Willamette Dental Group

# MULTICARE HEALTH SYSTEM

## SELF-FUNDED DENTAL BENEFIT PLAN BENEFITS BOOKLET

**EFFECTIVE JANUARY 1, 2024**

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## Definitions

The following are definitions of terms used in this Benefits Booklet.

“Adverse Benefit Determination” means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part for, a Benefit.

“Appeal” is a written request by an Enrollee or his or her representative to review an Adverse Benefit Determination.

“Benefit” means a service that is covered under this Plan.

“Copayment” means the fixed dollar amount for each visit or covered service that is the Enrollee’s responsibility to pay under this Plan. All Copayments are due at the time of visit or service.

“Dental Emergency” means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in: (i) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part.

“Dentally Necessary” is a term for describing a dental service that is required to prevent, diagnose, or treat a dental condition and which is:

- Consistent with the symptoms or treatment of a dental condition;
- Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community, evidence-based medicine, and professional standards of care as effective;
- Not solely for the convenience of the Enrollee or a provider of the service; and
- The most cost effective of the alternative levels of dental services that can be safely provided to the Enrollee.

“Dentist” means a person licensed to practice dentistry in the state where treatment is provided.

“Denturist” means a person licensed to practice denturism in the state where treatment is provided.

“Dependent,” for the purposes of this document, means an eligible dependent as defined in MultiCare Health System Flexible Benefits Program Summary Plan Description that is enrolled for coverage under this Plan.

“Enrollee” for the purposes of this document, means an eligible employee or eligible dependent as defined in MultiCare Health System Flexible Benefits Program Summary Plan Description that is enrolled for coverage under this Plan

“Experimental or Investigational” means a service that is determined to be experimental or investigational. In determining whether services are Experimental or Investigational, the Plan will consider the following:

- Whether the services are in general use in the dental community in the state of Washington;
- Whether the services are under continued scientific testing and research;

- Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
- Whether the services are proven safe and effective.

“General Office Visit Copayment” means the Copayment an Enrollee must pay for each visit for emergency, general, or orthodontic treatment.

“Non-Participating Provider” means a Dentist or Denturist, who is not employed by or under contract with the Participating Provider to provide dental services under this Plan.

“Participating Provider” means a Dentist employed by Willamette Dental Group, P.C., which provides dental services under this Plan.

“Plan” means this plan funded by the Plan Sponsor for dental benefits.

“Plan Sponsor” means MultiCare Health System. MultiCare Health System is the employer, Plan Sponsor and plan administrator of this self-funded plan. MultiCare maintains the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

“Reasonable Cash Value” means Willamette Dental Group, P.C.’s usual fee-for-service price of a service.

“Service Copayment” means the Copayment the Enrollee must pay for each dental service. Service Copayments are in addition to the General Office Visit Copayment or the Specialist Office Visit Copayment.

“Specialist Office Visit Copayment” means the Copayment the Enrollee must pay for each visit for specialty treatment, including: endodontic; oral surgery; periodontic; or prosthodontic dental services.

## Eligibility and Enrollment

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. MultiCare Health System expects to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time, for any reason.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after it terminated, even if the expenses result from an accident, injury or disease that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is amended or terminated, the rights of participants and beneficiaries are limited to charges incurred before amendment or termination.

This Dental Benefits Booklet is part of and should be read in conjunction with the MultiCare Health System Flexible Benefits Program Summary Plan Description (SPD). A copy of the SPD and, if desired, the formal legal document for the Plan, known as the MultiCare Health System Flexible Benefits Program plan document, is available from the MultiCare Human Resources Benefits Department. These materials do not create a contract of employment or any rights to continued employment with MultiCare Health System.

## Coordination of Benefits

This Coordination of Benefits (COB) provision applies when a person has dental coverage under more than one Plan. Plan is defined below.

The Order of Benefit Determination Rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

**Definitions**

- *A Plan* is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate Plan.
    - *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group or individual coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
    - *Plan* does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.
    - Each contract for coverage is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- *This Plan* means, in this COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- *The Order of Benefit Determination Rules* determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

- *Allowable Expense* is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. The Allowable Expense for the Secondary Plan is the amount it allows for the service in the absence of other coverage that is primary. The following are examples of expenses that are not Allowable Expenses:
  - The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
  - If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
  - If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

- *Closed Panel Plan* is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

- *Custodial Parent* is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the calendar year excluding any temporary visitation.

