Willamette
Dental Group

GROUP DENTAL CERTIFICATE OF COVERAGE

Policyholder Name: State Accident Insurance Fund dba SAIF Corporation

Effective Date: January 1, 2020

Group Number: OR223

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 Covered Services and other provisions of the Contract, please refer to the Contract on file with the Policyholder. If any information in this Certificate is inconsistent with the provisions of the Contract, the Certificate shall control.

Underwritten by Willamette Dental Insurance, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611

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Section 1 Definitions

1.1 **"Child"** means a child of the Member (or Member's spouse or Member's domestic partner). Child includes a natural child; stepchild; adopted child; child for whom the Member (or Member's spouse or Member's domestic partner) has assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child; or child by virtue of court-appointed legal guardianship. "Placed" means the assumption by the Member of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Child also includes a child for whom the Member (or Member's spouse or Member's domestic partner) is required to provide dental coverage by a legal qualified medical child support order (QMCSO).

1.2 **"Company"** means Willamette Dental Insurance, Inc.

1.3 **"Contract"** means the agreement between the Company and the Policyholder. The Contract, including the Application for Group Dental Coverage, appendices, amendments, and endorsements, if any, is the entire contract between the parties.

1.4 **"Copayment"** means the fixed dollar amount that is the Enrollee's responsibility to pay under the Contract for each office visit or Covered Service. All Copayments are due at the time of visit or service.

1.5 **"Covered Service"** means a dental service listed as covered in this Certificate for which benefits are provided to Enrollees.

1.6 **"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).

1.7 **"Dentist"** means a person licensed to practice dentistry in the state where treatment is provided.

1.8 **"Denturist"** means a person licensed to engage in the practice of denture technology in the state where treatment is provided.

1.9 **"Dependent"** means a spouse, domestic partner, or Child, who is eligible and enrolled for coverage.

1.10 **"Enrollee"** means a Member or a Dependent.

1.11 **"Experimental or Investigational"** means a service that is determined to be experimental or investigational. In determining whether services are Experimental or Investigational, the Company will consider the following:

a. Whether the services are in general use in the dental community in the state of Oregon;
b. Whether the services are under continued scientific testing and research;
c. Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
d. Whether the services are proven safe and effective.

1.12 **"General Office Visit Copayment"** means the Copayment the Enrollee must pay for each visit for emergency, general, or orthodontic treatment.

1.13 **"Member"** means an employee of the Policyholder, who is eligible and enrolled for coverage.

1.14 **"Non-Participating Provider"** means a Dentist or Denturist who is not a Participating Provider.

1.15 **"Participating Provider"** means Willamette Dental Group, P.C., and the Dentists and Denturists who are employees of Willamette Dental Group, P.C. The Participating Provider contracts with the Company to provide Covered Services to Enrollees. The Participating Provider agrees to charge Enrollees only the Copayments specified in the Contract for Covered Services.

1.16 **"Policyholder"** means State Accident Insurance Fund dba SAIF Corporation, the legal entity that the Contract is issued to.

1.17 **"Premium"** means the monthly payment the Policyholder must submit to the Company, including any Enrollee contributions, for coverage of each Enrollee.

1.18 **"Reasonable Cash Value"** means the Participating Provider's usual and customary fee-for-service price of services.

1.19 **"Retired Member"** means a former employee of the Policyholder who has retired from the Policyholder and is eligible and enrolled for coverage.

1.20 **"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.

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

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

Section 2 Eligibility and Enrollment

2.1 **Eligible Employees**. Employees must work a minimum of 20 hours each week to be eligible for coverage. Employees become eligible for coverage on the date of hire for continuous employment. Retired employees who are rehired in a temporary status and are not enrolled in a Policyholder's retirement dental plan are eligible for coverage if the employee works a minimum of 20 hours each week and works a minimum of 90 days.

2.2 **Eligible Family Members**. The Policyholder or Company may require proof of eligibility periodically.

