Willamette
Dental Group

GROUP DENTAL CERTIFICATE OF COVERAGE

Policyholder Name: City of Bellevue

Effective Date: January 1, 2022

Group Number: WA38

Provider Network: Willamette Dental Group, P.C.

This Certificate of Coverage, including any amendments, appendices, endorsements, notices, and riders, summarizes the essential features of the Contract. This Certificate of Coverage replaces and supersedes all prior certificates of coverage. Possession of this Certificate of Coverage does not necessarily mean the Enrollee is covered.

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

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

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Section 1 Definitions

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

1.2 **"Company"** means Willamette Dental of Washington, Inc.

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

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

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

1.6 **"Dental Emergency"** means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in: (i) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part.

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

1.8 **"Denturist"** means a person licensed to practice denturism in the state where treatment is provided. Benefits for Covered Services provided by a Denturist will be provided if (i) the service is within the lawful scope of the license, and (ii) the Contract would have provided benefits if the Covered Service had been performed by a Dentist.

1.9 **"Dependent"** means a Member's spouse, domestic partner, or Child, who is eligible and enrolled for coverage. For the purposes of the Contract, all terms and benefits available to a spouse shall apply equally to domestic partners.

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

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

a. Whether the services are in general use in the dental community in the State of Washington;

b. Whether the services are under continued scientific testing and research;
c. Whether the services show a demonstrable benefit for a particular illness, disease, or condition; and
d. Whether the services are proven safe and effective.

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

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

1.14 **"Non-Participating Provider"** means a Dentist or Denturist, who is not employed by or under contract with the Company or Participating Provider to provide dental services.

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

1.16 **"Policyholder"** means City of Bellevue, the legal entity, including approved affiliates and subsidiaries that the Contract is issued to.

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

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

1.19 **"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.

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

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

Section 2 Eligibility and Enrollment

2.1 **Eligible Employees**. Employees must be one of the following to be eligible for coverage: a. a full-time employee assigned to work a minimum of 30 hours per week (including regular, limited term, training pool, and transitional employment status positions or such other fully-benefited positions as council designates); b. an elected official; or c. an active regular part-time fully benefited employee working at least 20 hours per week, but less than 30 hours per week as of March 31, 2014. Employees become eligible for coverage on the first day of the month following the date of hire for continuous employment.

2.2 **Eligible Family Members**. The eligible employee must enroll to include coverage for eligible family members. The Policyholder or Company may require proof of eligibility periodically.

2.2.1 The spouse of the Member or the domestic partner of the Member is eligible for coverage as a Dependent. Domestic partners must be either: (i) in a state registered domestic partnership with the Member; (ii) in a non-registered domestic partnership with the Member as of December 31, 2020; or (iii) in a non-registered domestic partnership that meets the requirements of the applicable collective bargaining agreement.

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

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

a. The Child is and continues to be incapable of self-sustaining employment by reason of a developmental disability or physical handicap.
b. The Child is and continues to be chiefly dependent upon the Member (or Member's spouse or Member's domestic partner) for support and maintenance.
c. The Policyholder provides proof of such incapacity and dependency to the Company no later than 31 days after the Child's attainment of the limiting age. Proof may be requested annually.

2.3 **Initial Enrollment Period.** The eligible employee must submit an enrollment application to the Policyholder for himself/herself and any eligible family members to be covered no later than 31 days after attaining initial eligibility. Coverage begins on the date the eligible employee attains initial eligibility. Eligible employees and their eligible family members who do not enroll during the initial enrollment period may enroll only during an open enrollment period or a special enrollment period.

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

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

2.5.1 Birth or Adoption. Eligible employees and their eligible family members may enroll following the birth or adoption of an eligible Child by submitting an enrollment application to the Policyholder. If additional Premium is required, the additional Premium must be paid no later than 60 days after the eligible Child's date of birth for a newborn Child or 60 days after the date of placement for adoption. Coverage will begin on the newborn Child's date of birth or on the adopted Child's date of placement for adoption. Coverage for an enrolled newborn Child includes, but is not limited to benefits for Covered Services provided for treatment of congenital anomalies from the date of birth.

