CERTIFICATE OF COVERAGE

Effective: January 1, 2020

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Willamette Dental Group

002-WAPEBB(1/20)

Underwritten by Willamette Dental of Washington, Inc.

Welcome to Willamette Dental Group!

Willamette Dental Group would like to welcome you!

Please utilize the following contact information for questions or assistance. Members who wish to schedule an appointment may do so by contacting our Appointment Center. Willamette Dental Group has a full staff of member service representatives who will answer any question that you may have about your dental plan or service.

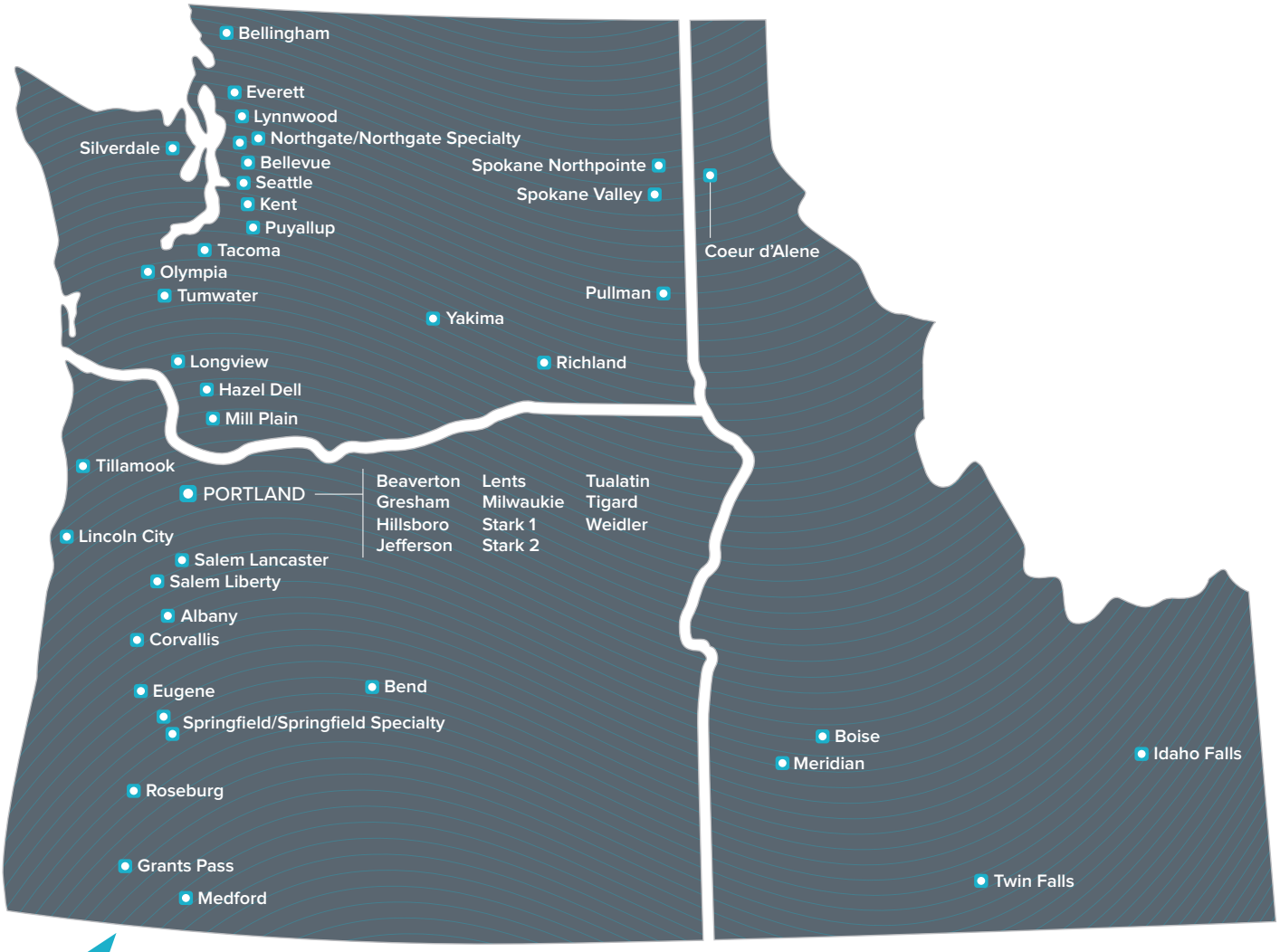
Contact Information

Appointments or Emergencies

Toll Free 1.855.4DENTAL (433-6825)

Member Services

Monday – Friday .....8 AM to 5 PM PST
Toll Free 1.855.4DENTAL (433-6825)
E-mail .... memberservices@willamettedental.com
Website .....wapebb.willamettedental.com



wapebb.willamettedental.com

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.