2.2.1 The spouse, state-registered domestic partner, or qualifying unregistered domestic partner of the Member is eligible for coverage as a Dependent. To qualify as a domestic partner, the partnership must satisfy the following criteria:

1. The Member and the domestic partner are both at least 18 years of age;
2. The Member and the domestic partner are responsible for each other's welfare and are each other's sole domestic partners;
3. The Member and the domestic partner are not married to anyone and have not had another domestic partner within the prior 6 months;
4. The Member and the domestic partner share a close personal relationship and are not related by blood closer than a first cousin or nearer;
5. The Member and the domestic partner have jointly shared the same regular and permanent residence with the current intention of doing so indefinitely;
6. The Member and the domestic partner are jointly financially responsible for basic living expenses such as food and shelter;
7. The Member and the domestic partner provide the documentation required by the Policyholder to establish that a domestic partnership exists; and
8. The Member and the domestic partner must have been mentally competent to consent to contract when the domestic partnership began.

2.2.2 A Child is eligible for coverage as a Dependent to age 26.

2.2.3 A Child is eligible as a Dependent beyond the limiting age if all of the following conditions are met.

1. The Child is and continues to be incapable of self-sustaining employment due to a developmental disability or physical handicap.
2. The Child is and continues to be chiefly dependent upon the Member (or Member's spouse or Member's domestic partner) for support and maintenance.
3. The Company receives proof of disability or handicap within 31 days after the Child's attainment of the limiting age. The Company may request proof annually.

2.3 **Initial Enrollment Period.** The eligible employee must submit an enrollment application to the Policyholder for himself/herself and any eligible persons to be covered within 31 days after attaining initial eligibility. Coverage begins on the date the eligible employee attains initial eligibility. Eligible employees and their eligible family members who do not enroll during the initial enrollment period may enroll only during an open enrollment period or a special enrollment period.

2.4 Open Enrollment Period. Eligible employees and their eligible family members may enroll during the open enrollment period by submitting an enrollment application to the Policyholder. Coverage will begin on the anniversary date of the Contract.

2.5 Special Enrollment Period. A special enrollment period is granted for employees and their eligible family members after the triggering events described below.

2.5.1 Birth or Adoption. A newborn Child may be enrolled following the birth and an adopted Child may be enrolled upon placement for adoption. If additional Premium is required, the additional Premium must be paid within 60 days after the eligible Child's birth for newborn Children or 60 days after the date of placement for adoption or following assumption of a legal obligation for the Child's support for an adopted Child. To ensure timely provision of services, an enrollment application should be submitted to complete the enrollment of a newborn Child or adopted Child even if additional Premium is not required. Coverage will begin on the newborn Child's date of birth or on the adopted Child's date of placement for adoption or assumption of a legal obligation for the Child's support in anticipation of adoption of the Child.

2.5.2 Newly Acquired Family Members. Eligible employees and their newly acquired family members may enroll following marriage or registration of a domestic partnership; court appointed legal guardianship of a Child; or issuance of a QMCSO by submitting an enrollment application and the applicable Premium to the Policyholder no later than 30 days after the event. Eligible employees or eligible family members may enroll if he/she becomes newly eligible for premium assistance under Children's Health Insurance Program (CHIP) or Medicaid by submitting an enrollment application and the applicable Premium to the Policyholder no later than 60 days after the determination for eligibility of premium assistance. Coverage will begin on the first day of the month after receipt of the enrollment application.

2.5.3 Loss of Coverage. Eligible employees or their eligible family members may enroll following the loss of coverage under another dental plan. Reasons for the loss of coverage may include exhaustion of COBRA continuation coverage, loss of eligibility (including as a result of legal separation, divorce, dissolution of domestic partnership, death, termination of employment, or reduction in the number of hours of employment), termination of premium assistance under CHIP or Medicaid, or reduction in employer contribution towards coverage. An enrollment application must be submitted no later than 60 days after the loss of coverage or no later than 30 days if the loss of coverage was CHIP or Medicaid. Coverage will begin on the first day of the month after receipt of the enrollment application.

2.6 Retired Members.

2.6.1 Eligibility for Retired Members. Employees under age 65 who retire from the Policyholder and apply for Public Employee Retirement System (PERS) benefits within 60 days of the date of retirement are eligible for coverage as Retired Members.

2.6.2 Eligibility for Dependents of a Retired Member. The Retired Member's spouse, state-registered domestic partner, or qualifying unregistered domestic partner meeting the criteria in Section 2.2.1 are eligible for coverage as a Dependent of a Retired Member if

the spouse, state-registered domestic partner, or unregistered domestic partner is under the age of 65, ineligible for Medicare, and enrolls within 60 days of the Retired Member's date of retirement. The Retired Member's, spouse's or eligible domestic partner's Child under the age of 26 is eligible for coverage as a Dependent of a Retired Member if the Child enrolls within 60 days of the Retired Member's date of retirement.

