



## Dental Optima™

4018525



**BLUE CROSS**

An Independent Licensee of the Blue Cross Blue Shield Association

## INTRODUCTION

This plan is self-funded by City of Redmond, which means that City of Redmond is financially responsible for the payment of plan benefits. City of Redmond ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

City of Redmond has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. City of Redmond has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross doesn't insure this plan. In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

## HOW TO USE THIS BOOKLET

This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **Who Is Eligible For Coverage?** — eligibility requirements for this dental plan
- **What Do I Need To Know Before I Get Care?**— important information about the requirements of your dental coverage, including selecting a dental care provider, benefit maximums and any applicable calendar year deductibles
- **What Are My Benefits?** — what is covered and the percentage you pay under this dental plan
- **Exclusions and Limitations** — benefits that are limited and services not covered under this dental plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **Complaints and Appeals** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: "You" and "your" refer to members under this plan. "We," "us" and "our" refer to Premera Blue Cross.

## FOR MORE INFORMATION

You'll find our contact information on the back cover of this booklet. Please call or write customer service for help with:

- Questions about benefits or claims
- Questions or complaints about care you receive
- Changes of address or other personal information

You can also get benefit, eligibility and claim information through our Interactive Voice Response system when you call.

### **Online information about this plan is at your fingertips whenever you need it**

You can use our website to:

- Locate a dental care provider near you
- Get details about the types of expenses you're responsible for and this plan's benefit maximums
- Check the status of your claims
- Visit our health information resource to learn about diseases, medications, and more

Group Name: City of Redmond

Effective Date: January 1, 2025

Group Number: 4018525

Plan: Dental Optima

Certificate Form Number: 40185250125DA

**Notice of availability and nondiscrimination 800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

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呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាសោយភក្ដីគិតថ្លៃ ប្រមាទាំងសេវាផ្សេងៗ ដើម្បីជួយលក់លក់ដល់មនុស្សច្រើន។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ ኢንሹራንስ ለአገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໃຫ້ເພື່ອນຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.  
برای خدمات کمک زبانی رایگان و کمکها و خدمات امدادی مقتضی، تماس بگیرید.

**Discrimination is against the law.** Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.



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## WHAT DO I NEED TO KNOW BEFORE I GET CARE?

The covered services under this dental plan are classified as Class I – Diagnostic and Preventive, Class II – Basic, and Class III – Major. The lists of services that relate to each type are outlined in the following pages under **Description of Covered Services**. These services are covered once all of the following requirements are met. It's important to understand all of these requirements so you can make the most of your dental benefits.

Benefits are available for the services described in this plan that are furnished for a covered dental condition. "Covered dental condition" means a covered member's illness, injury or disease, or a dependent child's congenital malformation. Such services must meet all of the following requirements:

- They must be dentally necessary. See definition of **Dentally Necessary**.
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (DMD or DDS) or dentist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual such as a Registered Nurse (RN) or an Advanced Registered Nurse Practitioner (ARNP) performing within the scope of their license or certification, as allowed by law. These providers are referred to as "dental care providers."
- They must not be excluded from coverage under this benefit

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. These materials will be requested directly from your dental care provider. If we're unable to obtain necessary materials, the plan will provide benefits only for those dental services we can verify as covered.

Coverage under this dental plan is based on allowed amounts for dentally necessary covered services. The percentage of the allowed amount you're responsible for is called coinsurance. See **Definitions** for a detailed explanation of "allowed amount."

### Alternative Treatment

To determine benefits available under this plan, we consider alternative procedures or services with different fees that are consistent with acceptable standards of dental practice. In all cases where there's an alternative course of treatment that's less costly, the plan will only provide benefits for the treatment with the lesser fee. If you and your dental care provider choose a more costly treatment, you're responsible for the additional charges beyond those for the less costly alternative treatment.

### Requesting An Estimate Of Benefits

A dental estimate of benefits verifies, for the dental care provider and yourself, your eligibility and benefits. Because we consider alternative treatment at the time we review the estimate, our review may result in a lower cost of treatment and additional services under this benefit. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

A dental estimate of benefits isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit a dental estimate to us for any proposed dental services in which you are concerned about your out-of-pocket expenses.

Our dental estimate of benefits shouldn't be considered a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time services are rendered.

### Coinsurance

"Coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. It's the percentage you're responsible for, not including any applicable calendar year deductibles, is called "coinsurance."

### Dental Benefit Maximum

The maximum amount of dental benefits available to any one member in a calendar year is \$3,000 (shared with orthodontia benefit).

Covered dental services requiring multiple treatment dates are considered incurred on the date the services are completed. This is known as the seat date. Amounts paid for such procedures will be applied to the dental benefit maximum based on the incurred date.

## Network Providers

This dental plan utilizes the Dental Choice network providers.

This plan makes available to you sufficient numbers and types of providers to give you access to all covered services in compliance with applicable Washington State regulations governing access to providers.

**Note:** We will notify you at least 30 days prior to your provider's termination date. When a termination for cause provides us less than 30 days' notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

For the most current information on participating Dental Choice providers, refer to our website or contact customer service. You'll find this information on the back cover of this booklet.

This plan is designed to cover all dental care providers at the same benefit level.

When you receive services from Dental Choice providers, your claims will be submitted directly to us, and available benefits will be paid directly to the dental care provider. Dental Choice providers agree to accept our "allowed amount" (see **Definitions** in this booklet) as payment in full. You're responsible only for any applicable calendar year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services.

## Contracted Health Care Benefit Managers

The list of Premiera's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at <https://www.premera.com/visitor/partners-vendors> and changes to these contracts or services are reflected on the website within 30 business days.

## Non-Network Providers

If you decide not to use a Dental Choice provider, you may choose any dental care provider. If you receive services from non-network dental care providers, you're responsible for amounts above the allowed amount in addition to any applicable calendar year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services. Amounts that are in excess of the allowed amount don't accrue toward your calendar year deductible if one applies.

You may be required to submit the dental claim yourself if your dental care provider doesn't do this for you. See **How Do I File A Claim?** for instructions on submitting claims for reimbursement.

