CERTIFICATE OF COVERAGE

Oregon Educators Benefit Board
Effective: October 1, 2019

Willamette Dental Insurance, Inc.
Form No. OEBB2019COC

oebb

Willamette Dental Group

Welcome to Willamette Dental Group!

Please utilize the following contact information for questions or assistance. Members who wish to schedule an appointment may do so by contacting our Appointment Center. Willamette Dental Group has a full staff of member service representatives who will answer any question that you may have about your dental plan or service.

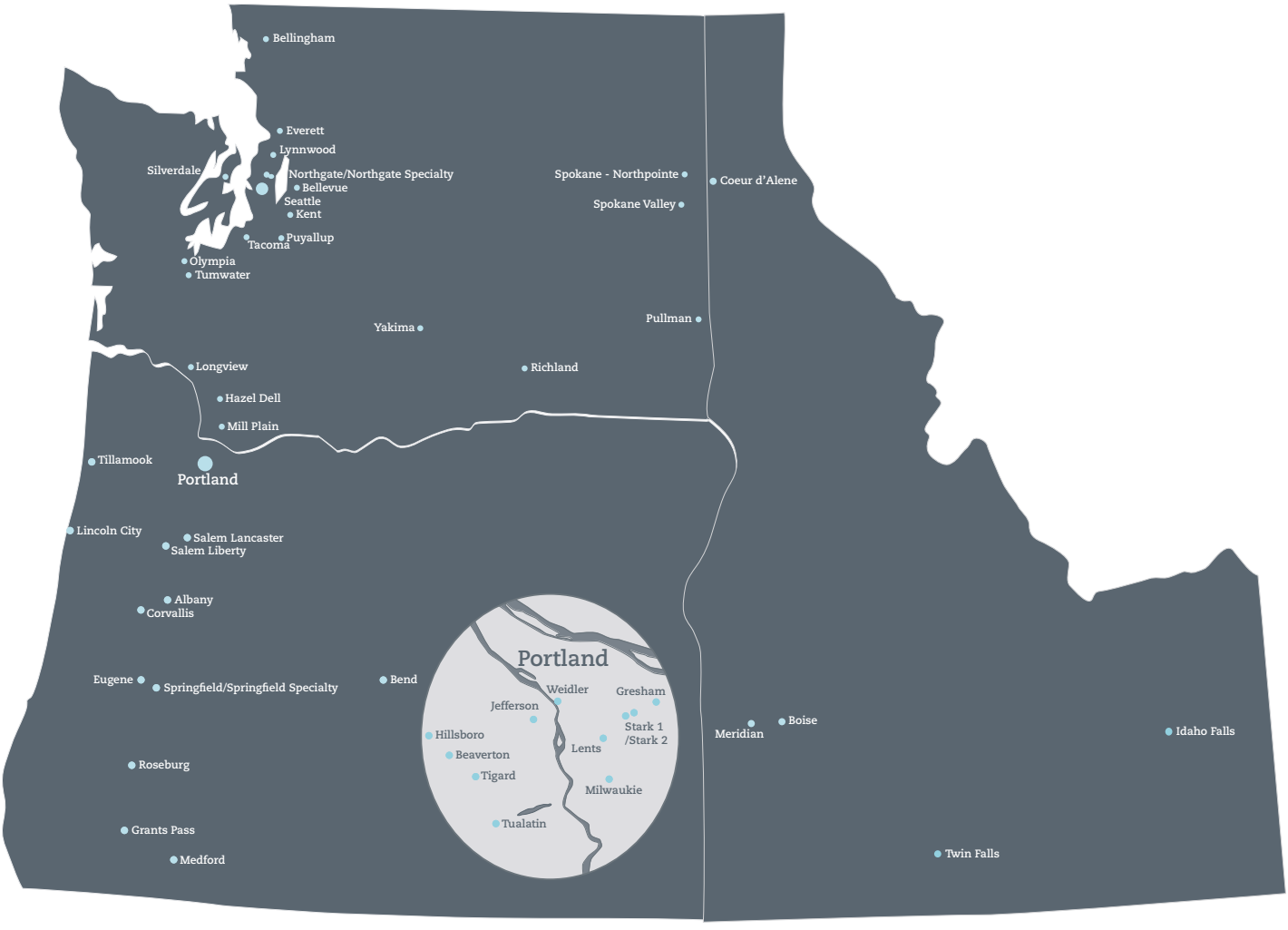
Contact Information

Appointments or Emergencies

Toll Free ..... 1.855.4DENTAL (433-6825), Option 1

Member Services

Monday – Friday .....8 AM to 5 PM PST
Toll Free ..... 1.855.4DENTAL (433-6825), Option 2
E-mail ..... memberservices@willamettedental.com
Website .....oebb.willamettedental.com