2.6.3 When Retiree Coverage is Effective. Coverage for a Retired Member and/or his or her eligible family members will begin on the first day of the month following election and enrollment. A Retired Member and his or her Dependents who voluntarily terminate coverage may not re-enroll.

2.6.4 When Retiree Eligibility Ends.

a. Eligibility for a Retired Member will end on the last day of the month following the earlier of the following events:
   1. Reaches age 65; or
   2. Becomes eligible for Medicare;
   3. Voluntarily terminates enrollment for him or herself and any Dependents.

b. Eligibility for a spouse or domestic partner of a Retired Member will end on the last day of the month following the earlier of the following events:
   1. Reaches age 65;
   2. Becomes eligible for Medicare;
   3. A decree of divorce is final (may then be eligible for COBRA continuation or state continuation); or
   4. He or she voluntarily terminates enrollment, either individually or through the Retired Member.

c. Eligibility for a Child of a Retired Member will end on the last day of the month following the earlier of the following events:
   1. Reaches the limiting age for Children described in Section 2.2.2; or
   2. Voluntarily terminates enrollment, either individually or through the Retired Member.

Section 3 Premium

3.1 **Payment of Premium.** The payment of the Premium for each Enrollee is due on the first day of each month. The payment of the Premium must be submitted to the Company for all Enrollees in a single lump sum. A 30-day grace period is granted for payment of the Premium. If the Premium remains unpaid at the end of the grace period, the Company is released from all further obligations under the Contract. Only Enrollees for whom the Premium has been paid are entitled to Covered Services.

3.2 **Payment of Premium when Coverage is Continued.** If the Enrollee is eligible for continuation rights and elects to continue coverage, the Enrollee must submit timely payment of the Premium through the Policyholder.

3.3 **Return of Advance Payment of Premium.** The Company will refund to the Policyholder any advanced Premium payments paid for coverage after the termination of the Contract. The Policyholder must promptly notify all Enrollees of the termination of the Contract. The Participating Provider is entitled to payment of the Reasonable Cash Value of the services provided if an Enrollee receives benefits after the date of termination or for any period for which the Premium is unpaid.

Section 4 Dental Coverage

4.1 Agreement to Provide Covered Services. The Company agrees to provide benefits for prescribed Covered Services listed as covered in the appendices. Covered Services must be provided by a Participating Provider, except as specified otherwise. All Covered Services are expressly subject to the Copayments, exclusions, limitations, and all other provisions of the Contract.

4.2 Referrals. The Participating Provider may refer Enrollees to a Specialist or Non-Participating Provider for Covered Services. The Company agrees to provide benefits for Covered Services provided by a Specialist or Non-Participating Provider only if:

a. The Participating Provider refers the Enrollee;
b. The Covered Services are specifically authorized by the Participating Provider's referral; and
c. The Covered Services are listed as covered in the appendices and are not otherwise limited or excluded.

4.3 Dental Emergency.

4.3.1 Participating Providers will provide treatment for Dental Emergencies during office hours. The Company will provide benefits for Covered Services provided by Participating Providers for treatment of a Dental Emergency. If the Participating Providers' 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.

4.3.2 The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is 50 miles or more from any Participating Provider office. The Company will reimburse the Enrollee up to the out of area emergency reimbursement amount less any Copayments for the cost of the Covered Services. The Enrollee must submit a written request for reimbursement to the Company no later than 6 months after 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 by the Company to process the request. The benefit for out of area Dental Emergency treatment will not be provided if the requested information is not received.

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

4.5 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.

4.5.1 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 subsection 4.5.1.a.1. or 4.5.1.a.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.

4.5.2 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 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 subsection 4.5.2.d.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 subsection 4.5.2.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 subsection 4.5.2.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.

4.5.3 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.

4.5.4 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.

4.5.5 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.

4.5.6 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.

Section 5 Exclusions and Limitations

5.1 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 Participating Provider.

5.1.1 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.

