Willamette Dental Group

CERTIFICATE OF COVERAGE

Effective: January 1, 2025

Underwritten by Willamette Dental Insurance, Inc.
002-OR90(1/25)

Willamette Dental Group

WELCOME TO WILLAMETTE DENTAL!

WILLAMETTE DENTAL WOULD LIKE TO WELCOME YOU!

Please use the contact information below for any assistance needed. To schedule an appointment, please contact our local Appointment Center. Willamette Dental has a full staff of member services representatives to answer questions about your dental plan as well.

CONTACT INFORMATION

Appointments or Emergencies

Toll Free: **1.855.433.6825**

Member Services

Monday - Friday 8am to 5pm PT

Toll Free: **1.855.433.6825**

E-mail: memberservices@willamettedental.com

willamettedental.com/pebb

willamettedental.com/pebb

Visit our website for the most up-to-date locations and doctor profiles, complete with photos, to help you find the best office and provider for you and your family.

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This Certificate of Coverage ("Certificate"), including any amendments, appendices, endorsements, notices, and riders, summarizes the essential features of the Contract.

Possession of this Certificate does not necessarily mean the Enrollee is covered. This Certificate replaces and supersedes all prior issued certificates.

For complete details on Benefits and other provisions of the Contract, please refer to the Contract on file with the Group. If any information in this Certificate is inconsistent with the provisions of the Contract, the Contract shall control.

Willamette Dental Insurance, Inc.
6950 NE Campus Way
Hillsboro, Oregon 97124

DEFINITIONS

The following defined terms are used throughout this Certificate.

“Benefit” means a dental service that is covered under the Contract, subject to the terms, conditions, limitations, and exclusions set forth in this Certificate.

“Company” means Willamette Dental Insurance, Inc.

“Contract” means the agreement between the Company and the Group.

“Copayment” means the dollar amount Enrollees must pay for Benefits.

“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).

“Dentist” means a licensed doctor of dental surgery or a licensed doctor of medical dentistry, licensed in the state where treatment is provided.

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

“Dependent” means an eligible spouse, domestic partner, or child, who is eligible and enrolled for coverage.

“Enrollee” means any Member or Dependent.

“Group” means the Public Employees’ Benefit Board.

“Member” means an eligible employee of the Group, who is enrolled for coverage.

“Non-Participating Provider” means a Dentist or Denturist that is not a Participating Provider.

“Participating Provider” means Willamette Dental Group, P.C., and the Dentists and Denturists who are employees of Willamette Dental Group, P.C. The Company contracts with the Participating Provider to provide dental services to Enrollees under the terms of the Contract.

“Premiums” means the amount, including any Member contributions, which the Group must pay to the Company for coverage of each Enrollee.

“Reasonable Cash Value” means the Participating Provider’s usual, and customary fee-for-service price of services.

“Specialist” means a Dentist professionally qualified as an endodontist, oral pathologist, oral surgeon, orthodontist, pediatric dentist, periodontist, or prosthodontist.

ELIGIBILITY

Member and Dependent Eligibility. To be eligible for coverage under the Contract, the Member and Dependent must be eligible and remain eligible under the Oregon Administrative Rules, Chapter 101 (Public Employees’ Benefit Board (PEBB)). All rules pertaining to enrolling for coverage and when coverage begins will also be in accordance with Oregon Administrative Rules, Chapter 101 (Public Employees’ Benefit Board). The Benefits listed in this Certificate are not subject to a pre-existing condition waiting period.

DENTAL COVERAGE

Agreement to Provide Benefits. The Company agrees to provide Benefits for prescribed services listed in this Certificate as covered, subject to the limitations and exclusions. Services must be provided by a Participating Provider to receive Benefits, unless specified otherwise. The Participating Provider agrees it will accept the amounts established by the Company and the Copayments specified in the appendices as full payment for the covered services provided. All Benefits are expressly subject to the Copayments stated in the appendices and to all other provisions of the Contract.

Referral to a Specialist. If a Participating Provider cannot provide a covered service, the Participating Provider may refer an Enrollee to a Specialist or Non-Participating Provider. Benefits will be provided for services provided by a Specialist or Non-Participating Provider only if all of the following conditions are met:

- The Participating Provider refers the Enrollee;
- The services are authorized by the referral; and
- The services are listed as covered in the appendices.

Office Visit Copayment. The Enrollee is responsible for payment of an office visit Copayment for each visit to a Participating Provider, Specialist, or authorized referral Non-Participating Provider. Office visit Copayments are payable at each visit.

