Willamette
Dental Group

GROUP DENTAL CERTIFICATE OF COVERAGE

Policyholder Name: Multnomah County

Effective Date: January 1, 2020

Group Number: OR331

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 County. 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

TABLE OF CONTENTS

Section 1 Definitions

The following terms where used and capitalized in this Certificate, are defined as follows.

1.1 **"Child"** means a natural child; stepchild; adopted child; child for whom the Member has assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child; or child for whom the Member is designated the court-appointed guardian. "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 is required to provide dental coverage for pursuant to a Qualified Medical Child Support Order (QMCSO) as defined in the Employee Retirement Income Security Act of 1974, as amended.

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

1.3 **"Contract"** means the agreement between the Company and the County. The Contract, including the Application for Group Dental Coverage, appendices, exhibits, riders, amendments and endorsements, if any, constitute the entire Contract between the parties and supersedes all prior agreements between the parties.

1.4 **"Copayment"** means the fixed dollar amount for each visit or Covered Service that is the Enrollee's responsibility to pay under the Contract. 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 acute infection, traumatic damage to the oral cavity or discomfort that cannot be controlled by non-prescription pain medication.

1.7 **"Dentist"** means a person licensed to practice dentistry pursuant to the laws of the state where treatment is rendered.

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

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

1.10 **"Enrollee"** means a Member, a Retired 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 efficacious.

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 County, who is eligible and enrolled for coverage.

1.14 **"Non-Participating Provider"** means any 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 is under contract 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 **"County"** means Multnomah County who is sponsoring this group dental benefits plan for Enrollees.

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

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

1.19 **"Retired Member"** means a former employee of the County who has retired from the County 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; oral surgery; periodontic; or prosthodontic dental services.

Section 2 Eligibility and Enrollment

2.1 **Eligible Employees**. A non-represented employee must work at least 20 hour per week on a regular basis in a permanent non-represented position for the County to be eligible for coverage. A represented employee must be covered by a labor contract and work at least 20 hours a week on a regular basis in a permanent position for the County to be eligible for coverage. An employee becomes eligible for coverage on the first day of the month following or coinciding with the date of hire for continuous employment, if all enrollment requirements are satisfied.

2.2 **Eligible Family Members**. Proof of dependency may be required periodically.

2.2.1 The spouse of the Member or the domestic partner of the Member is eligible for coverage as a Dependent.

2.2.2 The Member's, spouse's, or domestic partner's Child from birth to age 26 is eligible for coverage as a Dependent. The Member's grandchild who meets the County's requirements for eligibility as a dependent grandchild is eligible for coverage as a Dependent.

2.2.3 A Member's, spouse's, or domestic partner's Child is eligible as a Dependent beyond the limiting age stated above if all of the following conditions are met.

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

2.3 **Initial Enrollment Period.** To enroll, the eligible employee must submit an enrollment application listing all eligible persons to be covered within 31 days after attaining initial eligibility. Coverage begins on the date the eligible employee satisfies applicable eligibility and enrollment requirements. 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 open enrollment period. The Member's portion of monthly Premium for Enrollees added or dropped during the initial enrollment period will be collected by the County from Members in accordance with the County's terms and policies for payment of Premium.

2.4 **Open Enrollment Period.** If an eligible employee or eligible family member did not enroll during the initial enrollment period or during a special enrollment period, an eligible employee may enroll during the open enrollment period by submitting an enrollment application to the County. Coverage will begin on the anniversary date of the Contract. The Member's portion of monthly Premium for Enrollees added or dropped during open enrollment will be collected by the County from Members in accordance with the County's terms and policies for payment of Premium.

2.5 **Special Enrollment Period.** If an eligible employee or eligible family member did not enroll during the initial enrollment period or during an open enrollment period, the eligible employee may apply for coverage during a special enrollment period after the following triggering events. Coverage will

begin on the first day of the month after receipt of the enrollment application, except as stated otherwise for birth and adoption, if all enrollment requirements are satisfied. The Member's portion of monthly Premium for Enrollees added or dropped during a special enrollment period described below will be collected by the County from Members in accordance with the County's terms and policies for payment of Premium.

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 90 days after the eligible Child's birth for newborn Children or 90 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, if all enrollment requirements are satisfied.

2.5.2 Newly Eligible Family Members. An eligible employee and the newly eligible family members may enroll following the date of marriage or registration of a domestic partnership; court appointment as a custodian or legal guardian; or issuance of a QMCSO by submitting an enrollment application and applicable Premium to the County within 90 days after the triggering event. In addition, an eligible employee or eligible family member 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 County within 90 days after the employee or family member is determined to be eligible for such assistance.

