



**Willamette**  
Dental Group

**ASSOCIATION OF WASHINGTON CITIES  
EMPLOYEE BENEFIT TRUST**

**ACTIVE EMPLOYEES PLAN 2**

**SELF-FUNDED DENTAL BENEFIT PLAN  
BENEFITS BOOKLET**

**EFFECTIVE JANUARY 1, 2024**

## Table of Contents

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<b>Definitions.....</b>	<b>3</b>
<b>Eligibility and Enrollment.....</b>	<b>5</b>
Employee Eligibility.....	5
Family Member Eligibility.....	5
Eligibility Waiting Period and Initial Enrollment .....	5
Annual Open Enrollment .....	5
Change in Status .....	5
Rehires .....	6
Special Enrollment Following a Qualifying Event.....	6
When Coverage Ends.....	6
Continuation Rights .....	7
<b>Coordination of Benefits .....</b>	<b>8</b>
<b>Subrogation .....</b>	<b>11</b>
<b>Claim and Appeal Procedures.....</b>	<b>12</b>
Claims.....	12
Complaints .....	12
Appeals .....	12
<b>Dental Coverage Provisions .....</b>	<b>14</b>
Participating Provider .....	14
Referrals .....	14
Orthodontic Benefits .....	14
Temporomandibular Joint Disorder Treatment Benefits.....	14
Dental Implants.....	15
Emergency Care.....	16
Extension of Benefits.....	16
<b>Schedule of Covered Services and Copayments.....</b>	<b>17</b>
<b>Exclusions and Limitations .....</b>	<b>25</b>
Exclusions.....	25
Limitations .....	26

## Definitions

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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.

“Child” means a natural child; stepchild; adopted child; child for whom the Subscriber has assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child; or child for whom the Subscriber has court-appointed legal guardianship. Child also includes a child for whom the Subscriber is required to provide dental coverage, pursuant to a Qualified Medical Child Support Order (QMCSO) as defined in the Employee Retirement Income Security Act of 1974, as amended, or a foster child.

“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 requiring immediate attention, including the following conditions: acute infection; acute abscesses; severe tooth pain; unusual swelling of the face or gums; or a tooth that has been avulsed (knocked out).

“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 engage in the practice of denture technology pursuant to the laws of the state where treatment is rendered.

“Dependent” means a legal spouse, state registered domestic partner, or Child, who is eligible and enrolled for coverage under this Plan.

“Enrollee” means any Subscriber or Dependent.

“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 Association of Washington Cities Employee Benefit Trust.

“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.

“Subscriber” means an employee of the Plan Sponsor, who is eligible and enrolled for coverage under this Plan.

## **Eligibility and Enrollment**

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### **Employee Eligibility**

To be eligible to enroll under this Plan, an active employee must work the minimum number of hours required by the Plan Sponsor.

### **Family Member Eligibility**

The following family members are eligible for coverage as a Dependent under this Plan.

- The legal spouse of the employee.
- The state registered domestic partner of the employee.
- The Child of the Subscriber, Subscriber's legal spouse, or Subscriber's state registered domestic partner, to the age of 26.
- The Child of the Subscriber, Subscriber's legal spouse, or Subscriber's state registered domestic partner, age 26 or older, if the Child is and continues to be incapable of self-sustaining employment because of a developmental disability or physical disability that began before the Child reached age 26 and is and continues to be chiefly dependent on the Subscriber, Subscriber's legal spouse, or Subscriber's state registered domestic partner for support and maintenance. Documentation of the requirements described herein must be provided to the Plan Sponsor within 31 days after the Child's attainment of the limiting age.

### **Eligibility Waiting Period and Initial Enrollment**

A prospective Subscriber becomes eligible for coverage on the first day of the month following or coinciding with the date of hire.

The waiting period is waived for employees transitioning from part-time to full-time status.

If enrollment does not occur when initially eligible, the eligible employee and any eligible family member(s) must wait until this Plan's next open enrollment period or until a qualifying event occurs to enroll.

### **Annual Open Enrollment**

Each year the Plan Sponsor holds an annual open enrollment period during which eligible active employees may enroll or drop enrollment for themselves and their eligible family members. Coverage will begin on the following January 1.