Service Copayment. Some services may require a service Copayment. Service Copayments are payable at the time of service.

Member Coverage. A Member may not be simultaneously covered more than once as a Member under the Contract.

Rights Not Transferable. Benefits are offered personally to the Enrollee and are not transferable.

EXCLUSIONS & LIMITATIONS

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

- Bridges, crowns, dentures, or 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 the Contract, including the following:
  1. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under the Contract; or
  2. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under the Contract.
- Endodontic services, prosthetic services, and implants that are defective, were not provided in accordance with the professional standard of care, or were provided prior to the effective date of coverage under the Contract. Such services are the liability of the Enrollee, prior dental insurance carrier, and/or Dentist.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Exams or consultations needed solely in connection with a service that is not listed as covered in this Certificate.
- Experimental or investigational services and related exams or consultations. In determining whether services are experimental or investigational, the Company will consider the following:
  1. Whether the services are in general use in the dental community in the State of Oregon;
  2. Whether the services are under continued scientific testing and research;
  3. Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
  4. Whether the services are proven safe and efficacious.
- 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, deep sedation, or moderate sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- 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 lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by the 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 licensed Dentist, Denturist, hygienist, or dental assistant within the scope of his or her license.
- Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.
- Services for the treatment of intentionally self-inflicted injuries.
- 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 which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services provided to correct congenital or developmental malformations of the teeth and supporting structure if primarily for cosmetic reasons.
- Services that are not listed as covered in this Certificate.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations.

- *Athletic Mouth Guard Replacements.* The replacement of an athletic mouth guard is limited to once every 12 months.
- *Alternative Services.* If alternative services can be used to treat a condition, the service recommended by the Participating Provider is covered. If the Enrollee elects a 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 service and the Reasonable Cash Value of the more costly requested service.
- *Congenital Malformations.* Services listed in this Certificate, which are provided to correct congenital or developmental malformations of the teeth and supporting structure, will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
- *Endodontic Retreatment.*
  1. 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 the first 24 months, the applicable Copayments will apply.
  2. 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 services provided by a Dentist in a hospital setting are covered if the following criteria are met:
  1. A hospital or similar setting is medically necessary.
  2. The services are authorized in writing by a Participating Provider.
  3. The services provided are the same services that would be provided in a dental office.
  4. The Hospital Call Copayment and other applicable Copayments are paid.
- *Occlusal Guard Replacements.* The replacement of a lost occlusal guard is covered only once in a 2-year period. Repair or replacement of a broken or damaged occlusal guard is covered as needed.
- *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:
  1. A tooth within an existing denture or bridge is extracted;
  2. The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or

3. The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under the Contract, and replacement by a permanent denture is necessary.

- *Restorations.* Crown, cast, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Participating Provider. A crown, cast, or other indirect fabricated restorations is considered dentally necessary if it is 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.

TERMINATION OF COVERAGE

Termination of Coverage. Coverage for Enrollees will terminate on the earliest of the following:

- On the date of termination of the Contract.
- On the last day of the month for which Premiums are paid, if the Premiums are not received by the due date or at the end of the grace period as specified in the Contract.
- On the last day of the month during which eligibility ends.
- On the last day of the month, following at least 30 days' advance written notice 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.
- If coverage terminates for a Member, it will terminate for Dependents, except in certain circumstances when the Dependent is eligible to continue coverage in accordance with the Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board).

False Statements. False statements or withholding information, with intent to affect eligibility or enrollment, affect the risks assumed by the Company or mislead the Company into providing Benefits it would not have otherwise provided, is a material breach of the Contract. Any ineligible person mistakenly enrolled will not be entitled to Benefits. The Company is entitled to repayment for the Reasonable Cash Value of the Benefits provided in the form of services during the period of ineligibility from the ineligible person and any person responsible for making false statements.

Cessation of Benefits. No person is entitled to Benefits after termination of the Contract. Termination of the Contract completely ends all obligations of the Company to provide Benefits, even if the Enrollee was receiving treatment while the Contract was in force or needs treatment for any existing condition, except as specified otherwise.

Continuation Rights. Coverage may be continued in certain circumstances in accordance with the Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board). The Group agrees to notify all Enrollees of their right to continuation of coverage and administer continuation of coverage in accordance with state and federal laws. For further details, Enrollees should refer to the PEBB Summary Plan Description for detailed information on continuation of coverage.