**Order of Benefit Determination Rules.** When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

- A Plan that does not contain a coordination of benefits provision that is consistent with state regulation regarding coordination of benefits is always primary unless the provisions of both Plans state that the complying Plan is primary. Except coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

- Each Plan determines its order of benefits using the first of the following rules that apply:

    - **Nondependent or dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
    - **Dependent Child covered under more than one Plan.** Unless there is a court decree stating otherwise, when a dependent Child is covered by more than one Plan the order of benefits is determined as follows:
        - For a dependent Child whose parents are married or are living together, whether or not they have ever been married: the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan ("Birthday Rule").
        - For a dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            - If a court decree states that one of the parents is responsible for the dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
            - If a court decree states one parent is to assume primary financial responsibility for the dependent Child but does not mention responsibility for health care expenses, the Plan of the parent assuming financial responsibility is primary;
            - If a court decree states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the Birthday Rule described above determines the order of benefits;
            - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent Child, the Birthday Rule described above determines the order of benefits; or

- If there is no court decree allocating responsibility for the dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:
    1. The Plan covering the Custodial Parent, first;
    2. The Plan covering the spouse or domestic partner of the Custodial Parent, second;
    3. The Plan covering the noncustodial parent, third; and then
    4. The Plan covering the spouse or domestic partner of the noncustodial parent, last.
    - For a dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the Birthday Rule described above or court decree determines the order of benefits as if those individuals were the parents of the Child.
- **Active employee or retired or laid-off employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the Nondependent or dependent rule can determine the order of benefits.
- **COBRA or state continuation coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the Nondependent or dependent rule can determine the order of benefits.
- **Longer or shorter length of coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

- If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

**Effect on the Benefits of This Plan.**

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal one hundred percent of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

**Right to Receive and Release Needed Information.**

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

**Facility of Payment.**

If payments that should have been made under This Plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, the issuer is fully discharged from liability under This Plan.

**Right of Recovery.**

The issuer has the right to recover excess payment whenever it has paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or from any other issuers or Plans.

If an Enrollee is covered by more than one Plan, and the Enrollee does not know which is the Primary Plan, the Enrollee may contact any one of the Plans to verify which Plan is primary. The Plan the Enrollee contacts is responsible for working with the other Plan to determine which is primary and will let the Enrollee know within 30 days. Plans may have timely claim filing requirements. If the Enrollee or provider fails to submit a claim to a secondary Plan within that Plan's claim filing time limit, the Plan can deny the claim. If the Enrollee experiences delays in the processing of a claim by the Primary Plan, the Enrollee or provider will need to submit a claim to the Secondary Plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if an Enrollee is covered by more than one Plan, the Enrollee should promptly report to providers and Plans any changes in coverage.

## Subrogation

Benefits under this Plan are available for the diagnosis or treatment of an injury or disease, which is allegedly the liability of a third party. Such Benefits provided by this Plan are solely to assist the Enrollee. By providing Benefits, this Plan is not acting as a volunteer and is not waiving any right to reimbursement or subrogation.

If the Plan and Participating Provider provide Covered Services for the treatment of an injury or disease, which is possibly caused by a third party, it will:

- Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Covered Services provided; and
- Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Covered Services provided, subject to the limitations specified below.

As a condition of receiving Covered Services, the Enrollee shall:

- Provide the Plan and Participating Provider with the name and address of the parties liable, all facts known concerning the injury, and other information as reasonably requested;
- Hold in trust any damage recoveries until the final determination or settlement is made and to execute a trust agreement guaranteeing the Plan's and Participating Provider's subrogation rights; and
- Take all necessary action to seek and obtain recovery to reimburse the Plan and Participating Provider for the Reasonable Cash Value of the Covered Services.

The Enrollee is entitled to be fully compensated for the loss. After the Enrollee has been fully compensated for the loss, the Plan and Participating Provider are entitled to the remaining proceeds of any settlement or judgment that results in a recovery from the third party or third party's insurer(s) up to the Reasonable Cash Value of the Covered Services provided.

Services payable under any motor vehicle medical, motor vehicle no-fault, underinsured or uninsured motorist, personal injury protection, homeowner's, commercial premises coverage, workers' compensation, or other similar contract or insurance are not covered.

## Claim and Appeal Procedures

### Claims

Claims for Benefits for services provided by a Participating Provider will be processed at the time of service. Claims for Benefits for services provided by a Non-Participating Provider will be processed within 30 days after receipt of the claim by the Plan, unless special circumstances require an extension of time for processing the claim. If an extension of time for up to 15 days for processing is required, written notice of the extension will be provided prior to the end of the initial 30-day period. If additional information from the Enrollee is necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Enrollee has 45 days from receipt of the notice within which to provide the specified information.

### Complaints

Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider's staff. Most complaints can be resolved with the Participating Provider's staff. Enrollees may also contact the Member Services Department with questions or complaints.