TABLE OF CONTENTS

Effective: January 1, 2020 • Group Plan Number WA82 •

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

INTRODUCTION

Willamette Dental of Washington, Inc., is pleased to offer you a high value dental insurance plan that has the best health of you and your family in mind. Willamette Dental Group offers a unique system that not only offers you value-based dental insurance but provides you with quality dental care as well. Professional general practitioners, specialists, hygienists, and quality support staff from Willamette Dental Group, P.C., in Washington, Oregon, and Idaho provide the care for the dental plans offered by Willamette Dental of Washington, Inc. Willamette Dental Group has been providing dental care in the Pacific Northwest for over 45 years.

At Willamette Dental Group, we don't start any treatment without a thorough evaluation and planning process. We don't drill until clinically it's the right thing to do, and we certainly don't wait for problems to arise. Willamette Dental Group has been the leader in proactive preventive care for over 45 years, and we practice dentistry a little differently. We believe a healthy mouth is the foundation of all dental care, and because our focus is health-based rather than disease-based, our proactive method is wholly rooted in prevention. In fact, with your individualized, health-based treatment plan and with proper care, your teeth will be healthy enough to last the rest of your life.

DEFINITIONS

The following defined terms are used throughout this Certificate of Coverage:

Benefit Appeal: A written or oral request from an Enrollee or authorized representative to change a previous Grievance 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 Washington state insurance regulations.

Copayment: The dollar amount the Enrollee must pay when receiving specific services.

Dental Emergency: 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.

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.

Dentist: A person licensed to practice dentistry pursuant to the laws of the state where treatment is provided.

Denturist: A person licensed to practice denture technology licensed 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) this Plan would have provided benefits if the Covered Service had been performed by a Dentist.

Dependent: An eligible dependent covered under the Subscriber.

Enrollee: The Subscriber or a Dependent enrolled in this Plan.

Experimental or Investigative: A service or supply that is determined by Willamette Dental of Washington, Inc., to be experimental or investigative. In determining whether services are experimental or investigative, Willamette Dental of Washington, Inc., will consider the following:

1. Whether the services are in general use in the dental community in the State of Washington;
2. Whether the services are under continued scientific testing and research;
3. Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
4. Whether the services are proven safe and effective.

Grievance: A written or oral request from an Enrollee or the Enrollee's representative, if authorized by the Enrollee, to change a previous decision made by Participating Provider or Willamette Dental of Washington, Inc., concerning: a) access to 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 care services; or e) other matters as specifically required by Washington state insurance regulations.

HCA: The Washington State Health Care Authority.

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.

Non-Participating Provider: A Dentist or Denturist who is not employed by or under contract with the Participating Provider.

Plan: This PEBB dental benefit plan of coverage.

Participating Provider: Willamette Dental Group, P.C., and the Dentists and Denturists who are employees of Willamette Dental Group, P.C. The Participating Provider is engaged by Willamette Dental of Washington, Inc., to provide dental services to Enrollees under the terms of this Plan.

Reasonable Cash Value: The Participating Provider's usual and customary fee-for-service price of dental services.

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

Subscriber: The employee, retiree, continuation coverage subscriber, or survivor enrolled in this Plan.

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 1.855.4DENTAL (1.855.433.6825).

APPOINTMENTS

Each of Willamette Dental Group's over 50 office locations practice our 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. Our 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 our Appointment Center toll free: 1.855.4DENTAL (1.855.433.6825)

Appointment Center Hours:
Monday – Friday: ..... 7 a.m. to 6 p.m. PT
Saturday: ..... 7 a.m. to 4 p.m. PT

Your First Visit
At your first visit to our 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 Dentists 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 dental 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 our 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 the "Schedule of Covered Services and Copayments" section will apply.

Willamette Dental of Washington, Inc., 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

Willamette Dental Group provides care for Dental Emergencies during regular office hours. If you have a Dental Emergency, call the Appointment Center toll free at 1.855.4DENTAL (1.855.433.6825). If necessary, you will be able to see a Participating Dentist within approximately 24 hours. You may pay an office visit Copayment for this service. After-hours, a Dentist is available for Dental Emergency consultation over the telephone, at no cost.