5.1.2 The completion or delivery of treatments or services initiated prior to the effective date of coverage under the Contract, including the following:

a. Endodontic services and prosthetic services;
b. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under the Contract; or
c. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under the Contract.

Such services are the liability of the Enrollee, prior dental plan, and provider.

5.1.3 Endodontic therapy completed more than 60 days after termination of coverage.

5.1.4 Exams or consultations needed solely in connection with a service that is not covered.

5.1.5 Experimental or Investigational services and related exams or consultations.

5.1.6 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.

5.1.7 General anesthesia or moderate sedation.

5.1.8 Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees, except as covered under Section 5.2.5.

5.1.9 Nightguards.

5.1.10 Orthognathic surgery.

5.1.11 Personalized restorations.

5.1.12 Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.

5.1.13 Prescription and over-the-counter drugs and pre-medications.

5.1.14 Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.

5.1.15 Replacement of dental appliances that are damaged due to abuse, misuse, or neglect.

5.1.16 Replacement of lost, missing, or stolen dental appliances.

5.1.17 Replacement of sound restorations.

5.1.18 Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by the Participating Provider.

5.1.19 Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.

5.1.20 Services by any person other than a Dentist, Denturist, hygienist, or dental assistant within the scope of his or her license.

5.1.21 Services for the diagnosis or treatment of temporomandibular joint disorders.

5.1.22 Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.

5.1.23 Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.

5.1.24 Services for the treatment of intentionally self-inflicted injuries.

5.1.25 Services for which coverage is available under any federal, state, or other governmental program, unless required by law.

5.1.26 Services that are not listed as covered in the appendices.

5.1.27 Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

5.2 Limitations.

5.2.1 Alternate 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.

5.2.2 Congenital Malformations. Services listed in Appendix A 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.

5.2.3 Crown, cast, or other indirect fabricated restorations are covered only if dentally necessary or if recommended by the Participating Provider. Dentally necessary means 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.

5.2.4 Endodontic Retreatment.

a. When 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 as identified in Appendix A.
b. 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 identified in Appendix A.

5.2.5 Hospital Setting. The services provided by a Dentist in a hospital setting are covered if the following criteria are met:

a. A hospital or similar setting is medically necessary;
b. The services are authorized in writing by the Participating Provider;
c. The services provided are the same services that would be provided in a dental office; and
d. The applicable Copayments as specified in Appendix A are paid.

5.2.6 Replacements. The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary due to one of the following conditions:

a. A tooth within an existing denture or bridge is extracted;
b. The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or
c. 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.

Section 6 Termination

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

6.1.1 On the date the Contract is terminated.

6.1.2 On the last day of the month for which the Premium is paid, if the Premium is not received at the end of the grace period as specified in Section 3.

6.1.3 On the last day of the month during which eligibility ends.

6.1.4 On the last day of the month with 30 days' prior written notice to the Enrollee 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 the Participating Provider, threats or abuse towards a Participating Provider, office staff, or other patients, or nonpayment of Copayments.

6.1.5 If coverage terminates for the Member, it will terminate for the Dependents covered under the Member.

6.2 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 Covered Services it would not have otherwise provided, is a material breach of the Contract. Any ineligible person mistakenly enrolled will not be entitled to Covered Services. The Company is entitled to repayment for the Reasonable Cash Value of the Covered Services provided during the period of ineligibility from the ineligible person and any person responsible for making false statements.

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

6.4 Continuation Rights. The Policyholder agrees to notify all Enrollees of their rights to continuation of coverage and administer continuation of coverage in accordance with state and federal laws. For more information regarding continuation rights, Enrollees should contact the Policyholder.

6.4.1 Leave of Absence. Coverage may be continued during a temporary, employer approved leave of absence for up to 3 months. For more information regarding coverage during a leave of absence, please contact the Policyholder.

6.4.2 Federal or State-Mandated Continuation Coverage. Coverage for Enrollees may continue during a leave of absence taken in accordance with applicable federal or state-mandated leave or continuation of coverage laws. This includes, but is not limited to continuation of coverage for a legally separated, divorced, or surviving spouse age 55 or over and any eligible Children whose coverage under the Contract otherwise would terminate due to the legal separation, divorce, or death, as required under Oregon state

law. For more information regarding state-mandated continuation coverage, please contact the Policyholder.

