Washington Alliance For Healthcare Insurance Trust

Dental Base

100000006

PREMERA BLUE CROSS

INTRODUCTION

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association. The benefits, limitations, exclusions and other coverage provisions in this booklet are subject to the terms of our contract with the Group. This booklet is a part of that contract, which is on file in the Group's office and at Premera Blue Cross. This booklet replaces any other benefit booklet you may have received. The Group has delegated authority to Premera Blue Cross to use its expertise and judgment as part of the routine operation of the plan to reasonably apply the terms of the contract for making decisions as they apply to specific eligibility, benefits and claims situations. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal or bring a civil lawsuit challenging any eligibility or claims determinations under the contract, including our exercise of our judgment and expertise.

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
- **What's Not Covered?** — 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
- **What If I Have A Question Or An Appeal?** — 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 in Washington.

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 Web site 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:	Washington Alliance For Healthcare Insurance Trust
Effective Date:	July 1, 2018
Group Number:	100000006
Plan:	Dental Base
Certificate Form Number:	2237DB2018

PREMERA BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the 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, or sex, you can file a grievance with:
Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese): この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ภาสาเขฺมร (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស្លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریقPremera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

TABLE OF CONTENTS

CONTACT US .....(SEE BACK COVER OF THIS BOOKLET)

WHAT DO I NEED TO KNOW BEFORE I GET CARE? 1

Alternative Benefits 1

Requesting An Estimate Of Benefits.....1

Coinsurance 1

Dental Benefit Maximum 1

Network Providers.....2

Non-Network Providers 2

WHAT ARE MY BENEFITS? 2

Benefit Percentages.....2

Description Of Covered Services 2

Class I Diagnostic And Preventive Services 2

Class II Basic Services.....3

Dental Care Services For Injuries 3

WHAT'S NOT COVERED? 4

WHAT IF I HAVE OTHER COVERAGE? 7

Coordinating Benefits With Other Dental Care Plans 7

Subrogation And Reimbursement.....9

Uninsured And Underinsured Motorist /Personal Injury Protection Coverage.....10

WHO IS ELIGIBLE FOR COVERAGE? 10

Subscriber Eligibility 10

Dependent Eligibility.....10

WHEN DOES COVERAGE BEGIN? 11

Enrollment 11

Special Enrollment 12

Open Enrollment 13

Changes In Coverage 13

Plan Transfers.....13

WHEN WILL MY COVERAGE END? 13

Events That End Coverage 13

HOW DO I CONTINUE COVERAGE? 14

Continued Coverage For A Disabled Child 14

Leave Of Absence.....14

Labor Dispute 15

Continuation Under USERRA 15

COBRA.....15

HOW DO I FILE A CLAIM? 18

WHAT IF I HAVE A QUESTION OR AN APPEAL? **19**
When You Have Ideas 19
When You Have Questions 19
When You Have A Complaint 19
When You Have An Appeal 20
OTHER INFORMATION ABOUT THIS PLAN **21**
WHAT ARE MY RIGHTS UNDER ERISA? **23**
DEFINITIONS **25**

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

The covered services under this dental plan are classified as Diagnostic and Preventive, and Basic. 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. 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 (D.M.D. or D.D.S.) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her 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. Please see the "Definitions" section in this booklet for a detailed explanation of "allowed amount."

Alternative Benefits

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

An 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.

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

Our 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

As used in this plan, "coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. 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 $750.

Benefits for covered services with multiple treatment dates are subject to the dental benefit maximum of the calendar year in which the services are started.

However, if you receive dental implant services, the post insertion and the final crown or bridgework will be

considered to be separate services, and those services will be calculated under the calendar year limitation in which they are received.

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.

Important Note: You're entitled to receive a provider directory automatically, without charge.

For the most current information on network Dental Choice providers, please refer to our Web site 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. However, as a Premera Blue Cross member, you have access to a nationwide network of Dental Choice providers who can provide preventive and specialty dental care services. 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" (please see the "Definitions" section 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.

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. Please see the "How Do I File A Claim?" section in this booklet for instructions on submitting claims for reimbursement.

WHAT ARE MY BENEFITS?

BENEFIT PERCENTAGES

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 2 categories: Diagnostic and Preventive services and Basic services. In this section you'll find a description of the services included in each category.