Out of Area Emergency Care

Participating Provider will provide care 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 the "Schedule of Covered Services and Copayments" section.

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

SCHEDULE OF COVERED SERVICES AND COPAYMENTS

The services covered under this Plan are listed as follows. These Copayments are the Enrollee's out-of-pocket costs for the covered services. Enrollees are responsible for payment of Copayments at the time of the service. All coverage is subject to the exclusions and limitations set forth in this Certificate of Coverage.

Office Visit Copayment

General Office Visit $0

CDT 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 3 years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed & 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 intraorally or extraorally	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$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	$20
D1516	Space maintainer - fixed – bilateral, maxillary	$30
D1517	Space maintainer - fixed – bilateral, mandibular	$30
D1520	Space maintainer - removable - unilateral	$20

D1526 Space maintainer - removable – bilateral, maxillary $30
D1527 Space maintainer - removable – bilateral, mandibular $30
D1550 Re-cement or re-bond space maintainer $10
D1555 Removal of fixed space maintainer $0

3. Restorative Services

D2140 Amalgam - 1 surface, primary or permanent $10
D2150 Amalgam - 2 surfaces, primary or permanent $10
D2160 Amalgam - 3 surfaces, primary or permanent $10
D2161 Amalgam - 4 or more surfaces, primary or permanent $10
D2330 Resin-based composite - 1 surface, anterior $15
D2331 Resin-based composite - 2 surfaces, anterior $15
D2332 Resin-based composite - 3 surfaces, anterior $15
D2335 Resin-based composite - 4 or more surfaces involving incisal angle (anterior) $15
D2390 Resin based composite crown, anterior $50
D2391 Resin-based composite - 1 surface, posterior $50
D2392 Resin-based composite - 2 surfaces, posterior $50
D2393 Resin-based composite - 3 surfaces, posterior $50
D2394 Resin-based composite - 4 or more surfaces, posterior $50
D2510 Inlay - metallic - 1 surface $115
D2520 Inlay - metallic - 2 surfaces $115
D2530 Inlay - metallic - 3 or more surfaces $115
D2542 Onlay - metallic - 2 surfaces $125
D2543 Onlay - metallic - 3 surfaces $125
D2544 Onlay - metallic - 4 or more surfaces $125
D2610 Inlay - porcelain/ceramic - 1 surface $125
D2620 Inlay - porcelain/ceramic - 2 surfaces $125
D2630 Inlay - porcelain/ceramic - 3 or more surfaces $125
D2642 Onlay - porcelain/ceramic - 2 surfaces $125
D2643 Onlay - porcelain/ceramic - 3 surfaces $125
D2644 Onlay - porcelain/ceramic - 4 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
D2782 Crown - ¾ cast noble metal $175
D2792 Crown - full cast -noble metal $150
D2799 Provisional crown - further treatment or completion of diagnosis necessary prior to final impression $0
D2910 Re-cement or re-bond inlay, onlay, or partial coverage restoration $0
D2920 Re-cement or re-bond crown $0
D2930 Prefabricated stainless steel crown - primary tooth $100
D2931 Prefabricated stainless steel crown - permanent tooth $100
D2932 Prefabricated resin crown $100
D2933 Prefabricated stainless steel crown with resin window $100
D2940 Protective 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
D2970 Temporary crown (fractured 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 (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 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
D3920 Hemisection (including any root removal), not including root canal therapy $100
D3950 Canal preparation and fitting of a preformed dowel or post $0

6. Periodontics

D4210 Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant $75
D4211 Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant $35
D4240 Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant $100
D4241 Gingival flap procedure, including root planing - 1 to 3 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) - 4 or more contiguous teeth or tooth bounded spaces per quadrant $100