Willamette Dental of Washington, Inc.
Attn: Member Services Department
6950 NE Campus Way
Hillsboro, Oregon 97124
1-855-433-6825

### Appeals

If a claim for Benefits has been denied, either in whole or in part, the Enrollee has the right to request an Appeal. The Enrollee must submit the request for an Appeal within 180 days from the date the claim was denied. A request for an Appeal of a benefit denial may be made by submitting a written request to:

Willamette Dental of Washington, Inc.
Attn: Member Services Department
6950 NE Campus Way
Hillsboro, Oregon 97124
1-855-433-6825

Appeals of eligibility determinations or any termination of coverage should be submitted to the Plan Sponsor.

Written comments, documents, records, and other information relating to the claim for Benefits may be submitted. Upon request and free of charge, the Enrollee may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for Benefits. The review will take into account all comments, documents, records, and other information submitted by the Enrollee relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, or a subordinate of such individual. In the event the review decision is based in whole or in part on a dental clinical judgment, a qualified dental professional, who was not consulted in connection with the initial benefit determination, will be consulted.

Notification of the determination regarding the Appeal will be provided to the Enrollee within 30 days of the Plan's request for an Appeal.

Enrollees may authorize another person to represent the Enrollee regarding a specific Appeal. The authorization must be in writing and signed by the Enrollee. The Appeal process for an Appeal submitted by a representative of the Enrollee will not commence until this authorization is received. If the written authorization is not received, the Appeal will be closed.

## Dental Coverage Provisions

### Participating Provider

This Plan only provides Benefits for services provided by a Participating Provider, except as described as covered below for referrals from a Participating Provider and out of area Dental Emergency treatment.

### Referrals

If a Participating Provider cannot provide a covered service, the Participating Provider may refer an Enrollee to a Non-Participating Provider. Benefits for services provided by a Non-Participating Provider will be covered under this Plan only if:

- The Participating Provider refers the Enrollee;
- The services are specifically included by the Participating Provider's referral; and
- The services are listed as covered by this Plan in the Schedule of Covered Services and Copayments and are not otherwise limited or excluded.

### Orthodontic Benefits

Benefits for orthodontic treatment are provided only if a Participating Provider prepares the treatment plan prior to rendering services. The treatment plan is based on an examination that must take place while the Enrollee is covered under this Plan. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.

The Enrollee must remain covered under this Plan for the entire length of treatment. The Enrollee is responsible for payment of the Copayments listed in the Schedule of Covered Services and Copayments. The pre-orthodontic Service Copayments will be deducted from the comprehensive orthodontic Service Copayment if the Enrollee accepts the treatment plan. The Copayment for limited orthodontic services may be prorated based on the treatment plan. The Enrollee must follow the post-treatment plan and keep all appointments after the Enrollee is de-banded to avoid additional Copayments.

For orthodontic treatment started prior to the effective date of coverage, Copayments may be adjusted based upon the services necessary to complete the treatment.

If Benefits for orthodontic services terminate prior to completion of orthodontic treatment, Benefits will continue through the end of the month. If coverage terminates prior to completion of treatment, the Copayment may be prorated. The services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

### Temporomandibular Joint Disorder Treatment Benefits

Temporomandibular Joint Disorder (TMJ) means a disorder that has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint; internal derangements of the temporomandibular joint; arthritic problems with the temporomandibular joint; or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Benefits for treatment of TMJ are limited to a yearly benefit maximum of $1,000 and a lifetime benefit maximum of $5,000.

TMJ treatment is covered only if the Participating Provider prepares the treatment plan prior to starting treatment and provides the treatment. The repair or replacement of lost, stolen, or broken TMJ appliances is not covered.

To be covered, the Covered Services must be:

- Reasonable and appropriate for the treatment of TMJ;
- Effective for the control or elimination of pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food, which is caused by TMJ;
- Recognized as effective, in accordance with the professional standard of care;
- Not deemed Experimental or Investigational; and
- Not primarily intended to improve, alter, or enhance appearance.

**Emergency Care**

Participating Providers will provide Enrollees with treatment of a Dental Emergency during office hours. The Plan will provide Benefits for covered services provided by Participating Providers for treatment of a Dental Emergency. If the Participating Provider's offices are closed, the Enrollee may access after-hours telephonic clinical assistance by calling the Appointment Center at 1.855.4DENTAL (1-855-433-6825). There is no cost for accessing after-hours telephonic clinical assistance.