### **Change in Status**

If an employee is not eligible to participate in the Plan and later changes employment status and becomes eligible, this will be considered a "change in status" that allows enrollment in the Plan mid-year. If an eligible employee changes elections mid-year, the eligible employee must complete the enrollment process within 60 calendar days after the date of the event that qualifies the eligible employee to make a mid-year change. If the eligible employee declines coverage under the Plan or fail to enroll within 60 days after first becoming eligible, the eligible employee will not be able to enroll until the next annual open enrollment period. The only exception is if the eligible employee qualifies to make another mid-year benefit election change.

## Rehires

If a Subscriber's employment is terminated and the employee is rehired in a benefits-eligible status, the eligible employee may make new benefit elections subject to the applicable waiting period determined by the Plan Sponsor.

## Special Enrollment Following a Qualifying Event

The following events are considered qualifying events during which eligible employees and eligible family members may enroll mid-plan year.

- *Marriage or Domestic Partnership Registration.* Family members who are newly eligible due to marriage or registration of domestic partnership may enroll. Requests to enroll must be submitted to the Plan Sponsor within 60 days following the date of marriage or domestic partnership registration to enroll. Coverage begins on the first day of the month following the date of marriage or domestic partnership registration.
- *Births and Adoptions.* Newborns or newly adopted Children may enroll. Requests to enroll must be submitted to the Plan Sponsor within 60 days following the date of the birth, adoption, or placement for adoption. Coverage will begin on the date of the birth, adoption, or placement for adoption.
- *Guardianship or QMCSO.* Employees may enroll newly eligible family members due to court appointment as a legal guardian or issuance of a QMCSO. Requests to enroll must be submitted to the Plan Sponsor within 60 days following the effective date of legal guardianship or issuance of a QMCSO. Coverage begins on the first day of the month following the effective date of legal guardianship or date of the issuance of a QMCSO.
- *Loss of Other Coverage.* Employees and eligible family members may enroll mid-plan year following loss of coverage under another dental plan. Examples of reasons of loss of coverage include legal separation, divorce, dissolution of a domestic partnership, death, loss of dependent status, termination of employment, reduction in hours, the end of a maximum period of continuation coverage, or any other reason as approved by the Plan Sponsor. Requests to enroll must be submitted to the Plan Sponsor within 60 days of the loss of other dental coverage. Coverage will begin on the first day of the month following the loss of coverage.

## When Coverage Ends

Coverage for Enrollees will terminate on the earliest of the following events:

- On the date of termination of this Plan by the Plan Sponsor.
- On the last day of the month following the date the Enrollee ceases to be eligible under the Plan.
- On the last day of the month the Enrollees fails to make any required contributions under the Plan.
- On the last day of the month following the date the Subscriber fails to provide required information necessary to determine an individual's status as a dependent (within the time period specified to provide such information).
- On the date the Plan Sponsor amends the Plan such that the Enrollee is no longer eligible, or terminates the Plan.
- On the last day of the month during which an Enrollee exhausts continuation rights.
- On the last day of the month following 30 days' prior written notice from the Participating Provider of good cause for termination. Good cause includes, but is not limited to, a documented inability to establish or maintain an appropriate provider-patient relationship with a Participating Provider, physical or verbal abuse towards a Participating Provider, office staff, or other patients, or non-payment of Copayments.

When coverage terminates for a Subscriber, coverage will also terminate for the Dependents of the Subscriber.

## Continuation Rights

- *Federal or State Mandated Continuation Coverage.* Coverage may continue in accordance with any federally-mandated or state-mandated leave act or law.
  - *COBRA.* Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, certain circumstances, called qualifying events, may provide Subscribers and some Dependents the right to continue coverage for a temporary period of time. Please contact the Plan Sponsor's Human Resources Department for more information about coverage available pursuant to COBRA.
  - *USERRA.* Continuation and reinstatement rights may also be available if an Enrollee is absent from employment due to service in the uniformed services pursuant to USERRA. Please contact the Plan Sponsor's Human Resources Department for more information about coverage available pursuant to USERRA.
- *Leave of Absence.* Coverage may be continued during certain leaves of absence. Please contact the Plan Sponsor's Human Resources Department for more information about eligibility and coverage during a leave of absence.