D4261 Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 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 - 4 or more teeth per quadrant $35
D4342 Periodontal scaling and root planing - 1 to 3 teeth per quadrant $15
D4346 Scaling in presences of generalized moderate or severe gingival inflammations – 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 any conventional clasps, rests and teeth) $140
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $140
D5282 Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary $140
D5283 Removable unilateral partial denture - one piece cast metal (including clasps 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 (each 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 broken teeth - per tooth $15
D5650 Add tooth to existing partial denture $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 (chairside) $40
D5731 Reline complete mandibular denture (chairside) $40
D5740 Reline maxillary partial denture (chairside) $40
D5741 Reline mandibular partial denture (chairside) $40
D5750 Reline complete maxillary denture (laboratory) $50
D5751 Reline complete mandibular denture (laboratory) $50
D5760 Reline maxillary partial denture (laboratory) $50
D5761 Reline mandibular partial denture (laboratory) $50
D5810 Interim complete denture (maxillary) $70
D5811 Interim complete denture (mandibular) $70
D5820 Interim partial denture (maxillary) $70
D5821 Interim partial denture (mandibular) $70
D5850 Tissue conditioning, maxillary $15
D5851 Tissue conditioning, mandibular $15
D5863 Overdenture - complete maxillary $140
D5864 Overdenture - partial maxillary $140
D5865 Overdenture - complete mandibular $140
D5866 Overdenture - partial mandibular $140
D5986 Fluoride gel carrier $0

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
D7310 Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant $0
D7311 Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant $0
D7320 Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant $0
D7321 Alveoloplasty not in conjunction with extractions - 1 to 3 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 & drainage of abscess - intraoral soft tissue $0
D7520 Incision & 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
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
D7960 Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another $50
D7970 Excision of hyperplastic tissue - per arch $50
D7971 Excision of pericoronal gingiva $50

10. Anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures $0
D9222 & D9223 Deep sedation/general anesthesia (When administered by a Participating Provider in conjunction with covered services when dentally necessary because the Enrollee is under age 7, developmentally disabled, or physically handicapped.) ..... First 30 minutes: $50
..... Each additional 15 minutes: $0

11. Miscellaneous

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$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 (Service 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
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

Orthodontic Services

Orthodontic treatment is covered only if a Participating Provider prepares the treatment plan prior to starting orthodontic 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.

The initial orthodontic diagnostic work-up and X-rays are subject to a Pre-Orthodontic Service Copayment of $50, which is due at the initial consultation. The Pre-Orthodontic Service Copayments will be deducted from the Comprehensive Orthodontic Service Copayment if the Enrollee accepts the treatment plan. The Orthodontic Service Copayment amount for comprehensive orthodontic treatment is $1,500 per case, which is due in full prior to commencement of orthodontic treatment. The Copayment for limited orthodontic treatment will be prorated based on the treatment plan. Services provided in connection with orthodontic treatment are subject to the Copayments listed in the “Schedule of Covered Services and Copayments” section.

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. If benefits for orthodontic services terminate prior to completion of orthodontic treatment, benefits will continue through the end of the month. If coverage terminates prior to completion of treatment, the Copayment may be prorated and the services necessary to complete treatment will be billed at the Reasonable Cash Value.

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.

Benefits for non-surgical treatment of TMJ are covered at a yearly maximum of $1,000 per Enrollee, not to exceed a lifetime maximum of $5,000 per Enrollee. Willamette Dental of Washington, Inc., will provide benefits for covered services provided in connection with TMJ treatment only if a Participating Provider pre-authorizes and provides the treatment. No benefits will be provided for repair or replacement of lost, stolen, or broken TMJ appliances or for surgical treatment, banding treatment or restorations. 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.

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.

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.

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.

Implant Services

Dental implant services are available to Enrollees at designated Willamette Dental Group offices.

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.

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.

Services provided in connection with implant treatment are subject to the Copayments listed below and the applicable Copayments listed in the "Schedule of Covered Services and Copayments" section. 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 the "Schedule of Covered Services and Copayments" section 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 supported prosthesis, by report	$0
D6095	Repair implant abutment, by report	$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 Service 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 Service 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.

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 any of the following conditions, treatments, services, or for any direct complications or consequences thereof:

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.

LIMITATIONS

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

2. General anesthesia is covered with the Copayments specified in the "Schedule of Covered Services and Copayments" section only if the following criteria are met:
   a. It is performed in a dental office;
   b. It is provided in conjunction with a covered service; and
   c. The Participating Provider determines that it is Dentally Necessary because the Enrollee is under age 7, developmentally disabled, or physically handicapped.

3. The services provided by a Dentist in a hospital setting are covered if the following criteria are met:
   a. A hospital or similar setting is Dentally Necessary.
   b. The services are authorized in writing by a Participating Provider.
   c. The services provided are the same services that would be provided in a dental office.
   d. The Hospital Call Copayment and applicable Copayments are paid.

