.

Congenital Anomalies: Congenital or developmental malformations including, but not limited to maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and ectodental dysplasia and those services or supplies provided to correct such conditions including, but not limited to, cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and ectodermal dysplasia.

Co-payment: The dollar amount the Enrollee must pay when receiving specific services.

Dental Emergency: An acute infection, traumatic damage to the oral cavity, or discomfort that cannot be controlled by non-prescription pain medication.

Dental Necessity: A service is “dentally necessary” if it is recommended by the treating Participating Dentist and if all of the following conditions are met:

1. The purpose of the service, supply, or intervention is to treat a dental condition;
2. It is the appropriate level of service, supply or intervention considering the potential benefits and harm to the Enrollee;
3. The level of service, supply, or intervention is known to be effective in improving health outcomes;
4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

A health “**intervention**” is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a dental condition (i.e., disease, illness, injury, genetic or congenital defect or a biological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of “**dental necessity**,” a health intervention means not only the intervention itself, but also the dental condition and Enrollee indications for which it is being applied.

“**Effective**” means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention, supply or level of service may be dentally indicated yet not be a covered benefit or meet the standards of this definition of “Dental Necessity.”

“**Treating provider**” means the Plan Designated Dentist who has personally evaluated the Enrollee.

“**Health outcomes**” are results that affect health status as measured by the length or quality (primarily as perceived by the Enrollee) of a person’s life. An intervention is considered new if it is not yet in widespread use for the dental condition and Enrollee indications being considered.

“**New interventions**” for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (See “existing interventions” below.)

“**Scientific evidence**” consists primarily of controlled clinical trials that directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained by the natural history of the medical condition or potential experimental biases.

For “**existing interventions**,” the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of “dental necessity.” If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet Willamette Dental of Washington Inc’s definition of “dental necessity” in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered “**cost effective**” if the benefits and harms relative to costs represent an economically efficient use of resources for Enrollees with this condition. In the application of this criterion to an individual case, the characteristics of the individual Enrollee shall be determinative. Cost-effective does not necessarily mean lowest price.

Enrollee: The Subscriber or a covered dependent enrolled in this Plan.

Experimental or Investigative: A service or supply that is determined by Willamette Dental of Washington, Inc., to meet any one of the following criteria.

1. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
2. The Plan Designated Provider has not demonstrated proficiency in the service, based on knowledge, training, experience and treatment outcomes.
3. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
4. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the Enrollee’s health or safety. Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider’s written protocols or scientific data from another provider studying the same service. The documentation used to establish the plan criteria will be made available for Enrollees to examine at the Willamette Dental of Washington, Inc. office, if an Enrollee sends a written request.

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

Participating Dentist: A dentist who is employed by or is under contract with the Plan Designated Provider to provide dental services.

Plan: This PEBB dental benefit plan of coverage.

Plan Designated Provider: Willamette Dental Group or any of its affiliated dental practices. The Plan Designated Provider is engaged by the Willamette Dental of Washington, Inc., to provide dental services under the terms of the Contract.

Reasonable Cash Value: The Plan Designated Provider's usual, customary, and reasonable fee-for-service price of dental services and supplies.

Subscriber: The employee or retired employee enrolled in this Plan.

Choosing a Primary Care Dentist

An Enrollee will only be covered for dental benefits when services are provided by a Participating Dentist or if the Participating Dentist refers the Enrollee to an outside dentist or specialist. If a referral is made to an outside dentist or specialist, the Co-payments as stated in the "Schedule of Covered Services and Co-payments" will apply.

Willamette Dental Group encourages the Enrollee to establish a long-term relationship with a primary Participating Dentist. Once the Enrollee selects his or her dentist, the Enrollee should schedule all future appointments with that dentist. The Enrollee is also free to change his or her Participating Dentist or location at any time. For further information, please call (800) 359-6019.

Appointments

To schedule an appointment, please call the Willamette Dental Appointment Center: Toll Free (800) 359-6019.

Appointment Center Hours: Monday - Thursday, 7 a.m. to 8 p.m. PST; Friday, 7 a.m. to 6 p.m. PST; Saturday, 7 a.m. to 4 p.m. PST.

Routine, non-emergency appointments generally will be scheduled and occur within 90 days after the date of the request. The wait-time for an appointment may vary based on the Enrollee's choice of provider, dental office location, and the desired day or time of appointment.

New Enrollee Examinations

As a new Enrollee, you can expect your first visit to include:

- A comprehensive examination and necessary X-rays.
- Review of your medical and dental history.
- Determination of risk factors for decay and gum disease, and recommendations to improve your oral health.
- A head and neck cancer screening.
- A personal dental care plan established to meet your individual needs.
- A blood pressure check.
- In most cases, children through age 12 will receive a cleaning and fluoride treatment.
- Based on the results of this first appointment, your Participating Dentist will determine your personal dental care plan and schedule your next appointment with a hygienist.

Specialty Services

The Enrollee's Participating Dentist will provide services or coordinate referrals for specialty care for all covered and prescribed Dental Necessities.

If the Enrollee's Participating Dentist cannot provide a prescribed covered service, the Participating Dentist may refer the Enrollee to a specialist or non-Participating Dentist. Willamette Dental of Washington, Inc., agrees to provide Benefits for services and supplies provided by a specialist or non-Participating Dentist only if:

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

Specialty services, including orthodontia and implant treatment, are generally available on a regional basis. To find out where specialty service is available in your area, simply contact our Appointment Center toll free at (800) 359-6019. Benefits for implant and orthodontic treatment are provided only if treatment is rendered from a Participating Dentist or a specialist employed by or under contract with the Plan Designated Provider.

Emergency Care

Willamette Dental provides emergency dental care during regular office hours. If you have a dental emergency, then you should call the Appointment Center toll free at (800) 359-6019. If necessary, you will be able to see a Willamette Dental dentist within approximately 24 hours. You will pay an emergency office visit co-payment for this service. After-hours, a dentist is available for dental emergency consultation over the telephone, at no cost.

Out of Area Emergency Care

A Plan Designated Provider shall provide care for Dental Emergency when an Enrollee is within 50 miles from a Plan Designated Provider office. In the event of a Dental Emergency, when an Enrollee is more than 50 miles from a Plan Designated Provider office, the Enrollee may obtain services from any licensed dentist. Emergency services received from a non-Plan Designated Provider will be reimbursed up to \$200 per covered emergency appointment minus the applicable Co-payments, to the extent that such services would have been covered if the Enrollee had seen a Participating Dentist. However, only treatment and supplies for pain, bleeding or swelling will be reimbursed. All follow up treatment and supplies must be provided by a Plan Designated Provider. The Enrollee will need to submit a written request for reimbursement for services received from a non-Plan Designated Provider in an emergency. After hours emergency care, whether received from a Plan Designated Provider or from a non-participating dentist, will be subject to a \$20 Co-payment in addition to any other Co-payments due for the services received.