- *Spouse Continuation Coverage.* A legally separated, divorced, or surviving spouse age 55 or over may elect to continue coverage, in accordance with Oregon law. Eligible children of the spouse may remain covered. For complete information regarding rights under the Spouse Continuation Coverage, please contact the Group.
- *State-Mandated Continuation Coverage.* Coverage may continue in accordance with any state-mandated leave act or law. For complete information regarding rights under the state-mandated continuation of coverage, please contact the Group.
- *COBRA.* Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, certain circumstances, called qualifying events, give Members and some Dependents the right to continue coverage beyond the time it ordinarily would end. Federal law governs COBRA continuation rights and obligations. The Group is responsible for administering COBRA continuation coverage. For complete information regarding rights under COBRA, please contact the Group.

If the Enrollee is eligible for continuation rights and elects to continue coverage, the Enrollee must submit timely payment of Premiums through the Group.

Reinstatement. If coverage terminates because a Member ceases to be eligible, reinstatement may be available in accordance with Oregon Administrative Rules, Chapter 101 (Public Employees' Benefit Board).

Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. Anyone terminated for good cause or failure to make timely payment of Copayments 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 of coverage and the crown or bridge is placed no later than 60 days of termination of coverage.
- *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 of coverage and the removable prosthetic device is delivered no later than 60 days after termination. Laboratory relines are not covered after termination of coverage.
- *Immediate Dentures.* Benefits for dentures may be extended if final impressions are taken prior to termination or coverage and the immediate dentures are delivered no later than 60 days after termination of coverage. If coverage terminates prior to the extraction of teeth, the extractions will not be covered.
- *Root Canal Therapy.* Benefits for root canal therapy will be extended if the root canal is started prior to termination of coverage and treatment is completed no later than 60 days after termination of coverage. Pulpal debridement is not a root canal start. If after 60 days from termination of coverage the root canal requires re-treatment, re-treatment will not be covered. Restorative work following root canal therapy 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 of coverage. 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.

GENERAL PROVISIONS

Dental Emergency.

- Participating Providers will provide treatment for Dental Emergency during office hours. The Company will provide Benefits for covered services provided for treatment of a Dental Emergency provided by Participating Providers. Generally, Enrollees can be seen by a Participating Provider for a Dental Emergency within approximately 24 hours.
- If Participating Providers' offices are closed, an 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 any Dentist 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 provided up to the Out of Area Emergency Reimbursement amount less any Copayment amounts specified in Appendix A – Schedule of Covered Services and Copayments. A written request for reimbursement must be submitted to the Company no later than 6 months of the date of service. The written request should include the Enrollee's signature, the attending Dentist's signature, and the attending Dentist's itemized statement. Additional information, including X-rays and other data, may be requested by the Company to process the request. The Out of Area Emergency Reimbursement will not be provided if the requested information is not received.

Coordination of Benefits.

This Coordination of Benefits (COB) provision applies when a person has dental care 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 benefits for covered services. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with 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. 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.
     1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) 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 and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
     2. Plan does not include: 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.

  Each contract for coverage under (1) or (2) 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.

  b. This Plan means, in this COB provision, the part of the contract providing 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 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.
  c. 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 may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.
  d. 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. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:
     1. 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.
     2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
     3. If a person is covered by 2 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.
     4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
     5. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
  e. Closed Panel Plan is a Plan that provides health 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.

f. 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:
  a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
  b. 1. Except as provided in Paragraph 2, 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.
     2. 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 shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
  c. 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.
  d. Each Plan determines its order of benefits using the first of the following rules that apply:
     1. 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 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, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
     2. Dependent 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 provisions of Subparagraph a) above 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 provisions of 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, the provisions of Subparagraph a) or b) above shall determine the order of benefits as if those individuals were the parents of the child.
        d) For a dependent child:
           (i) 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. applies.

(ii) 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.

3. 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 rule labeled d (1) can determine the order of benefits.
4. COBRA or State 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 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 rule labeled d (1) can determine the order of benefits.
5. 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.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall 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.*
  a. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Covered Service, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Covered Service do not exceed the total Allowable Expense for that Covered Service. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
  b. 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.
- *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 Participating Provider 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 Participating Provider need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Participating Provider any facts it needs to apply those rules and determine benefits payable.
- *Facility of Payment.* A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Participating Provider may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Participating Provider will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the Reasonable Cash Value of the benefits provided in the form of services.
- *Right of Recovery.* If the amount of the payments made by the Participating Provider is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the Reasonable Cash Value of any benefits provided in the form of services.