## WHAT ARE MY BENEFITS?

### BENEFIT PERCENTAGES (COINSURANCE)

After you satisfy the required calendar year deductible if one applies, you pay the following coinsurance per calendar year, up to the dental benefit maximum. Dental services fall into 3 categories: Class I – Diagnostic and Preventive services, Class II – Basic services, and Class III – Major services. In this section you'll find a description of the services included in each category.

- Class I – Diagnostic and Preventive Services ..0%
- Class II – Basic Services .....20%
- Class III – Major Services .....20%
- Orthodontia .....20%

### DESCRIPTION OF COVERED SERVICES

#### Class I - Diagnostic And Preventive Services

- Routine, comprehensive, periodic oral evaluations are limited to two per calendar year. Professional consultations, periodontal evaluations and other office visits apply to this limit.
- Problem focused (including emergency) oral evaluations and re-evaluations. See the definition of a Dental Emergency.
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per calendar year
- Topical application of fluoride is covered for members under the age of 19 and is limited to two treatments per calendar year.

- Dental x-rays include:
  - Bitewing x-rays, 2 series every calendar year
  - Either a panoramic x-ray or comparable cone beam or a complete full mouth series of x-rays, once every 36 consecutive months
  - Periapical x-rays
  - Occlusal x-rays
- Space maintainers, for members under the age of 19
- Sealants, for members under the age of 14, are limited to use on permanent molars only. Replacements are limited to one treatment every 36 months.

## **Class II - Basic Services**

- Simple extractions
- Oral surgery related to the tooth and gum includes
  - Surgical extractions of erupted or impacted teeth and removal of residual tooth roots
  - Oral excision of soft tissue or bone
  - Oral excision of intra-osseous lesions
  - Oral surgical Incision
  - Alveoplasty or vestibuloplasty
- Therapeutic drug injections administered in a dental office
- Application of desensitizing medicament or resin
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months.
- Prefabricated stainless steel, porcelain, ceramic, resin or other esthetic coated stainless steel crowns
- Protective restorations (sedative fillings)
- Non-surgical periodontal services of the gums and supporting structures include:
  - Periodontal scaling and root planing is limited to once per quadrant every 24 consecutive months.
  - Periodontal maintenance, as a follow-up to active periodontal treatment, is limited to 4 visits per calendar year.
  - Full mouth debridement is limited to once every 36 consecutive months
  - Localized delivery of antimicrobial agents, subject to review
- Repair or recement of inlays, onlays, crowns, bridgework and dentures are covered when services are performed done 6 or more months after initial placement.
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Limited occlusal adjustments are limited to once every 12 consecutive months as dentally necessary
- Occlusal guard (nightguard) is limited to once every 36 consecutive months. Occlusal guard repair, reline and adjustments are limited to once every 12 consecutive months when services are performed done 6 or more months after initial placement of occlusal guard.
- General anesthesia in a dental care provider's office, when dentally necessary. This includes members who are under the age of 7 or are disabled physically or developmentally. This benefit includes:
  - General anesthesia, deep sedation or intravenous (conscious) sedation when necessary due to age, condition, or degree of difficulty
  - Regional or trigeminal block anesthesia
- Periodontal Surgery is covered in the same quadrant once every 36 consecutive months
- Periodontal soft tissue grafts are covered in the same quadrant once every 36 consecutive months
- Endodontic services of teeth with diseased or damaged nerves include:
  - Direct pulp cap
  - Pulpotomy
  - Endodontic (root canal) treatment is limited to once per tooth every 24 consecutive months



- Retreatment of a root canal when services are done at least 12 months after the original procedure when performed by a different dental office
- Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
- Apexification, apicoectomy, periradicular surgery, and retrograde filling.
- Emergency palliative treatment. We require a written description and/or office records of services provided.

### **Class III – Major Services**

- Inlays, onlays, crowns and labial veneers for a tooth that is decayed, or fractured or where there is significant loss of clinical crown and no other dentally appropriate restoration will restore the tooth are limited to once every 5 calendar years from the original seat date.
- Labial veneers are limited to anterior teeth and subject to review for dental necessity. Labial veneers are often considered cosmetic and not covered by this dental plan. For this reason, a dental estimate of your benefits is strongly recommended.
- Initial placement of fixed bridge or denture. Replacement is limited to:
  - Once every 5 calendar years from the original seat date and only if it is unserviceable and cannot be made serviceable.
  - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement
- Reline rebase and adjustments of dentures are covered when services are done 6 or more months after denture installation.
- Crown build-ups or post and cores for covered crowns are limited to once every 5 calendar years
- Implants and implant services. Replacement implant/abutment supported crowns, dentures, and bridges are limited to once every 5 calendar years from the original seat date.
- Nightguards covered with TMJ treatment only

The plan will cover Class III – Major services and root canals while you are not covered when they:

- Were started after your effective date and before the date your coverage ended under this plan; and
- Were completed within 30 days after the date your coverage ended under this plan

### **High Risk Conditions**

Additional dental coverage described in this section is provided when services or supplies listed in another benefit of this plan are performed in the treatment of the following high-risk conditions that may have a significant impact to your oral health:

- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Diabetes
- Oral Cancer
- Pregnancy

These services are covered:

- One additional periodic oral evaluation or comprehensive oral evaluation or comprehensive periodontal evaluation per calendar year
- One additional prophylaxis (cleaning) or periodontal maintenance per calendar year
- One additional topical application of fluoride applied in the dental officer per calendar year.

**Note:** When submitting a dental claim for this benefit, be sure your dentist submits an appropriate diagnosis code on the dental claim form. Go to <https://www.cdc.gov/oralhealth/conditions/index.html> for more information about the association of oral health and these high risk conditions.

### **Dental Care Services For Injuries**

When services are related to injuries, benefits are available for Class II – Basic and Class III – Major services as follows:

Repreparation or repair of the natural tooth structure when it's required as a result of an injury to that structure, and such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Performed within 12 months of the injury
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
  - Extensive restoration, veneers, crowns or splints
  - Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

**Note:** An injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

### **Extension Requests For Injury Services**

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date.