## Coordination of Benefits

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If an Enrollee has dental care coverage under this Plan and another plan for dental care benefits, benefits will be coordinated. The purpose of coordination of benefits is to determine which plan will pay benefits first for the costs and which will pay second. Together, all plans combined may pay up to, but no more than, 100% of the total Allowable Expense.

For the purposes of this section, a “plan” is any of the following that provides benefits or services for dental care or treatment. Plan includes: group health insurance contracts, health maintenance organization contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law; and group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care. Plan does not include: individual, hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

An Allowable Expense is a dental care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the Enrollee. 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. If this Plan pays more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid.

The Order of Benefit Determination Rules determines the order in which each plan will pay benefits. The plan that pays first is called the “Primary Plan.” The plan that pays after the Primary Plan is the “Secondary Plan.” When this Plan is primary, it determines Benefits first without considering any other plan’s coverage. When this Plan is secondary, it determines Benefits after the coverage of another plan has been first applied and may reduce the Benefits of this Plan so that the total paid by all plans does not exceed 100% of the total Allowable Expense.

Each plan determines its order of benefits using the first of the following Order of Benefit Determination Rules that apply:

1. A plan that does not contain a coordination of benefits provision similar to this one is the Primary Plan.
2. **Non-dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree is the Primary Plan. 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, subscriber, or retiree is the Secondary Plan and the other plan is the Primary Plan.
3. **Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Child is covered by more than one plan the order of benefits is determined as follows:
  - a. For a Child whose parents are married or are living together, whether or not they have ever been married: The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
  - b. For a Child whose parents are divorced or separated or not living together, whether or not they have ever been married:



- (i) If a court decree states that one of the parents is responsible for the 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 plan years commencing after the plan is given notice of the court decree;
  - (ii) If a court decree states that both parents are responsible for the Child's health care expenses or health care coverage, the birthday rule in subparagraph a. shall determine the order of benefits;
  - (iii) 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 Child, the birthday rule in subparagraph a. above shall determine the order of benefits; or
  - (iv) If there is no court decree allocating responsibility for the Child's health care expenses or health care coverage, the order of benefits for the Child are as follows: the plan covering the custodial parent; the plan covering the spouse or domestic partner of the custodial parent; the plan covering the non-custodial parent; and then the plan covering the spouse or domestic partner of the non-custodial parent.
- c. For a Child covered under more than one plan of individuals who are not the parents of the Child, subparagraphs a. or b. above shall determine the order of benefits as if those individuals were the parents of the Child.
  - d. For a Child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's or domestic partner's plan, the longer or shorter length of coverage rule in paragraph 5. below applies. In the event the Child's coverage under his or her spouse's or domestic partner's plan began on the same date as the Child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph a. to the Child's parent and the Child's spouse or domestic partner.
4. **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 Non-dependent or Dependent rule in paragraph 2 can determine the order of benefits.
  5. **Continuation Coverage.** If a person whose coverage is provided pursuant to 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 continuation coverage, 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 Non-dependent or Dependent rule in paragraph 2 can determine the order of benefits.
  6. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, 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 a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that plan and other Closed Panel Plans. Closed Panel Plan is a plan that provides dental care benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or is 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.

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. This 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. This Plan need not tell or get the consent of the Enrollee to do this. Enrollees must provide any facts this Plan needs to apply these rules and determine benefits payable. It is the Enrollee's responsibility to notify this Plan if family members have dental care coverage under another plan.

#### **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**

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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**

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### **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**

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### **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, including payment of the General Office Visit Copayment at each visit for orthodontic treatment. 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.

## **Dental Implants**

The dental implant services described in this Benefits Booklet are covered for Enrollees if all of the following requirements are met:

- A Participating Provider determines that dental implants are dentally appropriate for the Enrollee.
- A Participating Provider prepares the treatment plan for dental implants prior to initiating any implant treatment.
- All dental implant services are provided by a Participating Provider or under a referral from a Participating Provider.
- The Enrollee follows the treatment plan prescribed by the Participating Provider.
- The Enrollee makes payment of amounts due.
- The dental implant service is listed as covered in this Benefits Booklet and is not otherwise limited or excluded.

