

The University of Puget Sound

Dental Optima Plan

1003592

HOW TO CONTACT US

Please call or write our Customer Service staff for help with the following:

- Questions about the benefits of this plan
- Questions about your claims
- Questions or complaints about care or services you receive
- Change of address or other personal information

CUSTOMER SERVICE

Mailing Address:

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

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

Physical Address:

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

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

You'll find answers to most of your questions about this plan in this benefit booklet. You also can explore our Web site at www.premera.com anytime you want to:

- Learn more about how to use this plan
- 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 gain knowledge about diseases, illnesses, medications, treatments, nutrition, fitness and many other health topics

You also can call our Customer Service department at the numbers listed above. We're happy to answer your questions and appreciate any comments you want to share. In addition, you can get benefit, eligibility and claim information through our Interactive Voice Response system when you call Customer Service.

Group Name: The University of Puget Sound

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Plan: DENTAL OPTIMA

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INTRODUCTION

This benefit booklet is for members of Premera Blue Cross, an Independent Licensee of the Blue Cross and Blue Shield Association. This booklet describes the benefits under this plan and replaces any other benefit booklet you may have received.

The benefits, limitations, exclusions and other coverage provisions described on the following pages are subject to the terms and conditions of the contract we've issued to the Group. The "Group" is the firm, corporation, partnership or association of employers that contracts with us. This booklet is a part of the complete contract, which is on file in the Group's office and at the headquarters of Premera Blue Cross.

HOW TO USE THIS BOOKLET

We realize that using a dental care plan can seem complicated, so we've prepared this booklet to help you understand how to get the most out of your benefits. Please familiarize yourself with the Table of Contents, which lists sections that answer many frequently asked questions.

Every section in this booklet contains important information, but the following sections may be particularly useful to you:

- **HOW TO CONTACT US** — our Web site address, phone numbers, mailing addresses and other contact information conveniently located inside the front cover
- **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 and/or waiting periods
- **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?** — addresses and processes to follow if you want to share ideas, ask questions, file a complaint or submit an appeal
- **DEFINITIONS** — many terms that have specific meanings under this dental plan. Example: The terms "you" and "your" refer to members under this plan. The terms "we," "us" and "our" refer to Premera Blue Cross in the state of Washington and Premera Blue Cross Blue Shield of Alaska in the state of Alaska.

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

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

Benefits are available for the services described in this section that are furnished for a covered dental condition. Such services must meet all of the following requirements:

- They must be, in our judgment, dentally necessary (see definition of "Dentally Necessary")
- They must be named in this benefit as covered
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.) or dentist. 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, we'll provide benefits only for those dental services we can verify as covered.

Coverage under this dental plan is based on allowable charges for dentally necessary covered services. The percentage of the allowable charge you're responsible for is called coinsurance. Please see the "Definitions" section in this booklet for a detailed explanation of "allowable charge."

Alternative Benefits

To determine benefits available under this plan, we consider alternative procedures or services with different fees that, in our judgment, are consistent with acceptable standards of dental practice. In all cases where there's an alternative course of treatment that's less costly, we'll 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 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 if the total charge will exceed \$1,000.

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.

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.

Calendar Year Deductible

Diagnostic and Preventive covered services aren't subject to a calendar year deductible. However, a calendar year deductible does apply to Basic and Major covered services. A calendar year deductible is the amount you must pay for Basic and Major covered services per calendar year before benefits are payable under this plan for those services. The amount credited toward the calendar year deductible won't exceed the allowable charge for the covered service.

For each member, the individual calendar year deductible amount is \$50.

This plan has an annual dollar maximum described below. We don't count allowable charges that apply to your individual calendar year deductible toward that annual dollar maximum. However, the plan also has limits on how often some Basic or Major procedures can be covered in a specific period of time. If you receive services or supplies covered by a benefit that has such a limit, we do count the procedures that apply to your individual calendar year deductible toward that limit.

Family Dental Deductible

We also keep track of the expenses applied to the individual calendar year deductible that are incurred by all enrolled family members combined. When the total equals \$150, we will consider the individual calendar year deductible of every enrolled family member to be met for the year. The \$150 is called the "family dental deductible." Only the amounts used to satisfy each enrolled family member's individual calendar year deductible will count toward

the family dental deductible.

Coinsurance

As used in this plan, "coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. The percentage you're responsible for, not including 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 \$1,500.