## **ORTHODONTIA**

### **Covered Services And Supplies**

Covered orthodontic services and supplies include only the following:

- Diagnostic services and supplies, including examinations, x-rays, models, and photographs
- Active treatment, including initial and subsequent necessary appliances
- Retention treatment, including necessary appliances

We reserve the right to review your dental records, including x-rays, models and photographs, to determine if the requested services and supplies are within the limits of this benefit.

Benefits are available for the services and supplies described in this section subject to the following requirements:

- An existing orthodontic condition must be diagnosed as consisting of a handicapping malocclusion that's abnormal and which can be reduced or eliminated by correcting abnormally positioned teeth
- An expense for an orthodontic service or supply is incurred on the date the service is received or the supply is ordered

### **Benefits**

This benefit is subject to coinsurance, up to the benefit maximum for diagnosis and banding. Benefits are provided at 100% of the allowed amount up to an annual maximum of \$3,000 (shared with the annual dental maximum) for each member, or until the member's total treatment plan, including retention treatment, is paid, whichever occurs first.

**Note:** The *Orthodontia* benefit is subject to a 6-month waiting period for employees hired, or dependents added to plan, on or after January 1, 2020.

**In addition to Exclusions and Limitations this benefit doesn't cover any of the following:**

- Any replacement or repair to any appliance
- Charges beyond the month of termination of orthodontic services if such services are terminated for any reason before completion
- Further orthodontic services and supplies, after completion of the initial treatment plan, unless this benefit's lifetime maximum hasn't been reached
- Expenses incurred for orthodontic services or supplies when this benefit isn't in effect or when you're not covered under this benefit

## **TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS**

Services and supplies for treatment of temporomandibular joint (TMJ) disorders are covered on the same basis as any other condition. Any calendar year of lifetime limits in this plan do not apply to this benefit.

When services or supplies listed in another benefit of this plan are performed in the treatment of a TMJ disorder or symptomatic disorder as described in this section, any calendar year deductibles or coinsurance of that other benefit apply to this benefit.

TMJ disorders include those disorders that have some of the following symptomatic diagnoses:

- Muscular pain associated with the temporomandibular joint
- Headaches associated with the temporomandibular joint
- Arthritic problems with the temporomandibular joint
- Clicking or locking of the temporomandibular joint
- An abnormal range of motion or limited motion of the temporomandibular joint

“Medical Services” for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food
- Recognized as effective, according to the professional standards of good medical practice
- Not experimental or investigational, according to the criteria stated under **Definitions**, or primarily for cosmetic purposes

“Dental Services” for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food
- Recognized as effective, according to the professional standards of good dental practice
- Not experimental or investigational, according to the criteria stated under **Definitions**, or primarily for cosmetic purposes

TMJ services covered under this plan include procedures such as the following:

- TMJ examinations and x-rays
- Non-invasive physical therapies
- TMJ Splint

## **EXCLUSIONS AND LIMITATIONS**

In addition to services listed as not covered under **Description of Covered Services**, this section lists the services that are either limited or not covered by this plan:

### **Amounts Over the Allowed Amount**

Costs over the allowed amount as defined by this plan for a non-emergency service from a non-participating provider.

### **Benefits From Other Sources**

Services that are covered by other insurance or coverage such as:

- Motor vehicle medical or motor vehicle no-fault coverage
- Any type of no-fault coverage, such as Personal Injury Protection (PIP), Medical Payment coverage or Medical Premises coverage
- Any type of liability insurance, such as homeowners’ coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

**Benefits That Have Been Exhausted**

Services in excess of benefit limitations or maximums of this plan

**Broken or Missed Appointments****Case Management**

Case management, presentation, or extensive treatment planning.

**Charges For Records Or Reports**

Charges from providers for supplying records or reports not requested by Premera for utilization review

**Cleaning and Inspection of Appliance**

Services to clean and inspect appliances such as complete and partial dentures.

**Complications Of A Non-Covered Service**

Including follow-up services.

**Cosmetic Services**

Drugs, services, or supplies for cosmetic services, including enamel microabrasion, odontoplasty, and bleaching of teeth.

**Counseling, Education and Training**

Counseling, education or training in the absence of illness or injury, including but not limited to:

- Job help and outreach
- Social or fitness counseling
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff
- Private school or boarding school tuition
- Community wellness or safety programs

**Counseling, Oral**

Oral counseling, education or training, including:

- Nutritional counseling for control of dental disease
- Tobacco counseling for the control and prevention of oral diseases
- Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use disorder

**Court-Ordered Services**

Services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically or dentally necessary.

**Dental Services Received From A:**

- Dental or medical department maintained for employees by or on behalf of an employer; or
- Mutual benefit association, labor union, trustee, or similar person or group.

**Dietary Services**

Dietary planning for the control of dental caries, oral hygiene instruction and training in preventive dental care.

**Experimental Or Investigational Services**

Experimental or investigational services or supplies including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.

**Extra Or Replacement Items**

Extra dentures or other appliances, including replacements due to loss or theft.

## **Facility Charges**

Hospital and ambulatory surgical center care for dental procedures.

## **Family Members Or Volunteers**

Services that you provide to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer

## **Genetic or Caries Risk and Susceptibility Tests**

### **Government Facilities**

Services provided by a state or federal facility that are not emergency services or required by law or regulation.

### **Home-Use Products**

Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.

### **Illegal Acts, Illegal Services and Terrorism**

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.

### **Increase Of Vertical Dimension**

Any service to increase or alter the vertical dimension.

### **Magnetic Resonance Imaging (MRI) and Ultrasounds**

### **Maxillofacial Prosthetics**

This plan does not cover maxillofacial prosthetics, this includes but is not limited to artificial replacement of the ear, nose, eyes, or other areas of the face.

### **Military Service And War**

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country, including any related civilian forces or units.

### **Multiple Providers**

Services provided by more than one dental care provider for the same dental procedure.

### **Non-Covered Services**

Services or supplies directly related to any non-covered condition.