Schedule of Covered Services and Co-Payment

ADA Code	Procedure	Co-payment	ADA Code	Procedure	Co-payment
1. Office Visit Charge					
		\$0			
2. Diagnostic and Preventative Services					
D0120	Periodic oral evaluation	\$0	D2150	Fillings – 2 surfaces	\$10
D0140	Limited oral evaluation-problem focused	\$0	D2160	Fillings – 3 surfaces	\$10
D0145	Oral evaluation - under three years of age	\$0	D2161	Fillings – 4 or more surfaces	\$10
D0150	Comprehensive oral evaluation	\$0	D2951	Pin retention – per tooth, in addition to restoration	\$10
D0160	Detailed & extensive oral evaluation	\$0	b. Resin Restorations		
D0170	Re-evaluation - limited	\$0	D2330	Resin-1 surface (anterior only)	\$15
D0180	Comprehensive Periodontal Evaluation	\$0	D2331	Resin-2 surfaces (anterior only)	\$15
D0210	Complete series x-rays	\$0	D2332	Resin-3 surfaces (anterior only)	\$15
D0220	Periapical-first film	\$0	D2335	Resin-4 surfaces (anterior only)	\$15
D0230	Intraoral - each additional film	\$0	D2390	Resin based composite crown	\$50
D0240	Intraoral - occlusal film	\$0	D2950	Core buildup, including any pins	\$0
D0250	Extraoral - first film	\$0	D2391	Resin-one surface posterior	\$50
D0260	Extraoral - each additional	\$0	D2392	Resin-two surfaces posterior	\$50
D0270	Bitewings - single film	\$0	D2393	Resin-three surfaces posterior	\$50
D0272	Bitewings - two films	\$0	D2394	Resin four or more surfaces posterior	\$50
D0273	Bitewings - three films	\$0	c. Inlay/Onlay (cast restorations)		
D0274	Bitewings - four films	\$0	D2510	Inlay-metallic 1 surface	\$115
D0277	Vertical bitewings	\$0	D2520	Inlay-metallic 2 surfaces	\$115
D0330	Panoramic x-rays	\$0	D2530	Inlay-metallic 3 or more surfaces	\$115
D0340	Cephalometric film	\$0	D2542	Onlay-metallic 2 surfaces	\$125
D0350	Oral / facial images	\$0	D2543	Onlay-metallic 3 surfaces	\$125
D0425	Caries Susceptibility Tests	\$0	D2544	Onlay-metallic 4 or more surfaces	\$125
D0460	Pulp vitality test	\$0	D2610	Inlay-porcelain/ceramic 1 surface	\$125
D0470	Diagnostic casts	\$0	D2620	Inlay-porcelain/ceramic 2 surfaces	\$125
D0460	Pulp vitality tests	\$0	D2630	Inlay-porcelain/ceramic 3 surfaces	\$125
D0470	Diagnostic casts	\$0	D2642	Onlay-porcelain/ceramic 2 surfaces	\$125
D1110	Teeth cleaning (prophylaxis) adult	\$0	D2643	Onlay-porcelain/ceramic 3 surfaces	\$125
D1120	Teeth cleaning (prophylaxis) child	\$0	D2644	Onlay-porcelain 4 or more surfaces	\$125
D1203	Topical fluoride - child	\$0	D2910	Recement inlay	\$0
D1204	Topical fluoride - adult	\$0	5. Crowns		
D1206	Topical fluoride - therapeutic	\$0	D2710	Crown-resin laboratory	\$100
D1310	Nutritional counseling	\$0	D2720	Crown-resin with high noble metal	\$100
D1320	Tobacco counseling	\$0	D2721	Crown-resin with predominantly base metal	\$100
D1330	Oral Hygiene Instruction	\$0	D2722	Crown-resin with noble metal	\$100
D1351	Sealant/tooth	\$0	D2740	Crown-porcelain/ceramic	\$155
3. Space Maintainers					
D1510	Space Maintainer - unilateral-fixed	\$20	D2750	Crown-porcelain fused to high noble metal	\$175
D1515	Space Maintainer - bilateral-fixed	\$30	D2792	Full cast crown – noble	\$150
D1520	Space Maintainer - unilateral-removable	\$20			
D1525	Space Maintainer - bilateral removable	\$30			
D1550	Space Maintainer - recement	\$10			
D1555	Space Maintainer - removal	\$10			
4. Restorative Dentistry					
a. Amalgam Restorations					
D2140	Fillings - 1 surface	\$10			

closure, mucogingivoplastic surgery, frenectomy, periodontal grafts, root planning and curettage, and management of infection and oral lesions related to the supporting tooth structure.

14. Prosthodontic Services: Replacement of missing teeth with full or partial dentures, crowns or bridges is limited to the charge for the standard procedure. These services do not include and do not cover:

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

Orthodontic Services

The Plan Designated Provider must authorize orthodontic services before treatment begins. Initial orthodontic diagnostic work-up and X-rays are subject to a Pre-Orthodontic Service Co-payment of \$50, which is due at the initial consultation. However, if the Enrollee undergoes orthodontic treatment, the Pre-Orthodontic Service Co-payment will be deducted from Orthodontic Service Co-payment. The Co-payment for a partial orthodontic treatment plan (less than 24 months) will be prorated according to the extent of orthodontic services provided. The length of treatment of full orthodontic treatment is not limited. The Orthodontic Service Co-payment amount for full orthodontia is \$1,500 per case, which is due in full prior to commencement of orthodontic treatment. If coverage terminates prior to completion of orthodontic treatment, there may be additional charges for orthodontic services rendered after coverage is terminated. If benefits for orthodontic services terminate before the end of the prescribed treatment period, benefits will continue through the end of the month in which the benefits for orthodontic services are terminated. Continuing orthodontic treatment will be pro-rated based on the Reasonable Cash Value of the services.