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

ELIGIBILITY

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

The employee's employing agency will inform the employee whether or not they are eligible for benefits upon employment and whenever the employee's eligibility status changes. The communication will include information about the employee's right to appeal eligibility and enrollment decisions. Information about an employee's right to an appeal can be found on page 28 of this Certificate of Coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of a completed *PEBB Retiree Coverage Election Form*. 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. Information about appealing a PEBB Program decision can be found on page 28 of this Certificate of Coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program determines if a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor upon receipt of a completed *PEBB Retiree Coverage Election Form*. 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 appealing a PEBB Program decision can be found on page 28 of this Certificate of Coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program will determine eligibility for Continuation Coverage. If the subscriber is not eligible for Continuation Coverage, the PEBB Program will notify them of the right to appeal. Information about appealing a PEBB Program decision can be found on page 28 of this Certificate of Coverage. For information on how to enroll, see the "Enrollment" section.

A retiree or survivor and their enrolled dependents are required to enroll and stay enrolled in Medicare Part A and Part B, if entitled. This is a condition of their enrollment in a PEBB retiree health plan. A subscriber or their dependent must provide a copy of their Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B effective dates to the PEBB Program as proof of enrollment in Medicare. If a subscriber or their dependent is not entitled to either Medicare Part A or Part B on their 65th birthday, they must provide the PEBB Program with a copy of their denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the "Enrollment" section. The PEBB Program or employing agency verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurred except as described in subsection (g) of this section. Children are defined as the subscriber's:
   a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
   b. 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;
   c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
   d. 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;
   e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
   f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or 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 a foster child 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; and
   g. Children of any age with a developmental or physical disability that renders the child 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, within 60 days of the last day of the month the child is no longer eligible under this subsection;
      - A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection 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 under this subsection if they later become incapable of self-support; and
      - 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, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the subscriber.

4. Parents of the subscriber.
    a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:
        - The parent maintains continuous enrollment in PEBB medical;
        - 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 enroll additional dependents to their PEBB insurance coverage.

ENROLLMENT

A subscriber or their dependent is eligible to enroll in only one PEBB dental plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same, or two different employers that participate in PEBB coverage may be enrolled as a dependent under only one parent.

An employee is <u>required</u> to enroll in a PEBB dental plan and any dependents enrolled on the employee's account for dental coverage will be enrolled in the same dental plan as the subscriber.

A Continuation Coverage subscriber, retiree, or survivor <u>may</u> enroll in a dental plan. If a retiree or survivor chooses to enroll in a dental plan under PEBB retiree insurance coverage, any dependents enrolled on the retiree or survivor's account will be enrolled in dental coverage and in the same dental plan as the retiree or survivor. The retiree or survivor must stay enrolled in retiree dental coverage for at least two years before dental can be dropped unless they defer or terminate coverage according to PEBB Program rules.

How to enroll

An employee must submit a *PEBB Employee Enrollment/Change* form to their employing agency when they become newly eligible for PEBB benefits. The form must be received no later than 31 days after the date the employee becomes eligible. If the employee does not return the form by the deadline, the employee will be enrolled in the Uniform Dental Plan and any eligible 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.

A retiree or survivor must submit a *PEBB Retiree Coverage Election Form* along with any other required form, to the PEBB Program. The forms must be received within the required enrollment time limits listed under "When dental coverage begins." The first premium payment and applicable premium surcharges are due to the HCA no later than 45 days after the election period ends.

To enroll an eligible dependent, the subscriber must include the dependent's information on the form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified.

A subscriber enrolling in Continuation Coverage may enroll by submitting the required forms to the PEBB Program. The election must be received by the PEBB Program no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB Program, whichever is later. The first premium payment and applicable premium surcharges are due no later than 45 days after the election period ends as described above. Premiums associated with continuing PEBB dental must be made to the HCA. For more information see, "Options for continuing PEBB dental coverage" on page 26.

A subscriber or their dependents may also enroll during the PEBB Program's annual open enrollment (see "Annual open enrollment" on page 22) or during a special open enrollment (see "Special open enrollment" on page 23). The subscriber must provide proof of the event that created the special open enrollment.

A subscriber must provide notice to remove dependents who are no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child. The notice must be received within 60 days of the last day of the month the dependents no longer meet the eligibility criteria described in the "Eligibility" section on page 18. An employee must notify their employing agency. Any other subscriber must notify the PEBB Program. Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent losing eligibility to continue dental plan coverage under one of the continuation coverage options described on page 26 of this Certificate of Coverage;
- The subscriber being billed for claims paid by the dental plan that were received after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's dental plan coverage after the dependent lost eligibility.