2.5.2 Newly Acquired Family Members. Eligible employees and their newly acquired family members may enroll following marriage or registration of a domestic partnership; court appointed legal guardianship of a Child; or issuance of a QMCSO by submitting an enrollment application and the applicable Premium to the Policyholder no later than 31 days after the event. Eligible employees or eligible family members may enroll if he/she becomes newly eligible for premium assistance under Children's Health Insurance Program (CHIP) or Medicaid by submitting an enrollment application and the applicable Premium to the Policyholder no later than 60 days after the determination for eligibility of premium assistance. Coverage will begin on the first day of the month after receipt of the enrollment application.

2.5.3 Loss of Coverage. Eligible employees or their eligible family members may enroll following the loss of coverage under another dental plan. Reasons for the loss of coverage may include exhaustion of COBRA continuation coverage, loss of eligibility (including as a result of legal separation, divorce, dissolution of domestic partnership, death, termination of employment, or reduction in the number of hours of employment), termination of premium assistance under CHIP or Medicaid, or reduction in employer contribution towards coverage. An enrollment application must be submitted no later than 31 days after the loss of coverage or no later than 60 days if the loss of coverage was CHIP or Medicaid. Coverage will begin on the first day of the month after receipt of the enrollment application.

Section 3 Premium Provisions

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

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

3.3 **Return of Advance Payment of Premium.** If the Policyholder submits early payment of the Premium prior to the termination of the Contract, the Company will return the unearned Premium to the Policyholder. Prior written notice of the intent to terminate in accordance with the Contract must be provided. The Policyholder must promptly notify all Enrollees of the termination of the Contract. If an Enrollee receives Covered Services after termination or during any period for which the Premium is unpaid, the Participating Provider is entitled to recover the Reasonable Cash Value of the services provided.

Section 4 Dental Coverage

4.1 **Agreement to Provide Covered Services.** The Company shall provide benefits for prescribed Covered Services listed as covered in the appendices. Covered Services must be provided by the Participating Provider, except as specified otherwise. All Covered Services are expressly subject to the Copayments, exclusions, limitations, and all other provisions of the Contract. Enrollees may freely contract at any time to obtain health care services outside of the Contract or for services not covered under the Contract on any terms or conditions acceptable to the health care provider and Enrollee.

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

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

4.3 **Dental Emergency.**

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

4.3.2 The Enrollee may seek treatment for a Dental Emergency from a Non-Participating Provider if the Enrollee is 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 Copayments specified in Appendix A for the cost of the Covered Services. The Enrollee must submit a written request for reimbursement to the Company no later than 6 months after the date of service. The written request should include the Enrollee's signature, the attending Non-Participating Provider's signature, and the attending Non-Participating Provider's itemized statement. Additional information, including X-rays and other data, may be requested by the Company to process the request. The benefit for out of area Dental Emergency treatment will not be provided if the requested information is not received.

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

4.5 **Coordination of Benefits.** This coordination of benefits (COB) provision applies when a person has dental coverage under more than one Plan. Plan is defined below.

4.5.1 The Order of Benefit Determination Rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to 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.

4.5.2 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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate Plan.
    1. Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group or individual coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
    2. Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.
    3. 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 a COB provision, the part of the contract providing the health care 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 must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

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. The Allowable Expense for the Secondary Plan is the amount it allows for the service in the absence of other coverage that is primary.

e. 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 method or other similar reimbursement method, 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.

f. Closed Panel Plan is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily 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.

g. 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.

4.5.3 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. Except as provided in subsection c, 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.
c. 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 is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
d. 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.
e. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Nondependent or dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, 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, policyholder, 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 dependent 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 dependent 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 dependent 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 claim determination periods commencing after the Plan is given notice of the court decree;
            (ii) If a court decree states one parent is to assume primary financial responsibility for the dependent Child but does not mention responsibility for health care expenses, the Plan of the parent assuming financial responsibility is primary;
            (iii) 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 determine the order of benefits;

(iv) 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 subsection (a) above determine the order of benefits; or

(v) 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, first;
- The Plan covering the spouse or domestic partner of the Custodial Parent, second;
- The Plan covering the noncustodial parent, third; and then
- The Plan covering the spouse or domestic partner of the noncustodial parent, last.

(c) For a dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the Child.