Temporomandibular Joint Treatment

All treatments of temporomandibular joint disorders (TMJ) must be authorized before treatment begins. Benefits will be denied if treatment is not preauthorized. Benefits for non-surgical treatment of TMJ are covered at a maximum benefit of \$1,000 per calendar year and up to a lifetime maximum benefit of \$5,000. Covered services must be: 1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint; 2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; 3) recognized as effective, according to the professional standards of evidenced based dental practice; 4) not investigational; and 5) not primarily for cosmetic purposes. All services must be provided or ordered by a Participating Dentist. No surgical treatment, banding treatment or restorations will be covered under this benefit.

Orthognathic Surgery

All orthognathic surgery must be authorized 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. Orthognathic surgery performed by a dentist is defined as the necessary surgical procedures or treatment to correct the mal-position of the maxilla (upper jawbone) and/or the mandible (lower jawbone). It may also include treatment of Congenital Anomalies for a Subscriber's dependent child under the age of 19, if the treatment is appropriate to be performed by a dentist. Treatment for complications will be covered only if treatment begins within 30 days of the original treatment. In addition to the limitations and exclusions set forth in this Certificate of Coverage, the following limitations and exclusions also apply to orthognathic treatment:

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

Implants

Dental implants are available to Enrollees at designated Willamette Dental Regional Dental Implant Centers. Regional Implant Centers are located in Olympia, West Tacoma, Northgate, Seattle, Spokane, and Richland.

The following is the typical process that an Enrollee will follow for dental implant services.

- **First Appointment:** Evaluation by a Participating Dentist to determine if the Enrollee is a viable candidate to receive a dental implant.
- **Second Appointment:** Enrollee receives a consultation at a Regional Dental Implant Center with a Participating Dentist who specializes in performing dental implants. A stint is fitted for the implant during this appointment.
- **Third Appointment:** Implant surgery is performed at the Regional Dental Implant Center.
- **Fourth Appointment:** Once the Enrollee is healed, an impression will be taken in order to place the implant appliance(s). This will occur at a Plan Designated Provider office or the Regional Dental Implant Center, as appropriate for the Enrollee.
- **Fifth Appointment:** The implant appliance will be placed on implant. This will occur at a Plan Designated Provider office or Regional Dental Implant Center, as appropriate for the Enrollee.
- **Follow-up Appointments:** Follow-up appointments will be scheduled to evaluate the Enrollee's progress. These appointments will be at a Plan Designated Provider office or Regional Dental Implant Center, as appropriate for the Enrollee.

Implant services will only be provided if the entire implant procedure (surgery and prosthetics) are performed and provided while the Enrollee is covered under the Plan.

Benefits for implant services will only be provided if all of the following conditions are met:

- A Participating Dentist determines and approves the Enrollee as a viable candidate for dental implants;
- The treatment plan is prepared by a Participating Dentist prior to rendering services;
- The treatment plan is based on an examination that occurs while the Enrollee is covered;
- The entire implant procedure, including surgery and application of prosthetic, occurs while the Enrollee is covered.

If coverage under the Plan terminates prior to completion of implant treatment (including application of prosthetic), there may be additional charges for implant services rendered after termination. 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. Continuing implant treatment (including application of prosthetic) will be pro-rated based on the Reasonable Cash Value of the services.

Services provided in connection with implant treatment are subject to the Co-pays listed below and the applicable Co-pays listed in the Schedule of Covered Services and Co-payments.

Pre-Implant Service Co-Pays Schedule: The payment of pre-implant service Co-pays will be deducted from the Implant Service co-payment listed below.

Initial implant consultation	\$25
Diagnostic cast and X-rays	\$125
Case presentation	None

Implant Service Co-Pays Schedule:

Single implant and crown	\$2,800
Two implants and crowns	\$5,464
Three implants and crowns	\$7,644
Denture with two implants	\$5,120
Each additional implant and crown	\$2,095
Denture with three implants	\$6,885
Each additional implant per denture	\$1,780

The following services are covered under the implant benefit:

- D0160 – Implant Detailed
- D0470 – Implant Records, Facebow and Study Models
- D5730 – Reline Upper Implant Denture
- D5731 – Reline Lower Implant Denture
- D5740 – Reline Upper Implant Partial
- D5741 – Reline Lower Implant Partial
- D5982 – Implant Location Stent U/L
- D6010 – Surgical Placement of Endosteal Implant
- D6053 – Implant Removable Denture
- D6054 – Implant Removable Partial
- D6055 – Hader Bar Abutment Per Implant
- D6056 – Prefab Abutment for Implant
- D6057 – Custom Abutment for Implant
- D6058 – Abutment Supported Ceramic crown
- D6059 – Abutment Supported PFM crown
- D6062 – Abutment Supported Metal FPD
- D6068 – Abutment Retainer Ceramic FPD
- D6069 – Abutment Retainer PFM FPD
- D6072 – Abutment Retainer Metal FPD
- D6080 – Implant Maintenance Procedure
- D6090 – Repair Implant Prosthesis
- D6095 – Repair Implant Abutment
- D6240 – Pontic - Porcelain/Metal Implant
- D9310 – Implant Consultation

Submitting Claims

The Enrollee is not responsible for filing claims for services received from a WDG office. The Enrollee should simply show their dental identification card and pay any appropriate Co-payments when services are received. The Enrollee will need to submit a written request for reimbursement after receiving services for treatment of a Dental Emergency from a non-participating dentist. Be sure to request two copies of the itemized bill from the non-participating dentist and submit the following information:

- Subscriber's name, date of birth, address, Insurance ID number, group name, and number.
- Nature of the Dental Emergency and an itemized statement by the attending, non-Plan Designated Provider.
- All claims must be submitted within six months after the date of service.
- Mail claims to: Willamette Dental Group
Attn: Outside Claims
6950 NE Campus Way
Hillsboro, OR 97124-5611