oebb.willamettedental.com

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 Plan. This Certificate replaces and supersedes all prior Certificates. For complete details on Benefits and other terms of the Plan, please refer to the *Group Benefits Contract* on file with OEBB. If any information in this Certificate is inconsistent with the terms and provisions of the *Group Benefits Contrac*t, the *Group Benefits Contract* shall control.

Possession of this Certificate does not necessarily mean the Member is covered.

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

PLAN INTRODUCTION

We are pleased to offer you, as an OEBB member, a high value dental insurance plan designed with the best health of you and your family in mind. We offer a unique system that not only offers you value-based dental insurance but provides you with quality dental care as well. Professional general practitioners, specialists, hygienists, and quality support staff from Willamette Dental Group, P.C., in Oregon, Washington, and Idaho provide the care for your dental plan. Willamette Dental Group has been providing dental care in the Pacific Northwest for over 45 years and has been providing quality care to educators for over 30 years.

DEFINITIONS

The following defined terms are used throughout this Certificate, unless the context specifically states otherwise:

"Active Eligible Employee" means an employee of an Entity who meets the definition of an Eligible Employee under OAR 111-010-015.

"Appeal" means a request for action/resolution on a denial of authorization for a covered service, denial of payment for a claim, or a denial of Benefits.

"Benefits" means the dental services which a Member is covered under this Plan, subject to the terms, conditions, limitations, and exclusions set forth in this Certificate.

"Copay" and *"Copayment"* means the dollar amount a Member must pay for Benefits.

"Company" means Willamette Dental Insurance, Inc.

"Complaint" means an expression of dissatisfaction that is about a specific problem encountered by a Member or about a decision by the Company that includes a request for action to resolve the problem or change the decision. Complaint does not include an inquiry for information.

"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.

"*Entity"* means a public school district (K-12), education service district (ESDs), community college and public charter schools participating in OEBB or Local Government as defined in OAR 111-010-0015.

"Eligible Early Retiree" means a previously Active Eligible Employee, who meets the definition of an Eligible Early Retiree under OAR 111-010-0015.

"Eligible Employee" means an Active Eligible Employee or Eligible Early Retiree.

"Experimental or Investigational Service" means a service classified as experimental or investigational. In determining whether services or supplies are experimental or investigational, the Company will consider the following: (1) whether the services or supplies are in general use in the dental community in the State of Oregon; (2) whether the services or supplies are under continued scientific testing and research; (3) whether the services or supplies show a demonstrable benefit for a particular illness, disease, or condition; and (4) whether the services or supplies are proven to be safe and effective.

"Family Member" means an Eligible Employee's spouse, eligible domestic partner, or dependent child as defined in OAR 111-010-0015.

"Grievance" means any expression of dissatisfaction about any matter other than one that is an Appeal.

"*Late Enrollee"* means a Member who did not enroll during their initial eligibility period. Late Enrollees are subject to benefit waiting periods for select services, as described in the Schedule of Covered Services and Copayments.

"Local Government" means cities, counties, and Special Districts.

"Member" means an Eligible Employee or Family Member, who is enrolled under this Plan.

"Non-Participating Provider" means any Dentist or Denturist that is not a Participating Provider.

"OEBB Premium" means the monthly or other periodic charge, including OEBB's administrative fees, payable by the Member for the Plan.

"Oregon Educators Benefit Board (OEBB)" means the program established under Chapter 243 of the Oregon Revised Statutes, as amended.

"Participant" means an OEBB member who is an Eligible Employee of an Entity who is covered by the Plan.

"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 dental services to Members under the terms of the Plan.

"Plan" means this OEBB-sponsored dental plan provided under the Group Benefits Contract between Willamette Dental Insurance, Inc., and OEBB as described in this Certificate of Coverage.

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

"*Special District"* means any district listed in ORS Chapter 198 "Special Districts generally," or as determined by OEBB.