6.4.3 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 Policyholder is responsible for administering COBRA continuation coverage. For more information regarding COBRA, please contact the Policyholder.

6.4.4 Labor Disputes. If a Member's compensation is suspended or terminated as the result of a strike, lockout, or other labor dispute, coverage may continue for up to 6 months if the Member pays the Premium to the Policyholder as it becomes due, including the Policyholder's portion, if any. The Policyholder shall notify the Member in writing of the right to continue coverage. The Premium rates during a work stoppage are equal to the Premium rates in place before the work stoppage. The Company may change the Premium rates according to the provisions of the Contract. Coverage will terminate on the earliest of the following events:

a. The last day of the month for which the Premium is paid, if the Premium is unpaid at the end of the grace period.
b. The last day of the 6th month, following the date the work stoppage began.
c. The last day of the month after the Member begins full-time employment with another employer.
d. The date of termination of the Contract.

6.4.5 If coverage ends because continuation rights expire, coverage may reinstate pursuant to applicable federal or state law, if the Member satisfies the applicable eligibility and enrollment requirements.

6.5 Reinstatement. The probationary period is waived for employees who are rehired no later than 9 months after employment terminates. The probationary period is waived for Members who become ineligible for coverage due to a reduction of work hours, if the employee becomes eligible again no later than 9 months after the date coverage was terminated. Coverage will begin on the date of re-hire or re-eligibility for coverage. Coverage for retired employees who are rehired in a temporary status will begin on the date of re-hire.

6.6 Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. Enrollees who are terminated for good cause or failure to pay the Premium are not eligible for an extension of benefits.

6.6.1 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 no later than 60 days after termination.

6.6.2 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 no later than 60 days after termination. Laboratory relines are not covered after termination.

6.6.3 Immediate Dentures. The delivery of immediate dentures will be covered if final impressions are taken prior to termination and the immediate dentures are delivered no later than 60 days after termination. If coverage terminates prior to the extraction of teeth, the extractions will not be covered.

6.6.4 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 no later than 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, retreatment will not be covered. Restorative work following root canal therapy is a separate procedure and not covered after termination.

6.6.5 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.

Section 7 General Provisions

7.1 Subrogation. Covered Services for the diagnosis or treatment of an injury or disease, which is possibly caused by a third party, are provided solely to assist the Enrollee. By providing Covered Services, the Company and the Participating Provider are not acting as volunteers and are not waiving any right to reimbursement or subrogation.

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

a. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Covered Services provided; and
b. 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.

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

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

7.1.3 The Enrollee is entitled to be fully compensated for the loss. After the Enrollee has been fully compensated for the loss, the Company 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.

7.1.4 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.

7.2 Complaints, Grievances, and Appeals.

7.2.1 Complaints.

a. 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.
b. If the Enrollee requests a specific service, the Participating Provider will use his/her judgment to determine if the service is dentally necessary. The Participating Provider will recommend the most appropriate course of treatment.

c. 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)

d. If the Enrollee is unsatisfied after discussing with the Participating Provider, Participating Provider's staff, or Member Services Department, grievance and appeal procedures are available.

7.2.2 Grievances.

a. A grievance is a written complaint expressing dissatisfaction with a service provided by the Company or other matters related to the Contract. The Enrollee should outline his/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.

b. The Company will review the grievance and all information submitted. The Company will provide a written reply no later than 30 days after receipt. 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 grievance involves:
   1. A preauthorization, the Company will provide a written reply no later than 15 days after the receipt of a written grievance.
   2. Services deemed Experimental or Investigational, the Company will provide a written reply no later than 20 working days after the receipt of a written grievance.
   3. Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours of the receipt of a written grievance.

c. 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.

7.2.3 Appeals.

a. An appeal is a request for review of a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. Appeal request must be submitted in writing to the Member Services Department no later than 180 days after the date of the denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. The Enrollee should indicate the reason for the appeal and may include written comments, documents, records, or any relevant information.

b. The Company will review the appeal and all information submitted. The Company will provide a written reply no later than 60 days after the receipt of a written request for an appeal. If the appeal involves:
   1. A preauthorization, the Company will provide a written reply no later than 30 days after the receipt of a written request for an appeal.
   2. Services deemed Experimental or Investigational, the Company will provide a written reply no later than 20 working days after the receipt of a written request for an appeal.

3. Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours after the receipt of a written request for an appeal.

c. 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.

7.2.4 Authorized Representative. Enrollees may authorize another person to represent the Enrollee and to whom the Company can communicate regarding a specific grievance or 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 by the Company, the grievance or appeal will be closed.

7.3 Rights Not Transferable. The benefits of the Contract are not transferable.

7.4 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.

7.5 State Law and Forum. The Contract is entered into and delivered in the State of Oregon. Oregon law will govern the interpretation of provisions of the Contract unless federal law supersedes.

7.6 Waiver and Severability. If the Company does not enforce a provision of the Contract, it will not constitute a waiver of that or any other provision at any time in the future. If any provision of the Contract is declared unenforceable by a court having jurisdiction, the provision is ineffective only to the extent declared unenforceable. The remainder of the provision and all other provisions of the Contract shall continue in full force and effect.

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

7.8 Statements. All statements made by applicants, the Policyholder 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 Policyholder or the insured person.

Appendix A - Schedule of Covered Services and Copayments

Office Visit Copayments

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

Code	Procedure	Enrollee Pays
1. Diagnostic and Preventive Services		
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 & 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
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	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	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cement or re-bond of space maintainer	$0
D1555	Removal of fixed space maintainer	$0

2. Restorative Services

D2140	Amalgam - 1 surface, primary or permanent	$0
D2150	Amalgam - 2 surfaces, primary or permanent	$0
D2160	Amalgam - 3 surfaces, primary or permanent	$0
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0
D2330	Resin - based composite - 1 surface, anterior	$0
D2331	Resin - based composite - 2 surfaces, anterior	$0
D2332	Resin - based composite - 3 surfaces, anterior	$0
D2335	Resin - based composite - 4 or more surfaces involving incisal angle (anterior)	$0
D2390	Resin - based composite crown, anterior	$0
D2391	Resin - based composite - 1 surface, posterior	$0
D2392	Resin - based composite - 2 surfaces, posterior	$0
D2393	Resin - based composite - 3 surfaces, posterior	$0
D2394	Resin - based composite - 4 or more surfaces, posterior	$0
D2510	Inlay – metallic – 1 surface	$0
D2520	Inlay - metallic - 2 surfaces	$0
D2530	Inlay - metallic - 3 or more surfaces	$0
D2542	Onlay - metallic - 2 surfaces	$0
D2543	Onlay - metallic - 3 surfaces	$0
D2544	Onlay - metallic - 4 or more surfaces	$0
D2610	Inlay - porcelain/ceramic - 1 surface	$0
D2620	Inlay - porcelain/ceramic - 2 surfaces	$0
D2630	Inlay - porcelain/ceramic - 3 surfaces	$0
D2642	Onlay - porcelain/ceramic - 2 surfaces	$0
D2643	Onlay - porcelain/ceramic - 3 surfaces	$0
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$0

3. Crowns

D2710	Crown - resin based composite (indirect)	$0
D2740	Crown - porcelain/ceramic	$0
D2750	Crown - porcelain fused to high noble metal	$0
D2782	Crown - ¾ cast noble metal	$0
D2792	Crown - full cast noble metal	$0
D2910	Re-cement or re-bond inlay, onlay, or partial coverage restoration	$0
D2920	Re-cement or re-bond crown	$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
D2940	Protective 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
D2970	Temporary crown (fractured tooth)	$0
D2975	Coping	$0
D2980	Crown repair necessitated by restorative material failure	$0

4. 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
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)	$0
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$0
D3330	Endodontic therapy, molar (excluding final restoration)	$0
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	$0
D3347	Retreatment of previous root canal therapy - premolar	$0
D3348	Retreatment of previous root canal therapy - molar	$0
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
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
D3410	Apicoectomy - anterior	$0
D3421	Apicoectomy - premolar (first root)	$0
D3425	Apicoectomy - molar (first root)	$0
D3426	Apicoectomy - (each additional root)	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$0
D3950	Canal preparation and fitting of a preformed dowel or post	$0

5. Periodontics

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4240	Gingival flap procedures, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4249	Clinical crown lengthening – hard tissue	$0
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$0
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$0