2.5.3 Loss of Coverage. An eligible employee and eligible family members may enroll following a loss of coverage. Loss of coverage includes, but is not limited to, termination of Dependent's employment, divorce or legal separation, death of spouse, or spouse's leave of absence. The Company must receive the enrollment application and Premiums within 90 days of loss of coverage. If coverage is lost under a CHIP premium assistance or Medicaid, the Company must receive the enrollment application and applicable Premium within 90 days of the loss of coverage.

2.6 Waiving Dental Coverage. Employees may elect to waive dental benefits offered by the County. Employees should refer to their labor agreement or Personnel Rule 110 for non-represented employee benefits for details. If an employee waives dental coverage due to coverage under another dental plan and subsequently loses that other coverage, the employee may enroll in accordance with Section 2.5.3. If dental coverage is waived without other dental coverage, the employee may enroll only during an open enrollment period or a special open enrollment period following a qualifying triggering event.

2.7 Retirement.

2.7.1 Eligibility for Retired Members. Retired Members must meet the County's eligibility requirements for retired employee coverage to be eligible for coverage. To enroll, eligible prospective retired members must submit an application for enrollment as a Retired Member as required by the County.

2.7.2 Eligibility for Dependents of a Retired Member. The spouse or domestic partner of the Retired Member must be under the age of 65 and ineligible for Medicare to be eligible for coverage as a Dependent. The Child of a Retired Member must be under the age of 26 to be eligible for coverage as a Dependent. The grandchild of a Retired Member must meet the County's requirements for eligibility as a dependent grandchild to be eligible for coverage as a Dependent.

2.7.3 When Retiree Coverage is Effective. Coverage for a Retired Member and his or her eligible family members will begin on the first day of the month following or coinciding with the date of retirement or as otherwise specified by the County. If the retired employee and his or her eligible family members choose not to enroll at the time of the retirement, enrollment at a later date is not permitted. A Retired Member and his or her Dependents who voluntarily terminate coverage may not re-enroll at a later date. The Retired Member's portion of monthly Premium will be collected by the County from Retired Members in accordance with the County's terms and policies for payment of Premium.

Section 3 Premium Provisions

3.1 Payment of Premium. The payment of Premium for each Enrollee is due monthly on or before the first day of each month. Payment of Premium must be submitted to the Company for all Enrollees in a single lump sum. A 30-day grace period is granted for the payment of Premium. If Premium remains unpaid at the end of the grace period, the Contract will terminate on the last day of the month for which Premium is paid and accepted by the Company. Only Enrollees for whom Premium has been paid are entitled to Covered Services. The Member's portion of monthly Premium for Enrollees will be collected by the County from Members in accordance with the County's terms and policies for payment of Premium.

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 Premiums through the County.

3.3 Return of Advance Payment of Premium. The Company will refund to the County any advanced Premium payments paid for coverage after the termination of the Contract. The County 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 Premium remains unpaid.

Section 4 Dental Coverage

4.1 **Agreement to Provide Covered Services.** The Company agrees to provide benefits for prescribed Covered Services that are 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 **Referral to a Specialist.** The Participating Provider may refer an Enrollee 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 **Emergency Care.**

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

4.3.2 The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is more than 50 miles from any Participating Provider office. The Company will reimburse the Enrollee up to the Out of Area Emergency Reimbursement amount less any Copayment amounts specified in the Appendix A for the cost of the Covered Services rendered. The Enrollee must submit a written request for reimbursement to the Company within 6 months of the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information, including X-rays and other data, may be requested by the Company to process the request. The benefit for out of area 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 & 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 an excluded service even if approved, prescribed, or recommended by a Participating Provider.

5.1.1 Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.

5.1.2 The completion or delivery of treatments, services, or supplies 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 insurance carrier, and/or provider.

5.1.3 (Reserved)

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

5.1.5 Exams or consultations needed solely in connection with a service not listed as covered in the appendices.

5.1.6 Experimental or investigational services or supplies and related exams or consultations.

5.1.7 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.

5.1.8 General anesthesia or moderate sedation.

5.1.9 Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees, except as specified under Section 5.2.3.

5.1.10 Orthognathic surgery.

5.1.11 Personalized restorations that are not dentally necessary.

5.1.12 Plastic, reconstructive, or cosmetic surgery and other services or supplies, 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 of the prescribed treatment plan and/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 treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.

5.1.24 Services for 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 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.

5.2.2 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.

5.2.3 Alternate Services. If alternative services can be used to treat a condition, the service recommended by the Participating Provider is covered. In the event 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 Reasonable Cash Value of the recommended service and Reasonable Cash Value of the more costly requested service.