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 under section e.1. can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided under 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 under section e.1. can determine the order of benefits.
5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, 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 must 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.

4.5.4 Effect on the Benefits of This Plan. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal one hundred percent of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4.5.5 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.

4.5.6 Facility of Payment. If payments that should have been made under This Plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, the issuer is fully discharged from liability under This Plan.

4.5.7 Right of Recovery. The issuer has the right to recover excess payment whenever it has paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or from any other issuers or Plans.

4.5.8 If an Enrollee is covered by more than one Plan, and the Enrollee does not know which is the Primary Plan, the Enrollee may contact any one of the Plans to verify which Plan is primary. The Plan the Enrollee contacts is responsible for working with the other Plan to determine which is primary and will let the Enrollee know within 30 days. Plans may have timely claim filing requirements. If the Enrollee or provider fails to submit a claim to a secondary Plan within that Plan's claim filing time limit, the Plan can deny the claim. If the Enrollee experiences delays in the processing of a claim by the Primary Plan, the Enrollee or provider will need to submit a claim to the Secondary Plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if an Enrollee is covered by more than one Plan, the Enrollee should promptly report to providers and Plans any changes in coverage.

Section 5 Exclusions and Limitations

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

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

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

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

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

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

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

5.1.5 Experimental or Investigational services and related exams or consultations.

5.1.6 Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions, or correcting attrition, abrasion, or erosion.

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

5.1.8 Maxillofacial prosthetic services.

5.1.9 Nightguards.

5.1.10 Personalized restorations.

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

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

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

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

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

5.1.16 Replacement of sound restorations.

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

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

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

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

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

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

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

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

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

5.2 Limitations.

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

5.2.2 Congenital Malformations. Services listed in Appendix A which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for Dependent Children if dental necessity has been established. Dental necessity means that treatment is primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function. Orthognathic surgery is covered as specified in Appendix A, if the Participating Provider determines orthognathic surgery is dentally necessary and authorizes the orthognathic surgery for treatment of an Enrollee who is under the age of 19 with congenital or developmental malformations.

5.2.3 Endodontic Retreatment.

a. When the initial root canal therapy was performed by the Participating Provider, the retreatment of the root canal therapy will be covered as part of the initial treatment for the first 24 months. After 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 the Participating Provider will be subject to the applicable Copayments.

5.2.4 General Anesthesia. General anesthesia is covered with the Copayments specified in Appendix A only if the following criteria are met:

a. It is performed in a dental office;
b. It is provided in conjunction with a Covered Service; and
c. The Participating Provider determines that it is necessary because the Enrollee is under age 7, developmentally disabled, or physically handicapped.

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

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

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

a. A tooth within an existing denture or bridge is extracted;
b. The existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration cannot be made serviceable; or
c. The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under the Contract, and replacement by a permanent denture is necessary.

5.2.7 Restorations. Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Participating Provider. Crowns, casts, or other indirect fabricated restorations are dentally necessary if provided for treatment for decay, traumatic injury, or substantial loss of tooth structure undermining one or more cusps and the tooth cannot be restored with a direct restorative material or the tooth is an abutment to a covered partial denture or fixed bridge.

Section 6 Termination Provisions

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

6.1.1 On the date the Contract is terminated.

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

6.1.3 On the last day of the month during which eligibility ends or continuation rights expire.

6.1.4 On the last day of the month with 30 days' prior written notice to the Enrollee of good cause for termination. Good cause includes, but is not limited to, a documented inability to establish or maintain an appropriate provider-patient relationship with the Participating Provider, threats or abuse towards the Participating Provider, office staff, or other patients, or nonpayment of Copayments.

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

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

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

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

6.4.1 Federal or State Mandated Continuation Coverage. Coverage for Enrollees may continue during a leave of absence taken in accordance with any federally-mandated or state-mandated leave act or law.

6.4.2 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 would ordinarily end. Federal law governs COBRA continuation rights and obligations. The Policyholder is responsible for administering COBRA continuation coverage.