The Enrollee may seek treatment from a Non-Participating Provider for a Dental Emergency that occurs while traveling outside of a 50-mile radius of any Participating Provider office. The Enrollee may seek reimbursement for the cost of the covered services rendered up to $100, less any Copayments specified in the Schedule of Covered Services and Copayments. A written request for reimbursement must be submitted within 6 months of the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information, including X-rays and other data, may be requested to process the request. The reimbursement to the Enrollee for out of area Dental Emergency treatment will not be provided if the requested information is not received.

**Extension of Benefits**

Benefits for the following covered services are available after coverage ends for a limited time period and according to the conditions described below. An Enrollee terminated for good cause is not eligible for an extension of Benefits.

- *Crowns or Bridges.* Adjustments for crowns or bridges will be covered for up to 6 months after placement if the final impressions are taken prior to termination and the crown or bridge is placed within 60 days after termination.
- *Removable Prosthetic Devices.* Adjustments for removable prosthetic devices will be covered for up to 6 months after placement if final impressions are taken prior to termination and the prosthesis is delivered within 60 days after termination. Laboratory relines are not covered after termination.
- *Immediate Dentures.* The delivery of immediate dentures will be covered if final impressions are taken prior to termination and the dentures are delivered within 60 days after termination. If coverage terminates prior to the extraction of teeth, the extractions will not be covered.

- *Root Canal Therapy.* The completion of root canal therapy will be covered if the root canal is started prior to termination and treatment is completed within 60 days after termination. Pulpal debridement is not a root canal start. If the root canal requires retreatment after 60 days from termination of coverage, re-treatment will not be covered. Restorative work following root canal treatment is a separate procedure and not covered after termination.
- *Extractions.* Post-operative checks are covered for 60 days from the date of the extraction for extractions performed prior to termination. If teeth are extracted in preparation for a prosthetic device and coverage terminates prior to the final impressions, coverage for the prosthetic device will not be extended. Extractions are a separate procedure from prosthetic procedures.

## Schedule of Covered Services and Copayments

The Enrollee is responsible for payment of the General Office Visit Copayment or Specialist Office Visit Copayment for each dental visit. Some covered services may require a Service Copayment. All Copayments are payable at each visit.

### Office Visit Copayments

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| General Office Visit Copayment | $20 |
| Specialist Office Visit Copayment | $30 |

### Diagnostic and Preventive

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| D0120 Periodic oral evaluation - established patient | $0 |
| D0140 Limited oral evaluation - problem focused | $0 |
| D0145 Oral evaluation for patient under 3 years of age and counseling with primary caregiver | $0 |
| D0150 Comprehensive oral evaluation - new or established patient | $0 |
| D0160 Detailed and extensive oral evaluation - problem focused, by report | $0 |
| D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit) | $0 |
| D0180 Comprehensive periodontal evaluation - new or established patient | $0 |
| D0191 Assessment of a patient | $0 |
| D0210 Intraoral - complete series of radiographic images | $0 |
| D0220 Intraoral – periapical first radiographic image | $0 |
| D0230 Intraoral - periapical each additional radiographic image | $0 |
| D0240 Intraoral - occlusal radiographic image | $0 |
| D0250 Extraoral - 2D projection radiographic image | $0 |
| D0270 Bitewing - single radiographic image | $0 |
| D0272 Bitewings - two radiographic images | $0 |
| D0273 Bitewings - three radiographic images | $0 |
| D0274 Bitewings - four radiographic images | $0 |
| D0277 Vertical bitewings - 7 to 8 radiographic images | $0 |
| D0330 Panoramic radiographic image | $0 |
| D0340 Cephalometric radiographic image | $0 |
| D0350 2D oral/facial photographic image obtained intraorally or extraorally | $0 |
| D0425 Caries susceptibility tests | $0 |
| D0460 Pulp vitality tests | $0 |
| D0470 Diagnostic casts | $0 |
| D1110 Prophylaxis - adult | $0 |
| D1120 Prophylaxis - child | $0 |
| D1206 Topical application of fluoride varnish | $0 |
| D1208 Topical application of fluoride | $0 |
| D1310 Nutritional counseling for control of dental disease | $0 |
| D1320 Tobacco counseling for the control and prevention of oral disease | $0 |
| D1330 Oral hygiene instructions | $0 |
| D1351 Sealant - per tooth | $0 |
| D1510 Space maintainer - fixed - unilateral | $0 |

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| D1515 Space maintainer - fixed - bilateral | $0 |
| D1520 Space maintainer - removable - unilateral | $0 |
| D1525 Space maintainer - removable - bilateral | $0 |
| D1550 Re-cementation of space maintainer | $0 |
| D1555 Removal of fixed space maintainer | $0 |