- Ordered when this plan is not in effect or when the person is not covered under this plan.
- Provided to someone other than the ill or injured member.
- That are not listed as covered under this plan.
- Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.
- Non-treatment charges, including charges for provider time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping.
- Doing housework or chores for the member or helping the member do housework or chores.

### **Non-Standard Techniques**

Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

## **Non-Treatment Facilities, Institutions or Programs**

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide treatment for covered conditions. Examples are prisons, nursing homes and juvenile detention facilities.

## **Not Covered Under This Plan**

- Services that aren't listed in this booklet as covered or that are directly related to any condition, service or supply that isn't covered under this plan.
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for Class III – Major services and root canals that:
  - Were started after your effective date and before the date your coverage ended under this plan; and
  - Were completed within 30 days after the date your coverage ended under this plan.

## **Oral Pathology**

Oral pathology laboratory services, not including the removal of tissue sample, are not covered. Review to determine if it should be allowed under the medical benefit.

## **Orthognathic Surgery**

Procedures to lengthen or shorten the jaw for cosmetic services not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

## **Personal comfort or convenience items**

- Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping, and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan.
- Dietary assistance, including "Meals on Wheels"

## **Prescription Drugs**

Any prescription drugs or medicines, including drugs or medicines dispensed in the office for home use. This includes vitamins, food supplements, oral antibiotics, oral analgesics, and fluoride and patient management drugs, such as premedication, sedation and nitrous oxide.

## **Provider's Licensing or Certification**

Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers.

## **Serious Adverse Events and Never Events**

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.

Members and this plan are not responsible for payment of services provided by providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Providers may not bill members for these services and members are held harmless.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) website.

## **Services or Supplies Not Dentally Necessary**

Services that are not dentally necessary

## **Sleep Apnea**

Services or supply for sleep apnea including sleep apnea appliance fabrication placement, adjustment, or repair

## **Temporary, Interim Or Provisional Services**

Temporary, interim or provisional services for crowns, bridges or dentures

## **Testing And Treatment Services**

Testing and treatment for mercury sensitivity or that are allergy-related.

## **Work-Related Illness or Injury**

Any illness or injury for which you get benefits under:

- Separate coverage for illness or injury on the job
- Workers' compensation laws
- Any other law that would repay you for an illness or injury you get on the job

However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

## **WHAT IF I HAVE OTHER COVERAGE?**

### **COORDINATING BENEFITS WITH OTHER DENTAL CARE PLANS**

You may also be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations.

All of the benefits of this plan are subject to coordination of benefits. However, note that benefits provided under this plan for allowable dental expenses will be coordinated separately from allowable medical expenses.

If you have other coverage besides this plan, we recommend that you send your claims to the primary plan first. In that way, the proper coordinated benefits may be most quickly determined and paid.

### **Definitions Applicable To Coordination Of Benefits**

To understand coordination of benefits, it's important to know the meaning of the following terms:

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Claim Determination Period** means a calendar year.
- **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 half of the calendar year, excluding any temporary visitation.
- **Medical Plan** means all of the following types of health care coverage, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans

- Government programs that provide benefits for their own civilian employees or their dependents
- Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
- Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following types of dental care coverage, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents

Each contract or other arrangement for coverage described above is a separate plan. We'll coordinate benefits for allowable medical expenses separately from allowable dental expenses, as separate plans.

### Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." When this plan is secondary, it will reduce its benefits for each claim so that the benefits from all medical plans aren't more than the allowable medical expense for that claim and the benefits from all dental plans aren't more than the allowable dental expense for that claim.

We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

Certain governmental plans, such as Medicaid and TRICARE, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

A plan that doesn't have a coordination of benefits provision that complies with this plan's rules is primary to this plan unless the rules of both plans make this plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

**Non-Dependent Or Dependent** The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

**Dependent Children** Unless a court decree states otherwise, the rules below apply:

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse does, that spouse's plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.
  - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
  - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.



- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
  - The plan covering the custodial parent, first
  - The plan covering the spouse of the custodial parent, second
  - The plan covering the non-custodial parent, third
  - The plan covering the spouse of the non-custodial parent, last
  - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

**Retired Or Laid-Off Employee** The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

**Continuation Coverage** If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that isn't through COBRA or other continuation law.

**Note:** The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

**Length Of Coverage** The plan that covered you longer is primary to the plan that didn't cover you as long. If we do not have your start date under the other plan, we will use the employee's hire date with the other group instead. We will compare that hire date to the date your coverage started under this plan to find out which plan covered you for the longest time.

If none of the rules above apply, the plans must share the allowable expenses equally.

#### **Right Of Recovery/Facility Of Payment**

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons the plan paid or for whom the plan paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this plan was made by another plan, the plan also has the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this plan and will meet the plan's obligations to the extent of that payment.

#### **SUBROGATION AND REIMBURSEMENT**

If the plan makes claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, the plan is entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or the plan. This party includes a UIM carrier because it stands in the shoes of a third party tortfeasor and because the plan excludes coverage for such benefits.

**Definitions** The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of the plan, directly from third parties to the extent the plan has paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated to repay any monies advanced by the plan from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that the plan has to the monies advanced under your plan. Because the plan has paid for your illness or injuries, the plan is entitled to recover those expenses.

The plan is entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits the plan paid for the condition, whether or not you have been made whole prior to the plan's recovery. The plan's right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. This right allows the plan to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. The plan's rights and priority are limited to the extent the plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights.

The plan's first priority right of reimbursement will not be reduced due to a member's own negligence; or due to a member not being made whole; or due to attorney's fees and costs.

In recovering benefits provided on behalf of the plan, we may at the Group's election hire an attorney or have the plan be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by the plan or the Group or on their behalf. If you retain an attorney or other agent to represent you in the matter, you must require that legal representative to reimburse the plan directly from the settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify us in writing of any terms or conditions offered in a settlement, and you or your legal representative must notify the third party of the plan's interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by the plan on your behalf. If you or your legal representative fail to cooperate fully with us in the recovery of benefits the plan has paid as described above, you are responsible for reimbursing the plan for such benefits.