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

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

If coverage is no longer available to the Member under the Contract, then the Member may purchase an individual dental plan from the Company at a premium rate consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

6.4.4 Leave of Absence. Coverage may continue in any of the following circumstances:

a. When the law governing a Member's approved leave mandates continuation of benefits (e.g. Family and Medical Leave Act, Uniformed Services Employment and Reemployment Rights Act, Washington Paid Family & Medical Leave). Continuation of benefits during such leave runs concurrently with, but is not necessarily limited by, the six-month time frame in item 2. below.
b. While in an approved continuous paid or unpaid leave from work for up to six-months in a rolling 12-month period (excluding personal unpaid leave).
    1. Six months will mean a total of six (6) one-month periods (e.g. February 1 – July 31).
    2. Rolling 12-month period will be determined by looking back from the month the approved leave begins.
c. For the calendar month immediately following any month in which a Member is in paid status (including pay for time worked and paid leave received through the City of Bellevue) for at least an average of 30 or more hours per week or 130 hours in a calendar month.

If an employee is on personal unpaid leave, coverage will end the last day of the month in which the employee ceases to work at least an average of 30 or more hours per week or 130 hours in a given month.

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

6.5 Reinstatement. Coverage will be reinstated effective on the first day of the month following the date the employee satisfies the plan eligibility requirements.

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

6.6.1 Crowns or Bridges. Adjustments for crowns or bridges will be covered for up to 6 months after placement, if the final impressions are taken prior to termination and the crown or bridge is placed no later than 60 days after termination.

6.6.2 Removable Prosthetic Devices. Adjustments for removable prosthetic devices will be covered for up to 6 months after placement, if final impressions are taken prior to termination and the prosthesis is delivered no later than 60 days after termination. Laboratory relines are not covered after termination.

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

6.6.4 Root Canal Therapy. The completion of root canal therapy will be covered if the root canal is started prior to termination and treatment is completed no later than 60 days after termination. Pulpal debridement is not a root canal start. If the root canal requires retreatment after 60 days from termination of coverage, retreatment will not be covered. Restorative work following root canal therapy is a separate procedure and not covered after termination.

6.6.5 Extractions. Post-operative checks are covered for 60 days from the date of the extraction for extractions performed prior to termination. If teeth are extracted in preparation for a prosthetic device and coverage terminates prior to the final impressions, coverage for the prosthetic device will not be extended. Extractions are a separate procedure from prosthetic procedures.

Section 7 General Provisions

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

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

a. Be subrogated to the rights of the Enrollee to recover the Reasonable Cash Value of the Covered Services provided; and
b. Have security interests in any damage recoveries to the extent of all payments made or the Reasonable Cash Value of the Covered Services provided, subject to the limitations specified below.

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

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

7.1.3 The Enrollee is entitled to be fully compensated for the loss. After the Enrollee has been fully compensated for the loss, the Company and Participating Provider are entitled to the remaining proceeds of any settlement or judgment that results in a recovery from the third party or third party's insurer(s) up to the Reasonable Cash Value of the Covered Services provided.

7.1.4 Services payable under any motor vehicle medical, motor vehicle no-fault, underinsured or uninsured motorist, personal injury protection, homeowner's, commercial premises coverage, workers' compensation, or other similar contract or insurance are not covered.

7.2 Complaints, Grievances, and Appeals.

7.2.1 Complaints.

a. Enrollees are encouraged to discuss matters regarding service, care, or treatment with the Participating Provider and Participating Provider's staff. Most matters can be resolved with the Participating Provider and Participating Provider's staff.
b. If the Enrollee requests a specific service, the Participating Provider will use his/her judgment to determine if the service is dentally necessary. The Participating Provider will recommend the most appropriate course of treatment.
c. Enrollees may also contact the Member Services Department with questions or complaints at:

Willamette Dental of Washington, Inc.
Attn: Member Services
6950 NE Campus Way
Hillsboro, OR 97124-5611
1.855.4DENTAL (1-855-433-6825)

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

7.2.2 Grievances.

a. A grievance is a written complaint expressing dissatisfaction with a service provided by the Company or other matters related to the Contract. The Enrollee should outline his/her concerns and specific request in writing. The Enrollee may submit comments, documents, and other relevant information. Grievances must be submitted to the Member Services Department no later than 180 days after the event occurred.
b. The Company will review the grievance and all information submitted. The Company will provide a written reply no later than 30 days after receipt. If additional time is needed, the Company will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws. If the grievance involves:
    1. A preauthorization, the Company will provide a written reply no later than 15 days after the receipt of a written grievance.
    2. Services deemed Experimental or Investigational, the Company will provide a written reply no later than 20 working days after the receipt of a written grievance.
    3. Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours of the receipt of a written grievance.
c. If the grievance is denied, the written reply will include information about the basis for the decision, how to appeal, and other disclosures as required under state and federal laws.