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.

Participating 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 participating providers, please refer to our Web site at www.premera.com or contact Customer Service.

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 participating providers who can provide preventive and specialty dental care services. When you receive services from participating providers, your claims will be submitted directly to us, and available benefits will be paid directly to the dental care provider. Participating providers agree to accept our "allowable charge" (please see the "Definitions" section in this booklet) as payment in full. You're responsible only for the calendar year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services.

Non-Participating Providers

If you decide not to use a participating provider, you may choose any dental care provider. If you receive services from non-participating dental care providers, you're responsible for amounts above the allowable charge in addition to the 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 allowable charge don't accrue toward your calendar year deductible.

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, you pay the following coinsurance per calendar year, up to the dental benefit maximum. Dental services fall into 3 categories: Diagnostic and Preventive services, Basic services, and Major services. In this section you'll find a description of the services included in each category.

- Diagnostic and Preventive Services ... 20%
- Basic Services 20%
- Major Services 50%

DESCRIPTION OF COVERED SERVICES

Diagnostic And Preventive Services

- Routine oral examinations are limited to 2 per calendar year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations.
- Emergency oral examinations. 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 only. 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 14, are limited to use on permanent teeth

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 silver amalgam, silicate and composite resins. For other types of fillings, such as gold foils, the allowance will be limited to what would have otherwise been allowed for amalgam or composite fillings. A filling on any given tooth surface is a benefit only once in any 24 consecutive months.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth. Periodontal scaling and root planing and sub-gingival curettage are 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 1 visit every 3 consecutive months.
- 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.
- Repair and recementing of crowns, inlays, bridgework and dentures
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- 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.

Major Services

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when, in our judgment, amalgam or composite resin fillings wouldn't adequately restore the teeth.
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns, but only when:
 - The existing restoration was seated at least 5 years before replacement; or
 - The service is a result of an injury as described under "Dental Care Services For Injuries"
- Initial placement of dentures

- Initial placement of fixed bridgework (including inlays, onlays and crowns to form abutments)
- Replacement dentures and fixed bridgework, but only when:
 - The existing denture or bridgework was installed at least 5 years before replacement;
 - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement; or
 - Repreparation of the natural tooth structure under the existing fixed bridgework is required as a result of an injury to that structure, and such repair is performed within 12 months of the injury as described under "Dental Care Services For Injuries."
- Relining and rebasing of dentures when performed 6 or more months after denture installation. Charges for relines, rebases and adjustments performed during the first 6 months following denture installation are limited to the allowance for the denture.
- Tooth build-ups for covered onlays and crowns, including bridge abutments
- Implants and implant related services, subject to our review for dental necessity
Note: Covered services including implant abutment and/or crowns over the implants are covered only once in a 5-consecutive year period (5 years from the date of the installation of the prosthetic service).
- Precision attachments, subject to our review, for dental necessity

Dental Care Services For Injuries

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

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

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Performed within 12 months of the injury
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the effected teeth don't have:
 - Extensive restoration, veneers, crowns or

splints

- Periodontal disease or other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

Extension Requests For Injury Services

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

ORTHODONTIA

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

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

Any calendar year deductibles and coinsurance of other benefits in this dental plan don't apply to this benefit.

Covered Services And Supplies

Covered orthodontic services and supplies include only the following:

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

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

Benefits

No coinsurance is required under the Orthodontia benefit. Benefits are provided up to a lifetime maximum of \$1,000 for each member, or until the member's total treatment plan, including retention treatment, is paid, whichever occurs first. No more than \$250 of the lifetime maximum is provided for diagnostic services and initial banding of the teeth. "Diagnostic services" include examinations and

orthodontic records. Monthly adjustments accumulate to the Orthodontia lifetime maximum and not the diagnostic and initial banding limit.

Limitations

In addition to "What's Not Covered?" this benefit doesn't cover any of the following:

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

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 Allowable Charge

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 type of liability or insurance coverage

Benefits That Have Been Exhausted

Amounts that exceed the allowable charge 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 after effects thereof, except as specified in the Orthodontia benefit.

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.

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 Major services and root canals that:
 - Were started after your effective date and before the date your coverage ended under this plan; and
 - Were completed within 30 days after the date your coverage ended under this plan.