When dental coverage begins

For an employee and their eligible dependents, enrolling **no later than 31 days after the date the employee becomes newly eligible,** 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.

For an eligible retiring employee or retiring school employee, and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the employee's or school employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends.** Dental coverage begins on the first day of the month after the loss of employer-paid coverage, COBRA coverage, or continuation coverage.

For an eligible elected or full-time appointed official and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the official leaves public office.** Dental coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the death of the retiree.** Dental coverage will be continued without a gap subject to payment of premiums and any applicable premium surcharges.

For an eligible survivor of an employee or school employee and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the later of the date of the employee's or school employee's death, or the date the survivor's PEBB, educational service district, or School Employees Benefits Board (SEBB) insurance coverage ends.** 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, educational service district, or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement, and their dependents, the PEBB Program must receive the required form(s) and formal determination letter **no later than 60 days after the date on the determination letter**. Dental coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible survivor of an emergency service personnel killed in the line of duty, the PEBB Program must receive the required form(s) **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 a health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

Dental coverage begins on the date chosen as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan, the PEBB Program must receive the required forms **no later than 60 days after a loss of other qualifying coverage,** dental coverage begins the first day of the month after the loss of other qualifying coverage. See the "Annual open enrollment" section for an additional enrollment time line.

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

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

For a subscriber or their eligible dependent enrolling during a special open enrollment, dental coverage begins the first of the month following the later of the event date or the date the form is received. If that day is the first of the month, coverage is effective on that day.

Exceptions:

1. If the special enrollment is due to 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 begins as follows:.
    a. For an employee, dental coverage begins the first day of the month in which the event occurs;
    b. For the newly born child, dental coverage begins the date of birth;
    c. For a newly adopted child, dental coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
    d. For a spouse or state-registered domestic partner of a subscriber, dental coverage begins the first day of the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a dependent child with a disability, dental coverage begins on the first day of the month following eligibility certification.

Annual open enrollment

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

- Enroll or remove eligible dependents; or

- Change their dental plan.

A retiree, survivor, or Continuation Coverage subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment:

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

An employee must submit the change online in PEBB My Account or return the required form to their employing agency. Any other subscriber must submit the change online in PEBB My Account or return the required form(s) to the PEBB Program. The form(s) must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1 of the following year.

Exception: A Continuation Coverage subscriber, a retiree, or a survivor may voluntarily terminate enrollment in a PEBB dental plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB dental plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, dental enrollment will be terminated on the last day of the previous month.

Note: A retiree or survivor must stay enrolled in dental coverage for at least two years before dental can be dropped unless they defer or terminate coverage according to PEBB Program rules.

Special open enrollment

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

The special open enrollment may allow a subscriber to:

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

To make an enrollment change, the employee must submit the required form(s) to their employing agency. Any other subscriber must submit the required form(s) to the PEBB Program. The form(s) must be received no later than 60 days after the event that creates the special open enrollment. In addition to the required forms, the PEBB Program or the employing agency will require the subscriber to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exceptions:

- 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 their employing agency or the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form(s) 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.

- A Continuation Coverage subscriber, a retiree, or a survivor may voluntarily terminate enrollment in a PEBB dental plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB dental plan will be terminated the last day of the month in which the PEBB Program receives the

request. If the request is received on the first day of the month, dental enrollment will be terminated on the last day of the previous month.

Note: A retiree or survivor must stay enrolled in dental coverage for at least two years before dental can be dropped unless they defer or terminate coverage according to PEBB Program rules.

When may a subscriber change their health plan?

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

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. 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);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
   Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.
5. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;
6. 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);
7. Subscriber or their dependent becomes entitled to 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;
8. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP;
9. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or their dependent's entitlement to Medicare, the subscriber must select a new health plan;
10. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA); or
11. 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 if the subscriber's 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 is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment for a high-risk pregnancy.

NOTE: If an enrollee's provider or dental care facility discontinues participation with this dental plan, the enrollee may not change dental plans until the PEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the PEBB Program determines that a continuity of care issue exists. This plan cannot guarantee that any one dentist, facility, or other provider will be available or remain under contract with us.

When may a subscriber enroll or remove eligible dependents?

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

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. 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);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
   Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.
5. Subscriber or their dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
6. 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;
7. 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);
8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP) program, or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Medicare entitlement

If an employee or their dependent becomes entitled to Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.
If a Continuation Coverage subscriber or their dependent is entitled to Medicare, federal regulations require enrollment in Medicare the month before turning age 65. Otherwise, the Medicare effective date may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first entitled, a Medicare late enrollment penalty may apply.