7.2.3 Appeals.

a. An appeal is a request for review of a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. An appeal must be submitted in writing to the Member Services Department no later than 180 days after the date of the denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a Covered Service. The Enrollee should indicate the reason for the appeal and may include written comments, documents, records, or any relevant information.
b. The Company will review the appeal and all information submitted. The Company will provide a written reply no later than 60 days after the receipt of a written request for an appeal. If the appeal involves:
    1. A preauthorization, the Company will provide a written reply no later than 30 days after the receipt of a written request for an appeal.
    2. Services deemed Experimental or Investigational, the Company will provide a written reply no later than 20 working days after the receipt of a written request for an appeal.
    3. Services not yet provided for an alleged Dental Emergency, the Company will provide a reply no later than 72 hours of the receipt of a written request for an appeal.

c. If the appeal is denied, the written reply will include the basis for the decision and other disclosures as required under state and federal laws.

7.2.4 Authorized Representative. Enrollees may authorize another person to represent the Enrollee and to whom the Company can communicate regarding a specific grievance or appeal. The authorization must be in writing and signed by the Enrollee. The appeal process for an appeal submitted by a representative of the Enrollee will not commence until this authorization is received. If the written authorization is not received by the Company, the grievance or appeal will be closed.

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

7.4 Modification of Contract. Modification of the Contract becomes binding when it is in writing and signed by an officer of the Company.

7.5 Force Majeure. If the provision of benefits available under the Contract is delayed or rendered impractical 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 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 Premium 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.

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

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

7.8 Notices. Notices required by the Contract must be in writing and sent by first-class United States Mail, overnight delivery service, personal delivery, or electronic mail. Notices are deemed given when deposited in the United States mail, delivered in person, or sent via email. Notices will be addressed to the Policyholder at his/her last address appearing in the records of the Company, or addressed to the Company at: 6950 NE Campus Way, Hillsboro, OR 97124-5611.

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

7.10 Statements. In the absence of fraud, statements made by the Policyholder or an insured person are representations which the Company may rely upon. Statements made for the purpose of acquiring coverage will not void the coverage or reduce benefits, unless contained in a written instrument signed by the Policyholder or the insured person.

Appendix A - Schedule of Covered Services and Copayments

Office Visit Copayments

General Office Visit Copayment $5
Specialist Office Visit Copayment..... $30

Code	Procedure	Enrollee Pays
1. Diagnostic and Preventive Services		
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under 3 years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed & extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical-first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic image	$0
D0350	2D oral/facial photographic image obtained intraorally or extraorally	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride - excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed - unilateral - per quadrant	$0
D1516	Space maintainer - fixed - bilateral, maxillary	$0
D1517	Space maintainer - fixed - bilateral, mandibular	$0
D1520	Space maintainer - removable - unilateral - per quadrant	$0
D1526	Space maintainer - removable - bilateral, maxillary	$0
D1527	Space maintainer - removable - bilateral, mandibular	$0
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$0
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$0
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$0
D1556	Removal of fixed unilateral space maintainer - per quadrant	$0
D1557	Removal of fixed bilateral space maintainer - maxillary	$0
D1558	Removal of fixed bilateral space maintainer - mandibular	$0
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	$100
D2520	Inlay - metallic - 2 surfaces	$100
D2530	Inlay - metallic - 3 or more surfaces	$100
D2542	Onlay - metallic - 2 surfaces	$100
D2543	Onlay - metallic - 3 surfaces	$100
D2544	Onlay - metallic - 4 or more surfaces	$100
D2610	Inlay - porcelain/ceramic - 1 surface	$100
D2620	Inlay - porcelain/ceramic - 2 surfaces	$100
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$100
D2642	Onlay - porcelain/ceramic - 2 surfaces	$100
D2643	Onlay - porcelain/ceramic - 3 surfaces	$100
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$100