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

ELIGIBILITY

Eligibility for OEBB benefits is based on rules in Oregon Administrative Rules (OAR) as amended. OEBB eligibility rules are codified in OAR 111-015-0001, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at: http://www.oregon.gov/oha/OEBB/Pages/Admin-Rules.aspx.

ENROLLMENT

OEBB's enrollment rules are codified in OAR Chapter 111, Division 40, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at:
http://www.oregon.gov/oha/OEBB/Pages/Admin-Rules.aspx.

Per OAR 111-040-0050, Late Enrollees are subject to benefit waiting periods for select services, as described in the Schedule of Covered Services and Copayments.

EFFECTIVE DATE OF COVERAGE

OEBB's rules for the effective date of coverage are codified in OAR Chapter 111, Division 40, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at: http://www.oregon.gov/oha/OEBB/Pages/Admin-Rules.aspx.

TERMINATION OF COVERAGE

OEBB's rules for the termination of coverage are codified in OAR Chapter 111, Division 40, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at:
http://www.oregon.gov/oha/OEBB/Pages/Admin-Rules.aspx.

Termination for Just Cause

The Company may terminate coverage on the last day of the month following 30 days' prior written notice to the Member, if the Member:

a. Abuses or threatens the safety of Company personnel or of any person or property of the Participating Provider;
b. Fails to comply with the provisions of this Plan, which shall include, but are not limited to, the following:
   (1) An inability to establish or maintain a satisfactory provider-patient relationship with a Participating Provider at office locations reasonably accessible to the Member.
   (2) Repeatedly failure to make timely payment of Copays.
c. Knowingly commits fraud. Some examples of fraud include, but are not limited to, the following:
   (1) Letting someone else pretend to be the Member to obtain services.
   (2) Providing false material or eligibility information with the intent to mislead the Company into providing Benefits it would not otherwise have provided.
   (3) Failure to notify OEBB or the Entity of changes that affect eligibility or Benefits.

CONTINUATION OF COVERAGE

A Member's coverage may be continued in certain circumstances when coverage would otherwise be terminated. OEBB's continuation of coverage rules are codified in OAR Chapter 111, Division 50, as amended. These rules are accessible through OEBB's Administrative Rules section on the OEBB website at:
http://www.oregon.gov/oha/OEBB/Pages/Admin-Rules.aspx.

Below is a brief overview of continuation coverage options that may be available to Members. All options are administered by OEBB. Please refer to OEBB or the Entity for specific details. The Member is responsible for timely payment of OEBB Premiums and reporting changes in eligibility or address. Failure to report changes may result in loss of the right to continue coverage.

The Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA allows a Member losing group dental plan coverage due to a qualifying event to continue their coverage for a limited time on a self-pay basis. OEBB will issue or cause the issuance of an initial COBRA notice explaining the right to continue coverage to all newly Eligible Employees and individuals. The Member is responsible for making the full monthly OEBB Premium payment to OEBB or its designated third party administrator. The OEBB Premium may include a 2% additional charge to administer the program. Please contact the Entity or OEBB for further details.

Federal Family Medical Leave Act

OEBB will allow Entities to continue coverage for Active Eligible Employees and covered Family Members, if the Active Eligible Employee is granted leave under the Federal Family Medical Leave Act (FMLA), as required under related federal rules and regulations. Please contact the Entity or OEBB for further details.

Oregon Family Leave Act

OEBB will allow Entities to continue coverage for Active Eligible Employees and covered Family Members, if the Active Eligible Employee is granted leave under the Oregon Family Leave Act (OFLA), as required under related state rules and regulations. You must notify the Entity no later than 31 days after the event. OEBB Premium may increase by an additional 2% to administer the program. Please contact the Entity or OEBB for further details.

Leave of Absence

OEBB will allow Entities to continue coverage for Active Eligible Employees and covered Family Members, if the Active Eligible Employee is granted a leave of absence based on OAR 111-050-0070. Please contact the Entity or OEBB for further details.

Spouse Continuation of Coverage

According to Oregon law (ORS 743B.343), a legally separated, divorced, or surviving spouse age 55 or over may elect to continue coverage under this Plan. Children of the spouse may remain covered provided the children are otherwise eligible under this Plan. Please contact the Entity or OEBB for further details.

State Continuation Coverage After Workers' Compensation Claim

If the Participant files a workers' compensation claim for an injury or illness, the Participant and Family Members may be able to continue coverage for up to 6 months after the Active Eligible Employee and Family Members would otherwise lose eligibility. Please contact the Entity or OEBB for further details.