General Limitations and Exclusions

In addition to the specific exclusions and limitations stated elsewhere in this Certificate of Coverage, Willamette Dental of Washington, Inc. does not provide benefits for:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
2. Restorations or appliances necessary 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 mal-alignment of teeth.
3. Services or supplies that Willamette Dental of Washington, Inc. determines are Experimental or Investigative.
4. Any drugs or medicines even if they are prescribed. This includes analgesics (medications to relieve pain) and pain management drugs such as pre-medication and nitrous oxide.
5. General anesthesia, including moderate or deep sedation, unless otherwise specified as covered in this Certificate.
6. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all of the following requirements are met:
 - a. A hospital setting for the dental care must be medically necessary.
 - b. Expenses for such care are not covered under the Enrollee's employer-sponsored medical plan.
 - c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by Willamette Dental of Washington, Inc. Such request for preauthorization must be accompanied by a physician's statement of medical necessity. If hospital or facility care is approved, available benefits will be provided at the same Co-payment as those performed by the Plan Designated Provider, up to the available benefit maximum.
7. Dental services started prior to the date the person became eligible for services under this Plan.
8. Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.
9. Expenses incurred after termination of coverage, except expenses for:
 - a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
 - b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
 - c. Root canal treatment, if tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
10. Completing insurance forms or reports, or for providing records.
11. Habit-breaking appliances, except as specified under the orthodontia benefit.
12. Full-mouth reconstruction.
13. Replacement of sound fillings. (Replacement of sound fillings will not be covered unless recommended by a Participating Dentist; preauthorization is required.)
14. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, or denturist.
15. Orthodontic treatment, orthognathic treatment, or treatment of TMJ disorders that are not authorized in advance.
16. Replacement of lost or stolen dental appliances.
17. Services or supplies not listed as covered in this Certificate of Coverage.

Eligibility

Eligibility for Public Employees Benefits Board (PEBB) benefits is based on rules in Washington Administrative Code (WAC). PEBB rules are codified in chapter 182-12 WAC and are accessible through the PEBB Rules section on the PEBB website at www.pebb.hca.wa.gov.

Employees (referred to in this Certificate as "employees," "Subscribers" or, in some cases, "enrollees") are eligible for enrollment in PEBB dental plans as described in the PEBB eligibility rules in chapter 182-12 WAC.

Retired or permanently disabled employees (referred to in this book as “retirees,” “Subscribers” or, in some cases, “enrollees”) of state government, higher education, participating K-12 school districts, educational service districts and participating employer groups are eligible for enrollment in PEBB dental plans in accordance with PEBB rules in chapter 182-12 WAC. Retiree and surviving dependent dental enrollment is contingent upon enrollment in a PEBB medical plan.

Surviving dependents (referred to in this book as “Subscribers” or in some cases “enrollees”) who meet eligibility criteria are eligible for enrollment in PEBB dental plans in accordance with PEBB rules in chapter 182-12 WAC. Surviving dependents will lose their right to enroll in PEBB coverage if they do not apply to enroll or defer coverage within the timelines stated in PEBB rules or do not maintain continuous comprehensive employer-sponsored health plan coverage during a deferral.

Eligibility criteria for surviving dependents of an eligible employee or an eligible retiree are outlined in WAC 182-12-265. Eligibility criteria for surviving dependents of emergency service personnel who are killed in the line of duty are outlined in WAC 182-12-250.

Dependents. Subscribers may enroll dependents in their PEBB dental plan if the dependent is eligible and the dependent is not enrolled in a PEBB dental plan under another Subscriber. Surviving dependents of emergency service personnel may not add newly acquired dependents. The dependent of a retiree or surviving dependent must enroll in a PEBB medical plan in order to enroll in dental.

The following are eligible as dependents:

1. Lawful spouse
2. Washington State-registered domestic partners.
3. Children. Children are defined as the Subscriber’s biological children, stepchildren, legally adopted children, 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 Washington State-registered domestic partner, or children specified in a court order or divorce decree. In addition, children include extended dependents in the legal custody or legal guardianship of the Subscriber, the Subscriber’s spouse, or the Subscriber’s Washington State-registered domestic partner. The legal responsibility is shown in a valid court order and the child’s official residence with the custodian or guardian. “Children” does not include foster children for whom support payments are made to the Subscriber through the state Department of Social and Health Services foster care program. Eligible children include:
 - a. Unmarried children through age 19.
 - b. Married children through age 19 who qualify as dependents of the Subscriber under the Internal Revenue Code.
 - c. Unmarried children age 20 through 23 who are attending high school or are registered students at an accredited secondary school, college, university, vocational school, or school of nursing (students). A married child is eligible as a student if the child is a dependent of the Subscriber under the Internal Revenue Code. If a student becomes seriously ill or injured and requires a medically necessary leave of absence from attending school, his or her coverage may continue if qualified under and in accordance with the federal Michelle’s Law (Public Law 110-381)
 - d. Unmarried children age 20 through 24 (adult dependents). The Subscriber must pay the adult dependent premium for adult dependents whom the Subscriber has enrolled. Nonpayment of premium will result in termination of coverage back to the end of the last full month premium was paid. Adult dependents must enroll in the same medical plan as the Subscriber unless the dependent does not reside within the Subscriber’s medical plan service area or the Subscriber has waived his or her medical plan as required in PEBB rule.
 - e. Children of any age with disabilities, developmental disabilities, mental illness or mental retardation, who are incapable of self-support, provided such condition occurs before age 20 or during the time, the dependent was eligible as a student. The Subscriber must provide evidence that such disability occurred as stated below:
 - For a child enrolled in PEBB insurance coverage, the Subscriber must provide evidence of the disability within 60 days of the child reaching age 20.
 - For a child enrolled in PEBB insurance coverage as a student, the Subscriber must provide evidence of the disability within 60 days after the student is no longer eligible under PEBB rules.
 - For a child 20 or older who is a new dependent or for a child 20 or older who is a dependent of a newly eligible Subscriber, the child may be enrolled as a child with disabilities if the Subscriber provides evidence that the condition occurred before the child reached age 20 or evidence that when the condition occurred the child would have satisfied PEBB eligibility for student coverage under PEBB rules had the Subscriber been eligible for PEBB benefits at that time.
 - The Subscriber must notify the PEBB Program in writing no later than 60 days after the date the child age 20 or older no longer qualifies under PEBB rules.

Children age 20 and older who become capable of self-support do not regain eligibility as a child with disabilities under PEBB rules if they later become incapable of self-support. The PEBB Program will recertify children with disabilities periodically.

4. Parents.

a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:

- The parent maintains continuous enrollment in a PEBB medical plan;
- The parent qualifies under the Internal Revenue Code as a dependent of the Subscriber;
- The Subscriber continues enrollment in PEBB insurance coverage; and
- The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the Subscriber. Parents may not add additional dependents to their insurance coverage.

Enrollment

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules are accessible through the PEBB Rules section of the PEBB website at www.pebb.hca.wa.gov.

A Subscriber or Subscriber's dependent is eligible to enroll in only one PEBB dental plan even if eligibility criteria are met under two or more Subscribers. For example, a dependent child who is eligible for enrollment under two or more parents employed by PEBB participating employers may be enrolled as a dependent under one parent, but not more than one.