You or your legal representative must, within 14 business days of receiving a request from the plan, provide all information and sign and return all documents necessary to exercise the plan's right under this provision.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until the plan's subrogation and reimbursement rights are fully determined.

**Agreement To Arbitrate** Any disputes that arise as part of this provision will be resolved by arbitration. Both you and the plan will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in King County, Washington.

This agreement to arbitrate will begin on the effective date of the plan, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

## **UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE**

The plan has the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

## **WHO IS ELIGIBLE FOR COVERAGE?**

This section of your booklet describes who is eligible for coverage.

### **SUBSCRIBER ELIGIBILITY**

The following categories of employees are eligible to enroll for coverage under this Plan. Active employees must be employed by the City of Redmond; retired or disabled LEOFF I employees must be retired or on disability leave from the City of Redmond.

- LEOFF I employees who are full-time law enforcement officers or firefighters hired prior to October 1, 1977, and who are members of the LEOFF system as defined in Sections (3) and (4), CH 131, Law of 1972 1st Ex. Session.
- Eligible LEOFF II employees who are full-time law enforcement officers or firefighters hired on or after October 1, 1977, and who are not members of the LEOFF system as defined in Sections (3) and (4), CH 131, Law of 1972 1st Ex. Session.
- Non-uniformed employees who are employed on a regular full-time or part-time basis working 20 or more hours per week and who are eligible for a premium contribution by their employer.
- Supplemental employees, their spouses, domestic partners, and dependents who meet the threshold for benefit eligibility as defined by the Patient Protection and Affordable Care Act (PPACA).
- Retired or disabled LEOFF I employees eligible for a premium contribution by the City of Redmond.
- Council members who are employed on a part-time basis and who are eligible for a premium contribution by the City of Redmond are eligible for benefits as of the date that they are seated as an elected official after election.

An employee who has a status change from a part-time employee to a full-time employee will be eligible to enroll in the City of Redmond Benefit Plan at the time that their status changes to a full-time active employee. The employee will have 31 days to enroll. If they do not enroll within 31 days they will not be eligible until the next open enrollment

**Employees who have signed an Executive Severance Agreement, who have been terminated or laid off** and have been offered and have accepted a severance arrangement, will be eligible for coverage on the same basis as any other employee. Eligibility will continue for a period of up to 5 months, which will commence on the first of the month following the date of termination or lay off. The employee is responsible for their portion of premium contributions, if any. Upon exhaustion of the severance period, the employee will be entitled to continue coverage under the COBRA Continuation of Coverage provisions of the Plan.

An employee in one of the following situations will be eligible for coverage on the same basis as any other employee.

- Employees who are on an approved unpaid employee sabbatical (to last no greater than three (3) months). The employee is responsible for their portion of premium contributions, if any.
- Employees who are in a leave without pay status resulting from an approved time-loss injury. The employee is responsible for their portion of premium contributions, if any.

## **DEPENDENT ELIGIBILITY**

To be a dependent under this plan, the family member must be:

- The lawful spouse of the subscriber, unless legally separated. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction.)
- A dependent child who is under 26 years of age, except as provided for in the ***How Do I Continue Coverage? Continued Coverage For a Disabled Child*** provision. An eligible child is one of the following:
  - A natural offspring of either or both the subscriber or spouse;
  - A legally adopted child of either or both the subscriber or spouse;
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child; or
  - A legal dependent of the subscriber or spouse. There must be a court order signed by a judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

## **WHEN DOES COVERAGE BEGIN?**

### **ENROLLMENT**

Enrollment is timely when we receive the completed enrollment application and required premiums within 60 days of the date the employee becomes an "eligible employee" as defined in ***Who Is Eligible For Coverage?***

When enrollment is timely, coverage for the employee and enrolled dependents will start on the effective date specified by the Group. Contact the Group for information on your effective date.

See ***Open Enrollment*** and ***Special Enrollment*** for more information on timely enrollment.

### **Dependents Through Marriage After The Subscriber's Effective Date**

When we receive the completed enrollment application and any required premiums within 60 days after the marriage, coverage will become effective on the date of marriage. If we don't receive the enrollment application within 60 days of marriage, see the ***Open Enrollment*** provision.

### **Newborn Children**

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child's coverage beyond the 3-week period or to enroll the child from birth if the child qualifies as an eligible dependent a completed enrollment application may be required. Please contact the Group for more information. We must receive the enrollment application from the Group within 60 days following birth. Coverage becomes effective from the date of birth. If we don't receive the enrollment application within 60 days of birth, see the ***Open Enrollment*** provision.

### **Adoptive Children**

Coverage becomes effective for adoptive children on the date of placement with the subscriber. A completed enrollment application may be required. Contact the Group for more information.

We must receive the enrollment application from the Group within 60 days following the date of placement. We may request additional information if necessary to establish eligibility of the dependent child. If we don't receive

the enrollment application within 60 days of the date of placement with the subscriber, see the **Open Enrollment** provision.

### **Children Through Legal Guardianship**

When we receive the completed enrollment application, any required premiums, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the date legal guardianship began. If we don't receive the enrollment application within 60 days of the date legal guardianship began, see the **Open Enrollment** provision.

### **Medical Child Support Orders**

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that's required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. When premiums being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Contact your Group for detailed procedures.

## **SPECIAL ENROLLMENT**

The plan allows employees and dependents who didn't enroll when they were first eligible or at the plan's last open enrollment period to enroll outside the plan's annual open enrollment period only in the cases listed below. If we don't receive a completed enrollment application within the time limits stated below, see the **Open Enrollment** provision later in this section.

Coverage will start on the first of the month following the date we receive the application for coverage. In order to be enrolled, the applicant may be required to give us proof of special enrollment rights.

### **Involuntary Loss of Other Coverage**

If an employee and/or dependent doesn't enroll in this plan or another plan sponsored by the Group when first eligible because they aren't required to do so, that employee and/or dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements are met:

- The employee and/or dependent was covered under group health coverage or a health insurance plan at the time coverage under the Group's plan is offered
- The employee and/or dependent's coverage under the other group health coverage or health insurance plan ended as a result of one of the following:
  - Loss of eligibility for coverage for reasons including, but not limited to legal separation, divorce, death, termination of employment, the reduction in the number of hours of employment
  - Termination of employer contributions toward such coverage
  - The employee and/or dependent was covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee isn't enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

We must receive the completed enrollment application and any required premiums from the Group within 30 days of the date such other coverage ended.