During a Labor Dispute

If an Active Eligible Employee ceases to satisfy the minimum working requirement due to a strike, lockout, or other general work stoppage caused by a labor dispute, coverage may continue for up to 6 months. The following rules will apply:

a. If an Active Eligible Employee's compensation is suspended or terminated because of a work stoppage caused by a labor dispute, OEBB or the Entity will notify the Active Eligible Employee in writing of the right to continue coverage.
b. The Active Eligible Employee must pay OEBB Premiums on a self-pay basis through the Entity, including the Entity's portion.
c. OEBB Premium rates during a work stoppage are equal to the OEBB Premium rates in place before the work stoppage. OEBB Premium rates may change according to the provisions of the Plan. Coverage will terminate on the earlier of:
    (1) The last day of the month for which OEBB Premium was paid, if OEBB Premiums are unpaid;
    (2) The last day of the 6th month following the date the work stoppage began;
    (3) The last day of the month after the Active Eligible Employee begins full-time employment with another employer; or
    (4) The date of termination of the Plan.

EXTENSION OF BENEFITS

Benefits will be extended to cover the following services if coverage ends, so long as OEBB, the Entity, and affected Member are in compliance with the terms of the Plan as of the date of termination.

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 of coverage. 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 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 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 of coverage.

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.

COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when a person has dental coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay 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 the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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 two 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 two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   (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 have contracted with or are 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 dependent 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 dependent 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 dependent 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 dependent 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 dependent 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 his or her spouse's or domestic partner's plan, the Longer or Shorter Length of Coverage rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under his or her spouse's or domestic partner's plan began on the same date as the dependent 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 dependent child's parent and the dependent 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 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 dental 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 Company 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 Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company 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 Company 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 Company 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 Company 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.

GENERAL PROVISIONS

Agreement to Provide Benefits

The Company agrees to provide Benefits for prescribed services that are listed in the Schedule of Covered Services and Copayments, subject to the limitations and exclusions. Services must be provided by a Participating Provider to receive Benefits, unless specified otherwise. All Benefits are expressly subject to the Copayments stated in the Schedule of Covered Services and Copayments and to all other provisions of the Plan.

Referral to a Specialist

If a Participating Provider cannot provide a covered service, the Participating Provider may refer a Member to a Specialist or Non-Participating Provider. Services provided by a Specialist or Non-Participating Provider will be covered only if all of the following conditions are met:

a. The Participating Provider refers the Member;
b. The services are authorized by the referral; and
c. The services are listed as covered in this Certificate.

Copayments

The Member is responsible for payment of an office visit Copay for each visit to a Participating Provider, Specialist, or authorized referral Dentist. Office visit Copays are payable at each visit. Some services may require a service Copay as described in the Schedule of Covered Services and Copays. Service Copays are payable at the time of service.

Participant Dual Coverage

A Participant will not be allowed to be simultaneously covered more than once as a Participant under this Plan.

DENTAL EMERGENCY

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 Participating Providers' offices are closed, Members 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 Member may seek treatment for a Dental Emergency from a Non-Participating Provider if the Member is 50-miles or more from the nearest Participating Provider's office. The Company will reimburse to the Member up to $100 for the cost of services provided for treatment of the Dental Emergency, minus applicable Copays, to the extent that such services would have been covered under this Plan if the Member had used a Participating Provider. The Member is financially responsible for any charges for Covered Services provided for treatment of Dental Emergency in excess of $100 and any services not covered under this Plan. The Member must submit to the Company a written request for reimbursement no later than 6 months of the date of service. The request should include: the Member's signature; the attending Non-Participating Provider's signature; and the attending Non-Participating Provider's itemized statement. The Company may request additional information, including X-rays. The Benefit for out of area Dental Emergency treatment is contingent upon receipt of complete information.

SUBROGATION

a. 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 Member. 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.

b. 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 Member 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 below.
c. As a condition of receiving Benefits, the Member 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.
d. After the Member 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.
e. This Plan 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 plan or insurance.
f. The refusal or failure, without good cause, to cooperate with the Company or Participating Provider is grounds for recovery by the Participating Provider.

COMPLAINTS, GRIEVANCES, AND APPEALS PROCEDURES

Complaints

Members 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. If the Member 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.