The following are deemed service start dates:

- For root canals, it's the date the canal is opened.
- For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the preparation date.
- For partial and complete dentures, it's the impression date.

The following are deemed service completion dates:

- For root canals, it's the date the canal is filled.
- For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the seat date.
- For partial and complete dentures, it's the seat or delivery date.

Not Dentally Necessary

Services that aren't dentally necessary, in our judgment.

Orthodontia Services

Orthodontia, including casts, models, x-rays, photographs, examinations, appliances, braces and retainers, except as specified in this plan and in the Orthodontia benefit. However, this exclusion doesn't apply to extractions incidental to orthodontic services.

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 Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

Coordinating Benefits With Other Dental Care Plans

You may also be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations. We'll coordinate the benefits of this plan with those of your other plans to make certain that, in each calendar year, the total payments from all medical plans aren't more than the total allowable medical expenses and the total payments from all dental plans aren't more than the total allowable dental expenses.

All of the benefits of this plan are subject to coordination of benefits.

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

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under any of the medical plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.

- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under any of the dental plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Claim Determination Period** means a calendar year.
- **Medical Plan** means all of the following types of health care coverage, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents
 - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
 - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following types of dental care coverage, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents

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

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." This means they reduce their payment amounts so the total benefits from all dental plans aren't more than the total allowable dental expenses. We will coordinate benefits when you have other dental care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed on the primary coverage.

Here's the order in which the plans should provide benefits:

First: A plan that doesn't provide for coordination of benefits.

Next: A plan that covers you as **other than a dependent**.

Next: A plan that covers you as a dependent. For dependent children, the following rules apply:

When the Parents **Aren't** Separated or Divorced: The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.

When the Parents **Are** Separated or Divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who doesn't have custody.

If the rules above don't apply, the plan that has covered you for the longest time will be primary. However, benefits of a plan that covers you as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any plan that covers you as other than a laid-off or retired employee, or as the dependent of such an employee. This applies only when other plans involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the plan that has covered the employee or subscriber for the longest time will be primary.

Any amount by which a secondary plan's benefits

have been reduced in accord with this section shall be used by the secondary plan to pay your allowable medical expenses or allowable dental expenses not otherwise paid. The reduced amount shall be charged against the applicable plan's benefit limit (medical or dental). However, you must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable medical expenses or allowable dental expenses based on all claims that were submitted up to that time during the claim determination period.

Right Of Recovery/Facility Of Payment

We have the right to recover any payments we make that are greater than those required by the coordination of benefits provisions from 1 or more of the following: the persons we paid or for whom we have paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this plan was made by another plan, we also have the right to pay directly to another plan any amount that should have been paid by us. Our payment will be considered a benefit under this plan and will meet our obligations to the extent of that payment.

Coordinating Benefits With Medicare

If you're covered under Medicare, federal law may require this plan to be primary over Medicare. When this plan isn't primary, we'll coordinate benefits with Medicare.

Third Party Liability (Subrogation)

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 may be entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or us. "Subrogation" means that we may collect directly from that third party to the extent we have paid on your behalf for illness or injury caused by the third party. Because we have paid for your illness or injuries, we may be entitled to recover for those expenses.

To the fullest extent permitted by law, we're entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. In recovering benefits provided, we may at our election either hire our own attorney or be represented by your attorney. If we choose to be represented by your attorney, we'll pay, on a contingent basis, a reasonable portion of the attorney fees which are necessary for asserting our right of recovery in the

case. This portion will usually not be more than 20% of the amount we seek to recover. We won't pay for any legal costs incurred by you or on your behalf, and you won't be required to pay any portion of the costs incurred by us or on our behalf.

Prior to 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. You must also cooperate 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.

To the maximum extent permitted by law, we're "subrogated" to your rights against any third party who is responsible for the condition, meaning that we have the right to sue any such third party in your name, and have a security interest in, and lien upon, any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. We may also assert our right to recover benefits directly from the third party.

Uninsured And Underinsured Motorist 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 or similar type of insurance or contract.

The amount of reimbursement that we're entitled to receive under this provision is the amount in excess of the amount you receive from all insurance sources which fully compensate you for damages arising from the injury for which such benefits have been paid.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage. We have the discretionary authority to determine your eligibility for benefits.