### **Subscriber And Dependent Special Enrollment**

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under **Enrollment** in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents.

## **OPEN ENROLLMENT**

If you're not enrolled when you first become eligible, or as allowed under the **Special Enrollment** section, you can't be enrolled until the Group's next open enrollment period. An open enrollment period occurs once a year

unless determined otherwise by the Group. During this period, eligible employees and their dependents can enroll for coverage under this plan.

If the Group offers multiple dental care plans and you're enrolled under one of the Group's other dental care plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

## **CHANGES IN COVERAGE**

Its terms, benefits and limitations may be changed by us at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

## **PLAN TRANSFERS**

Subscribers (with their enrolled dependents) may be allowed to transfer to this dental plan from another dental plan offered by the Group. Transfers also occur if the Group replaces another dental plan with this plan. All transfers to this plan must occur during open enrollment or on another date agreed upon by us and the Group.

When you transfer from the Group's other dental plan, and there's no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Calendar year deductible, if applicable.
- Benefit maximums
- Lifetime maximums

## **WHEN WILL MY COVERAGE END?**

### **EVENTS THAT END COVERAGE**

Coverage will end without notice on the last day of the monthly period for which premiums have been paid in which one of these events occurs:

- For the subscriber and dependents when:
  - The Group Contract is terminated
  - The next monthly premium isn't paid when due or within the grace period;
  - The subscriber dies or is otherwise no longer eligible as a subscriber; or
  - In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement.
- For a spouse when their marriage to the subscriber is annulled, or when they become legally separated or divorced from the subscriber.
- For a child when they no longer meet the requirements for dependent coverage shown in the ***Who Is Eligible For Coverage?*** section.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. The Group must give us written notice of a member's termination within 30 days of the date the Group is notified of such event.

## **PLAN TERMINATION**

The Group is not required to keep the plan in force for any length of time. The Group reserves the right to change or terminate this plan, in whole or in part, at any time with no liability. Plan changes are made as described in ***Changes In Coverage*** in this booklet. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan's end date.

## **HOW DO I CONTINUE COVERAGE?**

### **CONTINUED COVERAGE FOR A DISABLED CHILD**

Coverage may continue beyond the limiting age (shown under ***Dependent Eligibility***) for a dependent child who can't support themselves because of a developmental or physical disability. The child will continue to be eligible if **all** the following are met:

- The child became disabled before reaching the limiting age

- The child is incapable of self-sustaining employment by reason of developmental or physical disability and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's premiums, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Disabled Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

## **LEAVE OF ABSENCE**

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and premiums continue to be paid.

The leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

## **LABOR DISPUTE**

A subscriber may pay premiums through the Group to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike or other labor dispute.

The 6-month labor dispute period counts toward the maximum COBRA continuation period.

## **CONTINUATION UNDER USERRA**

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its website at [www.dol.gov/vets](http://www.dol.gov/vets). An online guide to USERRA can be viewed at [webapps.dol.gov/elaws/vets/userra/](http://webapps.dol.gov/elaws/vets/userra/).

## **COBRA**

When group coverage is lost because of a "qualifying event" as outlined in this section, federal laws and regulations known as "COBRA" require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay a monthly charge for it.

The plan will provide qualified members with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

### **Qualifying Events And Length Of Coverage**

Contact the Group immediately when one of the following qualifying events occurs. The continuation periods listed extend from the date of the qualifying event.

**Note:** Covered domestic partners and their children have the same rights to COBRA coverage as covered spouses and their children.

The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:

- **The subscriber's work hours are reduced.**
- **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.

The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:

- **The subscriber dies.**
- **The subscriber and spouse legally separate or divorce.**
- **The subscriber becomes entitled to Medicare.**
- **A child loses eligibility for dependent coverage.**

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who wasn't on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

**The Group must offer the retired subscriber and covered dependents an election to continue their retiree coverage if that coverage is lost because the Group filed for bankruptcy.** COBRA also considers coverage to have been lost due to this qualifying event if the retiree group coverage was substantially eliminated at any time between 1 year before the bankruptcy proceeding commenced and 1 year after it commenced.

Under this qualifying event, the retired subscriber may continue coverage for up to the rest of his or her life. The retired subscriber's covered spouse and children may continue for up to 36 months after the retired subscriber's death or until they lose eligibility as dependents, whichever occurs first. (If the retired subscriber died before the bankruptcy, but his or her spouse is still covered under this plan when the bankruptcy filing occurred, that surviving spouse may continue coverage for up to the rest of his or her life.)

### **Conditions Of COBRA Coverage**

For COBRA coverage to become effective, all of the following requirements must be met:

#### **You Must Give Notice Of Some Qualifying Events**

The plan will offer COBRA coverage only after the Group receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in **Qualifying Events And Lengths Of Coverage**. The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

#### **If the required notice isn't given or is late, the qualified member loses the right to COBRA coverage.**

Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date the qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Note: Determinations that a qualified member is disabled must be given to the Group before the 18-month continuation period ends. This means that**

**the subscriber or qualified member might not have the full 60 days in which to give the notice.** Include a copy of the determination with your notice to the Group.

Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See ***When COBRA Coverage Ends***.

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

**Important Note: The Group must tell you where to direct your notice and any other procedures that you must follow. If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you're informed by the Group.**

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement no later than 44 days after the **later** of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.

### **You Must Enroll And Pay On Time**

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Contact the Group or your bargaining representative for more information if you believe this may apply to you.

Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

- You must send your first premium payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent premiums must also be paid to the Group.

### **Adding Family Members**

Eligible family members may be added after the continuation period begins, but only as allowed under ***Special Enrollment*** or ***Open Enrollment*** in ***When Does Coverage Begin?***. With one exception, family members added after COBRA begins aren't eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under ***Qualifying Events And Lengths Of Coverage***. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

### **Keep The Group Informed Of Address Changes**

In order to protect your rights under COBRA, you should keep the Group informed of any address changes. It's a good idea to keep a copy, for your records, of any notices you send to the Group.