Members 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)

If the Member is unsatisfied after discussing with the Participating Provider, Participating Provider's staff, or Member Services Department, Grievance and Appeal procedures are available for Complaints pertaining to a denied Benefit or service.

Grievances

The Member should outline his/her concerns and specific request in writing. The Member may submit comments, documents, and other relevant information. Grievances must be submitted to the Member Services Department no later than 180 days after the denial of Benefits or services.

a. The Company will review the Grievance and all information submitted. The Company will acknowledge receipt of the Grievance no later than 7 business days and will resolve the Grievance no later than 30 calendar days, unless the Member has been notified of a 15 day extension if additional information is needed. If the Benefit request involves:
   (1) A preauthorization, the Company will provide a reply no later than 15 days.

(2) Services deemed experimental or investigational, the Company will provide a reply no later than 20 working days.
(3) Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours.

b. 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

An Appeal is the process for requesting reconsideration of a denied Grievance. 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 Member should indicate the reason for the Appeal and may include written comments, documents, records, or any relevant information.

a. The Company will review the Appeal and all information submitted. The Company will provide a written reply no later than 60 days of receipt. 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.
b. 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.

SCHEDULE OF COVERED SERVICES AND COPAYMENTS

There are no benefit waiting periods for Members who enroll within their initial eligibility period or have been continuously covered under an OEBB-sponsored dental plan for 12 or more consecutive months.

There is a 12-month benefit waiting period for select services, as noted below, for Late Enrollees. Diagnostic and Preventive Services and select Miscellaneous Services will be covered for Late Enrollees during first 12 months of coverage.

1. Office Visit Copays

General Office Visit $20
Specialist Office Visit $20

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 - complete series of radiographic images ..... None
D0220 Intraoral - periapical first 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 - two radiographic images ..... None
D0273 Bitewings - three radiographic images ..... None
D0274 Bitewings - four radiographic images ..... None
D0277 Vertical bitewings - 7 to 8 radiographic images ..... None
D0330 Panoramic radiographic image ..... None
D0340 Cephalometric radiographic image ..... None
D0350 2D oral/facial photographic image obtained intraorally or extraorally ..... None
D0425 Caries susceptibility tests ..... 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
D1208 Topical application of fluoride - excluding 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

3. Space Maintainers *(12-month benefit waiting period for Late Enrollees)*

D1510 Space maintainer - fixed - unilateral ..... None

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D1516 Space maintainer - fixed - bilateral, maxillary ..... None
D1517 Space maintainer - fixed – bilateral, mandibular ..... None
D1520 Space maintainer - removable - unilateral ..... None
D1526 Space maintainer - removable – bilateral, maxillary ..... None
D1527 Space maintainer - removable – bilateral, mandibular ..... None
D1550 Re-cement or re-bond space maintainer ..... None
D1555 Removal of fixed space maintainer ..... None

4. Restorative Dentistry *(12-month benefit waiting period for Late Enrollees)*
D2140 Amalgam - 1 surface, primary or permanent ..... None
D2150 Amalgam - 2 surfaces, primary or permanent ..... None
D2160 Amalgam - 3 surfaces, primary or permanent ..... None
D2161 Amalgam - 4 or more surfaces, primary or permanent ..... None
D2330 Resin-based composite - 1 surface, anterior ..... None
D2331 Resin-based composite - 2 surfaces, anterior ..... None
D2332 Resin-based composite - 3 surfaces, anterior ..... None
D2335 Resin-based composite - 4 or more surfaces or involving incisal angle, anterior ..... None
D2390 Resin-based composite crown, anterior ..... None
D2391 Resin-based composite - 1 surface, posterior ..... None
D2392 Resin-based composite - 2 surfaces, posterior ..... None
D2393 Resin-based composite - 3 surfaces, posterior ..... None
D2394 Resin-based composite - 4 or more surfaces, posterior ..... None
D2510 Inlay - metallic - 1 surface ..... None
D2520 Inlay - metallic - 2 surfaces ..... None
D2530 Inlay - metallic - 3 or more surfaces ..... None
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 ..... None
D2620 Inlay - porcelain/ceramic - 2 surfaces ..... None
D2630 Inlay - porcelain/ceramic - 3 or more surfaces ..... None
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 *(12-month benefit waiting period for Late Enrollees)*
D2710 Crown - resin-based composite (indirect) $250
D2740 Crown - porcelain/ceramic $250
D2750 Crown - porcelain fused to high noble metal $250
D2752 Crown - porcelain fused to noble metal $250
D2782 Crown - ¾ cast noble metal $250
D2910 Re-cement or re-bond inlay, onlay, or partial coverage restoration ..... None
D2920 Re-cement or re-bond crown ..... 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