Subrogation. Benefits may be available for an injury or disease, which is allegedly the liability of a third party. Such services provided by the Participating Provider are solely to assist the Enrollee. By providing Benefits in the form of services, the Participating Provider is not acting as a volunteer and is not waiving any right to reimbursement or subrogation.

- If the Participating Provider provides services for the treatment of an injury or disease, which is allegedly the liability of a third party, it will:
    1. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Benefits provided in the form of services; and
    2. Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Benefits provided in the form of services, subject to the limitations specified in below.
- As a condition of receiving Benefits, the Enrollee shall:
    1. Provide the Participating Provider with the name and address of the parties liable, all facts known concerning the injury, and other information as reasonably requested;
    2. Hold in trust any damage recoveries until the final determination or settlement is made and to execute a trust agreement guaranteeing the Participating Provider's subrogation rights; and
    3. Take all necessary action to seek and obtain recovery to reimburse the Participating Provider.
- After the Enrollee has been fully compensated for the loss, the Participating Provider shall be reimbursed with any amounts received from the third party or third party's insurer(s). The amount shall not exceed the Reasonable Cash Value of the services provided for treatment of the injury or disease.
- The Contract does not provide Benefits for 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.
- The refusal or failure, without good cause, to cooperate with the Company or Participating Provider are grounds for recovery by the Participating Provider from the Enrollee for the Reasonable Cash Value of the Benefits provided in the form of services.

Complaints, Grievances, and Appeals Procedures.

- *Complaints.*
    1. Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider and Participating Provider's staff. Most complaints can be resolved with the Participating Provider and Participating Provider's staff.
    2. If the Enrollee requests a specific service, the Participating Provider will use his or her judgment to determine if the service is dentally necessary. The Participating Provider will recommend the most appropriate course of treatment.
    3. Enrollees may also contact the Member Services Department with questions or complaints.
       Willamette Dental Insurance, Inc.,
       Attn: Member Services
       6950 NE Campus Way
       Hillsboro, OR 97124-5611
       1.855.4DENTAL (1.855.433.6825)
    4. If the Enrollee is unsatisfied after discussing with the Participating Provider, Participating Provider's office staff, or Member Services Department, grievance and appeal procedures are available for complaints pertaining to a denied Benefit or service.
- *Grievances.*
    1. A grievance is a written complaint expressing dissatisfaction with the denial of a requested Benefit or service. The Enrollee should outline his or her concerns and specific request in writing. The Enrollee may submit comments, documents, and other relevant information. Grievances must be submitted to the Member Services Department no later than 180 days after the event occurred.
    2. The Company will review the grievance and all information submitted. The Company will provide a written reply no later than 30 days of the Company's receipt of the grievance. If additional time is needed, the Company will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws. If the Benefit request involves:
        - A preauthorization, the Company will provide a written reply no later than 15 days of the Company's receipt of the grievance.
        - Services deemed experimental or investigational, the Company will provide a written reply no later than 20 working days of the Company's receipt of the grievance.
        - Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours of the Company's receipt of the grievance.
    3. If the grievance is denied, the written reply will include information about the basis for the decision; how to appeal; and other disclosures as required under state and federal laws.

- *Appeals.*
  1. An appeal is the process for requesting reconsideration of a denied grievance. An appeal request must be submitted, in writing, to the Member Services Department no later than 180 days of the date on the written reply to the grievance. The Enrollee should indicate the reason for the appeal and may include written comments, documents, records, or any relevant information.
  2. The Company will review the appeal and all information submitted. The person conducting the appeal review will be someone other than the person who denied the claim and will not be subordinate to that person. The Company will provide a written reply no later than 60 days of the Company's receipt of the appeal. If the appeal involves:
     - A preauthorization, the Company will provide a written reply no later than 30 days after the Company's receipt of the request for an appeal.
     - Services deemed experimental or investigational, the Company will provide a written reply no later than 20 working days after the Company's receipt of the request for an appeal.
     - Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours after the Company's receipt of the request of an appeal.
  3. If the appeal is denied, the written reply will include the basis for the decision and other disclosures as required under state and federal laws.
     Note: The Enrollee also has the right to file a dental coverage complaint with the Oregon Division of Financial Regulation at the following address:
     Consumer Advocacy Unit, Oregon Division of Financial Regulation
     P.O. Box 14480, Salem, OR 97309-0405
     Website: dfr.oregon.gov or E-mail: cp.ins@oregon.gov
     (503) 947-7984 or (888) 877-4894 (toll-free)