- Diagnostic and Preventive Services 0%
- Basic Services 20%

DESCRIPTION OF COVERED SERVICES

Class I Diagnostic And Preventive Services

- Routine comprehensive, periodic and limited oral evaluations (including problem focused) are limited to 2 per calendar year. Professional consultations, periodontal evaluations and other office visits apply to this limit.
- Emergency oral examinations. (Please see the "Definitions" section for the definition of a Dental Emergency.) Services that are determined to be routine will be limited to 2 per calendar year.
- 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 20. They're limited to 2 treatments per calendar year.
- Covered dental x-rays include either a complete series or panoramic x-ray once in any 36 consecutive months, but not both. X-rays taken for root canal therapy are limited to 1 periapical x-ray per tooth.
- Space maintainers, for members under the age of 20.
- Sealants, for members under the age of 19, are limited to use on permanent teeth.

- Oral pathology laboratory services, not including the removal of tissue sample, is covered when directly related to teeth and gums

Class II Basic Services

- Simple extractions
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, and diagnosis and treatment of cysts and abscesses
- Dentally necessary injectable drugs administered in a dental office
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance.
- Stainless steel crowns are limited to one per tooth every 2 calendar years
- Non-surgical treatment of periodontal and other diseases of the gums and tissues of the mouth:
  - Periodontal scaling and root planing and sub-gingival curettage is limited to a total of 2 full-mouth treatments in any 12 consecutive months.
  - Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, polishing, periodontal evaluation and review of oral hygiene, is limited to 4 visits per calendar year.
  - Full mouth debridement
- Repair and recementing of crowns, inlays, bridgework and dentures
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Limited occlusal adjustments once every 12 consecutive months
- Nightguards for bruxism
- 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.
- Osseous surgery, which includes gingivectomy, gingivoplasty, and gingival flap procedures
- Endodontic (root canal) treatment:
  - Benefits for root canals performed in conjunction with overdentures are limited to 2 per arch
  - 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
  - X-rays done in conjunction with a root canal. The primary periapical x-ray for diagnostic purposes is covered. Additional x-rays are limited to the allowance for the root canal therapy.

Dental Care Services For Injuries

When services are related to injuries, benefits are available for Basic 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

Please 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.

WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which benefits of this plan are limited or not available. Benefits can also be affected by your eligibility. Some benefits may also have their own specific limitations.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, this plan doesn't cover:

Amounts That Exceed The Allowed amount

Benefits From Other Sources

Benefits aren't available under this plan when coverage is available through:

- Motor vehicle medical/dental or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other types of liability insurance
- Worker's Compensation or similar coverage

Benefits That Have Been Exhausted

Amounts that exceed the allowed amount or maximum benefit for a covered service.

Broken Appointment Charges

Amounts that are billed for broken or late appointments.

Charges For Records Or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.

Cosmetic Services

- Treatment of congenital malformations, except when the patient is an eligible dependent child.
- Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof.

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

Any service or supply that Premera Blue Cross determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Definitions" section in this booklet).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "What If I Have A Question Or An Appeal?" section in this booklet for an explanation of the appeals process.

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 or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child.
- Services or supplies provided by volunteers

Home-Use Products

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

Increase Of Vertical Dimension

Any service to increase or alter the vertical dimension.

Major Restorative Dental Services

Services, supplies or prosthetics as determined by us to fall under the major service category including, but not limited to;

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns
- Initial placement of dentures
- Initial placement of fixed bridgework (including inlays, onlays and crowns to form abutments)
- Replacement dentures and fixed bridgework
- Relining and rebasing of dentures
- Tooth build-ups for onlays and crowns, including bridge abutments
- Implants and implant related services
- Precision attachments

Military And War-Related Conditions, Including Illegal Acts

This includes:

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

Multiple Providers

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

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, unless benefits must be provided by law

Non-Standard Techniques

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

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're not covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for 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.

    The following are deemed service start dates:
    - For root canals, it's the date the canal is opened.

    The following are deemed service completion dates:
    - For root canals, it's the date the canal is filled.

Not Dentally Necessary

Services that aren't dentally necessary (see definition of "Dentally Necessary").

Orthodontia Services

Orthodontia, including casts, models, x-rays, photographs, examinations, appliances, braces and retainers are only covered under the Orthodontia benefit, if this plan includes that benefit.