Employees are required to enroll in a dental plan under their employing agency. Employees are not required to enroll eligible dependents in dental. The employee must submit the appropriate enrollment form to his or her employing agency no later than 31 days after the date the employee becomes eligible for PEBB benefits. To enroll an adult dependent, the employee must submit the Adult Dependent Enrollment/Change form to the PEBB Program no later than 31 days after the date the employee becomes eligible for PEBB benefits.

Dependents who are not enrolled when they are initially eligible may be enrolled during the annual open enrollment or outside of the annual open enrollment if a special open enrollment event occurs.

Retirees and surviving dependents may enroll in dental. If a retiree or surviving dependent chooses to enroll in a dental plan at retirement or during an open enrollment, the retiree or surviving dependent must maintain dental coverage for no less than two years, and any dependents enrolled on the Subscriber's account will be enrolled in dental as well. The retiree or surviving dependent must return the appropriate enrollment form(s), as instructed on the form, within the time limits required in PEBB rules. (See WAC 182-12).

Retirees and surviving dependents who do not enroll when they are initially eligible may enroll during the annual open enrollment period. The Subscriber must submit the appropriate change form, as instructed on the form, before the end of the annual open enrollment. The enrollment change will become effective January 1 of the following year.

Removing or changing enrollment

Employees, retirees and surviving dependents may make enrollment changes outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be related to the special open enrollment event.

Exception:

A retiree or a surviving dependent may cancel a dependent's enrollment at any time. Surviving dependents of emergency service personnel may not add newly acquired dependents. Unless noted, these qualifying events for a special open enrollment do not apply to eligible retirees or survivors who have deferred their PEBB retiree insurance coverage.

Special open enrollment events are:

- Subscriber acquires an eligible dependent through marriage, Washington State-registered domestic partnership, birth, adoption or placement for adoption, legal custody or legal guardianship;
- Subscriber's dependent no longer meets PEBB eligibility criteria;
- Subscriber has a change in marital status, including legal separation documented by a court order or dissolution of a domestic partnership;
- Subscriber or a dependent loses comprehensive group health plan coverage;
- Subscriber or a dependent has a change in employment status that affects the employee's or the employee's dependent's eligibility, the level of benefits, or the cost of health plan coverage;
- Subscriber or a dependent has a change in place of residence that affects the Subscriber's or the dependent's eligibility, the level of benefits, or cost of the health plan coverage;

- Subscriber receives a court order or medical support enforcement order requiring the Subscriber, their spouse or qualified Washington State-registered domestic partner to provide health plan coverage for an eligible dependent;
- Subscriber receives a formal notice that the Department of Social and Health Services has determined it is more cost effective to enroll an eligible dependent in a PEBB medical plan than a medical assistance program;
- Subscriber or dependent becomes eligible for a medical assistance program under the Department of Social and Health Services, including Medicaid or the Children's Health Insurance Program (CHIP), or the Subscriber or dependent loses eligibility in such a medical assistance program; or
- Dependent dies.

To make an enrollment change (enroll or remove a dependent who is no longer eligible) the Subscriber must submit the appropriate form(s), as instructed on the form, no later than 60 days after the event that created the special open enrollment.

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 notify PEBB by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the Subscriber must submit the appropriate enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Employees should contact their payroll, personnel or insurance office to obtain the appropriate forms. The PEBB Program verifies the eligibility of all dependents periodically. The PEBB Program reserves the right to request documents from Subscribers that provide evidence of a dependent's eligibility. The PEBB Program will remove a Subscriber's enrolled dependents if the PEBB Program is unable to verify a dependent's eligibility. Retirees and surviving dependents should contact the PEBB Program to obtain the appropriate forms. In addition, the PEBB Program or employing agency may require the Subscriber to provide evidence of eligibility and evidence of the event that created the special open enrollment.

Subscribers must remove dependents who no longer meet PEBB eligibility criteria as defined in WAC 182-12-260. Subscribers must report eligibility changes no later than 60 days after the event that creates a change in premium or loss of eligibility. The PEBB Program verifies the eligibility of all dependents periodically and reserves the right to request documents from Subscribers that provide evidence of a dependent's eligibility. If the Subscriber does not report a change within 60 days after an event that creates a change in premium or loss of eligibility or if the PEBB Program is unable to verify a dependent's eligibility, the consequences may include any one or all of the following:

- The dependent's loss of eligibility to continue health plan enrollment under one of the continuation options described in this certificate of coverage;
- The Subscriber being billed for claims paid by the health plan for services after the dependent lost eligibility;
- The Subscriber being billed for the difference in premium or not receiving a refund of premium that results from the change (see WAC 182-08-180); or

The Subscriber being responsible for premiums paid by the state for a dependent's health plan enrollment after the dependent lost eligibility.

Appeals of Determinations of Ineligibility For Benefits

Any employee, retiree, survivor, or dependent aggrieved by a decision with regard to PEBB benefits may appeal that decision. Guidance on filing an appeal can be obtained in chapter 182-16 WAC (which governs PEBB appeals), on PEBB's website's under "How Do I" (www.pebb.hca.wa.gov) or by calling the PEBB Appeals Manager through the PEBB Program customer service phone line at 1-800-200-1004.

Changing Dental Plans

Subscribers may change dental plans during the annual open enrollment. The Subscriber must submit the appropriate form(s) or make the change online no later than the end of the annual open enrollment.

In some situations, a Subscriber may change dental plans outside of the annual open enrollment if a special open enrollment event occurs. The change in dental plan will begin the first of the month following the event, unless the special open enrollment is due to the birth or adoption of a child. If the special open enrollment event is the birth or adoption of a child, the change in dental plan will begin the first of the month in which the event occurred. The Subscriber must submit the appropriate form(s), as instructed on the form, no later than 60 days after a special open enrollment event occurs and the change must relate to one of the following events:

- Change in the enrollment status of the Subscriber or the Subscriber's dependent due to a special open enrollment event as described in the Enrollment section of this booklet.
- If the employee retires for any reason, the employee may change dental plans at the time of application for retiree insurance coverage. The change will become effective on the first day of the month following the retirement date.

- Seasonal employees whose off-season occurs during annual open enrollment may change dental plans within 60 days of returning to work.
- Subscribers may change dental plans when they or an eligible dependent becomes entitled to Medicare or enrolls in a Medicare Part D plan.
- If a Subscriber's dental plan becomes unavailable, the Subscriber may choose another dental plan within 60 days after notification by the PEBB Program. Anyone that does not choose another dental plan within this time period will be enrolled in the contracted vendor's successor dental plan if one is available or will be enrolled in the Uniform Dental Plan (UDP) by default. Anyone defaulted to the UDP may not change dental plans until the next open enrollment.