Force Majeure. If due to circumstances not within the Company's reasonable control, including but not limited to, major disaster, labor dispute, complete or partial destruction of facilities, disability of a material number of the Participating Providers, or similar causes, the provision of Benefits available under the Contract is delayed or rendered impractical, the Company and its affiliates shall not have any liability or obligation on account of such delay or failure to provide Benefits, except to refund the amount of the unearned advanced Premiums held by the Company on the date such event occurs. The Company is required to make a good-faith effort to provide Benefits, taking into account the impact of the event.

Severability. If any provision of the Contract is deemed invalid or illegal, that provision shall be fully severable and the remaining provisions of the Contract shall continue in full force and effect.

Clerical Error. Clerical error shall not invalidate coverage or extend coverage. Upon discovery of an error, the Premiums, Copayments, and/or fees shall be adjusted. The Company may revise any contractual document issued in error.

Statements. All statements made by applicants, the Group, or an insured person are representations which the Company may rely upon. Statements made for acquiring insurance shall not void the insurance or reduce Benefits, unless contained in a written instrument signed by the Group or the insured person.

APPENDIX A – SCHEDULE OF COVERED SERVICES AND COPAYMENTS

CDT Code	Description	Copayment
1. Office Visit		
	General Office Visit	$10*
	*The General Office Visit Copay is $0 for the first new patient preventive visit for Enrollees who have not previously seen a Participating Provider.	
	Specialist Office Visit	$10
2. Diagnostic and Preventive Services		
D0120	Periodic oral evaluation - established patient	None
D0140	Limited oral evaluation - problem focused	None
D0145	Oral evaluation for patient under 3 years of age and counseling with primary caregiver	None
D0150	Comprehensive oral evaluation - new or established patient	None
D0160	Detailed & extensive oral evaluation - problem focused, by report	None
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	None
D0180	Comprehensive periodontal evaluation - new or established patient	None
D0210	Intraoral - comprehensive series of radiographic images	None
D0220	Intraoral - periapical 1st radiographic image	None
D0230	Intraoral - periapical each additional radiographic image	None
D0240	Intraoral - occlusal radiographic image	None
D0250	Extra-oral - 2D projection radiographic image	None
D0270	Bitewing - single radiographic image	None
D0272	Bitewings - 2 radiographic images	None
D0273	Bitewings - 3 radiographic images	None
D0274	Bitewings - 4 radiographic images	None
D0277	Vertical bitewings - 7 to 8 radiographic images	None
D0330	Panoramic radiographic image	None
D0340	2D Cephalometric radiographic image	None
D0350	2D oral/facial photographic image obtained intraorally or extraorally	None
D0460	Pulp vitality tests	None
D0470	Diagnostic casts	None
D1110	Prophylaxis - adult	None
D1120	Prophylaxis - child	None
D1206	Topical application of fluoride varnish	None
D1310	Nutritional counseling for control of dental disease	None
D1320	Tobacco counseling for the control and prevention of oral disease	None
D1330	Oral hygiene instructions	None
D1351	Sealant - per tooth	None
D1354	Application of caries arresting medicament - per tooth	None
D1355	Caries preventive medicament application - per tooth	None
3. Space Maintainers		
D1510	Space maintainer - fixed - unilateral - per quadrant	None
D1516	Space maintainer - fixed - bilateral, maxillary	None
D1517	Space maintainer - fixed - bilateral, mandibular	None
D1520	Space maintainer - removable - unilateral - per quadrant	None
D1526	Space maintainer - removable - bilateral, maxillary	None
D1527	Space maintainer - removable - bilateral, mandibular	None
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	None
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	None
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	None
D1556	Removal of fixed unilateral space maintainer - per quadrant	None
D1557	Removal of fixed bilateral space maintainer - maxillary	None
D1558	Removal of fixed bilateral space maintainer - mandibular	None