D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	$0
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	$0
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	$0
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	$0
D4341	Periodontic scaling and root planing - 4 or more teeth per quadrant	$0
D4342	Periodontic scaling and root planing - 1 to 3 teeth per quadrant	$0
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0
D4910	Periodontic maintenance	$0

6. Prosthodontics - Removable

D5110	Complete denture - maxillary	$0
D5120	Complete denture - mandibular	$0
D5130	Immediate denture - maxillary	$0
D5140	Immediate denture - mandibular	$0
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$0
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$0
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 clasp - per tooth	$0
D5640	Replace broken teeth - per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture - per tooth	$0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0
D5710	Rebase complete maxillary denture	$0
D5711	Rebase complete mandibular denture	$0

D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline complete maxillary denture (chairside)	$0
D5731	Reline complete mandibular denture (chairside)	$0
D5740	Reline maxillary partial denture (chairside)	$0
D5741	Reline mandibular partial denture (chairside)	$0
D5750	Reline complete maxillary denture (laboratory)	$0
D5751	Reline complete mandibular denture (laboratory)	$0
D5760	Reline maxillary partial denture (laboratory)	$0
D5761	Reline mandibular partial denture (laboratory)	$0
D5810	Interim complete denture (maxillary)	$0
D5811	Interim complete denture (mandibular)	$0
D5820	Interim partial denture (maxillary)	$0
D5821	Interim partial denture (mandibular)	$0
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D5863	Overdenture – complete maxillary	$0
D5864	Overdenture – partial maxillary	$0
D5865	Overdenture – complete mandibular	$0
D5866	Overdenture – partial mandibular	$0
D5986	Fluoride gel carrier	$0

7. Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$0
D6240	Pontic - porcelain fused to high noble metal	$0
D6241	Pontic - porcelain fused to predominantly base metal	$0
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$0
D6720	Retainer crown - resin with high noble metal	$0
D6750	Retainer crown - porcelain fused to high noble metal	$0
D6780	Retainer crown - ¾ cast high noble metal	$0
D6790	Retainer crown - full cast high noble metal	$0
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

8. 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	$0
D7220	Removal of impacted tooth - soft tissue	$0
D7230	Removal of impacted tooth - partially bony	$0
D7240	Removal of impacted tooth - completely bony	$0
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$0
D7250	Removal of residual tooth roots (cutting procedure)	$0
D7260	Oroantral fistula closure	$0
D7261	Primary closure of a sinus perforation	$0
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$0
D7280	Exposure of an unerupted tooth	$0
D7283	Placement of device to facilitate eruption of impacted tooth	$0

D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$0
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$0
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	$0
D7510	Incision & drainage of abscess - intraoral soft tissue	$0
D7520	Incision & drainage of abscess - extraoral soft tissue	$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	$0
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another	$0
D7970	Excision of hyperplastic tissue - per arch	$0
D7971	Excision of pericoronal gingiva	$0

9. Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$40
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9420	Hospital or ambulatory surgical center call	$125
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9910	Application of desensitizing medicament	$0
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$0
D9951	Occlusal adjustment - limited	$0
D9970	Enamel microabrasion	$0
	Out of Area Emergency Reimbursement (The Enrollee is reimbursed up to $100 per visit.)	All charges in excess of $100

Appendix B - Orthodontic Treatment

1. General Provisions.

a. Orthodontic treatment is covered only if the Participating Provider prepares the treatment plan prior to starting 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.

b. 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.

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

d. The Copayment may be prorated if coverage terminates prior to completion of treatment. The services necessary to complete treatment are based on the Reasonable Cash Value after coverage terminates.

e. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services. The Pre-Orthodontic Service Copayments are credited towards the Orthodontic Service Copayment due if the Enrollee accepts the treatment plan. The Copayment for limited orthodontic treatment may be prorated based on the treatment plan.

f. The General Office Visit Copayment listed in Appendix A is charged at each visit for orthodontic treatment. Services provided in connection with orthodontic treatment are subject to the Service Copayments listed in Appendix A.

2. Pre-Orthodontic Service Copayment.

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

3. Orthodontic Service Copayment.

Comprehensive Orthodontic Service Copayment: $2,000
The following orthodontic procedures are Covered Services under this benefit:
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8060 Interceptive orthodontic treatment of the transitional 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

Appendix C - Dental Implants

1. 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**. 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

2. 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.

3. 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.