If a retiree, survivor, or their enrolled dependent becomes entitled to Medicare, they should contact the Social Security Administration to ask about Medicare enrollment. The Medicare entitled subscriber or their dependent

must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage. The only exception is if retirement occurred before July 1, 1991, or the enrollee is a dependent of an employee or school employee who retired before July 1, 1991 and is enrolled in PEBB retiree insurance coverage.

When dental coverage ends

Dental coverage ends on the following dates:

1. On the last day of the month when any enrollee ceases to be eligible;
2. On the date a dental plan terminates. If that should occur, the subscriber will have the opportunity to enroll in another PEBB dental plan;
3. For an employee, 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; or
   - On the date specified in any contract or hire letter, or on the effective date of an employer-initiated termination notice.
4. On the last day of the month in which the monthly premium and applicable premium surcharges were paid. The subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharges remain unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid. A full month's premium is charged for each calendar month of coverage. Payments are not prorated during any month, even if an enrollee dies or if the subscriber requests to terminate their coverage before the end of the month.

When dental plan coverage ends, an enrollee may be eligible for continuation coverage described in the "Options for continuing PEBB dental coverage" section below.

An employee who needs the required forms for an enrollment or benefit change may contact their personnel, payroll, or benefits office. Any other subscriber may contact the PEBB Program at 1-800-200-1004.

OPTIONS FOR CONTINUING PEBB DENTAL COVERAGE

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

1. PEBB Continuation Coverage (COBRA)
2. PEBB Continuation Coverage (Unpaid Leave)

These two options 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 law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types. An enrollee who qualifies for both types of PEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

The PEBB Program administers both continuation coverage options. Refer to the *PEBB Continuation Coverage Election Notice* booklet for details.

Option for coverage under PEBB retiree insurance

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

Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB insurance coverage in accordance with the 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 the employee monthly premium contribution and applicable premium surcharges during this period to maintain eligibility. If the employee's monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.

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

Paid Family 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 insurance coverage in accordance with the PFML. The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay the employee monthly premium contribution and applicable premium surcharges during this period to maintain eligibility. If the employee’s monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.

If an employee exhausts the period of leave approved under PFML, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharges set by the HCA, with no contribution from the employing agency while on approved leave. For additional information on continuation coverage, see the section titled “Options for Continuing PEBB dental coverage.”

Payment of premium 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 the plan or the HCA if the employee’s compensation is suspended or terminated 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 terminated, the HCA shall notify the employee immediately by mail to 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 Plan, then the employee may purchase an individual dental plan from Willamette Dental of Washington, Inc. at a premium rate 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 coverage from this plan for Just Cause.
An enrollee or an eligible dependent may have coverage terminated by HCA for the following reasons:

1. 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;
2. Knowingly providing false information;
3. Failure to pay the monthly premium and applicable premium surcharges when due;
4. Misconduct. Examples of such termination include, but are not limited to the following:
    a. 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;
    b. Abusive or threatening conduct directed to an HCA employee, a health plan, Participating Provider, or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.
    c. Repeated failure to make timely payment of Copayments.

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. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date.

The PEBB Program will enroll the 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 by the employing state agency regarding PEBB eligibility, enrollment, or premium surcharges to the employing agency.

Any current or former employee of an employer group or their dependent may appeal a decision 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 health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

SUBROGATION

Benefits may be available for an injury or disease, which is allegedly the liability of a third party. Such services provided by the Participating Provider are solely to assist the Enrollee. By incurring the Reasonable Cash Value of the benefits provided in the form of services, the Participating Provider is not acting as a volunteer and is not waiving any right to reimbursement or subrogation.

If the Participating 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 the Reasonable Cash Value of the 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 services provided, subject to the limitations below.

As a condition of receiving the benefits, the Enrollee or the Enrollee's representative shall:

a) Provide the Participating Provider with the name and address of the parties liable, all facts known concerning the injury, 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 Participating Provider's subrogation rights; and
c) Take all necessary action to seek and obtain recovery to reimburse the Participating Provider.

This Plan does not provide benefits for services payable under any motor vehicle medical, motor vehicle no-fault, personal injury protection, homeowner's, commercial premises coverage, workers compensation or similar contract or insurance.

The Participating Provider shall be reimbursed with any amounts received from the third party or third party's insurer(s). The Participating 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. The amount shall not exceed the Reasonable Cash Value of the services provided for treatment of the injury or disease.