**Restorative**

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|---|---|
| D2140 Amalgam - one surface, primary or permanent | $5 |
| D2150 Amalgam - two surfaces, primary or permanent | $5 |
| D2160 Amalgam - three surfaces, primary or permanent | $5 |
| D2161 Amalgam - four or more surfaces, primary or permanent | $5 |
| D2330 Resin-based composite - one surface, anterior | $5 |
| D2331 Resin-based composite - two surfaces, anterior | $5 |
| D2332 Resin-based composite - three surfaces, anterior | $5 |
| D2335 Resin-based composite - four or more surfaces involving incisal angle (anterior) | $5 |
| D2390 Resin-based composite crown, anterior | $5 |
| D2391 Resin-based composite - one surface, posterior | $5 |
| D2392 Resin-based composite - two surfaces, posterior | $5 |
| D2393 Resin-based composite - three surfaces, posterior | $5 |
| D2394 Resin-based composite - four or more surfaces, posterior | $5 |
| D2510 Inlay - metallic - one surface | $350 |
| D2520 Inlay - metallic - two surfaces | $350 |
| D2530 Inlay - metallic - three or more surfaces | $350 |
| D2542 Onlay - metallic - two surfaces | $350 |
| D2543 Onlay - metallic - three surfaces | $350 |
| D2544 Onlay - metallic - four or more surfaces | $350 |
| D2610 Inlay - porcelain/ceramic - one surface | $350 |
| D2620 Inlay - porcelain/ceramic - two surfaces | $350 |
| D2630 Inlay - porcelain/ceramic - three surfaces | $350 |
| D2642 Onlay - porcelain/ceramic - two surfaces | $350 |
| D2643 Onlay - porcelain/ceramic - three surfaces | $350 |
| D2644 Onlay - porcelain/ceramic - four or more surfaces | $350 |
| D2710 Crown - resin based composite (indirect) | $350 |
| D2740 Crown - porcelain/ceramic substrate | $350 |
| D2750 Crown - porcelain fused to high noble metal | $350 |
| D2752 Crown - porcelain fused to noble metal | $350 |
| D2782 Crown - ¾ cast noble metal | $350 |
| D2792 Crown - full cast noble metal | $350 |
| D2799 Provisional crown - further treatment or completion of diagnosis necessary prior to final impression | $0 |
| D2910 Recement inlay, onlay, or partial coverage restoration | $0 |
| D2915 Recement cast or prefabricated post and core | $0 |
| D2920 Recement crown | $0 |
| D2921 Reattachment of tooth fragment, incisal edge or cusp | $0 |
| D2930 Prefabricated stainless steel crown - primary tooth | $0 |
| D2931 Prefabricated stainless steel crown - permanent tooth | $0 |

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| D2932 Prefabricated resin crown | $0 |
| D2933 Prefabricated stainless steel crown with resin window | $0 |
| D2934 Prefabricated esthetic coated stainless steel crown - primary tooth | $0 |
| D2940 Protective restoration | $0 |
| D2941 Interim therapeutic restoration - primary dentition | $0 |
| D2949 Restorative foundation for an indirect restoration | $0 |
| D2950 Core buildup, including any pins when required | $0 |
| D2951 Pin retention - per tooth, in addition to restoration | $0 |
| D2954 Prefabricated post and core in addition to crown | $0 |
| D2955 Post removal | $0 |
| D2957 Each additional prefabricated post - same tooth | $0 |
| D2980 Crown repair necessitated by restorative material failure | $0 |
| D2981 Inlay repair necessitated by restorative material failure | $0 |
| D2982 Onlay repair necessitated by restorative material failure | $0 |
| D2983 Veneer repair necessitated by restorative material failure | $0 |

**Endodontics**

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|---|---|
| D3110 Pulp cap - direct (excluding final restoration) | $0 |
| D3120 Pulp cap - indirect (excluding final restoration) | $0 |
| D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | $0 |
| D3221 Pulpal debridement, primary and permanent teeth | $0 |
| D3222 Partial pulpotomy for apexogensis – permanent tooth with incomplete root development | $0 |
| D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | $0 |
| D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | $0 |
| D3310 Endodontic therapy, anterior tooth (excluding final restoration) | $100 |
| D3320 Endodontic therapy, bicuspid tooth (excluding final restoration) | $175 |
| D3330 Endodontic therapy, molar (excluding final restoration) | $225 |
| D3331 Treatment of root canal obstruction; non-surgical access | $0 |
| D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | $0 |
| D3333 Internal repair of perforation defects | $0 |
| D3346 Retreatment of previous root canal therapy - anterior | $100 |
| D3347 Retreatment of previous root canal therapy - bicuspid | $175 |
| D3348 Retreatment of previous root canal therapy - molar | $225 |
| D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | $225 |
| D3352 Apexification/recalcification - interim medication replacement | $0 |
| D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | $0 |
| D3355 Pulpal regeneration - initial visit | $225 |
| D3356 Pulpal regeneration - interim medication replacement | $0 |
| D3357 Pulpal regeneration - completion of treatment | $0 |
| D3410 Apicoectomy - anterior | $100 |
| D3421 Apicoectomy - bicuspid (first root) | $175 |
| D3425 Apicoectomy - molar (first root) | $225 |
| D3426 Apicoectomy (each additional root) | $0 |