Orthognathic Surgery (Jaw Augmentation or Reduction)

Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.

Prescription Drugs

Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.

Temporomandibular Joint (TMJ) Disorders

Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and after effects thereof.

Testing And Treatment Services

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

Work-Related Conditions

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

- Occupational coverage required or voluntarily obtained by the employer;
- State or federal workers' compensation acts; or
- Any legislative act providing compensation for work-related illness or injury.

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

When you have more than one health plan, "coordination of benefits (COB)" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with your primary plan first. If you have Medicare, Medicare may submit your claims to your secondary plan. Please see "COB's Effect On Benefits" below in this section for details on primary and secondary plans.

If you do not know which is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan(s) to determine which is primary and will let you know within 30 calendar days.

Caution: All health plans have timely filing requirements. If you or your provider fails to submit your claim to your secondary plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary plan, you or your provider will need to submit your claim to the secondary plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers any changes in your coverage.

Definitions

For the purposes of COB:

- A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contact or benefit to which COB doesn't apply is treated as a separate plan.
  - "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
  - "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.
- **This plan** means your plan's dental care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your Premera Blue Cross plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.
- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See "Effect On Benefits" later in this section for rules on secondary plan benefits.
- **Allowable expense** is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that isn't covered by any of your plans isn't an allowable expense.

  The allowable expense for the secondary plan is the amount it allows for the service or supply in the absence of other coverage that is primary. This is true regardless of what method the secondary plan uses to set allowable expenses.

  The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
- **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.

Primary And Secondary Rules

Certain governmental plans, such as Medicaid, 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 COB provision that complies with Washington regulations is primary to a complying plan unless the rules of both plans make the complying 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. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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. 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.

Please 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.

COB's Effect On Benefits

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. **The secondary plan is never required to pay more than its benefit in the absence of COB plus any savings accrued from prior claims incurred in the same calendar year.**

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary. It must also calculate savings for each claim by subtracting its secondary benefits from the amount it would have provided as primary. It must use these savings to pay any allowable expenses incurred during that calendar year, whether or not they are normally covered.

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim to the secondary plan to make payment as if the secondary plan was primary. In such situations, the secondary plan is required to pay claims within 30 calendar days of receiving your claim and notice that your primary plan has not paid. However, the secondary plan may recover from the primary plan any excess amount paid under the “Right of Recovery/Facility of Payment” provision in the plan.

Right Of Recovery/Facility Of Payment If your other plan makes payments that this plan should have made, we have the right, at our reasonable discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

Questions about COB? Contact our Customer Service Department or the Washington Insurance Department.

SUBROGATION AND REIMBURSEMENT

If we make 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, we will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the injury or illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the "third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation,

reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third-parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. If you recover from a third party and we share in the recovery, we will pay our share of the legal expenses. Our share is that percentage of the legal expenses necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-parties payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. You must also cooperate fully with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

Agreement To Arbitrate Any disputes that arise as part of this provision will be resolved by arbitration. Both you and we 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 contract, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

We have 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. We will use our expertise and judgment to reasonably construe the terms of this booklet as they apply to your eligibility for benefits. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal or bring a civil challenge to any eligibility determination.

SUBSCRIBER ELIGIBILITY

To be a subscriber under this plan, an employee must meet all of the following requirements:

- Be a regular and active employee, owner, partner, or corporate officer of the Participating Employer who is paid on a regular basis through the Participating Employer’s payroll system, and reported by the Participating Employer for Social Security purposes. The employee must also meet 2 other requirements. The employee must:
  - Regularly work the minimum hours required by the Participating Employer
  - Complete the probationary period, if any, required by the Participating Employer

If we don't receive the enrollment application within 60 days of the date you became eligible, please see the "Open Enrollment" section.

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated. However, if the spouse is an owner, partner, or corporate officer of the Participating Employer who meets the requirements in "Subscriber Eligibility" earlier in this section, the spouse can only enroll as a subscriber.
- The domestic partner of the subscriber. All rights and benefits afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage," the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."

  Please Note: Domestic Partnerships that are **not** documented in a state registry must meet all requirements stated in the signed "Affidavit of Domestic Partnership."
- A dependent child who is under 26 years of age. 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 ward 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 subscription charges within 60 days of the date the employee becomes an “eligible employee” as defined in the “Who Is Eligible For Coverage?” section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that coincides with or next follows the **latest** of the applicable dates below.