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4. Restorative Services

Code	Description	Fee
D2140	Amalgam - 1 surface, primary or permanent	$20
D2150	Amalgam - 2 surfaces, primary or permanent	$20
D2160	Amalgam - 3 surfaces, primary or permanent	$20
D2161	Amalgam - 4 or more surfaces, primary or permanent	$20
D2330	Resin-based composite - 1 surface ,anterior	$20
D2331	Resin-based composite - 2 surfaces, anterior	$20
D2332	Resin-based composite - 3 surfaces, anterior	$20
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$20
D2390	Resin-based composite crown, anterior	$20
D2391	Resin-based composite - 1 surface, posterior	$20
D2392	Resin-based composite - 2 surfaces, posterior	$20
D2393	Resin-based composite - 3 surfaces, posterior	$20
D2394	Resin-based composite - 4 or more surfaces, posterior	$20
D2510	Inlay - metallic - 1 surface	$250
D2520	Inlay - metallic - 2 surfaces	$250
D2530	Inlay - metallic - 3 or more surfaces	$250
D2542	Onlay - metallic - 2 surfaces	$250
D2543	Onlay - metallic - 3 surfaces	$250
D2544	Onlay - metallic - 4 or more surfaces	$250
D2610	Inlay - porcelain/ceramic - 1 surface	$250
D2620	Inlay - porcelain/ceramic - 2 surfaces	$250
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$250
D2642	Onlay - porcelain/ceramic - 2 surfaces	$250
D2643	Onlay - porcelain/ceramic - 3 surfaces	$250
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$250

5. Crowns

Code	Description	Fee
D2710	Crown - resin-based composite (indirect)	$250
D2740	Crown - porcelain/ceramic	$250
D2750	Crown - porcelain fused to high noble metal	$250
D2780	Crown - ¾ cast high noble metal	$250
D2790	Crown - full cast high noble metal	$250
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	None
D2920	Re-cement or re-bond crown	None
D2928	Prefabricated porcelain / ceramic crown – permanent tooth	None
D2929	Prefabricated porcelain / ceramic crown – primary tooth	None
D2930	Prefabricated stainless steel crown - primary tooth	None
D2931	Prefabricated stainless steel crown - permanent tooth	None
D2932	Prefabricated resin crown	None
D2933	Prefabricated stainless steel crown with resin window	None
D2940	Protective restoration	None
D2950	Core buildup, including any pins when required	None
D2951	Pin retention - per tooth, in addition to restoration	None
D2954	Prefabricated post and core in addition to crown	None
D2955	Post removal	None
D2957	Each additional prefabricated post - same tooth	None
D2975	Coping	None
D2980	Crown repair necessitated by restorative material failure	None

6. Endodontics

Code	Description	Fee
D3110	Pulp cap - direct (excluding final restoration)	None
D3120	Pulp cap - indirect (excluding final restoration)	None
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	None
D3221	Pulpal debridement, primary and permanent teeth	None
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	None
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	None
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$150
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$150

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Code	Description	Copay
D3330	Endodontic therapy, molar (excluding final restoration)	$150
D3331	Treatment of root canal obstruction; non-surgical access	None
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	None
D3333	Internal root repair of perforation defects	None
D3346	Retreatment of previous root canal therapy - anterior	$150
D3347	Retreatment of previous root canal therapy - premolar	$150
D3348	Retreatment of previous root canal therapy - molar	$150
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$150
D3352	Apexification/recalcification - interim medication replacement	None
D3353	Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/ calcific repair of perforations, root resorption, etc.)	None
D3410	Apicoectomy - anterior	$150
D3421	Apicoectomy - premolar (1st root)	$150
D3425	Apicoectomy - molar (1st root)	$150
D3426	Apicoectomy (each additional root)	None
D3430	Retrograde filling - per root	None
D3450	Root amputation - per root	$150
D3471	Surgical repair of root resorption - anterior	$150
D3472	Surgical repair of root resorption - premolar	$150
D3473	Surgical repair of root resorption - molar	$150
D3911	Intraorifice barrier	$20
D3920	Hemisection (including any root removal), not including root canal therapy	$150
D3921	Decoronation or submergence of an erupted tooth	$150
D3950	Canal preparation and fitting of a preformed dowel or post	None

7. Periodontics

Code	Description	Copay
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	None
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	None
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	None
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	None
D4249	Clinical crown lengthening - hard tissue	None
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$190
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$190
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	None
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	None
D4270	Pedicle soft tissue graft procedure	None
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	None
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	None
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	None
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	None
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth or edentulous tooth position in the same graft site	None
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	None
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	None
D4346	Scaling in presences of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	None
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	None
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	None
D4910	Periodontal maintenance	None

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8. Prosthodontics - Removable