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| D3427 Periradicular surgery without apicoectomy | $100 |
| D3430 Retrograde filling - per root | $0 |
| D3450 Root amputation - per root | $225 |
| D3920 Hemisection (including any root removal), not including root canal therapy | $225 |
| D3950 Canal preparation and fitting of a preformed dowel or post | $0 |

**Periodontics**

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| D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | $250 |
| D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | $85 |
| D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | $85 |
| D4240 Gingival flap procedures, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | $250 |
| D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | $250 |
| D4245 Apically positioned flap | $250 |
| D4249 Clinical crown lengthening - hard tissue | $250 |
| D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | $250 |
| D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | $250 |
| D4263 Bone replacement graft - first site in quadrant | $0 |
| D4264 Bone replacement graft - each additional site in quadrant | $0 |
| D4268 Surgical revision procedure, per tooth | $250 |
| D4270 Pedicle soft tissue graft procedure | $250 |
| D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft | $250 |
| D4274 Distal proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | $250 |
| D4276 Combined connective tissue and double pedicle graft, per tooth | $250 |
| D4277 Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft | $250 |
| D4278 Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site | $250 |
| D4341 Periodontic scaling and root planing - four or more teeth per quadrant | $85 |
| D4342 Periodontic scaling and root planing - one to three teeth per quadrant | $85 |
| D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis | $0 |
| D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth | $0 |
| D4910 Periodontic maintenance | $0 |
| D4921 Gingival irrigation - per quadrant | $0 |

**Prosthodontics – Removable**

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| D5110 Complete denture - maxillary | $350 |

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| D5120 Complete denture - mandibular | $350 |
| D5130 Immediate denture - maxillary | $350 |
| D5140 Immediate denture - mandibular | $350 |
| D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | $350 |
| D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | $350 |
| D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $350 |
| D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $350 |
| D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth) | $350 |
| D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth) | $350 |
| D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth) | $350 |
| D5410 Adjust complete denture - maxillary | $0 |
| D5411 Adjust complete denture - mandibular | $0 |
| D5421 Adjust partial denture - maxillary | $0 |
| D5422 Adjust partial denture - mandibular | $0 |
| D5510 Repair broken complete denture base | $0 |
| D5520 Replace missing or broken teeth - complete denture (each tooth) | $0 |
| D5610 Repair resin denture base | $0 |
| D5620 Repair cast framework | $0 |
| D5630 Repair or replace broken clasp – per tooth | $0 |
| D5640 Replace broken teeth - per tooth | $0 |
| D5650 Add tooth to existing partial denture | $0 |
| D5660 Add clasp to existing partial denture – per tooth | $0 |
| D5670 Replace all teeth and acrylic on cast metal framework (maxillary) | $0 |
| D5671 Replace all teeth and acrylic on cast metal framework (mandibular) | $0 |
| D5710 Rebase complete maxillary denture | $0 |
| D5711 Rebase complete mandibular denture | $0 |
| D5720 Rebase maxillary partial denture | $0 |
| D5721 Rebase mandibular partial denture | $0 |
| D5730 Reline complete maxillary denture (chairside) | $0 |
| D5731 Reline complete mandibular denture (chairside) | $0 |
| D5740 Reline maxillary partial denture (chairside) | $0 |
| D5741 Reline mandibular partial denture (chairside) | $0 |
| D5750 Reline complete maxillary denture (laboratory) | $0 |
| D5751 Reline complete mandibular denture (laboratory) | $0 |
| D5760 Reline maxillary partial denture (laboratory) | $0 |
| D5761 Reline mandibular partial denture (laboratory) | $0 |
| D5810 Interim complete denture (maxillary) | $175 |
| D5811 Interim complete denture (mandibular) | $175 |
| D5820 Interim partial denture (maxillary) | $175 |
| D5821 Interim partial denture (mandibular) | $175 |
| D5850 Tissue conditioning, maxillary | $0 |
| D5851 Tissue conditioning, mandibular | $0 |
| D5863 Overdenture - complete maxillary | $350 |
| D5864 Overdenture - partial maxillary | $350 |