- The employee's date of hire
- The date the employee enters a class of employees to which the Participating Employer offers coverage under this plan
- The next day following the date the probationary period ends, if one is required by the Participating Employer

If we don’t receive the enrollment application within 60 days of the date you became eligible, none of the dates above will apply. Please see “Open Enrollment” and "Special Enrollment" later in this section.

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage, coverage will become effective on the first of the month following the date of marriage. If we don’t receive the enrollment application within 60 days of marriage, please see the “Open Enrollment” provision later in this section.

Natural Newborn Children Born On Or After The Subscriber's Effective Date

- An enrollment application isn’t required for natural newborn children when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for natural newborn children on the date of birth.
- When subscription charges being paid don’t already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us 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, please see the "Open Enrollment" provision later in this section.

Adoptive Children Acquired On Or After The Subscriber's Effective Date

- An enrollment application isn’t required for adoptive children placed with the subscriber when subscription

charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for adoptive children on the date of placement with the subscriber.

- When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us by the Group within 60 days following the date of placement with the subscriber. Coverage becomes effective from the date of placement. If we don't receive the enrollment application within 60 days of the date of placement with the subscriber, please see the "Open Enrollment" provision later in this section.

Dependent children under the age of 2 are exempt from enrolling in the dental plan. The subscriber may choose to enroll children under the age of 2 if enrolling within 60 days of the date of birth or adoption, or during the group's open enrollment.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required subscription charges 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 first of the month following the date legal guardianship began. If we don't receive the enrollment application within 60 days of the date legal guardianship began, please see the "Open Enrollment" provision later in this section.

Children Covered Under 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 is 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 subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Participating Employer 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, please see the "Open Enrollment" provision later in this section.

Coverage will start on the first of the month following the qualified event. 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 is 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 subscription charges 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 "Special Enrollment" above, you can't be enrolled until the Participating Employer's next open enrollment period. An open enrollment period occurs once a year unless otherwise agreed upon between the Group and us. During this period, eligible employees and their dependents can enroll for coverage under this plan.

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

CHANGES IN COVERAGE

No rights are vested under this plan. 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 with us offered by the Group. Transfers also occur if the Group replaces another dental plan (with us) 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 we update the contract for this dental plan, or you transfer from the Group's other dental plan with us, 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

This provision doesn't apply to transfers from dental plans not offered by us.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when:
  - The Group Contract is terminated;
  - The next monthly subscription charge 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 an association, the employer's membership in the association ceases; 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 his or her marriage to the subscriber is annulled, or when he or she becomes legally

separated or divorced from the subscriber.

- For a child when he or she no longer meets the requirements for dependent coverage shown in the "Who Is Eligible For Coverage?" section.

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

CONTRACT TERMINATION

No rights are vested under this plan. Termination of the Group Contract for this plan completely ends all members' coverage and all our obligations.

This plan is guaranteed renewable. However, this plan will automatically terminate if subscription charges aren't paid when due. Coverage will end on the last day for which payment was made. This plan also may terminate as follows.

The Group may terminate the Group Contract:

- Upon 30 days' advance written notice to us on any subscription charge due date.
- By rejecting in writing the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, upon 30 days advance written notice to the Group if:

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
- The Group fails to meet the minimum participation or contribution requirements stated in its signed application;
- The Group no longer has any members who reside or work in Washington;
- Published policies, approved by the Office of the Insurance Commissioner, have been violated;
- There is a material breach of the Group Contract, other than non-payment; or
- We are otherwise permitted to do so by law.

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 himself or herself 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 disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes us with a Request for Certification of Handicapped Dependent form. We 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 we request it. We won't ask for proof 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 subscription charges 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 subscription charges through the Participating Employer 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 Web site at **www.dol.gov/vets**. An online guide to USERRA can be viewed at **www.dol.gov/elaws/userra.htm**.

COBRA

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require certain Participating Employers 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 the subscription charges for it. The Participating Employer is responsible to notify you whether it meets the standards set by the federal COBRA laws and regulations.

At the Group's request, we'll provide qualified members of Participating Employers that are subject to COBRA with COBRA coverage under this plan 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. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us or the Participating Employer's failure to perform COBRA-related duties. The Participating Employer, **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

Please contact the Participating Employer immediately when one of the following qualifying events occurs. The continuation periods listed extend from the date of the qualifying event.