Code	Description	Fee
D5110	Complete denture - maxillary	$290
D5120	Complete denture - mandibular	$290
D5130	Immediate denture - maxillary	$290
D5140	Immediate denture - mandibular	$290
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$290
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$290
D5282	Removable unilateral partial denture - 1 piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$290
D5283	Removable unilateral partial denture - 1 piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$290
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	$290
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	$290
D5410	Adjust complete denture - maxillary	None
D5411	Adjust complete denture - mandibular	None
D5421	Adjust partial denture - maxillary	None
D5422	Adjust partial denture - mandibular	None
D5511	Repair broken complete denture base, mandibular	None
D5512	Repair broken complete denture base, maxillary	None
D5520	Replace missing or broken teeth - complete denture (each tooth)	None
D5611	Repair resin partial denture base, mandibular	None
D5612	Repair resin partial denture base, maxillary	None
D5621	Repair cast partial framework, mandibular	None
D5622	Repair cast partial framework, maxillary	None
D5630	Repair or replace broken retentive/clasping materials - per tooth	None
D5640	Replace broken teeth - per tooth	None
D5650	Add tooth to existing partial denture	None
D5660	Add clasp to existing partial denture - per tooth	None
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	None
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	None
D5710	Rebase complete maxillary denture	None
D5711	Rebase complete mandibular denture	None
D5720	Rebase maxillary partial denture	None
D5721	Rebase mandibular partial denture	None
D5730	Reline complete maxillary denture (direct)	None
D5731	Reline complete mandibular denture (direct)	None
D5740	Reline maxillary partial denture (direct)	None
D5741	Reline mandibular partial denture (direct)	None
D5750	Reline complete maxillary denture (indirect)	None
D5751	Reline complete mandibular denture (indirect)	None
D5760	Reline maxillary partial denture (indirect)	None
D5761	Reline mandibular partial denture (indirect)	None
D5765	Soft liner for complete or partial removable denture - indirect	None
D5810	Interim complete denture (maxillary)	$95
D5811	Interim complete denture (mandibular)	$95
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$95
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$95
D5850	Tissue conditioning, maxillary	None
D5851	Tissue conditioning, mandibular	None
D5863	Overdenture – complete maxillary	$290
D5864	Overdenture – partial maxillary	$290
D5865	Overdenture – complete mandibular	$290
D5866	Overdenture – partial mandibular	$290
D5986	Fluoride gel carrier	None

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9. Prosthodontics - Fixed

Code	Description	Copayment
D6210	Pontic - cast high noble metal	$250
D6240	Pontic - porcelain fused to high noble metal	$250
D6241	Pontic - porcelain fused to predominantly base metal	$250
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250
D6720	Retainer crown - resin with high noble metal	$250
D6750	Retainer crown - porcelain fused to high noble metal	$250
D6780	Retainer crown - ¾ cast high noble metal	$250
D6790	Retainer crown - full cast high noble metal	$250
D6930	Re-cement or re-bond fixed partial denture	None
D6980	Fixed partial denture repair necessitated by restorative material failure	None

10. Oral Surgery

Code	Description	Copayment
D7111	Extraction, coronal remnants - primary tooth	None
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	None
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40
D7220	Removal of impacted tooth - soft tissue	$40
D7230	Removal of impacted tooth - partially bony	$40
D7240	Removal of impacted tooth - completely bony	$40
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	$40
D7250	Removal of residual tooth roots (cutting procedure)	$40
D7260	Oroantral fistula closure	$40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$40
D7280	Exposure of an unerupted tooth	$40
D7283	Placement of device to facilitate eruption of impacted tooth	$40
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	None
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	None
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	None
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	None
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$40
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$40
D7471	Removal of lateral exostosis (maxilla or mandible)	$40
D7510	Incision & drainage of abscess - intraoral soft tissue	None
D7520	Incision & drainage of abscess - extraoral soft tissue	None
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	None
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	None
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	None
D7670	Alveolus - closed reduction, may include stabilization of teeth	None
D7910	Suture of recent small wounds up to 5 cm	None
D7911	Complicated suture - up to 5 cm	None
D7953	Bone replacement graft for ridge preservation - per site	$40
D7961	Buccal/labial frenectomy (frenulectomy)	$40
D7970	Excision of hyperplastic tissue - per arch	$40
D7971	Excision of pericoronal gingiva	$40

11. Anesthesia

Code	Description	Copayment
D9223	Deep sedation/general anesthesia	Not covered
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	None