5.2.4 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 pre-authorized in writing by a 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 the Appendix A are paid.

5.2.5 Congenital Malformations. Services listed in the 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.

5.2.6 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.

5.2.7 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 Copayment will apply as identified in the 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 Copayment identified in the Appendix A.

Section 6 Termination of Coverage

6.1 Termination of Coverage. Coverage for an Enrollee shall terminate on the earliest of the following:

6.1.1 On the date of termination of the Contract.

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

6.1.3 If the employment termination date falls between the 1st and 15th of a month, on the last day of the same month; or if the employment termination date falls between the 16th and last day of a month, on the last day of the following month. Enrollees may have the opportunity to continue coverage, refer to Section 6.4.3. If a Member's active employment terminates with the County, coverage will end for the Member and all enrolled Dependents.

6.1.4 On the last day of the month during which eligibility ceases, for loss of eligibility other than termination of the Member's active employment. An enrolled Child's coverage will end of the last day of the month in which the Child no longer meets the eligibility requirements specified in Section 2.2.2 or 2.2.3. An enrolled spouse or domestic partner's coverage will end on the last day of the month in which a decree of divorce or annulment is entered or the domestic partnership is ended. An enrolled Child, spouse or domestic partner may have the opportunity to continue coverage, refer to Section 6.4.2 and 6.4.3.

6.1.5 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.

6.2 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 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 shall have or acquire a vested right to receive Covered Services after termination of the Contract. Termination of the Contract completely 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, unless specified otherwise.

6.4 Continuation Rights. The County may postpone the termination of coverage for any Enrollee as described below. The County agrees to notify all Enrollees of their right to continuation of coverage and administer continuation of coverage in accordance with state and federal laws.

6.4.1 Leave of Absence. If a Member is granted an unpaid, non-FMLA leave of absence by the County, coverage may continue for 30 days during the leave. The Member's eligibility will

end after the initial 30 days of leave. If coverage ends, Enrollees may have the opportunity to continue coverage, refer to Section 6.4.3. For more information regarding coverage during a leave of absence, please contact the County.

6.4.2 Federal or State-Mandated Continuation Coverage. Coverage may continue 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 federal or state-mandated continuation coverage, please contact the County.

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

6.4.4 Labor Disputes. If a Member ceases to satisfy the minimum working requirements due to a strike, lockout, or other general work stoppage caused by a labor dispute, coverage may continue for up to 6 months.

a. The following rules will apply:
    1. If a Member's compensation is suspended or terminated because of a work stoppage caused by a labor dispute, the County will notify the Member in writing of the right to continue coverage.
    2. The Member must pay Premium through the County, including the County's portion.
    3. Premium rate during a work stoppage is equal to the Premium rate. The Company may change Premium rates according to the provisions of the Contract.
b. Coverage will terminate on the earlier of:
    1. On the last day of the month for which Premium is paid, if Premium remains unpaid at the end of the grace period.
    2. On the last day of the 6th month, following the date the work stoppage began.
    3. On the last day of the month after the Member begins full-time employment with another employer.
    4. On 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 Rehire or Reduction of Hours. If (i) a Member's active employment with the County ends and the Member is rehired to a benefit eligible position with County within the same calendar year; or (ii) if a Member experiences a reduction in hours that results in loss of coverage and subsequently re-qualifies for coverage due to an increase in hours:

6.5.1 If no open enrollment period occurred: The Member and any previously enrolled Dependents will be re-enrolled under the previous elected County dental plan. If the

Member experienced a family status change during the period of ineligibility or is working at a different FTE or bargaining unit, the Member may request a change to the dental plan election through the County. For a re-hired Member, coverage will begin on the first of the month following or coinciding with the Member's rehire date. For Members re-qualifying for coverage after a reduction to hours, coverage will begin on the first of the month following or coinciding with the date the Member's scheduled hours increase to re-qualify for coverage.

6.5.2 If an open enrollment period occurred: The Member must submit an enrollment application listing all eligible persons to be covered within 31 days after the date of rehire. The Member may request a change to the dental plan election. For a re-hired Member, coverage will begin on the first of the month following or coinciding with the Member's rehire date. For Members re-qualifying for coverage after a reduction to hours, coverage will begin on the first of the month following or coinciding with the date the Member's scheduled hours increase to re-qualify for coverage.

6.6 Extension of Benefits. Benefits for the following services that require multiple appointments may extend after coverage ends. An Enrollee terminated for good cause or failure to pay Premium is 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 within 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 within 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 dentures are delivered within 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 within 60 days after termination. Pulpal debridement is not a root canal start. If the root canal requires retreatment after 60 days from termination of coverage, re-treatment will not be covered. Restorative work following root canal treatment is a separate procedure and not covered after termination.