GRIEVANCE AND BENEFIT APPEAL PROCESS

First Step: The Grievance

Willamette Dental of Washington, Inc., will accept a Grievance made orally or in writing. The Enrollee should call the Member Services Department toll free at 1.855.4DENTAL (1.855.433.6825), or should send written Grievances to: Willamette Dental of Washington, Inc., Attn: Member Services, 6950 NE Campus Way, Hillsboro, OR 97124.

What the Enrollee must do: If an Enrollee has a Grievance against the Participating Provider or Willamette Dental of Washington, Inc., regarding a claim or request for services that has been denied, the Enrollee or the Enrollee's authorized representative may request a review of the denial by writing or calling the Member Services Department at Willamette Dental of Washington, Inc., within 180 days after the Enrollee has received the denial. The Enrollee must explain what they are dissatisfied with based on a previous decision or action made by Willamette Dental of Washington, Inc. The Enrollee may submit comments, documents, and other information to support their Grievance. The Enrollee or the Enrollee's authorized representative may review pertinent documents at Willamette Dental of Washington, Inc., regarding their denial.

What Willamette Dental of Washington, Inc., does: The Member Services Department accepts and logs the Grievance and will send an acknowledgement letter to the Enrollee within 5 business days of receiving the Grievance. The Member Services Representative, who was not involved in the initial decision, will work together, as needed, with a reviewing Dentist, Participating Provider and other departments to investigate the Grievance. The Member Services Representative gathers facts, and prepares a "Grievance package" of detailed information. Based upon that package, the Member Services Representative makes a decision, records it in writing and sends a decision to the Enrollee within 30 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 30 days of the Grievance without the Enrollee's informed written consent. If the Member Services Representative does not receive all necessary documents from the Enrollee to make a decision, then the decision will be made on the information provided. If the Grievance involves services not yet provided for an alleged Dental Emergency, Willamette Dental of Washington, Inc., will provide a reply within 72 hours of the receipt of the Grievance and that period cannot be extended without the Enrollee's informed written consent. If the Grievance involves services deemed Experimental or Investigational Willamette Dental of Washington, Inc., will provide a written reply within 20 working days of the receipt of the Grievance and that period cannot be extended without the Enrollee's informed written consent.

After receiving this response, the Enrollee may ask Willamette Dental of Washington, Inc., to reconsider by submitting a request for a Benefit Appeal (see Second Step below).

<u>Second Step: Benefit Appeal</u>

Willamette Dental of Washington, Inc., will accept a Benefit Appeal request made orally or in writing. The Enrollee should call the Member Services Department toll free at 1.855.4DENTAL (1.855.433.6825), or should send written request for a Benefit Appeal to: Willamette Dental of Washington, Inc., Attn: Member Services, 6950 NE Campus Way, Hillsboro, OR 97124.

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 request a Benefit Appeal of 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 request for a Benefit Appeal.

What Willamette Dental of Washington, Inc., does: The Member Services Department accepts and logs the Benefit Appeal request and notifies the Enrollee within 5 days that it was received. The Member Services Department investigates the Benefit Appeal, gathers facts, and prepares an "appeal package" of detailed information. The panel consisting of the reviewing Dentist and a Member Services Representative, using the appeal package and appropriate resources will make a decision on the Benefit Appeal, record it in writing, and will send it to the Enrollee by certified mail (or other similar type of parcel delivery) within 30 days of receiving the Enrollee's Benefit Appeal unless Willamette Dental of Washington, Inc., notifies the Enrollee that an extension is necessary to complete the Benefit Appeal; however, the extension cannot delay the decision beyond 60 days of the request for Benefit Appeal without the Enrollee's informed, written consent. If the Benefit Appeal involves services not yet provided for an alleged Dental Emergency, Willamette Dental of Washington, Inc., will provide a reply within 72 hours of the receipt of a written request for a Benefit Appeal. If the Benefit Appeal involves services deemed Experimental or Investigational, Willamette Dental of Washington, Inc., will provide a written reply within 20 working days of the receipt of a request for a Benefit Appeal and that period cannot be extended without the Enrollee's informed written consent.

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 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.

<u>Order of Benefit Determination Rules</u>

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.

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 100% 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.

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.

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.

Notice to Enrollees

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.

GENERAL PROVISIONS

Relationship to Law and Regulations

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

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

This 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.

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Willamette Dental of Washington, Inc.
Certificate of Coverage