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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
D2970 Temporary crown (fractured tooth) ..... None
D2975 Coping ..... None
D2980 Crown repair necessitated by restorative material failure ..... None

6. Endodontics *(12-month benefit waiting period for Late Enrollees)*

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) $50
D3320 Endodontic therapy - premolar tooth (excluding final restoration) $50
D3330 Endodontic therapy - molar (excluding final restoration) $50
D3331 Treatment of root canal obstruction; non-surgical access ..... None
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth ..... None
D3333 Internal repair of perforation defects ..... None
D3346 Retreatment of previous root canal therapy - anterior $50
D3347 Retreatment of previous root canal therapy - premolar $50
D3348 Retreatment of previous root canal therapy - molar $50
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) $50
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 $50
D3421 Apicoectomy - premolar (1^{st} root) $50
D3425 Apicoectomy - molar (1^{st} root) $50
D3426 Apicoectomy (each additional root) ..... None
D3430 Retrograde filling - per root ..... None
D3450 Root amputation - per tooth $50
D3920 Hemisection (including any root removal), not including root canal therapy $50
D3950 Canal preparation and fitting of a preformed dowel or post ..... None

7. Periodontics (*12-month benefit waiting period for Late Enrollees)*

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 ..... None

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D4261 Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant ..... None
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 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 oral 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

8. Prosthodontics – Removable *(12-month benefit waiting period for Late Enrollees)*

D5110 Complete denture - maxillary $100
D5120 Complete denture - mandibular $100
D5130 Immediate denture - maxillary $100
D5140 Immediate denture - mandibular $100
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) $100
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) $100
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $100
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $100

D5282 Removable unilateral partial denture - 1 piece cast metal (including clasps and teeth), maxillary $100
D5283 Removable unilateral partial denture - 1 piece cast metal (including clasps and teeth), mandibular $100
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

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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 $100
D5711 Rebase complete mandibular denture $100
D5720 Rebase maxillary partial denture $100
D5721 Rebase mandibular partial denture $100
D5730 Reline complete maxillary denture (chairside) $100
D5731 Reline complete mandibular denture (chairside) $100
D5740 Reline maxillary partial denture (chairside) $100
D5741 Reline mandibular partial denture (chairside) $100
D5750 Reline complete maxillary denture (laboratory) $100
D5751 Reline complete mandibular denture (laboratory) $100
D5760 Reline maxillary partial denture (laboratory) $100
D5761 Reline mandibular partial denture (laboratory) $100
D5810 Interim complete denture (maxillary) $100
D5811 Interim complete denture (mandibular) $100
D5820 Interim partial denture (maxillary) $100
D5821 Interim partial denture (mandibular) $100
D5850 Tissue conditioning, maxillary ..... None
D5851 Tissue conditioning, mandibular ..... None
D5863 Overdenture – complete maxillary $100
D5864 Overdenture – partial maxillary $100
D5865 Overdenture – complete mandibular $100
D5866 Overdenture – partial mandibular $100
D5986 Fluoride gel carrier ..... None

9. Prosthodontics – Fixed *(12-month benefit waiting period for Late Enrollees)*

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 *(12-month benefit waiting period for Late Enrollees)*

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 $50
D7220 Removal of impacted tooth - soft tissue $50
D7230 Removal of impacted tooth - partially bony $50

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D7240 Removal of impacted tooth - completely bony $50
D7241 Removal of impacted tooth - completely bony with unusual surgical complications $50
D7250 Removal of residual tooth roots (cutting procedure) $50
D7260 Oroantral fistula closure $50
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth $50
D7280 Exposure of an unerupted tooth $50
D7283 Placement of device to facilitate eruption of impacted tooth $50
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) $50
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) $50
D7471 Removal of lateral exostosis (maxilla or mandible) $50
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
D7670 Alveolus - closed reduction, may include stabilization of teeth ..... None
D7910 Suture of recent small wound up to 5 cm ..... None
D7911 Complicated suture - up to 5 cm ..... None
D7953 Bone replacement graft for ridge preservation - per site $50
D7970 Excision of hyperplastic tissue - per arch $50
D7971 Excision of pericoronal gingiva $50