If the Enrollee's coverage ends before the completion of the dental implant services, the cost of any remaining treatment is the Enrollee's responsibility.

The following dental implant services are covered at 100%, up to an annual dental implant benefit maximum of \$1,500. The annual dental implant benefit maximum is the maximum dollar amount this Plan will cover for benefits for the below dental implant services in a calendar year. The dental implant Enrollee cost-share for implant services is permanent.

CDT Code and Procedure Description

D6010 Surgical placement of implant body: endosteal implant

D6011 Second stage implant surgery

The benefit for dental implants is subject to the following limitations:

- Benefits for surgical placement of a dental implant are limited to 1 implant per calendar year.
- Dental implants to replace an existing bridge or existing denture are not covered, unless 5 years have elapsed since the placement of the bridge or delivery of the denture.

The following services are not covered under this benefit for dental implants:

- Any dental implant services and related services that are not listed as covered on this Benefits Booklet.
- Bone grafting.
- Cone beam CT X-rays and tomographic surveys.
- Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
- A dental implant that was surgically placed prior to the Enrollee's effective date of coverage under this Plan that has not received final restoration.
- Eposteal, transosteal, endodontic endosseous, or mini dental implants.
- Maintenance, repair, replacement, or completion of an existing implant started or placed by a Non-Participating Provider without a referral from a Participating Provider.

- Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the effective date of coverage under this Plan.
- Treatment of a primary or transitional dentition.

## **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

General Office Visit Copayment	\$15
Specialist Office Visit Copayment	\$30

### Diagnostic and Preventive

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 Extra-oral - 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 2D 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 – excluding varnish	\$0
D1310 Nutritional counseling for control of dental disease	\$0
D1320 Tobacco counseling for the control and prevention of oral disease	\$0
D1330 Oral hygiene instructions	\$0
D1351 Sealant - per tooth	\$0
D1510 Space maintainer - fixed - unilateral - per quadrant	\$0
D1516 Space maintainer - fixed - bilateral, maxillary	\$0
D1517 Space maintainer - fixed - bilateral, mandibular	\$0
D1520 Space maintainer - removable - unilateral - per quadrant	\$0

D1526 Space maintainer - removable - bilateral, maxillary	\$0
D1527 Space maintainer - removable - bilateral, mandibular	\$0
D1551 Re-cement or re-bond bilateral space maintainer - maxillary	\$0
D1552 Re-cement or re-bond bilateral space maintainer - mandibular	\$0
D1553 Re-cement or re-bond unilateral space maintainer - per quadrant	\$0
D1556 Removal of fixed unilateral space maintainer - per quadrant	\$0
D1557 Removal of fixed bilateral space maintainer - maxillary	\$0
D1558 Removal of fixed bilateral space maintainer - mandibular	\$0

## Restorative

D2140 Amalgam - one surface, primary or permanent	\$0
D2150 Amalgam - two surfaces, primary or permanent	\$0
D2160 Amalgam - three surfaces, primary or permanent	\$0
D2161 Amalgam - four or more surfaces, primary or permanent	\$0
D2330 Resin-based composite - one surface, anterior	\$0
D2331 Resin-based composite - two surfaces, anterior	\$0
D2332 Resin-based composite - three surfaces, anterior	\$0
D2335 Resin-based composite - four or more surfaces involving incisal angle (anterior)	\$0
D2390 Resin-based composite crown, anterior	\$0
D2391 Resin-based composite - one surface, posterior	\$0
D2392 Resin-based composite - two surfaces, posterior	\$0
D2393 Resin-based composite - three surfaces, posterior	\$0
D2394 Resin-based composite - four or more surfaces, posterior	\$0
D2510 Inlay - metallic - one surface	\$150
D2520 Inlay - metallic - two surfaces	\$150
D2530 Inlay - metallic - three or more surfaces	\$150
D2542 Onlay - metallic - two surfaces	\$150
D2543 Onlay - metallic - three surfaces	\$150
D2544 Onlay - metallic - four or more surfaces	\$150
D2610 Inlay - porcelain/ceramic - one surface	\$150
D2620 Inlay - porcelain/ceramic - two surfaces	\$150
D2630 Inlay - porcelain/ceramic - three or more surfaces	\$150
D2642 Onlay - porcelain/ceramic - two surfaces	\$150
D2643 Onlay - porcelain/ceramic - three surfaces	\$150
D2644 Onlay - porcelain/ceramic - four or more surfaces	\$150
D2710 Crown - resin based composite (indirect)	\$150
D2740 Crown - porcelain/ceramic	\$150
D2750 Crown - porcelain fused to high noble metal	\$150
D2752 Crown - porcelain fused to noble metal	\$150
D2780 Crown - ¾ cast high noble metal	\$150
D2790 Crown - full cast high noble metal	\$150
D2799 Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	\$0
D2910 Re-cement or re-bond inlay, onlay, or partial coverage restoration	\$0
D2915 Re-cement cast or prefabricated post and core	\$0
D2920 Re-cement or re-bond 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
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
D2975 Coping	\$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