NOTE: If an enrollee's dentist or other dental practitioner discontinues participation in an enrollee's plan, the enrollee may not change plans until the next open enrollment period, except as provided in WAC 182-08-198(2). Also, if an enrollee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change plans, except as outlined above.

Employees should contact their payroll, personnel or insurance office for forms and information on how to update their records. Retirees and surviving dependents must contact the PEBB Program to update their records.

When Coverage Begins

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, dental plan enrollment will begin when the employee's insurance coverage begins as defined in WAC 182-12. PEBB dependent eligibility is defined in WAC 182-12-260 and dependent enrollment requirements are described in WAC 182-12-262.

Retiring or permanently disabled employees and surviving dependents must meet the procedural and eligibility requirements in chapter 182-12 WAC, which require the employee to submit the appropriate enrollment form(s), as instructed on the forms, to enroll in or defer enrollment in PEBB retiree insurance coverage within 60 days after their employer paid or COBRA coverage ends.

Eligible retirees who are enrolling in a PEBB health plan following deferment should refer to WAC 182-12-200 and 182-12-205 for coverage effective dates. For eligible dependents, dental coverage begins on the first day of the month in which the retiree or survivor's dental coverage begins if the retiree or survivor lists the dependent on the enrollment form and the dependent meets PEBB eligibility criteria.

For an enrollee enrolled in accordance with PEBB rules during the annual open enrollment, dental coverage will begin on January 1 of the upcoming year.

For an enrollee enrolled in accordance with PEBB rules during a special open enrollment, dental coverage will begin the first of the month following the event that created the special open enrollment unless specifically described below:

- For a spouse or newly eligible dependent child enrolled upon marriage, if the date of marriage is the first day of the month, dental coverage will begin on that date; otherwise, it will begin the first of the following month.
- For a Washington State-registered domestic partner or newly eligible dependent child enrolled upon registration of a domestic partnership (as defined in WAC 182-12-260), if the date of registration is the first day of the month, dental coverage will begin on that date; otherwise, it will begin the first of the following month.
- For a newborn child enrolled upon birth or a child enrolled by the Subscriber in anticipation of the child being adopted, the child's dental coverage will begin on the date of birth or the date the Subscriber assumes legal responsibility for the child in anticipation of adoption. For the Subscriber's other eligible dependents enrolling due to the birth or adoption of a child, dental coverage will begin the first of the month in which the birth or adoption occurs.
- For a child with disabilities enrolled in accordance with PEBB rules, dental coverage begins on the first day of the month that eligibility is certified by the PEBB Program.
- For a student enrolled in accordance with PEBB rules, dental coverage begins on the first day of the month of the quarter or semester for which the child is certified as an eligible registered student (as defined in WAC 182-12-260). Note: A child may not be enrolled as a student outside of an open enrollment if he or she was eligible as a student in the previous quarter/semester.
- For an extended dependent acquired through legal custody or legal guardianship. If legal custody or legal guardianship begins on the first day of the month, dental coverage will begin on that date; otherwise it will begin the first of the following month.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any individual who ceases to be eligible, PEBB insurance coverage ends on the last day of the month in which eligibility ends.
2. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage

will be given the opportunity to enroll in another PEBB plan.

3. For an enrollee who declines the opportunity or is ineligible to continue enrollment in a PEBB dental plan under one of the options for continuing PEBB benefits described in this certificate of coverage, coverage ends for the enrollee at 12 o'clock midnight on the last day of the month in which he or she ceases to be eligible under PEBB rules (such as a non-student child reaching age 20, or a spouse when a final decree of divorce is entered).

4. If the Subscriber stops paying monthly premiums, coverage ends for the Subscriber and enrolled dependents on the last day of the month for which the last full premium was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or cancels his or her coverage before the end of the month.

When dental plan enrollment ends, the enrollee may be eligible for continuation of coverage if application is made within the time limits explained in the Continuing Benefits sections of this booklet.

The enrollee is responsible for timely payment of premiums and reporting changes in eligibility or address.

As a PEBB plan enrollee it is the enrollee's responsibility to pay premiums when due. If the enrollee's coverage is canceled due to delinquency, the enrollee's eligibility to participate in the PEBB benefits will end.

Failure to report changes can result in loss of premiums and loss of your or your dependents right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB Program, please call the PEBB Customer Service staff at 1-800-200-1004.

Options for Continuing PEBB Benefits

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

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) Coverage
- PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical plan and dental plan coverage. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is only available to individuals who meet eligibility and procedural requirements defined in Washington Administrative Code (WAC) 182-12-171 or surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or 182-12-265. These rules are accessible through the PEBB Rules section of the PEBB website www.pebb.hca.wa.gov.

All four options are administered by the PEBB Program. Refer to your PEBB Initial Notice of COBRA and Continuation Coverage Rights for specific details or call the PEBB Program Customer Service at 1-800-200-1004.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to 26 weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. These employees may also continue current optional life and long-term disability insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Options for Continuing PEBB Benefits."

Payment of Premium During a Labor Dispute

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

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA, in writing, by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

Disenrollment 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 disenroll an Enrollee from this Plan for Just Cause.

Policy:

1. The Health Care Authority (HCA) may disenroll an Enrollee from this Plan if the Enrollee:
 - a. Repeatedly fails to make timely co-payments.
 - b. Commits abuse or intentional misconduct.
 - c. Poses such a danger to a person or property at a provider facility and/or to the attending dentist or staff that they have filed a formal complaint to HCA indicating that they no longer wish to provide services to that Enrollee.
2. Except in cases of imminent danger to a person or property, the HCA will not take action against an Enrollee, unless the Plan Designated Provider has made reasonable efforts to notify the Enrollee and the HCA in writing of the following:
 - a. The alleged problem;
 - b. What actions are necessary for the Enrollee to rectify the problem; and,
 - c. That the failure to correct the problem may result in the Plan Designated Provider requesting the HCA to disenroll the Enrollee this Plan, and would cause the Enrollee to be enrolled in a different dental plan.
3. In cases of alleged danger to the person or property at the provider facility, a decision by the HCA will take effect immediately upon notice of disenrollment when so specified in the notice.
 - a. In other cases, the decision will take effect when the Enrollee appeals under WAC 182-16-040 and WAC 182-16-050 have been exhausted.
 - b. When a disenrollment decision takes effect, HCA will select a dental plan for the disenrolled Enrollee to be enrolled into, with no lapse in coverage, in accordance with the service area rules.
 - c. If the Subscriber does not choose to enroll in an alternative plan with a disenrolled dependent, coverage for the disenrolled dependent may be unavailable under another plan.
4. An Enrollee may petition the HCA for the opportunity to enroll in a dental plan of his or her choice, including this Plan, after twelve months of the date of disenrollment and during a period of open enrollment. HCA will only grant the petition if the Enrollee provides clear, cogent, and convincing evidence that the reasons for disenrollment no longer exist and are unlikely to reoccur.