### **When COBRA Coverage Ends**

COBRA coverage will end on the last day for which premiums have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly premium isn't paid when due or within the 30-day COBRA grace period.



- When coverage is extended from 18 to 29 months due to disability (see **Qualifying Events And Lengths Of Coverage**), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which premiums have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.
- You become covered under another group dental care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any employee.

## If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Group. For more information about your rights under federal laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

## HOW DO I FILE A CLAIM?

Many providers will submit their bills to us directly. However, if you need to submit a claim to us, follow these simple steps:

### Step 1

Complete a Claim Reimbursement Form. A separate Claim Reimbursement Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling customer service.

### Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address, and IRS tax identification number of the provider
- Information about other insurance coverage
- American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event

### Step 3

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

### Step 4

Sign the Subscriber Claim Form in the space provided.

### Step 5

Mail your claims to us at the mailing address shown on the back cover of this booklet.

## Timely Filing

You should submit all claims within 90 days of the date of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies.

- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater.

The plan won't provide benefits for claims we receive after the later of these 2 dates, nor will the plan provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

## COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera.

### What is a Complaint?

Other than denial of payment for medical services or nonprovision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with Premera.

### How to file a complaint

**Call** customer service at 800-722-1471 (TTY:711)

**Send a fax** to 425-918-5592

**Send the details in writing to:**

Premera Blue Cross  
PO Box 91102  
Seattle, WA 98111-9202

For complaints received in writing, we will send a written response within 30 days.

### What is an Appeal?

An appeal is a request to review a specific decision or an adverse benefit determination Premera has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically or dentally necessary or appropriate, or not effective

### WHAT YOU CAN APPEAL

<b>Claims</b>	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes estimates of benefits.

### APPEAL LEVELS

You have the right to two levels of appeals:

<b>Appeal Level</b>	<b>What it means</b>	<b>Deadline to appeal</b>
<b>Level 1</b>	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
<b>Level 2</b>	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified or our Level 1 appeal decision.

## HOW TO SUBMIT AN APPEAL

<p><b>Step 1.</b> <b>Get the form</b></p>	<ul style="list-style-type: none"> <li>Complete the Member Appeal Form, you can find it on <a href="http://premera.com">premera.com</a> or call customer service to request a copy.</li> </ul> <p>If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-722-1471 (TTY:711)</p>
<p><b>Step 2.</b> <b>Collect supporting documents</b></p>	<ul style="list-style-type: none"> <li>Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request.</li> <li>If you would like someone to appeal on your behalf, including your provider, complete a Member Appeal Form with authorization, you can find it on <a href="http://premera.com">premera.com</a>. We can't release your information without this form.</li> </ul>
<p><b>Step 3.</b> <b>Send in my appeal</b></p>	<p>To help process your appeal, be sure to complete the form and return with any supporting documents.</p> <p><b>Send your documents to:</b></p> <p>Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592</p>

**Note: You may also call customer service to verbally submit an appeal.**

If you would like to review the information used for your appeal, send us a request in writing to:

### Appeal Response Time Limits

We'll review your appeal and send a decision within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, Premera representatives who have not reviewed the case before will review and make a decision. Medical and dental review denials will be reviewed by a medical or dental specialist.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 15 days
All other appeals	15-30 days

### If We Need More Time

Except for urgent appeals, we can extend the time limits. We will notify you, if for good cause, more time is needed. An extension cannot delay the decision beyond 30 days without your informed written consent.

## WHAT IF YOU HAVE ONGOING CARE

Ongoing care is continuous treatment you are currently receiving.

If you appeal a decision that affects ongoing care because we've determined the care is no longer dentally necessary, the plan will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts the plan paid for ongoing care during the appeal review.

## WHAT IF IT'S URGENT

If your condition is urgent, you will get our response sooner. See the table above. Urgent appeals are only available for services you are currently receiving or have not yet received.

Examples of urgent situations are:

- Your life or health is in serious danger, or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professionals or your treating physician
- You are requesting coverage for inpatient or emergency services that you are currently receiving

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor. The phone number is 866-444-EBSA (3272).

## **OTHER INFORMATION ABOUT THIS PLAN**

This section tells you about how this plan is administered. It also includes information about federal and state requirements we and the Group must follow and other information that must be provided.

### **Conformity With The Law**

If any provision of the plan or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

### **Evidence Of Dental Necessity**

We have the right to require proof of dental necessity for any services or supplies you receive before benefits under this plan. You or your dental care providers may submit this proof. No benefits will be available if the proof isn't provided or acceptable to the plan.

### **ID Card**

If you need a replacement Premera ID card, call our customer service or visit our website at [premera.com](http://premera.com). If coverage under the contract terminates, your Premera ID card will no longer be valid.

### **Intentionally False Or Misleading Statements**

If this plan's benefits are paid in error due to any intentionally false or misleading statements, the plan is entitled to recover these amounts. See ***Right Of Recovery***.

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, as directed by the Group:

- Deny your claim;
- Reduce the amount of benefits provided for your claim; or
- Rescind your coverage under this plan. Rescind means to cancel coverage back to its effective date as if it had never existed at all.

### **Member Cooperation**

You're under a duty to cooperate with us and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group in the event of a lawsuit.

### **Notice Of Information Use And Disclosure**

We may collect, use or disclose certain information about you. This protected personal information (PPI) may include dental information, or personal data such as your address, telephone number or Social Security number. We may receive this information from or release it to dental care providers, insurance companies or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other dental care plans
- Conducting care management, case management or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Contact our customer service department and ask that a representative mail a request form to you.

### **Notice Of Other Coverage**

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which the plan provides benefits, and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

### **Notices**

We may be required to send you certain notices. We will consider such a notice to be delivered if we mail or email it to your most recent mailing or email address in our records. The date of the postmark or email is the delivery date.

If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.

### **Right Of Recovery**

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider who doesn't have a contract with us.