11. Anesthesia *(12-month benefit waiting period for Late Enrollees)*
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis (per visit) $15

12. Miscellaneous
D9110 Palliative (emergency) treatment of dental pain - minor procedure ..... 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 Copays still apply and facility fees not covered)* $100
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed ..... None
D9440 Office visit - after regularly scheduled hours $20
D9910 Application of desensitizing medicament * ..... None
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth * ..... None
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
D9970 Enamel microabrasion * ..... None
Out-of-service area emergency treatment is reimbursed up to $100 minus applicable Copays.

* *These Miscellaneous Services have a 12-month benefit waiting period for Late Enrollees.*

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ORTHODONTIC SERVICES

Members must have been continuously covered under an OEBB-sponsored dental plan for 12 or more consecutive months to be eligible for Benefits for orthodontic services. Late Enrollees have a 12-month benefit waiting period for orthodontic services.

Benefits for orthodontic treatment are 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 Member is covered under this Plan. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.

The Member must remain covered under this Plan for the entire length of treatment. The Member must follow the post-treatment plan and keep all appointments after the Member is de-banded to avoid additional Copays. Benefits will not be provided for the replacement of appliances (such as headgear and retainers) or for services provided prior to the effective date of coverage.

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 Copay may be prorated. The services necessary to complete treatment will be billed at the Reasonable Cash Value.

The Member is responsible for payment of the applicable Copays listed below for pre-orthodontic and orthodontic services. The Pre-Orthodontic Service Copays will be deducted from the Comprehensive Orthodontic Service Copayment, if the Member accepts the treatment plan. The General Office Visit Copay listed in the Schedule of Covered Services and Copayments is charged at each visit for orthodontic treatment. Services connected with orthodontic treatment are subject to the Copays listed in the Schedule of Covered Services and Copayments.

Orthodontic Office Visit Copay

The Member will be responsible to pay the Orthodontic Office Visit Copay listed below for each visit to receive Orthodontic treatment.

• Orthodontic Office Visit Copay $20

Pre-Orthodontic Service Copay

The Member will be responsible to pay the Copays listed below for Pre-Orthodontic Services provided:

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

Orthodontic Service Copay

• Comprehensive Orthodontic Service Copay ..... $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
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
D8691 Repair of orthodontic appliance

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IMPLANT SERVICES

Members must have been continuously covered under an OEBB-sponsored dental plan for 12 or more consecutive months to be eligible for Benefits for implant services. Late Enrollees have a 12-month benefit waiting period for implant services.

The dental implant services described in this *Implant Services* section are covered for Members if all of the following requirements are met:

a. A Participating Provider determines that dental implants are dentally appropriate for the Member.
b. A Participating Provider prepares the treatment plan for dental implants prior to initiating any implant treatment.
c. All dental implant services are provided by a Participating Provider or under a referral from a Participating Provider.
d. The Member follows the treatment plan prescribed by the Participating Provider.
e. The Member makes payment of amounts due.
f. The dental implant service is listed as covered in this *Implant Services* section and is not otherwise limited or excluded.

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

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 this Plan 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 *Implant Services* section.
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 Member's effective date of coverage under this Plan 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 this Plan.
i. Treatment of a primary or transitional dentition.

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EXCLUSIONS AND LIMITATIONS

Benefits are not provided for any of the following conditions, treatments, services, or for any direct complications or consequences thereof:

Exclusions

- Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if 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, including the following:
    a. An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under this Plan; or
    b. A crown, bridge, or cast or processed restoration, if the tooth was prepared prior to the effective date of coverage under this Plan.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Exams or consultations needed solely in connection with a service that is not covered.
- Experimental or Investigational services and related exams or consultations.
- Full mouth reconstruction , including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia, 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 diagnosis or treatment of temporomandibular joint disorders.
- 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 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 the treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services 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.
- 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 Member elects a service that is more costly than the service the Participating Provider has approved, the Member 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.

a. 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.
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 Copays.

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 a Participating Provider.
c. The services provided are the same services that would be provided in a dental office.
d. The Hospital Call Copay and other applicable Copays 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:

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 this Plan, 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.

Oregon Educators Benefit Board

Willamette Dental Insurance, Inc.

Certificate of Coverage