Subrogation

If the Plan Designated Provider provides services for the treatment of an injury, whether or not caused by another party, it shall:

- a) be subrogated to the right of the Enrollee or the Enrollee's representative to recover compensation to the extent of the reasonable value of services and benefits provided for the injury; and
- b) have a security interest in any damage recoveries to the extent of all payments made or the reasonable value of services provided by the Plan Designated Provider, subject to the limitations specified in the "Collection by Enrollee or Enrollee's Representative" paragraph below.

As a condition of receiving the benefits of this Plan for the injury, the Enrollee or the Enrollee's representative shall:

- a) agree to hold in trust, any such damage recoveries until such time as a final determination or settlement is made regarding the amount that fully compensates the Enrollee for his or her loss and to execute a trust agreement guaranteeing the Plan Designated Provider's rights as described in this section;
- b) give the Plan Designated Provider, in writing, the name and address of the party who caused the injury, the facts of the accident, and any other information reasonably necessary to protect the Plan Designated Provider's subrogation rights;
- c) if the injury was caused by another party, submit the bills relating to the accident to the other party's liability insurer when the Enrollee knows that the other party has liability insurance and knows the identity and address of such insurer; and
- d) submit the bills relating to the accident to any underinsured or uninsured motorist insurer from which the Enrollee is entitled to recover.

The Enrollee or the Enrollee's representative shall cooperate fully with the Plan Designated Provider in recovering the amount the Plan Designated Provider has paid or incurred, including providing prior written notice of any intended settlement. Where the Enrollee has cooperated in providing the required information and is represented by an attorney, the Plan Designated Provider shall reduce its subrogated interest by a reasonable amount based on the services provided.

No benefits will be provided for services or supplies payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes coverage available to the Enrollee.

Any benefits provided by or advanced by the Plan Designated Provider contrary to this exclusion are provided solely to assist the Enrollee. By paying such benefits, the Plan Designated Provider is not acting as a volunteer and is not waiving any right to reimbursement or subrogation. When no-fault insurance is available and benefit payments have not been exhausted or denied for reasons other than the medical treatment being:

- a) not reasonable;
- b) not necessary;
- c) not related to the accident; or
- d) not incurred within three years of the accident, it will be the Enrollee's responsibility to pursue their coverage through the no-fault carrier to obtain the available limits of the no-fault coverage.

Collection by Enrollee or Enrollee's Representative

If a settlement is made or a judgment is recovered, the Plan Designated Provider shall be entitled to reimbursement to the extent that the Enrollee recovers payment for the same loss from the party who is responsible for the damages. The Plan Designated Provider may recover only the excess which the Enrollee has recovered from the responsible party remaining after the Enrollee is fully compensated for the Enrollee's loss as provided in the settlement or judgment as applicable. In cases where such excess occurs, the Plan Designated Provider shall have the right to enforce its subrogation rights against:

- a) the other party's reachable assets, including all present and future property and property rights of the other party, including but not limited to, the other party's liability insurance coverage, and excluding only that portion of property and property rights that is by law exempt from execution, attachment, or garnishment; and
- b) any amounts available under the terms of any contract or insurance offering automobile medical, personal injury protection ("PIP"), automobile no-fault, automobile uninsured or underinsured motorist, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to the Enrollee.

Uninsured or Underinsured Motorist Coverage

Where the Enrollee is entitled to be compensated by benefits available under the terms of any automobile uninsured or underinsured motorist coverage, when such contract or insurance is issued to or provides benefits to the Enrollee, the Plan Designated Provider shall be entitled to recover benefits provided under this Plan, provided that, where the Enrollee receives a judgment or a settlement under an uninsured or underinsured motorist coverage provision, and such judgment or settlement does not result in the Enrollee being fully compensated for nonmedical damages, the Plan Designated Provider shall have no right to reimbursement. By providing benefits, the Plan Designated Provider is carrying out its obligation under this Plan and is not acting as a volunteer, and is not waiving any rights to reimbursement or subrogation. The Enrollee shall reimburse the Plan Designated Provider for any amounts paid or incurred by Plan Designated Provider subject to this provision. Where the Enrollee has cooperated in providing the required information and is represented by an attorney, Plan Designated Provider shall reduce its subrogated interest by a reasonable amount based on the services provided.

Grievance and Appeal Process

"Grievance" means a written or oral request from an Enrollee or, if authorized by the Enrollee, the Enrollee's representative to change a previous decision made by Plan Designated Provider or Willamette Dental of Washington, Inc. concerning: a) access to health care benefits, including an adverse benefit determination; b) out of network reimbursements for health care services; c) matters pertaining to the contractual relationship between an Enrollee and Willamette Dental of Washington, Inc.; d) delays in obtaining dental care services, or e) other matters as specifically required by state law.

Willamette Dental of Washington, Inc. will accept a Grievance made orally or in writing. The Enrollee should call Patient Relations at 800-460-7644, or should send written Grievances to:

Willamette Dental of Washington, Inc., Attn: Patient Relations, 6950 NE Campus Way, Hillsboro, OR 97124.

First Step: The Grievance

What the Enrollee must do: If an Enrollee has a Grievance against the Plan Designated Provider or Willamette Dental of Washington, Inc., regarding a claim or request for services or supplies that has been denied, the Enrollee or the Enrollee's authorized representative may request a review of the denial by writing or calling the Patient Relations Department at Willamette Dental of Washington, Inc. within 180 days after the Enrollee has received the denial. The Enrollee must explain what he or she is dissatisfied with based on a previous decision or action by Willamette Dental of Washington, Inc. The Enrollee has the right to submit comments, documents, and other information to support his or her Grievance. The Enrollee or the Enrollee's authorized representative may review pertinent documents at Willamette Dental of Washington, Inc. regarding his or her denial.