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| D5865 Overdenture - complete mandibular | $350 |
| D5866 Overdenture - partial mandibular | $350 |
| D5986 Fluoride gel carrier | $0 |

**Prosthodontics – Fixed**

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| D6210 Pontic - cast high noble metal | $350 |
| D6240 Pontic - porcelain fused to high noble metal | $350 |
| D6241 Pontic - porcelain fused to predominantly base metal | $350 |
| D6253 Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression | $350 |
| D6545 Retainer - cast metal for resin bonded fixed prosthesis | $350 |
| D6720 Retainer crown - resin with high noble metal | $350 |
| D6750 Retainer crown - porcelain fused to high noble metal | $350 |
| D6751 Retainer crown - porcelain fused to predominantly base metal | $350 |
| D6780 Retainer crown - ¾ cast high noble metal | $350 |
| D6790 Retainer crown - full cast high noble metal | $350 |
| D6793 Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression | $350 |
| D6930 Recement fixed partial denture | $0 |
| D6975 Coping | $0 |
| D6980 Fixed partial denture repair necessitated by restorative material failure | $0 |

**Oral Surgery**

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| D7111 Extraction, coronal remnants - deciduous tooth | $10 |
| D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | $10 |
| D7210 Removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $120 |
| D7220 Removal of impacted tooth - soft tissue | $120 |
| D7230 Removal of impacted tooth - partially bony | $120 |
| D7240 Removal of impacted tooth - completely bony | $120 |
| D7241 Removal of impacted tooth - completely bony, with unusual surgical complications | $120 |
| D7250 Removal of residual tooth roots (cutting procedure) | $120 |
| D7251 Coronectomy – intentional partial tooth removal | $120 |
| D7260 Oroantral fistula closure | $120 |
| D7261 Primary closure of a sinus perforation | $120 |
| D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | $120 |
| D7272 Tooth transplantation (included reimplantation from one site to another and splinting and/or stabilization) | $120 |
| D7280 Exposure of an unerupted tooth | $120 |
| D7282 Mobilization of erupted or malpositioned tooth to aid eruption | $120 |
| D7283 Placement of device to facilitate eruption of impacted tooth | $120 |
| D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report | $120 |
| D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $0 |

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| D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $0 |
| D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $0 |
| D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $0 |
| D7340 Vestibuloplasty - ridge extension (secondary epithelialization) | $120 |
| D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | $120 |
| D7471 Removal of lateral exostosis (maxilla or mandible) | $120 |
| D7472 Removal of torus palatinus | $120 |
| D7473 Removal of torus mandibularis | $120 |
| D7485 Surgical reduction of osseous tuberosity | $120 |
| D7510 Incision & drainage of abscess - intraoral soft tissue | $0 |
| D7511 Incision & drainage of abscess - intraoral soft tissue - complicated (includes drainable of multiple fascial spaces) | $0 |
| D7520 Incision & drainage of abscess - extraoral soft tissue | $0 |
| D7521 Incision & drainage of abscess - extraoral soft tissue - complicated (includes drainable of multiple fascial spaces) | $0 |
| D7530 Remove of foreign body from mucosa, skin, or subcutaneous alveolar tissue | $0 |
| D7540 Remove of reaction producing foreign bodies, musculoskeletal system | $0 |
| D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone | $0 |
| D7670 Alveolus - closed reduction, may include stabilization of teeth | $0 |
| D7910 Suture of recent small wounds up to 5 cm | $0 |
| D7911 Complicated suture - up to 5 cm | $0 |
| D7953 Bone replacement graft for ridge preservation - per site | $120 |
| D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another | $120 |
| D7970 Excision of hyperplastic tissue - per arch | $120 |
| D7971 Excision of pericoronal gingiva | $120 |

**Orthodontic Treatment**

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| D8020 Limited orthodontic treatment of the transitional dentition | Prorated from $2,000 |
| D8030 Limited orthodontic treatment of the adolescent dentition | Prorated from $2,000 |
| D8040 Limited orthodontic treatment of the adult dentition | Prorated from $2,000 |
| D8060 Interceptive orthodontic treatment of the transitional dentition | Prorated from $2,000 |
| D8070 Comprehensive orthodontic treatment of the transitional dentition | $2,000 |
| D8080 Comprehensive orthodontic treatment of the adolescent dentition | $2,000 |
| D8090 Comprehensive orthodontic treatment of the adult dentition | $2,000 |
| D8210 Removable appliance therapy | Prorated from $2,000 |
| D8220 Fixed appliance therapy | Prorated from $2,000 |
| D8660 Pre-orthodontic exam | $25 |
| Pre-orthodontic records | $125 |
| D8999 Orthodontic case analysis | $0 |
| Rebond orthodontic appliance | $0 |