### **Right To And Payment Of Benefits**

Benefits of this plan are available only to members. Except as required by law, the plan won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan. At our option only and in accordance with the law we may pay the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

### **Venue**

All suits or legal proceedings brought against us, the plan or the Group by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date the rights or benefits claimed under this plan were denied in writing; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal or arbitration proceedings brought by the plan will be filed within the appropriate statutory period of limitation, and you agree that venue, at the plan's option, will be in King County, the state of Washington.

## DEFINITIONS

The terms listed in this section have specific meanings under this plan.

### Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time and place.

Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

### Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically or dentally necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

### Allowed amount

The allowed amount shall mean one of the following depending on whether the dental care provider is participating or non-participating:

- **Dental Care Providers Who Have Agreements With Us**

The amount for dentally necessary services and supplies these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

Your liability for any applicable calendar year deductibles, coinsurance and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount.

- **Dental Care Providers Who Don't Have Agreements With Us**

The allowed amount will be the maximum allowed amount as determined by Premera Blue Cross in the area where the services were provided, but in no case higher than the 90<sup>th</sup> percentile of provider fees in that geographic area.

When you seek services from dental care providers that don't have agreements with us, your liability is for any amount above the allowed amount, and for any applicable calendar year deductibles, coinsurance, amounts that are in excess of stated benefit maximums and charges for non-covered services and supplies.

We reserve the right to determine the amount allowed for any given service or supply.

### Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.

### Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

### Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

## **Claim**

A request for payment from us according to the terms of this plan.

## **Clinical Trials**

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by one of the following:

- An institutional review board that complies with federal standards for protecting human research subjects; and
- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- The United States Food and Drug Administration (FDA)
- The United States Department of Defense
- The United States Department of Veterans' Affairs
- A nongovernmental research entity abiding by current National Institutes of Health guidelines

## **Comprehensive Oral Evaluation**

Comprehensive oral evaluations include complete dental/medical history and general health assessment, complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; the evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screenings.

## **Congenital Anomaly**

A marked difference from the normal structure of an infant's body part that's present from birth.

## **Contract**

Contract describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan.

## **Cosmetic Services**

Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

## **Cost Share**

The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.

## **Covered Service**

A service, supply or drug that is eligible for benefits under the terms of this plan.

## **Dental Care Provider**

A state-licensed:

- Doctor of Medical Dentistry (DMD)
- Doctor of Dental Surgery (DDS)

The benefits of this plan are available if professional services are provided by a state-licensed dentist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of their license or certification, as allowed by law and this plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

## **Dental Emergency**

A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.

## **Dentally Necessary and Dental Necessity**

Those covered services which are determined to meet all of the following requirements:

- Appropriate and consistent with authoritative dental or scientific literature.

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan.
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider.

### **Dependent**

The subscriber's spouse or domestic partner and any children who are on this plan.

### **Effective Date**

The date on which your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

### **Eligibility Waiting Period**

The length of time that must pass before a subscriber or dependent is eligible to be covered under the Group's plan. If a subscriber or dependent enrolls under the **Special Enrollment** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered and eligibility waiting period, unless all or part of the initial eligibility waiting period had been met.

### **Emergency Medical Condition (also called "Emergency")**

A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.

### **Emergency Services**

- A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.
- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide such medical, mental health or substance use disorder treatment necessary to ensure that, within reasonable medical probability that no material deterioration of an emergency condition is likely to result from the transfer of the patient from a facility; and for a pregnant member in active labor to perform the delivery.
- Ambulance transport, as needed, in support of the services above.

### **Endorsement**

A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

### **Enrollment Date**

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There is one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this plan, but was later transferred to a class of employees to which the group does provide coverage under this plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.). For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.



## **Experimental/Investigational Services**

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board.
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

## **Explanation of Benefits**

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

## **Group**

The entity that sponsors this self-funded plan.

## **Injury**

Physical harm caused by a sudden event at a specific time and place. It's independent of illness, except for infection of a cut or wound. **Note:** An injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

## **Lifetime Maximum**

The maximum amount that Premera will provide during your lifetime.

## **Limited Oral Evaluation – Problem Focused**

A limited oral evaluation – problem focused is an evaluation limited to a specific oral health problem or complaint and may include evaluation of a specific dental problem or oral health complaint, dental emergency and referral for other treatment.

## **Medically Necessary and Medical Necessity**

Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:

- Agree with generally accepted standards of medical practice
- Be clinically appropriate in type, frequency, extent, site and duration., They must also be considered effective for the patient's illness, injury or disease
- Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

## **Member (also called "You" and "Your")**

A person covered under this plan as a subscriber or dependent.

## **Orthodontia**

The branch of dentistry that specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

## **Plan**

The Group's self-funded plan described in this booklet.

## **Premiums**

The monthly rates we establish as consideration for the benefits offered under this contract.

## **Services**

Procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.

## **Specialist**

A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

## **Spouse**

- An individual who is legally married to the subscriber.
- An individual who is a domestic partner of the subscriber.

## **Temporomandibular Joint (TMJ) Disorders**

TMJ disorders include those disorders that have 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.

## **Visit**

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

## **Visual Oral Screenings or Assessments**

Performed by a licensed dentist or dental hygienist under the supervision of a licensed dentist to determine the need for sealants, fluoride treatment, and/or when triage services are provided in settings other than dental offices or dental clinics.

## **We, Us and Our**

Premera Blue Cross



## Where To Send Claims

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### MAIL YOUR CLAIMS TO

Premera Blue Cross  
PO Box 91059  
Seattle, WA 98111-9159

## Customer Service

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### Mailing Address

Premera Blue Cross  
PO Box 91059  
Seattle, WA 98111-9159

### Physical Address

7001 220th St SW  
Mountlake Terrace, WA 98043-2124

### Phone Numbers

Local and toll-free number:  
800-722-1471

Local and toll-free TTY number:  
711

## When You Have An Appeal

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Premera Blue Cross  
Attn: Appeals Coordinator  
PO Box 91102  
Seattle, WA 98111-9202

## Visit Our Website

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[premera.com](http://premera.com)