What Willamette Dental of Washington, Inc., does: The Patient Relations Department accepts and logs the Grievance and will send an acknowledgement letter to the Enrollee within five business days of receiving the Grievance. The Patient Relations Specialist, who was not involved in the initial decision, will work together, as needed, with a reviewing dentist, Plan Designated Provider

and other departments to investigate the Grievance. The Patient Relations Specialist gathers facts, and prepares a "Grievance package" of detailed information. Based upon that package, the Patient Relations Specialist makes a decision, records it in writing and sends a decision to the Enrollee within 14 days of first receiving 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 thirty days of the Grievance without the Enrollee's informed written consent. If the Patient Relations Specialist does not receive all necessary documents from the Enrollee to make a decision, then the decision will be made on the information provided. The Enrollee will receive a decision regarding investigational dental procedures within 20 working days and that period cannot be extended without the Enrollee's informed written consent.

The decision must be understandable, describe how the Enrollee may appeal and the timing required, list the people at Willamette Dental of Washington, Inc., who helped make the decision, state the facts, referring to supporting documents. After receiving this response, the Enrollee may ask Willamette Dental of Washington, Inc. to reconsider by appealing the Grievance decision (see Second Step below).

Second Step: Appeal

What the Enrollee must do: If the Enrollee does not agree with the decision reached in the first step of the Grievance process, the Enrollee or the Enrollee's representative may appeal the decision to Willamette Dental of Washington, Inc., in writing within 180 days of receiving the notification. The Enrollee may submit written materials supporting their appeal and may appear in person.

What Willamette Dental of Washington, Inc., does: The Patient Relations Department accepts and logs the appeal and notifies the Enrollee within five days that it was received. The Patient Relations Department investigates the appeal, gathers facts, and prepares an "appeal package" of detailed information. The panel consisting of the reviewing dentist and Patient Relations Specialist, using the appeal package and appropriate resources will make a decision on the appeal, record it in writing, and will send it to the Enrollee by certified mail (or other similar type of parcel delivery) within 14 days of receiving the Enrollee's 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 30 days of the request for appeal without the Enrollee's informed, written consent. The Enrollee will receive a decision regarding investigational dental procedures within 20 working days and that period cannot be extended without the Enrollee's informed written consent.

Expedited Grievance and Appeal Process

If the treating Participating Dentist determines that the Enrollee's health could be jeopardized by waiting for a decision under the standard process, he or she may specifically request an expedited appeal. In this case, the Enrollee goes through an internal Grievance process similar to the one outlined above. Patient Relations Department and/or reviewing dentist will make a decision within 72 hours. If the Enrollee is not satisfied with that decision, the Enrollee may ask for an expedited, second-level appeal similar to the Appeal process described above. The second level review panel will make a decision within 72 hours.

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.

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.

Definitions

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

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 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-dental 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 dental 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 dental 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 dental 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 dental 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.
- 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 dental 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.

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.
 1. Except as provided in subsection 2., a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.
 2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the contract holder. 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.
- c. 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.
- d. 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 dental care expenses or dental 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 dental 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 dental care expenses or dental 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 dental care expenses or dental 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 dental care expenses or dental care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent, first;
- The plan covering the spouse of the custodial parent, second;
- The plan covering the noncustodial parent, third; and then
- The plan covering the spouse 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 d.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 d.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.

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 dental care coverage.

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. Willamette Dental Group 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. Willamette Dental Group need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Willamette Dental Group any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

If payments that should have been made under this plan are made by another plan, the 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.

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.

General Provisions

Relationship to Law and Regulations

The language of this Certificate of Coverage (COC) is based on the rules that administer the HCA's PEBB Program in Chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, Chapters 182-08, 182-12 and 182-16 WAC shall govern. The agreement for benefits between the HCA and Willamette Dental of Washington, Inc. shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

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.

State Law and Forum

The Plan is entered into and delivered in the State of Washington, and Washington law will govern the interpretation of its provisions subject to applicable federal law.

Severability

If any provision of this Plan or the applicability thereof to any person or circumstance is held invalid by a court, the applicability of the provision to other persons or circumstances, and the remainder of this Plan shall not be affected.

Enrollee's Rights and Responsibilities

As an Enrollee, you and your family have the right to:

- Understand your Plan and your benefits.
- Receive timely information about your Plan and Plan Designated Provider.
- Receive courteous, prompt answers to your questions.
- Be treated with respect by your providers and Plan.
- Obtain information about all dental services covered by Willamette Dental of Washington, Inc.
- Participate in the decision-making process in matters relating to your dental care.
- Choose your own primary care dentist available at the WDG office location you have selected.
- Receive proper dental care without discrimination of any kind regardless of dental status or condition, sex, ethnicity, race, marital status or religion.
- Receive all necessary, covered dental services and supplies prescribed by your Participating Dentist, subject to the schedule of covered services and copayment, limitations, and exclusions described in the Certificate of Coverage.
- Receive information in an understandable manner about the Enrollee's condition or treatment before services are provided.
- Obtain dental care without a long delay.
- Refuse treatment and be informed of the possible results of refusing.
- Expect confidentiality of information and records.
- Obtain a second opinion by another Participating Dentist when you disagree with the initial dentist's recommendations.
- Make a complaint about this Plan or providers and receive a timely response.
- File an appeal with this Plan.

As an Enrollee of the Plan, you and your family have the responsibility to:

- Select your primary care dentist from the Plan Designated Provider before receiving services.
- Inform the Enrollee's dentist of dental problems and ask questions.
- Receive a referral from the Plan Designated Provider for dental-related services outside the Participating Dentist network.
- Pay any Co-payments at the time of service.
- Inform your Participating Dentist of any additional sources of dental care coverage or payment.
- Not engage in fraud or abuse when dealing with Willamette Dental of Washington, Inc., the Plan Designated Provider, or your dental care provider.
- Keep appointments and be on time, and provide more than 24-hour prior notice of appointment cancelation.

- Show the Willamette Dental of Washington, Inc. insurance card at each dental appointment.
- Contact the Plan Designated Provider for emergency dental care, which is available 24 hours a day, 365 days a year.
- Use only providers within Willamette Dental Group to receive dental care.
- Comply with requests for information by the date requested.
- Report changes of address in a timely manner.
- Pay amounts due in full by the date they are due.
- Establish and maintain a satisfactory physician-patient relationship with the Plan Designated Dentist or responsible for your care.