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

- The Participating Employer 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 Participating Employer 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 Participating Employer 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. This happens only if the event would have caused a similar dependent who wasn't on COBRA coverage to lose coverage under this plan.
- 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 Participating Employer 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. The extended period will end no later than 36 months from the date of the first qualifying event.

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

The subscriber or affected dependent must notify the Participating Employer 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 Participating Employer 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 Participating Employer 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 Participating Employer. 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 qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please note: Determinations that a qualified member is disabled must be given to the Participating Employer 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.** Please 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 Participating Employer must tell you where to direct your notice and any other procedures that you must follow. If the Participating Employer 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 Participating Employer.

The Participating Employer must notify qualified members of their rights under COBRA. If the Group or Participating Employer 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 Participating Employer (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Participating Employer itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Participating Employer 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 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. Please contact the Participating Employer 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.

  If you're not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you're not notified of your right to elect COBRA coverage within the time limit, and you don't elect COBRA coverage within 60 days after the date coverage ends, we won't be obligated to provide COBRA benefits under this plan. The Participating Employer will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.
- You must send your first subscription charge payment to the Participating Employer no more than 45 days after the date you elected COBRA coverage.
- Subsequent subscription charges must be paid to the Participating Employer and submitted to us with the Group's regular monthly billings.

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 the "When Does Coverage Begin?" section. 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 Participating Employer Informed Of Address Changes

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

When COBRA Coverage Ends

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

- The applicable continuation period expires.
- The next monthly subscription charge 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" in this section), COBRA coverage beyond 18 months ends if 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 subscription charges 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 Participating Employer with a copy of the 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 health care plan after the date you elect COBRA coverage. If, however, 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 Participating Employer ceases to offer group dental care coverage to any employee.

However, even if one of the events above hasn't occurred, COBRA coverage **under this plan** will end on the date that the contract between the Group and us is terminated or the date that coverage under this plan ends for the Participating Employer.

Your eligibility for this dental plan is dependent on your also being enrolled on a medical plan through the Participating Employer which is provided by Premera Blue Cross. In order to be able to continue coverage under this plan, you must also continue coverage under that Premera Blue Cross medical plan.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Participating Employer. 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 Web site at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

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 Subscriber Claim Form. A separate Subscriber Claim 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.

Special Notice About Claims Procedure

We'll make every effort to process your claims as quickly as possible. We'll tell you if this plan won't cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to 15 days if it's decided that more time is needed due to matters beyond our control. We'll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we'll ask for that information in our notice and allow you or your provider at least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information we need, we have 15 days in which to give you our decision.

If your claim was denied, in whole or in part, our written notice will include:

- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information we may need to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of our complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter from our dental department stating these reasons. The letter will also include how ongoing care may be covered during the appeal process, as described in the "What If I Have A Question Or An Appeal?" section of this booklet.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a dentist, lawyer, or a friend or relative. You must notify us in writing and give us the name, address and telephone number where your appointee can be reached.

If your Participating Employer is subject to ERISA, ERISA gives you the right to file suit in a state or federal court if a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in these claims procedures.

WHAT IF I HAVE A QUESTION OR AN APPEAL?

As a Premera Blue Cross member, you have the right to offer your ideas, ask questions, voice complaints and submit appeals. Our goal is to listen, resolve your problems and improve our service to you.

When You Have Ideas

We want to hear your suggestions on how we can continue to improve our service. If you have an idea, suggestion or opinion, please let us know. You can call us at the numbers listed on the back cover of this booklet or send your ideas and comments to our Customer Assessment Manager at the Customer Service address on the back cover of this booklet.

When You Have Questions

Call your dental provider of care when you have questions about the dental services you receive. Please call our Customer Service Department with any other questions regarding this Premera Blue Cross plan.

If you need an interpreter to help with your question, please tell us when you call, and we'll provide one for the call.

When You Have A Complaint

A **complaint** is an expression of dissatisfaction about a benefit or coverage decision, customer service or the

quality or availability of a dental service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you have a concern about a benefit or coverage decision. If our Customer Service department finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. If your complaint is about the quality of care you receive, Customer Service will give it to our Clinical Quality Management staff for review. If your complaint is of a non-dental nature relating to a provider, Customer Service will give it to our Provider Network staff for review. We'll let you know when we receive your complaint. We also may request more information when needed. When we receive all needed information, we'll review your complaint and respond as soon as possible, but never more than 30 calendar days.