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 apexogenesis – 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)	\$75
D3320 Endodontic therapy, premolar tooth (excluding final restoration)	\$100
D3330 Endodontic therapy, molar (excluding final restoration)	\$125
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	\$75
D3347 Retreatment of previous root canal therapy - premolar	\$100
D3348 Retreatment of previous root canal therapy - molar	\$125
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$125
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	\$125
D3356 Pulpal regeneration - interim medication replacement	\$0
D3357 Pulpal regeneration - completion of treatment	\$0
D3410 Apicoectomy - anterior	\$75
D3421 Apicoectomy – premolar (first root)	\$100
D3425 Apicoectomy - molar (first root)	\$125
D3426 Apicoectomy (each additional root)	\$0
D3430 Retrograde filling - per root	\$0
D3450 Root amputation - per root	\$125

D3920 Hemisection (including any root removal), not including root canal therapy	\$125
D3950 Canal preparation and fitting of a preformed dowel or post	\$0

### Periodontics

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$60
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$60
D4240 Gingival flap procedures, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150
D4245 Apically positioned flap	\$150
D4249 Clinical crown lengthening - hard tissue	\$150
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150
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	\$150
D4270 Pedicle soft tissue graft procedure	\$150
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	\$150
D4274 Mesial/distal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$150
D4276 Combined connective tissue and double pedicle graft, per tooth	\$150
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	\$150
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	\$150
D4341 Periodontic scaling and root planing - four or more teeth per quadrant	\$60
D4342 Periodontic scaling and root planing - one to three teeth per quadrant	\$60
D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$0
D4355 Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent	\$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

D5110 Complete denture - maxillary	\$300
D5120 Complete denture - mandibular	\$300
D5130 Immediate denture - maxillary	\$300
D5140 Immediate denture - mandibular	\$300

D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$300
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$300
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$300
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$300
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$300
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$300
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$300
D5410 Adjust complete denture - maxillary	\$0
D5411 Adjust complete denture - mandibular	\$0
D5421 Adjust partial denture - maxillary	\$0
D5422 Adjust partial denture - mandibular	\$0
D5511 Repair broken complete denture base, mandibular	\$0
D5512 Repair broken complete denture base, maxillary	\$0
D5520 Replace missing or broken teeth - complete denture (each tooth)	\$0
D5611 Repair resin partial denture base, mandibular	\$0
D5612 Repair resin partial denture base, maxillary	\$0
D5621 Repair cast partial framework, mandibular	\$0
D5622 Repair cast partial framework, maxillary	\$0
D5630 Repair or replace broken retentive/clasping materials – 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 (direct)	\$0
D5731 Reline complete mandibular denture (direct)	\$0
D5740 Reline maxillary partial denture (direct)	\$0
D5741 Reline mandibular partial denture (direct)	\$0
D5750 Reline complete maxillary denture (indirect)	\$0
D5751 Reline complete mandibular denture (indirect)	\$0
D5760 Reline maxillary partial denture (indirect)	\$0
D5761 Reline mandibular partial denture (indirect)	\$0
D5810 Interim complete denture (maxillary)	\$150
D5811 Interim complete denture (mandibular)	\$150
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), (maxillary)	\$150
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), (mandibular)	\$150
D5850 Tissue conditioning, maxillary	\$0
D5851 Tissue conditioning, mandibular	\$0
D5863 Overdenture - complete maxillary	\$300