SUBSCRIBER ELIGIBILITY

To be eligible for benefits of this plan, you must be a faculty or staff member with at least a half-time appointment. Staff members with half-time appointments are in regular positions scheduled to work 1,040 hours per year or .50 FTE. Faculty members teaching part-time, who do not bear the full range of expectations associated with full-time faculty, have a half-time appointment when they are

contracted to reach four units of course work or to meet an equivalent set of responsibilities during the academic year.

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated.
- The domestic partner of the subscriber. If all requirements are met, as stated in the signed "Affidavit of Domestic Partnership," 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."
- An eligible child under 25 years of age and unmarried. Eligible children other than children placed for adoption or children for whom coverage is mandated by court decree must also be primarily dependent upon the subscriber for support. (Eligibility and enrollment requirements for children placed for adoption and children covered because of a court decree can be found later in this section.) 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 legally placed ward of the subscriber or spouse living permanently in the home of the subscriber.

Foster children aren't eligible for coverage.

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 employee's date of hire.

If we don't receive the enrollment application within 60 days of the date you became eligible, none of the dates above 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.

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's required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. When 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 Group for detailed procedures.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

If you didn't enroll in this plan when you were first eligible because you weren't required to do so, you may later enroll outside of the annual open enrollment period if each of the following requirements is met:

- You were covered under group dental coverage or a dental insurance plan (as defined in this section) at the time coverage under this plan was previously offered;
- Your coverage under the other group dental coverage or dental insurance plan was terminated as a result of one of the following:
 - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment);
 - Termination of employer contributions toward such coverage; or
 - You were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.

When we receive your completed enrollment application and any required subscription charges from the Group within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment application.

If we don't receive your completed enrollment application within 30 days of the date prior coverage ended, please see the "Open Enrollment" provision later in this section.

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 dental plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under "Special Enrollment" in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents.

OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under the "Special Enrollment" section, you can't be enrolled until the Group's next open enrollment period. An open enrollment period occurs once a year unless 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 Group offers multiple dental care plans and you're enrolled under one of the Group's other dental care plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

CHANGES IN COVERAGE

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
- Benefit maximums
- Lifetime maximums

In the event an employee enrolls for coverage under a different dental plan also offered by the Group, the employee can enroll for coverage under this plan only during the Group's next open enrollment period.

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

When Dental Plan Coverage Ends

Unless otherwise stated, your Dental Plan coverage ends on the earliest of:

- the end of the month in which you are no longer employed by the University;
- the date the Dental Plan is terminated;
- the end of the month in which you are no longer an eligible faculty or staff member under the Dental Plan; or
- the date you stop making contributions for coverage.

When Dental Plan Coverage Ends for Family Members

Unless otherwise stated, your enrolled family members' coverage ends on the earliest of:

- the end of the month in which you are no longer employed by the University;
- the date your coverage is terminated;
- the date you stop making contributions for coverage; or
- the end of the month in which a family member ceases to be eligible for coverage, such as when an enrolled child reaches the plan's age limits for eligibility.

When coverage ends for you or your enrolled family members you may elect continued coverage for a period of time. Please see "How Do I Continue Coverage" for more information.

Notice

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this program. The Group must give us written notice of an enrollee's

cancellation within 30 days of the date the Group is notified of such event.

If the Group does not cancel an enrollee's coverage on time, as stated above, the date coverage ends is determined by Premera Blue Cross. Retroactive cancellation may be considered if the Group pays the enrollee's subscription charges in full and if no benefits have been provided for expenses incurred after the date the enrollee's coverage is to end. But, cancellation will not be retroactive more than 60 days before the billing period in which we are notified of the cancellation.

IMPORTANT NOTE: We may rescind your coverage (that is, cancel it retroactively to your effective date) as explained under "Intentionally False Or Misleading Statements" in the General Provisions section of this booklet. In a rescission, you are treated as if you never had coverage under this program, so that you are not eligible for any continuation of coverage described in this booklet.

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 an unmarried 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

Your coverage may be affected if you are on a leave of absence. The effects on your coverage depend on the type of leave you take.

Family And Medical Leave

If you take a leave of absence under the provisions of the Family And Medical Leave Act of 1993 (FMLA), your coverage will continue during your leave, up to 12 weeks. You continue to pay any contributions through payroll deductions during the time you are on leave. You will continue to receive a Flexible Benefits Allowance while on unpaid FMLA leave. If your contributions for dental care coverage come from allowance dollars, those contributions will continue with no action required on your part. If your contributions are normally deducted on a pretax basis from your paycheck, you will be responsible for making those contributions on an after-tax basis while you are on an unpaid FMLA leave.