3. Crowns

D2710	Crown - resin based composite (indirect)	$100
D2740	Crown - porcelain/ceramic	$100
D2750	Crown - porcelain fused to high noble metal	$100
D2780	Crown - ¾ cast high noble metal	$100
D2790	Crown - full cast high noble metal	$100
D2910	Re-cement or re-bond inlay, onlay, or partial coverage restoration	$0
D2920	Re-cement or re-bond crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2932	Prefabricated resin crown	$0
D2933	Prefabricated stainless steel crown with resin window	$0
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2954	Prefabricated post and core in addition to crown	$0
D2955	Post removal	$0
D2957	Each additional prefabricated post - same tooth	$0
D2975	Coping	$0
D2980	Crown repair necessitated by restorative material failure	$0

4. Endodontics

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$0
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$0

D3330	Endodontic therapy, molar (excluding final restoration)	$0
D3331	Treatment of root canal obstruction; non-surgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$0
D3347	Retreatment of previous root canal therapy - premolar	$0
D3348	Retreatment of previous root canal therapy - molar	$0
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3352	Apexification/recalcification - interim medication replacement	$0
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3410	Apicoectomy - anterior	$0
D3421	Apicoectomy - premolar (first root)	$0
D3425	Apicoectomy - molar (first root)	$0
D3426	Apicoectomy - (each additional root)	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$0
D3950	Canal preparation and fitting of a preformed dowel or post	$0

5. Periodontics

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$0
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$0
D4240	Gingival flap procedures, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$100
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$100
D4249	Clinical crown lengthening - hard tissue	$100
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$100
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$100
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$0
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$100
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	$100
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	$100
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	$100
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth or edentulous tooth position in the same graft site	$100
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
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluations	$0
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0

D4910	Periodontic maintenance	$0

6. Prosthodontics - Removable

D5110	Complete denture - maxillary	$150
D5120	Complete denture - mandibular	$150
D5130	Immediate denture - maxillary	$150
D5140	Immediate denture - mandibular	$150
D5211	Maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$150
D5212	Mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$150
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$150
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$150
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$150
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$150
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5511	Repair broken complete denture base, mandibular	$0
D5512	Repair broken complete denture base, maxillary	$0
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0
D5611	Repair resin partial denture base, mandibular	$0
D5612	Repair resin partial denture base, maxillary	$0
D5621	Repair cast partial framework, mandibular	$0
D5622	Repair cast partial framework, maxillary	$0
D5630	Repair or replace broken retentive/clasping materials - per tooth	$0
D5640	Replace broken teeth - per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture – per tooth	$0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0
D5710	Rebase complete maxillary denture	$0
D5711	Rebase complete mandibular denture	$0
D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline complete maxillary denture (direct)	$0
D5731	Reline complete mandibular denture (direct)	$0
D5740	Reline maxillary partial denture (direct)	$0
D5741	Reline mandibular partial denture (direct)	$0
D5750	Reline complete maxillary denture (indirect)	$0
D5751	Reline complete mandibular denture (indirect)	$0
D5760	Reline maxillary partial denture (indirect)	$0
D5761	Reline mandibular partial denture (indirect)	$0
D5810	Interim complete denture (maxillary)	$75
D5811	Interim complete denture (mandibular)	$75
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$75
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$75
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D5863	Overdenture - complete maxillary	$150
D5864	Overdenture - partial maxillary	$150

D5865	Overdenture - complete mandibular	$150
D5866	Overdenture - partial mandibular	$150
D5986	Fluoride gel carrier	$0

7. Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$100
D6240	Pontic - porcelain fused to high noble metal	$100
D6241	Pontic - porcelain fused to predominantly base metal	$100
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$100
D6720	Retainer crown - resin with high noble metal	$100
D6750	Retainer crown - porcelain fused to high noble metal	$100
D6780	Retainer crown - ¾ cast high noble metal	$100
D6790	Retainer crown - full cast high noble metal	$100
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