D5864 Overdenture - partial maxillary	\$300
D5865 Overdenture - complete mandibular	\$300
D5866 Overdenture - partial mandibular	\$300
D5986 Fluoride gel carrier	\$0

### Prosthodontics – Fixed

D6210 Pontic - cast high noble metal	\$150
D6240 Pontic - porcelain fused to high noble metal	\$150
D6241 Pontic - porcelain fused to predominantly base metal	\$150
D6253 Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	\$0
D6545 Retainer - cast metal for resin bonded fixed prosthesis	\$150
D6720 Retainer crown - resin with high noble metal	\$150
D6750 Retainer crown - porcelain fused to high noble metal	\$150
D6751 Retainer crown - porcelain fused to predominantly base metal	\$150
D6780 Retainer crown - ¾ cast high noble metal	\$150
D6790 Retainer crown - full cast high noble metal	\$150
D6793 Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	\$0
D6930 Re-cement or re-bond fixed partial denture	\$0
D6980 Fixed partial denture repair necessitated by restorative material failure	\$0

### Oral Surgery

D7111 Extraction, coronal remnants - primary tooth	\$0
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$0
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$80
D7220 Removal of impacted tooth - soft tissue	\$80
D7230 Removal of impacted tooth - partially bony	\$80
D7240 Removal of impacted tooth - completely bony	\$80
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications	\$80
D7250 Removal of residual tooth roots (cutting procedure)	\$80
D7251 Coronectomy – intentional partial tooth removal	\$80
D7260 Oroantral fistula closure	\$80
D7261 Primary closure of a sinus perforation	\$80
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$80
D7272 Tooth transplantation (included reimplantation from one site to another and splinting and/or stabilization)	\$80
D7280 Exposure of an unerupted tooth	\$80
D7282 Mobilization of erupted or malpositioned tooth to aid eruption	\$80
D7283 Placement of device to facilitate eruption of impacted tooth	\$80
D7291 Transseptal fibrotomy/supra crestal fibrotomy, by report	\$80
D7294 Placement of temporary anchorage device without flap	\$250
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$0
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)	\$80
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$80
D7471 Removal of lateral exostosis (maxilla or mandible)	\$80
D7472 Removal of torus palatinus	\$80
D7473 Removal of torus mandibularis	\$80
D7485 Surgical reduction of osseous tuberosity	\$80
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 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$0
D7540 Removal of reaction producing foreign bodies, musculoskeletal system	\$0
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone	\$0
D7670 Alveolus - closed reduction, may include stabilization of teeth	\$0
D7910 Suture of recent small wounds up to 5 cm	\$0
D7911 Complicated suture - up to 5 cm	\$0
D7953 Bone replacement graft for ridge preservation - per site	\$80
D7970 Excision of hyperplastic tissue - per arch	\$80
D7971 Excision of pericoronal gingiva	\$80

### Orthodontic Treatment

D8020 Limited orthodontic treatment of the transitional dentition	Prorated from \$1,500
D8030 Limited orthodontic treatment of the adolescent dentition	Prorated from \$1,500
D8040 Limited orthodontic treatment of the adult dentition	Prorated from \$1,500
D8070 Comprehensive orthodontic treatment of the transitional dentition	\$1,500
D8080 Comprehensive orthodontic treatment of the adolescent dentition	\$1,500
D8090 Comprehensive orthodontic treatment of the adult dentition	\$1,500
D8210 Removable appliance therapy	Prorated from \$1,500
D8220 Fixed appliance therapy	Prorated from \$1,500
D8660 Pre-orthodontic exam	\$25
Pre-orthodontic records	\$125
D8999 Orthodontic case analysis	\$0
Rebond orthodontic appliance	\$0

### Adjunctive Services

D9110 Palliative (emergency) treatment of dental pain - minor procedure	\$0
D9120 Fixed partial denture sectioning	\$0
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis	\$20
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 (The Enrollee is reimbursed up to \$100 per visit.)	All charges in excess of \$100



## Exclusions and Limitations

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### 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.
- 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.
- General anesthesia, moderate sedation, and IV sedation.
- 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 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.
- *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.