If you do not return to work after the 12 weeks, you

may continue your coverage under COBRA by paying the full subscription charge. Please see "Continuation Of Group Coverage - COBRA" for information on extending coverage.

For more information about FMLA and the University's policies regarding these types of leaves, please contact the Human Resources Department.

Other Leaves Of Absence

If you are on a paid leave of absence, your coverage continues during the time you are on leave. You continue to pay any contributions for coverage through payroll deduction. If you are on an unpaid leave of absence (other than FMLA leave) your dental coverage continues during the time you are on leave only if you make the required contributions on an after-tax basis.

If You Retire While Covered

If you retire while covered by the plan, coverage for you and your enrolled dependents will end on the last day of the month in which you retire. You and your enrolled dependents may extend coverage under COBRA by paying the full monthly charge for coverage. Please see "Continuation of Group Coverage - COBRA."

If You Die While Covered

If you die while covered by the plan, coverage for your enrolled dependents may be continued under COBRA. Your enrolled dependents pay the full required contribution for COBRA coverage. Please see "Continuation of Group Coverage - COBRA."

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

LABOR DISPUTE

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

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

COBRA

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

At the Group's request, we'll provide qualified members 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. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

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

Qualifying Events And Length Of Coverage

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

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
 - **The subscriber's work hours are reduced.**
 - **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

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

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
 - **The subscriber dies.**
 - **The subscriber and spouse legally separate or divorce.**

- **The subscriber becomes entitled to Medicare.**
- **A child loses eligibility for dependent coverage.**

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

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

If the required notice isn't given or is late, the qualified member loses the right to COBRA coverage. Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date 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 Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.** 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 Group must tell you where to direct your notice and any other procedures that you must follow. If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you're informed by the Group.

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

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

You Must Enroll And Pay On Time

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

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

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 Group 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 Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent subscription charges must be paid to the Group 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" earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

COBRA coverage will end on the last day for which 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 there's a final

determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which 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 Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

- You become covered under another group dental care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group 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.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the ERISA plan administrator listed in the "ERISA Plan Description" section of this booklet. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other 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
- Procedure codes (ADA) or descriptive English nomenclature 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

If you're also covered by Medicare, as your primary plan, you must attach a copy of the "Explanation of Medicare Benefits."

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail Your Claims To:

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

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.

We won't provide benefits for claims we receive after the later of these 2 dates, nor will we 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 a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in this plan, you may file a suit in a state or federal court.

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 inside the front cover of this booklet or send your ideas and comments to:

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

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 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. Please send all written appeals to the address shown below. 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.

Mail appeals to:

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

Appeals Process

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

Level I The Level I Appeal panel will give you its decision within 30 calendar days. This panel will include dental care providers who weren'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 no more than 60 calendar days after the date you receive our Level I decision.**

Level II Your appeal will be reviewed by a Premera Blue Cross panel that includes dental care providers

and is different from the Level I panel. 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.

If you're appealing a decision to deny, change, reduce or end payment, coverage or authorization of coverage, and you're not satisfied with the outcome of the Level II appeal, you may ask for an independent review (please see the "Independent Review" provision). We must receive your request for independent review within 60 calendar days.

You also have the right to file suit in federal court if you're not satisfied with the outcome of the Level II appeal.

Independent Review Independent reviews are conducted by an independent review organization (IRO), which is an organization of dental experts qualified to review your appeal. We'll use IROs that have been certified by the state Department of Health. We'll submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will give you its decision in writing. We'll implement the IRO's determination promptly.

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 allowable charge 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 preempted 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

Your Group is your representative for all purposes under this plan and not the representative of Premera Blue Cross. Any action taken by the Group 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.

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.

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

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, or of the completion date of the independent review process if applicable; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal 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 Group 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.

ERISA PLAN DESCRIPTION

The following information has been provided by your Group to meet certain ERISA requirements for the summary plan description.

The Group has an employee welfare benefit plan that's subject to the Federal Employee Retirement Income Security Act of 1974 (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. ERISA gives subscribers and dependents the right to a summary describing the ERISA Plan.