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 provided for the diagnosis or treatment of an injury or disease, which is allegedly the liability of a third party are provided by the Company and Participating Provider solely to assist the Enrollee. By incurring the Reasonable Cash Value of the Covered Services, the Company and the Participating Provider are not acting as a volunteer 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 allegedly the liability of a third party, it shall:

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 in 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 their loss. The Company and Participating Provider are entitled to the 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 after the Enrollee has been fully compensated for their loss.

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 Procedures.

7.2.1 Complaints.

a. Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider's staff. Most complaints can be resolved with the Participating Provider's staff.
b. If the Enrollee requests a specific service, the Participating Provider will use his or her judgment to determine if the service is dentally necessary. The Participating Provider will recommend the most appropriate course of treatment.
c. Enrollees may also contact the Company's 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 remains unsatisfied after discussing with the Participating Provider or the 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 within 180 days after the denial of Benefits or services.
b. The Company will review the grievance and all information submitted. The Company will provide a written reply within 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 within 15 days after the receipt of a written grievance.
    2. Services deemed Experimental or Investigational, the Company will provide a written reply within 20 working days after the receipt of a written grievance.
    3. Services not yet rendered for an alleged Dental Emergency, the Company will provide a reply within 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 within 180 days of the date of the denial, reduction, or termination or, 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 within 60 days of the receipt. If the appeal involves:
    1. A preauthorization, the Company will provide a written reply within 30 days.
    2. Services deemed Experimental or Investigational, the Company will provide a written reply within 20 working days.
    3. Services not yet rendered for an alleged Dental Emergency, the Company will provide a reply within 72 hours.
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.

7.3 Rights Not Transferable. Benefits are offered personally to the Enrollee and 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 Headings. The headings of Sections and Paragraphs are used solely for convenience of reference and are not a part of the Contract, or guides to the interpretation hereof.

7.6 Severability. If any provision of the Contract is deemed unenforceable or illegal by a court of competent jurisdiction, that provision shall be fully severable and the remaining provisions of the Contract shall continue in full force and effect.

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

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

Appendix A – Schedule of Covered Services and Copayments

Office Visit Copayments

General Office Visit Copayment $10
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	Extraoral - first radiographic image	$0
D0260	Extraoral - each additional 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	Oral/facial photographic image obtained intraorally or extraorally	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cementation of space maintainer	$0
D1555	Removal of fixed space maintainer	$0

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 or more 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 substrate	$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	Recement inlay, onlay, or partial coverage restoration	$0
D2920	Recement 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
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, bicuspid 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 - bicuspid	$0
D3348	Retreatment of previous root canal therapy - molar	$0
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, 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 - bicuspid (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 flap entry and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4263	Bone replacement graft - first site in quadrant	$0
D4264	Bone replacement graft - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$0
D4273	Subepithelial connective tissue graft procedures, per tooth	$0

D4274	Distal proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$0
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in 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 comprehensive evaluation and diagnosis	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0
D4910	Periodontic maintenance	$0

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
D5510	Repair broken complete denture base	$0
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0
D5610	Repair resin denture base	$0
D5620	Repair cast framework	$0
D5630	Repair or replace broken clasp	$0
D5640	Replace broken teeth - per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture	$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	Crown - resin with high noble metal	$0
D6750	Crown - porcelain fused to high noble metal	$0
D6780	Crown - ¾ cast high noble metal	$0
D6790	Crown - full cast high noble metal	$0
D6930	Recement fixed partial denture	$0
D6975	Coping	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

8. Oral Surgery

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of 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	Surgical 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	Surgical access 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
D9940	Occlusal guard, by report	$0
D9941	Repair and/or reline of occlusal guard	$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. Benefits for orthodontic treatment are provided only if the Participating Provider prepares the treatment plan prior to rendering services. The treatment plan is based on an examination that must take place while the Enrollee is covered under 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. For orthodontic treatment started prior to the effective date of coverage, Copayments may be adjusted based upon the services necessary to complete the treatment.

d. If coverage terminates prior to completion of treatment, the Copayment may be pro-rated. The services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

e. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services rendered. The Pre-Orthodontic Service Copayments will be 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 the Appendix A is charged at each visit for orthodontic treatment. Services connected with orthodontic treatment are subject to the Service Copayments listed in the 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: $1,500
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

Appendix D - Dental Implants

1. Benefits.

a. The dental implant services described in this Appendix D 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 D 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 D.
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.