When You Have An Appeal

An **appeal** is an oral or written request that we reconsider 1) our decision on a complaint, or 2) our decision to deny, modify, reduce, or end payment, coverage or authorization of coverage. This includes admissions to and continued stays in a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you're appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

Although we accept Level I or urgent appeals made by phone to our Customer Service department, it's better for you to put appeals in writing so you can keep copies for your records. Level II appeals, unless urgent, must be submitted in writing. Please send all written appeals to the address shown on the back cover of this booklet. We'll let you know when we receive your appeal.

You have the right to give us comments, documents or other information to support your appeal. You can also request to review documents relevant to your claim.

Appeals Process

Our standard appeals process has 2 levels of review. We'll give you our appeal decisions in writing.

Level I Your Level I Appeal review will be completed and we will give you our decision within 30 calendar days. This review will include a dental care provider who wasn't involved in the initial decision.

There are 3 exceptions to the 30-day time limit:

- **A decision to change, reduce or end an ongoing service**

  We'll mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than an additional 15 calendar days.
- **Denial of an experimental or investigational service**

  We'll mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended for up to 10 more calendar days with your informed written consent.
- **Urgent Appeals** (please see the "Urgent Appeals" provision)

If you don't agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review in writing no more than 60 calendar days after the date you receive our Level I decision.** This time limit may be extended in the event you need to obtain additional medical documentation, physician consultations or opinions, if you are hospitalized or traveling, or for other reasonable cause beyond the member's control. In no case shall the extension exceed 180 days.

Level II Your Level II Appeal will be reviewed by a Premera Blue Cross panel that includes a dental care provider who is different from the Level I review and was not involved in the initial decision. You and/or your authorized representative may meet with the panel. Unless your appeal is deemed urgent (please see the "Urgent Appeals" provision), the panel will give you a decision within 30 calendar days of the date we receive your Level II request.

You have the right to file suit in state court if you're not satisfied with the outcome of the Level II appeal. If your Participating Employer is subject to ERISA, ERISA also gives you the right to file suit in federal court if you're not satisfied with the outcome of the Level I or Level II appeal.

Urgent Appeals We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and II responses on urgent appeals will be given within 72 hours after the appeal is received.

Appeals Of Ongoing Care While you're appealing a decision to change, reduce or end coverage because the service or level of service is no longer dentally necessary or appropriate, we'll suspend our denial. Our coverage for services received during the appeal period doesn't and shouldn't be construed to reverse our denial. **If our initial decision is upheld, you must repay us all amounts that we've paid for such services. You'll also have to pay providers any difference between our allowed amount and the provider's billed charge.**

Please call Customer Service if you have questions or need more information about our complaint or appeal process.

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how your Group's Contract and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

Conformity With The Law

The Group Contract is issued and delivered in the state of Washington and is governed by the laws of the state of Washington, except to the extent pre-empted by federal law. If any provision of the Group Contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Entire Contract

The entire contract between the Group and us consists of all of the following:

- The contract face page and "Standard Provisions"
- This benefit booklet
- The Group's signed application
- The Funding Arrangement Agreement between the Group and Us
- All attachments, endorsements and riders included or issued hereafter

No agent or representative of Premera Blue Cross or any other entity is authorized to make any changes, additions or deletions to the Group Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done over the signature of an officer of Premera Blue Cross.

Evidence Of Dental Necessity

We have the right to require proof of dental necessity for any services or supplies you receive before we provide 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 us.

The Group And You

The Group and the Participating Employer are your representatives for all purposes under this plan and not the representatives of Premera Blue Cross. Any action taken by the Group or Participating Employer will be binding on you.

Intentionally False Or Misleading Statements

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

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, at our option:

- 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.)

Finally, intentionally false or misleading statements on any group form required by us, which affect the acceptability of the Group or the risks to be assumed by us, may cause the rescinding of the Group Contract for this plan.

Member Cooperation

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

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. Please 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 we provide 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 other group or individual insurance plans that cover you

Notices

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if mailed to the Group or subscriber, at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you or your Group is required to submit notice to us, it will be considered delivered on the postmark date or the date we receive it, if not postmarked.