Name Of Plan

Group Dental Plan of The University of Puget Sound

Name And Address Of Employer Or Plan Sponsor

The University of Puget Sound
1500 North Warner
Tacoma, WA 98416

Employer Identification Number "EIN"

91-0564961

Type Of Plan

Fully insured employee welfare benefit plan that is a group health plan. The ERISA Plan provides dental benefits.

Type Of Administration

Premera Blue Cross administers the part of the ERISA Plan that it insures under the terms and conditions of its contract with the Group.

Name, Address, And Telephone Number Of ERISA Plan Administrator

The University of Puget Sound
1500 North Warner
Tacoma, WA 98416
(206) 756-3369

Agent For Service Of Legal Process

Secretary of the Corporation

Eligibility To Participate In The Plan

Employees and their dependents are eligible for the benefits of the plan when they meet the eligibility requirements in this booklet, are enrolled with Premera Blue Cross as described in this booklet, and all required subscription charges for them are and continue to be paid as required by the Group's Contract with Premera Blue Cross.

Benefits

The benefit booklet tells you the terms and limitations of each benefit of this plan. You may have lower out-of-pocket costs if you use providers that have signed contracts with us. This booklet explains the provider networks, when applicable. It also tells how benefits are affected if members don't use these providers. The benefit sections of this booklet also explain what part of the cost of covered dental care you must pay.

If you lose your benefit booklet, please contact the Group for a new one.

Disqualification, Ineligibility Or Denial, Loss, Forfeiture, Or Suspension Of Any Benefits

This booklet describes circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, reduction, offset or recovery

of any benefits for members.

Source Of Contributions

Employer and employee contribution. Self-payments are also permitted; please see the "How Do I Continue Coverage?" section in this booklet.

Funding Medium

This portion of the ERISA Plan is fully insured by Premera Blue Cross P.O. Box 327, Seattle, WA 98111-0327. Premera Blue Cross receives subscription charges that, upon receipt, become its property. In consideration of the payment of subscription charges, Premera Blue Cross provides benefits and administrative services described in this booklet, that are required by its contract with the Group.

Plan Changes and Termination

The "Contract Termination" and "Changes In Coverage" portions of this booklet describe the circumstances when the contract between the Group and Premera Blue Cross may be changed or terminated. Termination of the contract isn't the same as termination of the Group's ERISA Plan. The Group may choose to continue its ERISA Plan through other insurance contracts or arrangements. However, no rights are vested under the ERISA Plan. The Group reserves the right to change or terminate its ERISA Plan in whole or in part, at any time, with no liability.

The Group will tell employees if its ERISA Plan is changed or terminated. If the ERISA Plan were to be terminated, members would have a right to benefits only for covered services received before the ERISA Plan's end date.

ERISA Plan Year

The ERISA Plan year ends on each December 31.

WHAT ARE MY RIGHTS UNDER ERISA?

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. 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. 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. However, we do have the discretionary authority to determine eligibility for benefits and to construe the terms used in the portion of the Group's ERISA Plan that we insure.) No one, including your employer, 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 1-800-998-7542.

DEFINITIONS

The terms listed in this section have specific meanings under this plan. We have the discretionary authority to determine the terms used in this plan.

Allowable Charge

The allowable charge 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 allowable charge.

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

The allowable charge will be no greater than the maximum allowance we otherwise would have allowed had the dentally necessary covered services been furnished by a provider that has an agreement in effect with us.

When you seek services from dental care providers that don't have agreements with us, your liability is for any amount above the allowable charge, 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 dentist, 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.

Dentally Necessary

Those covered services and supplies that are, in our judgment, determined to meet all of the following requirements. They must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan
- Appropriate and consistent with authoritative dental or scientific literature
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider
- The least costly of the alternative levels of service that can safely be provided to the member
- Not primarily for research or data accumulation

The fact that the covered services were furnished, prescribed or approved by a dental care provider doesn't in itself mean that the services were dentally necessary.

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 and Blue Shield Association Technical Evaluation Center (TEC).

Group

A large employer, including a person, firm, corporation, partnership, or political subdivision, that's actively engaged in business and is a party to the Group Contract. The "Group" is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees

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).

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 Group. 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 and Premera Blue Cross Blue Shield of Alaska in the state of Alaska.

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross

P.O. Box 91059

Seattle, WA 98111-9159

www.premera.com