8. Oral Surgery

D7111	Extraction, coronal remnants - primary tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$0
D7220	Removal of impacted tooth - soft tissue	$0
D7230	Removal of impacted tooth - partially bony	$0
D7240	Removal of impacted tooth - completely bony	$0
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$0
D7250	Removal of residual tooth roots (cutting procedure)	$0
D7260	Oroantral fistula closure	$0
D7261	Primary closure of a sinus perforation	$0
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$0
D7280	Exposure of an unerupted tooth	$0
D7283	Placement of device to facilitate eruption of impacted tooth	$0
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$0
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$0
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$0
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	$0
D7510	Incision & drainage of abscess - intraoral soft tissue	$0
D7520	Incision & drainage of abscess - extraoral soft tissue	$0
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	$0
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$0
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$0
D7670	Alveolus - closed reduction, may include stabilization of teeth	$0
D7910	Suture of recent small wounds up to 5 cm	$0
D7911	Complicated suture - up to 5 cm	$0
D7953	Bone replacement graft for ridge preservation - per site	$0
D7961	Buccal / labial frenectomy (frenulectomy)	$0
D7970	Excision of hyperplastic tissue - per arch	$0
D7971	Excision of pericoronal gingiva	$0

	Orthognathic surgery for treatment of congenital anomalies for enrolled Children under age 19 - Subject to a lifetime benefit maximum of $3,000	75% of charges

9. Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9222 & D9223	Deep sedation/general anesthesia	First 30 Minutes: $250 Each Additional 15 Minutes: $0
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$10
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9420	Hospital or ambulatory surgical center call	$125
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9910	Application of desensitizing medicament	$0
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$0
D9951	Occlusal adjustment - limited	$0
D9970	Enamel microabrasion	$0
	Out of Area Emergency Reimbursement (The Enrollee is reimbursed up to $100 per visit.)	All charges in excess of $100

Appendix B - Orthodontic Treatment

1. General Provisions.

a. Orthodontic treatment is covered only if the Participating Provider prepares the treatment plan prior to starting treatment. The treatment plan is based on an examination that must take place while the Enrollee is covered under the Contract. The examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic treatment.

b. The Enrollee must remain covered under the Contract for the entire length of treatment. The Enrollee must follow the post-treatment plan and keep all appointments after the Enrollee is de-banded to avoid additional Copayments.

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

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

e. The Enrollee is responsible for payment of the Copayments listed below for pre-orthodontic and orthodontic services. The Pre-Orthodontic Service Copayments 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 Appendix A is charged at each visit for orthodontic treatment. Services provided in connection with orthodontic treatment are subject to the Service Copayments listed in Appendix A.

2. Pre-Orthodontic Service Copayment.

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

3. Orthodontic Service Copayment.

Comprehensive Orthodontic Service Copayment: $1,200

The following orthodontic procedures are Covered Services under this benefit:

D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

Appendix C - Temporomandibular Joint Disorder Treatment

Temporomandibular Joint Disorder (TMJ) means a disorder that has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint; internal derangements of the temporomandibular joint; arthritic problems with the temporomandibular joint; or an abnormal range of motion or limitation of motion of the temporomandibular joint.

1. Benefits. Benefits for treatment of TMJ are limited to a yearly benefit maximum of $1,000 per Enrollee and a lifetime benefit maximum of $5,000 per Enrollee.

2. Limitations and Exclusions.

a. TMJ treatment is covered only if the Participating Provider prepares the treatment plan prior to starting treatment and provides the treatment.
b. The repair or replacement of lost, stolen, or broken TMJ appliances is not covered.
c. To be covered, the Covered Services must be:
    1) Reasonable and appropriate for the treatment of TMJ;
    2) Effective for the control or elimination of pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food, which is caused by TMJ;
    3) Recognized as effective, in accordance with the professional standard of care;
    4) Not deemed Experimental or Investigational; and
    5) Not primarily intended to improve, alter, or enhance appearance.

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 per implant**. 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 is limited to 1 per calendar year
b. Dental implants to replace an existing bridge or existing denture will not be 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 that was surgically placed prior to the Enrollee's effective date of coverage under the Contract and has not received final restoration.
f. Eposteal, transosteal, endodontic endosseous, or mini dental implants.
g. Maintenance, repair, replacement, or completion of an existing implant that was 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 that was started or placed prior to the effective date of coverage under the Contract.
i. Treatment of a primary or transitional dentition.