12. Miscellaneous

Code	Description	Copayment
D9110	Palliative treatment of dental pain – per visit	None
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	None
D9420	Hospital or ambulatory surgical center call (Service Copayments still apply and facility fees not covered.)	$125
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	None
D9440	Office visit - after regularly scheduled hours	None
D9910	Application of desensitizing medicament	None
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	None

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Code	Description	Copayment
D9941	Fabrication of athletic mouth guard	$100
D9942	Repair and/or reline of occlusal guard	None
D9944	Occlusal guard – hard appliance, full arch	None
D9945	Occlusal guard – soft appliance, full arch	None
D9946	Occlusal guard – hard appliance, partial arch	None
D9951	Occlusal adjustment - limited	None
D9952	Occlusal adjustment - complete	None
D9970	Enamel microabrasion	None
	Out-of-service area emergency reimbursement	Enrollee is reimbursed up to $150

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APPENDIX B – ORTHODONTIC TREATMENT

- **General Provisions.**
  1. Orthodontic treatment is provided only if the Participating Provider prepares the treatment plan prior to starting orthodontic treatment. The treatment plan is based on an examination that must take place while the Enrollee is covered under the Contract. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.
  2. The Enrollee must remain covered under the Contract for the entire length of treatment. The Enrollee must follow the post-treatment plan and keep all appointments after the Enrollee is de-banded to avoid additional Copayments.
  3. For orthodontic treatment started prior to the effective date of coverage, Copayments may be adjusted based upon the services necessary to complete the treatment.
  4. 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 billed at the Reasonable Cash Value.
  5. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services provided. The Pre-Orthodontic Service Copayments will be deducted from the Comprehensive Orthodontic Service Copayment if the Enrollee accepts the treatment plan.
  6. The General Office Visit Copayment listed in Appendix A – Schedule of Covered Services and Copayments is charged at each visit for orthodontic treatment. Services connected with orthodontic treatment are subject to the Copayments listed in Appendix A – Schedule of Covered Services and Copayments. All Copayments must be paid in full at the time of service.

- **Pre-Orthodontic Service Copayments.**

Initial orthodontic exam:	$25
Study models and X-rays:	$125
Case presentation:	$0

- **Orthodontic Service Copayment.** The Orthodontic Service Copayment must be paid in full prior to commencement of orthodontic treatment.

Comprehensive Orthodontic Service Copayment:	$2,500 per case

The following procedures are provided under the Benefits for orthodontic services:
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

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APPENDIX C – IMPLANT SERVICES

- **Benefits.**
  a. The dental implant services described in this Appendix C are covered for Enrollees if all of the following requirements are met:
     1) A Participating Provider determines that dental implants are dentally appropriate for the Enrollee.
     2) A Participating Provider prepares the treatment plan for dental implants prior to initiating any implant treatment.
     3) All dental implant services are provided by a Participating Provider or under a referral from a Participating Provider.
     4) The Enrollee follows the treatment plan prescribed by the Participating Provider.
     5) The Enrollee makes payment of amounts due.
     6) The dental implant service is listed as covered in this Appendix C and is not otherwise limited or excluded.

  b. **Services After Termination of Benefits.** 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.

  c. **Dental Implant Surgery.** The following dental implant services are covered at 100%, **up to an annual dental implant benefit maximum of $1,500 per calendar year**. The annual dental implant benefit maximum is the maximum dollar amount the Contract will cover for benefits for the below dental implant services in a calendar year.

CDT Code and Procedure Description
D6010 Surgical placement of implant body: endosteal implant
D6011 Second stage implant surgery

- **Limitations.** The benefit for dental implants is subject to the following limitations:
  a. Benefits for surgical placement of a dental implant are limited to 1 implant per calendar year.
  b. 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.

- **Exclusions.** The following services are not covered under this benefit for dental implants:
  a. Any dental implant services and related services that are not listed as covered on this Appendix C.
  b. Bone grafting.
  c. Cone beam CT X-rays and tomographic surveys.
  d. Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
  e. A dental implant surgically placed prior to the Enrollee's effective date of coverage under the Contract that has not received final restoration.
  f. Eposteal, transosteal, endodontic endosseous, or mini dental implants.
  g. Maintenance, repair, replacement, or completion of an existing implant started or placed by a Non-Participating Provider without a referral from a Participating Provider.
  h. Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the effective date of coverage under the Contract.
  i. Treatment of a primary or transitional dentition.

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