**Adjunctive Services**

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| D9110 Palliative (emergency) treatment of dental pain - minor procedure | $0 |
| D9120 Fixed partial denture sectioning | $0 |
| D9223 Deep sedation/general anesthesia | First 30 Minutes: $250<br>Each Additional 15 Minutes: $0 |
| D9230 Inhalation of nitrous oxide/analgesia, anxiolysis | $40 |
| D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | $0 |
| D9420 Hospital or ambulatory surgical center call | $125 |
| D9430 Office visit for observation (during regularly scheduled hours) - no other services performed | $0 |
| D9440 Office visit - after regularly scheduled hours | $20 |
| D9450 Case presentation, detailed and extensive treatment planning | $0 |
| D9910 Application of desensitizing medicament | $0 |
| D9911 Application of desensitizing resin for cervical and/or root surface, per tooth | $0 |
| D9930 Treatment of complications (post-surgical) – unusual circumstances, by report | $0 |
| D9950 Occlusion analysis - mounted case | $0 |
| D9951 Occlusal adjustment - limited | $0 |
| D9952 Occlusal adjustment - complete | $0 |
| D9970 Enamel microabrasion | $0 |
| Out of Area Emergency Treatment<br>(The Enrollee is reimbursed up to $100 per visit.) | All charges in excess of $100 |

## Exclusions and Limitations

### Exclusions

This Plan does not provide Benefits for any of the following conditions, treatments, services, or for any direct complications or consequences thereof. This Plan does not provide Benefits for an excluded service even if approved, prescribed, or recommended by a Dentist.

- Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments or services initiated prior to the effective date of coverage under this Plan, including the following:
  - An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under this Plan; or
  - A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under this Plan.
- Dental implants, including attachment devices, maintenance, and dental implant-related services.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage. Such services are the liability of the Enrollee, prior dental plan, and/or provider.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Exams or consultations needed solely in connection with a service or supply not listed as covered in this Benefits Booklet.
- Experimental or Investigational services and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- Maxillofacial prosthetic services.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of lost, missing, or stolen dental appliances.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Participating Provider.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a Dentist, Denturist, hygienist, or dental assistant within the scope of his or her license.

- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.
- Services for treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services not listed in this Benefits Booklet.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

**Limitations**

- *Alternate Services.* If alternative covered services can be used to treat a condition, the service recommended by the Participating Provider is covered. In the event the Enrollee elects a covered service that is more costly than the service the Participating Provider has approved, the Enrollee is responsible for the Copayment for the recommended covered service plus the cost differential between the Reasonable Cash Value of the recommended covered service and the Reasonable Cash Value of the more costly requested covered service.
- *Congenital Malformations.* Services listed in the Schedule of Covered Services and Copayments which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for enrolled Children if dental necessity has been established. Dental necessity means that treatment is primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
- *Endodontic Retreatment.*
  - When the initial root canal therapy was performed by a Participating Provider, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After that time, the applicable Copayments will apply.
  - When the initial root canal therapy was performed by a Non-Participating Provider, the retreatment of such root canal therapy by a Participating Provider will be subject to the applicable Copayments.
- *General Anesthesia.* General anesthesia is covered with the Copayments specified in the Schedule of Covered Services only if the following criteria are met:
  - It is performed in a dental office;
  - It is performed in conjunction with a Covered Service; and
  - The Participating Provider determines that it is necessary because the Enrollee is under age 7, developmentally disabled, or physically disabled.
- *Hospital Setting.* The covered services provided by a Participating Provider in a hospital setting are covered if the following criteria are met:
  - A hospital or similar setting is Dentally Necessary;
  - The Participating Provider has issued a referral for the covered services;
  - The covered services provided are the same covered services that would be provided in a dental office; and
  - The applicable Copayments are paid.

- *Replacements.* The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is Dentally Necessary due to one of the following conditions:
  - A tooth within an existing denture or bridge is extracted;
  - The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or
  - The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under this Plan, and replacement by a permanent denture is necessary.
- *Restorations.* Crowns, casts, or other indirect fabricated restorations are covered only if Dentally Necessary and if recommended by the Participating Provider. Crowns, casts, or other indirect fabricated restorations are Dentally Necessary if provided for treatment for decay, traumatic injury, or substantial loss of tooth structure undermining one or more cusps and the tooth cannot be restored with a direct restorative material or the tooth is an abutment to a covered partial denture or fixed bridge.