Right Of Recovery

We have the right to recover amounts we paid that exceed the amount for which we're 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.

In addition, if the contract for this plan is rescinded as described in "Intentionally False Or Misleading Statements," we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, we 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 our obligation as to payment of benefits.

Venue

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

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

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

Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for the Participating Employer to provide workers' compensation insurance, employer's liability insurance or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance or other similar insurance and doesn't provide such coverage for its employees, the benefits available under this plan won't be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the "What's Not Covered?" section in this booklet.

WHAT ARE MY RIGHTS UNDER ERISA?

The Participating Employer may have an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA).

If so, this section of the booklet describes subscriber's rights under ERISA. Please see the Participating Employer to find out if this plan is subject to ERISA. Please see the Participating Employer to find out if this plan is subject to ERISA.

This employee welfare benefit plan is called the "ERISA Plan" in this section. The insured Premera Blue Cross plan described in this booklet is part of the ERISA Plan. For purposes of ERISA only, this plan is considered a separate plan for each Participating Employer.

When used in this section, the term "ERISA Plan" refers to the Participating Employer's employee welfare benefit plan. The "ERISA Plan administrator" is the Participating Employer or an administrator named by the Group. Premera Blue Cross is **not** the ERISA Plan administrator.

As participants in an employee welfare benefit plan, subscribers have certain rights and protections. This section

of this plan explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. (Please note that our contract with the Group by itself doesn't meet all the requirements for an ERISA plan document.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue dental care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event and the Participating Employer is required by law to offer COBRA coverage. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (Premera Blue Cross is a fiduciary only with respect to claims processing and payment.) No one, including your employer, the Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If the ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either:

- The Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Ave. Suite 860, MIDCOM Tower, Seattle, WA 98101-3212; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S.

Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan. As part of the routine operation of this plan, we use our expertise and judgment to apply the terms of the contracts for making decisions in specific benefits, eligibility and claims situations. For example, we use the dental judgment and expertise of Dental Directors to determine whether claims for benefits meet the definitions below of "Dentally Necessary" or "Experimental/Investigational Services." This does not prevent you from exercising rights you may have under applicable state or federal law to appeal or bring a civil challenge to any eligibility or claims determinations.

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 90th 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.

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.

Dental Care Provider

A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of his or her 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

Those covered services and supplies that a dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, dentist, or other dental care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

For those purposes, "generally accepted standards of dental practice" means standards that are based on authoritative dental or scientific literature.

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.

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

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management, or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes, but isn't limited to, reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Group

Washington Alliance For Healthcare Insurance Trust which is a party to this contract. All participating employers and segmented employers who are members of the Group shall be treated as one entity for the purposes of the Contract, including establishment of contractual rates, billing and calculation of late charges. The Group is to collect and pay all subscription charges and to receive notice and otherwise act on behalf of the Participating Employer and Subscriber.

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

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).

Participating Employer

A corporation, partnership, proprietorship, government, governmental agency, or other organization, unit or entity that is engaged in business and regularly employs at least one active employee who works twenty (20) or more hours per week and is paid on a regular basis through the employer's payroll system, has executed a Washington Alliance for Healthcare Insurance Trust Adoption Agreement joining the Group, is accepted by the Trustee(s) as a current member of the Group, and has agreed to the terms of selection and participation in the Group.

Plan (also called "This Plan" or "The Plan")

The benefits, terms, and limitations set forth in the Contract between us and the Group, of which this booklet is a part.

Subscriber

An enrolled employee of the Participating Employer. Coverage under this plan is established in the subscriber's name.

Subscription Charges

The monthly rates we set as consideration for the benefits offered in this plan.

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.

We, Us and Our

Means Premera Blue Cross in the state of Washington.

Where To Send Claims

MAIL YOUR CLAIMS TO
Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

Customer Service

Mailing Address
Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

Physical Address
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Phone Numbers
Local and toll-free number:
1-800-722-1471

Local and toll-free TDD number
for the hearing impaired:
1-800-842-5357

When You Have Ideas

Premera Blue Cross
Attn: Customer Assessment Manager
P.O. Box 91059
Seattle, WA 98111-9159

When You Have An Appeal

Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

Visit Our Web Site

www.premera.com

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association